Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of August 7–11, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Amarillo VA Health Care System (referred to as the system). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 208 employees. The Medical Center is under the jurisdiction of Veterans Integrated Service Network (VISN) 18.

Results of Review

The CAP review focused on six operational activities. The system complied with selected standards in four areas.

- Breast Cancer Management
- Environment of Care (EOC)
- Quality Management
- Survey of Healthcare Experiences of Patients (SHEP)

We identified two areas that needed additional management attention. To improve operations, we made the following recommendations:

- Strengthen the Contract Community Nursing Home program by improving documentation of discussions on quality indicators, and developing and documenting collaboration with local Ombudsman offices.
- Monitor HbA1c for all patients with diabetes who are receiving atypical antipsychotic medications, and document risk factors for diabetes in the medical record.

This report was prepared under the direction of Ms. Linda G. DeLong, Director, CAP Review Coordinator, Dallas Regional Office of Healthcare Inspections.
VISN and System Director Comments

The VISN 18 and System Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 9–14 for the full text of the Directors’ comments.) We will follow up on planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR, M.D.
Assistant Inspector General for Healthcare Inspections
Introduction

System Profile

Organization. The Amarillo VA Health Care System, Amarillo, TX, is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics located in Lubbock, Stratford, and Childress, Texas; along with Clovis, New Mexico; and Liberal, Kansas. The system is part of VISN 18 and serves a veteran population of about 78,775 in a primary service area that includes 52 counties in the Texas and Oklahoma panhandles, eastern New Mexico and southeast Kansas.

Programs. The system provides medical, surgical, mental health, geriatric, and rehabilitation services and substance abuse treatment. The system has 69 hospital beds and 120 nursing home beds.

Affiliations and Research. The system is affiliated with the Texas Tech University Health Sciences Center and supports 56 medical resident positions in Internal Medicine, Family Practice, and Specialty Care training programs. Other affiliations include Texas Tech University School of Pharmacy, Northeastern State University School of Optometry, West Texas A&M University, and Amarillo College, which provide a variety of educational opportunities in pharmacy, optometry, nursing, and various allied health programs. In fiscal year (FY) 2005, the medical center research program participated in six joint clinical trials.

Resources. In FY 2005, medical care expenditures totaled $104 million. The FY 2006 medical care budget is $110 million. FY 2005 staffing totaled 783 full-time equivalent employees (FTE), including 41 physician and 246 nursing FTE.

Workload. In FY 2005, the system treated 26,861 unique patients. The system provided 13,755 inpatient days of care in the hospital and 42,654 inpatient days of care in the Nursing Home Care Unit. The inpatient care workload totaled 2,754 discharges, and the average daily census, including nursing home patients, was 154. The outpatient workload was 216,117 visits.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG’s efforts to ensure that our Nation’s veterans receive high quality VA health care. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care and quality management.
• Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical records. The review covered the following six activities:

- Breast Cancer Management
- Contract Community Nursing Homes
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care
- Quality Management
- Survey of Healthcare Experiences of Patients

Activities needing improvement are discussed in the Opportunities for Improvement section (page 3). Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

During this review, we also presented fraud and integrity awareness briefings for 208 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Follow-Up on Prior CAP Review Recommendations

We also followed up on selected recommendations from our prior CAP review of the system (Combined Assessment Program Review of the VA Health Care System, Amarillo, Texas, Report Number 04-00566-173, August 9, 2004).
Results of Review

Opportunities for Improvement

Contract Community Nursing Home – Program Oversight Needs To Be Improved

Condition Needing Improvement. The purpose of the Contract Community Nursing Home (CNH) review is to assess Veterans Health Administration (VHA) facility compliance with requirements defined in Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures,* regarding the selection, placement, and monitoring of patients in contract community nursing homes, and the inclusion of patients and family members in this process. The purpose is also to determine if the VHA facility has improved the oversight of VA patients in CNHs to include the services contracted for and appropriate actions taken when problems are identified that adversely affect patient safety and quality of care.

