



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center Jackson, Mississippi

Office of Inspector General

Combined Assessment Program Reviews

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 services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- 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 May 22, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the G.V. (Sonny) Montgomery VA Medical Center (VAMC or medical center). The purpose of the review was to evaluate selected system operations, focusing on quality management (QM), and selected areas of patient care. During the review, we also provided fraud and integrity awareness training to 169 employees. The medical center is under the jurisdiction of the Veterans Integrated Service Network (VISN) 16.

Results of Review

This CAP review focused on six healthcare areas. The system complied with selected standards in the following two areas:

- Survey of Healthcare Experiences of Patients (SHEP)
- Diabetes and Atypical Antipsychotic Medications

We identified the following organizational strengths:

- Hurricane Katrina Response Efforts
- Governance Council
- Advanced Clinic Access Initiative

We made recommendations in four of the six activities reviewed. For the activities of Environment of Care, Quality Management, Breast Cancer Management, and Contract Nursing Homes (CNH), the medical center needed to:

- Ensure the safety of psychiatric patients subject to improperly draining bathroom showers.
- Perform and document specially required fire drills.
- Ensure all 30-day mortalities and major morbidities associated with surgical procedures undergo peer review.
- Comply with patient safety goals to ensure correct surgery guidelines are followed for invasive procedures performed in non-operating room settings.

- Comply with Veterans Health Administration (VHA) Handbook 1400.1 to ensure surgical resident supervision is properly documented.
- Implement a process for communication of suspicious or abnormal mammography reports to patients and from off-site affiliates.
- Document patient notification of mammography results in patient's medical records.
- Implement a policy to require use of VHA-recommended documents and forms for its CNH program.

This report was prepared under the direction of Ms. Marisa Casado, Director, and Mr. Raymond Tuenge, Associate Director, St. Petersburg Office of Healthcare Inspections.

VISN and Medical Center Director Comments

The VISN Director and the Medical Center Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. See Appendix A, beginning on page 13 for the full text of the Directors' comments. We will follow up on implementation of planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Healthcare System Profile

Organization. Located in Jackson, MS, the medical center consists of a tertiary care facility, a long-term care center, and community based outpatient clinics located in Meadville/Natchez, Meridian, Greenville, Kosciusko, Columbus, and Hattiesburg, MS. The medical center is part of VISN 16 and serves a veteran population of 132,000, including over 11,000 female veterans, in 50 counties in Mississippi and 6 parishes in Louisiana.

Programs. The medical center provides comprehensive outpatient, medical, surgical, psychiatric, and nursing home care services. Additionally, it has programs in physical medicine and rehabilitation, neurology, oncology, radiation therapy, and dentistry. The medical center has 148 hospital beds, 120 nursing home beds, and 15 substance abuse residential program beds. It is a referral center for cardiology, bariatric surgery, and cancer care.

Affiliations and Research. The medical center is affiliated with the University of Mississippi Medical School. It also has affiliations with 20 other university and college programs in nursing, dentistry, pharmacy, physical and occupational therapy, psychology, cytotechnology, medical technology, nuclear medicine, radiology, and health care administration.

Currently, the medical center has 84 approved research projects with 38 principal investigators. Major areas of research include hypertension, mental health and health promotions, and diabetes.

Resources. The medical center's budget in fiscal year (FY) 2005 was approximately \$192 million and over \$207 million in FY 2006. FY 2006 staffing was 1,700 full-time equivalent employees (FTE), which included 137 physician and 759.75 nursing FTE.

Workload. In FY 2005, the medical center treated 47,632 unique patients; in FY 2006 (through April 30, 2006), it treated 46,043 unique patients. In FY 2005, the average daily census was 105 Hospital/Residential and 117 Nursing Home, and in FY 2006 (through April 2006), the average daily census was 99 Hospital/Residential and 116 Nursing Home. The FY 2006 (through April 30, 2006) outpatient workload was 227,740 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 and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care, quality management, benefits, and financial and administrative controls.
- 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 Quality Management and patient care administration. We also conducted an inspection of the medical center's environment of care. QM is the process of monitoring the quality of patient care to identify and correct harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Environment of care is the cleanliness and condition of the facility's patient care areas, the condition of equipment, adherence to clinical standards for infection control and patient safety, and compliance with patient data and medicine security requirements.