There was no documented evidence that Centers for Medicare and Medicaid Services quality indicators were reviewed or monitored. The CNH Coordinator informed the healthcare inspectors that the quality indicators were discussed during the CNH Inspection Committee meetings, which is the equivalent to the CNH Oversight Committee. The documentation from the committee minutes revealed quality indicators were neither discussed in detail as to the scope, severity, or quantity of deficiencies, nor was the exclusionary review form used. Three of the four nursing homes reviewed were on the National Watch List. The average number of deficiencies for the State of Texas is nine. One of the nursing homes had 22 deficiencies. Additional documentation is needed to ensure the quality indicators are monitored by the CNH Oversight Committee to improve patient care.

There was no documented evidence that the CNH staff met with the local Ombudsman offices. The purpose for interaction with the regional offices is to discuss issues of mutual interest and concern. The CNH Coordinator communicated with the Ombudsman on an as needed basis without documenting the discussion. Annual meetings with the local Ombudsman offices should be conducted, and documentation of the meetings should be indicated on the Certification Report.

**Recommended Improvement Action 1.** We recommend the VISN Director ensure the System Director takes action to (a) improve documentation of discussions on quality indicators and (b) develop and document collaboration with local Ombudsman offices.

---

1 VHA Handbook 1143.2 was issued June 4, 2004.
Diabetes and Atypical Antipsychotic Medications – Improve Monitoring and Managing Hemoglobin A1c and Document Diabetes Risk Factors

Condition Needing Improvement. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient’s risk for the development of diabetes). Clinicians needed to improve monitoring hemoglobin A1c (HbA1c) for patients with diabetes, and document risk factors for diabetes in the medical record.

Criteria. VHA clinical practice guidelines for the management of diabetes suggests that: diabetic patients’ HbA1c, which reflects the average blood glucose level over a period of time, should be less than 9 percent to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dL).

To receive fully satisfactory ratings for these diabetes performance measures, the system must achieve the following scores:

- HbA1c greater than 9 percent (poor glycemic control) – 15 percent (lower percent is better)
- Blood Pressure less than or equal to 140/90mmHg – 72 percent (higher percent is better)
- Cholesterol (LDL-C) less than 120mg/dL – 75 percent (higher percent is better)

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggests that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1 to 3 years. A normal FBG is less than or equal to 110mg/dL. Patients with FBG values greater than 110 mg/dL but less than 126 mg/dL should be counseled about prevention strategies (calorie-restricted diets and exercise). A FBG value that is greater than or equal to 126 mg/dL on at least two occasions is diagnostic for diabetes mellitus.

Findings. We reviewed a random sample of 13 patients who were on 1 or more atypical antipsychotic medications for at least 90 days. The policy for VISN 18 mandates patients taking atypical antipsychotic medications have HbA1c monitored at a baseline, every 3 months, and annually. Three of the 13 medical records reviewed had a diagnosis of diabetes. Eight of the 13 patients have been on the medication several months with the length of time ranging from 18–54 months. Four of the eight have never had an HbA1c test performed. The other four had an HbA1c drawn in July 2006 for the first time. FY 2005 performance measures reflected the lack of monitoring HbA1c for diabetic
patients. A new protocol was implemented, which initiated the four patients getting HbA1c tests performed in July 2006.

The medical record reviews revealed inconsistencies and lack of documentation of diabetes risk factors for 11 of the 13 patients. Diabetes risk factors include components such as a family history of diabetes, tobacco use, weight status, abnormal glucose tolerance test, and diagnosis of hypertension.

<table>
<thead>
<tr>
<th>Diabetic patients with HbA1c greater than 9 percent</th>
<th>Diabetic patients with B/P less than 140/90 mm/Hg</th>
<th>Diabetic patients with LDL-C less than 120mg/dL</th>
<th>Non-diabetic patients appropriately screened</th>
<th>Non-diabetic patients who received diabetes prevention counseling</th>
</tr>
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<tbody>
<tr>
<td>33 percent (1/3)</td>
<td>100 percent (3/3)</td>
<td>67 percent (2/3)</td>
<td>70 percent (7/10)</td>
<td>40 percent (4/10)</td>
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</table>

**Recommended Improvement Action 2.** We recommend the VISN Director ensure the System Director requires clinicians to (a) monitor HbA1c for all patients with diabetes who are receiving atypical antipsychotic medications and (b) document risk factors for diabetes in the medical record.

**Other Observations**

**Breast Cancer Management – Processes Were Timely and Appropriate**

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes.

Mammogram services were offered to the patients by fee-basis providers. Timely radiology, consultative, and treatment services were provided to the patients. When indicated, an interdisciplinary treatment plan was developed, and providers promptly informed the patient of diagnosis and treatment options. The system improved steadily each quarter of FY 2005 in this performance measure.
Environment of Care – No Areas Needed Improvement

The purpose of the evaluation was to determine if VHA maintains a safe and clean healthcare environment. The system must establish a comprehensive EOC program that fully meets all VHA, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. To evaluate EOC, clinical and non-clinical areas are inspected for cleanliness, safety, infection control, and general maintenance.

The system maintained a clean and safe environment with no reportable findings or recommendations.

Quality Management – No Areas Needed Improvement

To evaluate QM activities, we interviewed the system Director, Chief of Staff, Chief Nurse Executive, and QM personnel; and we evaluated plans, policies, and other relevant documents. For the purpose of this review, we defined a comprehensive QM program as including the following program areas:

- QM and Performance Improvement committees, activities, and teams.
- Patient safety functions (including healthcare failure mode and effects analyses, root cause analyses, aggregated reviews, and patient safety goals).
• Risk management (including disclosure of adverse events and administrative investigations related to patient care).
• Utilization management (including admission and continued stay appropriateness reviews).
• Patient complaints management.
• Medication management.
• Medical record documentation reviews.
• Blood and blood products usage reviews.
• Operative and other invasive procedure reviews.
• Reviews of patient outcomes of resuscitation efforts.
• Restraint and seclusion usage reviews.
• Staffing effectiveness analyses.

We evaluated monitoring and improvement efforts in each of the program areas through a series of data management process steps consistent with JCAHO standards and including:

• Identifying problems or potential improvements.
• Gathering and critically analyzing the data.
• Comparing the data analysis results with established goals or benchmarks.
• Identifying specific corrective actions when results do not meet goals.
• Implementing and evaluating actions until the problems are resolved or the improvements are achieved.

We also evaluated whether clinical managers appropriately used the results of quality monitoring in the medical staff reprivileging process. Also, we reviewed mortality analyses to determine the level of system compliance with VHA guidance.

We found that the QM program provided comprehensive oversight of the quality of care. Generally, when problems were identified, actions were taken and adequately evaluated. We found good senior management support and clinician participation. We have no reportable findings or recommendations.

**Survey of Healthcare Experiences of Patients**

Presidential Executive Order 12862 requires agencies to publish customer service standards, survey their respective customers, and use customer feedback information to manage the agency. The Executive Career Field Performance Plan for FY 2006 established that 77 percent of ambulatory care patients and 76 percent of discharged
inpatients must report overall satisfaction of “very good or excellent” in order to meet or exceed target goals for satisfaction.

Following are tables showing the medical center’s SHEP results for inpatients and outpatients.²

The System Director was aware of the SHEP report results for the first 2 quarters of FY 2006, and results had been communicated to the employees. System analysis of the survey results identified three areas targeted for improvement. The system developed action plans based on these results to improve patient emotional support, education and information, and pharmacy pick-up services. As a result, outpatient appointment wait times and timeliness for pharmacy prescription pick-up survey results have improved in the 3rd quarter of FY 2006.

² Plus signs (+) indicate results that are significantly better than the national results.
Department of Veterans Affairs Memorandum

Date: September 28, 2006
From: VISN Director, 10N18
Subject: Amarillo VA Health Care System, Amarillo, Texas
To: Director, Dallas Audit Operations Division

I concur with the attached facility update on the recommendations for improvement contained in the Combined Assessment Program review at the Amarillo VA Health Care System.

Page 4 of this report under “Findings” states, “The policy for VISN 18 mandates patients taking atypical antipsychotic medications have HbA1c monitored at a baseline, every three months, and annually.” While VISN 18 does not have a policy on this topic, there are informal guidelines in place that were developed by the VISN 18 mental health leaders. Our review finds that those guidelines are confusing and they will be appropriately modified to eliminate the confusion.

If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2692.

Patricia A. McKlem
VISN Director’s Comments to Office of Inspector General’s Report

The following VISN Director’s comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

**Recommended Improvement Action** 1. We recommend the VISN Director ensure the System Director takes action to: (a) improve documentation of discussions on quality indicators, and (b) develop and document collaboration with local Ombudsman offices.

Concur Target Completion Date: 12/19/06

See facility Director’s comments.