In performing the review, we interviewed managers, employees, and patients; and reviewed clinical and administrative records. This review covered the following activities:

Quality Management Program	Environment of Care
Contract Nursing Homes	Breast Cancer Management
Diabetes and Atypical Antipsychotic Medications	Survey of Healthcare Experiences of Patients (SHEP)

The review covered facility operations for FY 2004 and FY 2005 and was done in accordance with VA OIG standard operating procedures for CAP reviews.

During the review, we also presented 4 fraud and integrity awareness briefings for 169 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.

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. We also noted several organizational strengths of the medical center during the course of the review, and we have included a brief description of these organizational strengths in this report.

Results of Review

Organizational Strengths

Hurricane Katrina Response Efforts. The medical center provided invaluable emergency and transition assistance both to victims and to VA employees in response to Hurricane Katrina's impact on the Gulf Coast in August 2005. For the first 4 months of FY 2006, the medical center served 6,772 unique veterans from Katrina disaster areas in Mississippi, Alabama, and Louisiana. In October and November 2005, the medical center's unique patient workload was 12 percent greater than the same 2-month period in FY 2005. Total outpatient visits and primary care visits were 7.4 percent and 13.75 percent higher, respectively. Prior to the hurricane, the majority of Biloxi VAMC specialty care patients were referred to New Orleans VAMC. In the aftermath of Katrina, however, many Biloxi VAMC as well as New Orleans VAMC specialty care patients were referred to Jackson VAMC. In September and November 2005, for example, 336 surgical consults were referred from Biloxi and New Orleans. The medical center's administrative workload also increased significantly. In the 6 months following Katrina, the medical center provided human resources and fiscal support for hundreds of displaced New Orleans medical center staff. The medical center provided employment for approximately 150 New Orleans VAMC personnel and assisted their transition to new employment and relocation.

Governance Council. The medical center has an excellent executive management structure that utilizes a Governance Council made up of its top executives to establish policy, develop strategic plans, provide performance oversight, and review resource and safety/quality management measures. As the medical center's senior interdisciplinary committee, the Governance Council meets bi-monthly to comprehensively review all medical center organizational activities. As such, the Governance Council functions both to provide oversight to other medical center committees and to coordinate their activities. The Governance Council uses an interdisciplinary reporting mechanism that tracks actions arising from all medical center management committees and service areas to ensure that issues are effectively addressed. The Governance Council structure assures that medical center executives provide effective leadership; it also requires them to assume full responsibility for all medical center clinical and administrative operations.

Advanced Clinic Access Initiative. The medical center has committed itself to the principles of Advanced Clinic Access (ACA), VA's national project to reduce patient waiting times and delays in outpatient clinics. The medical center has recruited two ACA Coordinators dedicated to implementation of the ACA practices throughout the medical center and its community clinics. The positive effect of the medical center's implementation of ACA has been demonstrated in FY 2005 overall performance measures, specifically by its ranking second in VISN 16 for quality and satisfaction, in which wait times are an integral component.

Opportunities for Improvement

Environment of Care

Condition Needing Improvement. VA policy requires that patient care areas be clean, sanitary, and maintained to optimize patient safety and infection control. We inspected all patient care areas and found that the medical center was generally clean with environmental employees demonstrating clear “pride of ownership” for their assigned work areas. We identified some general cleanliness issues that required management attention in inpatient areas involving dusting, ongoing interior maintenance, cleaning of clinical equipment, and replacement of damaged furniture. The Chiefs of Facility Management Service and Environmental Management Service were informed and initiated immediate corrective actions for these minor issues. We found additional Environment of Care (EOC) issues requiring further management attention for which we are making recommendations for improvement.

Improper Shower Drainage. We found that inpatient psychiatric bathroom floors were poorly designed, resulting in inadequate shower drainage. The medical center had redesigned and renovated the bathrooms using a design intended to optimize safety for psychiatrically compromised inpatients. However, the floor areas do not contain the flow of water from the shower area into the single floor drain. Water drains out into the main bathroom floor and continues out into the patient rooms, thus creating a slip and fall risk. The medical center was aware of this issue and has received tentative budget approval for a Minor Construction project to renovate the shower areas, but the renovation will not take place until FY 2009.

Interim Life Safety Measures. We found data in the Safety Office that there were Interim Life Safety Measures (ILSM) in place at the medical center. The facility managers elected to conduct two fire drills per shift per quarter in those areas that were under ILSM. We reviewed the medical center’s October 2005 through June 2006 EOC minutes, but found no documentation in the minutes that would validate adherence to ILSM Life Safety Code criteria (EC 5.5) because of the following:

- In the Construction Risk Assessment section (III.B.), the EOC Committee did not identify the construction projects that had ILSM criteria in effect during the reporting period. Furthermore, we found no additional explanation, data, or information on any ILSM conditions or duration in the ILSM section (VIII.D.).
- Under the Fire Safety-Fire Drill section (VIII.A.), fire drills conducted during the reporting period are documented; however, we could not identify the additional fire drills conducted within areas having ILSM conditions.

- There is no discussion or data provided through the EOC Committee that details the existence of any ILSM condition(s) within any construction area at the medical center.

Recommended Improvement Actions 1. The VISN Director should ensure that the Medical Center Director requires that (a) appropriate measures are taken to ensure the safety of psychiatric patients until bathrooms are renovated to correct improperly draining showers and (b) ILSM-mandated fire drills are separately identified and reviewed by the EOC Committee.

Quality Management Program Review

Condition Needing Improvement. The medical center's QM program was comprehensive and generally effective. However, we found four areas where performance improvements were needed.

Peer Reviews. VHA policy¹ requires a formal peer review of all mortalities and major morbidities associated with any surgical procedures within 30 days. We reviewed surgical mortality and morbidity reports for the period March 2005 through March 2006. We found that, for the 48 surgical deaths that occurred within 30 days of surgery at the medical center during that 12-month period, peer reviews were completed on only 32 (67 percent).

Ensuring Correct Surgery. The medical center was cited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in September 2005 for inconsistency in the process for ensuring correct surgery in non-operating room (OR) settings where invasive procedures are performed. VHA Directive 2004-028 provides guidelines to be applied to invasive procedures outside the OR to ensure that such invasive procedures are performed on the correct patient, at the correct site, and if applicable, with the correct implant. We reviewed data showing a compliance rate of 88 percent for non-OR invasive procedures during the period September 15 through December 15, 2005. The medical center's executive summary for FY 2006 shows that the compliance rate for non-OR procedures was 83 percent despite education efforts by the medical center.

Resident Supervision. Lack of documentation of resident supervision was cited in the Peer Review Annual Report for March 2006. Specifically, residents were not documenting the reasons for being called during off-duty hours and were not notifying the attending physician as required. This triggered a review of resident supervision documentation that showed a compliance rate of 55 percent for FY 2005 and 67 percent for the first half of FY 2006. At the time of our review in May 2006, the medical center had initiated intensive efforts to improve documentation of resident supervision. As a

¹ VHA Directive 2004-054, Peer Review for Quality Management, September 29, 2004.