**Recommended Improvement Action** 2. We recommend the VISN Director ensure the System Director requires clinicians to: (a) monitor HbA1c for all patients with diabetes who are receiving atypical antipsychotic medications, and (b) document risk factors for diabetes in the medical record.

Concur Target Completion Date: 12/29/06

See facility Director’s comments.
System Director Comments

Department of Veterans Affairs

Memorandum

Date: September 22, 2006
From: Director, Amarillo VA Health Care System (504/00)
Subject: CAP Review of the Amarillo VA Health Care System, Amarillo, Texas
To: Director, Veterans Integrated System Network 18 (10N18)

Enclosed, please find our response to the OIG/CAP review of the Amarillo VA Health Care conducted August 7–11, 2006.

I concur with the findings and submit actions to address each recommendation.

BYRON K. JAQUA, CPA, CHE

BYRON K. JAQUA, CPA, CHE
System Director's Comments to Office of Inspector General’s Report

The following System Director’s comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

Recommended Improvement Action 1. We recommend the VISN Director ensure the System Director takes action to: (a) improve documentation of discussions on quality indicators, and (b) develop and document collaboration with local Ombudsman offices.

Concur

Target Completion Date: 12/29/06

(a) In compliance with VHA Handbook 1143.2, the Amarillo Community Nursing Home (CNH) Review Committee will obtain and analyze the Medicare and Medicaid Services (CMS) quality indicator reports of all contracted community nursing home care centers prior to consummation of an initial contract with the AVAHCS, and no less than annually thereafter. The committee reviews of the quality indicator reports, as well as all other necessary state survey reports and information, will be documented in the committee minutes, signed by the Medical Director, Geriatrics and Extended Care (GEC), and copied to the Chief of Staff and to the Director.

(b) In compliance with VHA Handbook 1143.2, the Amarillo Community Nursing Home Review Committee will establish a working relationship with the local Ombudsman office to discuss subjects of mutual interest and concern. At a minimum, a yearly meeting will be held. Confirmation of these meetings will be indicated on the Certification Report. In addition, annual and any out-of-cycle meeting results will be documented in the quarterly CNH Review Committee minutes, signed by the Medical Director, GEC, and copied to the Chief of Staff and to the Director.
**Recommended Improvement Action** 2. We recommend the VISN Director ensure the System Director requires clinicians to: (a) monitor HbA1c for all patients with diabetes who are receiving atypical antipsychotic medications, and (b) document risk factors for diabetes in the medical record.

**Concur**

**Target Completion Date:** 12/29/06

(a) The Amarillo VA Health Care System (AVAHCS) developed a draft policy/protocol in July 2006 in order to improve the consistency of monitoring all patients who are prescribed one or more of the identified atypical antipsychotic medications.

A multidisciplinary workgroup was formed and the following actions were taken:

- Instruction letters were mailed to all patients currently prescribed an identified atypical antipsychotic. Pharmacy Service now generates a monthly list of these patients and Mental Health has developed a spreadsheet for monitoring follow-up.

- Screening clinics were developed and implemented to include baseline screening of past medical history, family medical history, weight, B/P, BMI, lipid profile, fasting blood glucose, and HgA1c. These clinics will be offered on a monthly basis until backlog has been completed. Thereafter, providers will assume screening responsibilities and expectations (order set developed and provider education completed 8/18/06).

- Follow-up monitoring of screening clinics for all out-of range HgA1c, blood glucose, and lipid profiles (triglycerides, cholesterol, HDL and LDL) was implemented. A monthly report is generated for Mental Health, Medical Service and for Primary Care.

- An order set was developed to guide providers in appropriate initial and follow-up monitoring of this patient population (see attached word document).

- A clinical reminder is currently under revision.
• Provider education for Mental Health, Medical Service and Primary Care staff was completed on 8/18/06.

(b) Documentation of risk factors for diabetes in the medical record has been accomplished through the screening clinics as described above.

(c) Page 4 of this report under “Findings” states, “The policy for VISN 18 mandates patients taking atypical antipsychotic medications have HbA1c monitored at a baseline, every three months, and annually.” While VISN 18 does not have a policy on this topic, there are informal guidelines in place that were developed by the VISN 18 mental health leaders. Our review finds that those guidelines are confusing and they will be appropriately modified to eliminate the confusion.
OIG Contact and Staff Acknowledgments

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