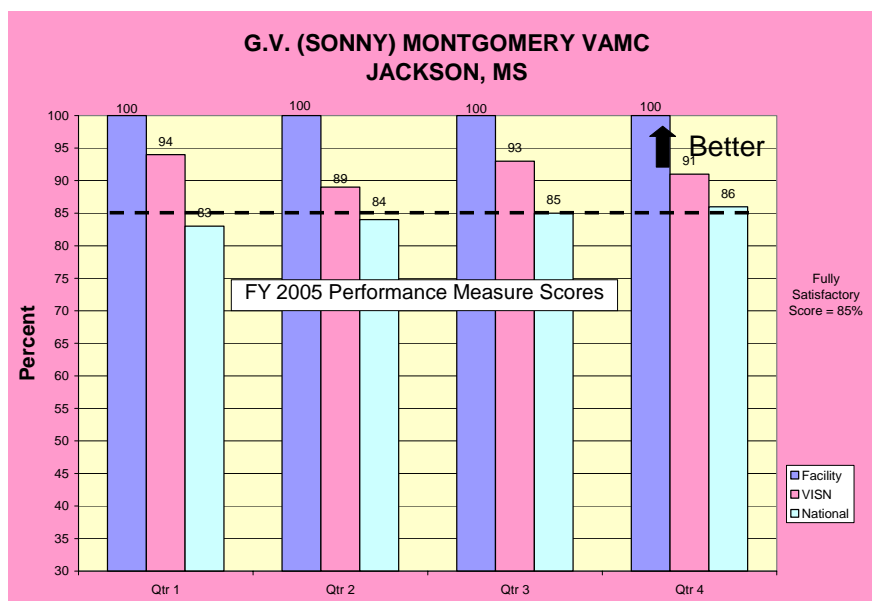
result of the education efforts and monitoring, the medical center had a 94 percent compliance rate for Surgical Service for the period May 1–22, 2006. Further data will be needed to determine if improvement in compliance continues.

Recommended Improvement Actions 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) ensure all 30-day mortalities and major morbidities associated with surgical procedures undergo peer review, (b) comply with patient safety goals to ensure correct surgery guidelines are followed for invasive procedures outside the OR setting, and (c) comply with VHA Handbook 1400.1 to ensure surgical resident supervision is properly documented.

Breast Cancer Management

Condition Needing Improvement. Although the medical center met the VHA performance measure for breast cancer screening in all 4 quarters for FY 2005, we found that the medical center's off-site contract affiliate did not provide results and notify patients as required by VHA policy.² Mammography results were not reported to patients within required timeframes, and there was a lack of documentation that the off-site affiliates forwarded results to the medical center within required timeframes. In addition, patient notification of mammography performed by the off-site was not documented in patient medical records as required by VHA policy.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The chart below shows the VHA's breast cancer management performance for FY 2005:



² VHA Handbook 1104.1, Mammography Standards, August 6, 2003.

Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. VHA mammography standards require normal findings to be documented in the medical record within 30 days of the procedure. Suspicious or abnormal results must be communicated to the ordering provider within 3 working days. Timely results need to be available and accessible to guide patient care and treatment. Furthermore, results must be communicated to patients within 30 days if normal and within 5 days if the results are suggestive of malignancy. We assessed these items in a review of nine patients who were diagnosed with breast cancer or had an abnormal mammography during FY 2005, FY 2004, and FY 2003. The results are shown in the table below:

Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
7/9	8/9	4 /7	4/4	6/6

Clinicians generally had developed coordinated interdisciplinary treatment plans and provided timely Surgery and Hematology/Oncology consultative and treatment services.

However, we determined through further review of medical records that three of seven patients (the other two patients were diagnosed at private facilities) were not notified of their mammography results. Furthermore, patient notifications of mammography performed off-site were not documented in the patients' medical records.

The medical center has a contract with an off-site affiliate to provide mammograms for their patients. We found that communication between the affiliate and the medical center was inadequate to ensure that procedures were completed and the affiliate notified patients according to Mammography Quality Standards Act and VHA policy. We also found that the medical center did not have a means to document that all the patients received timely notification of results. The medical center had no tracking system in process to monitor the patients who were having mammograms off-site. In April 2006, the medical center created a new position for a mammography coordinator to track patients receiving mammograms. The coordinator keeps track of signs of symptoms, schedules appointments, and follows up on results and further treatment.

Recommended Improvement Actions 3. We recommend that the VISN Director ensure that the Medical Center Director takes action to (a) implement a process for communication of suspicious or abnormal mammography reports to patients and from off-site affiliates as required in VHA Handbook 1104.1 and (b) document patient notification of mammography and biopsy results in medical records.

Contract Nursing Homes

Condition Needing Improvement. The medical center's CNH program complied with VHA policies and was generally effectively managed. However, we found that program could be improved through use of VHA's recommended tools for documenting and coordinating CNH programs.

The medical center had seven contracts with CNHs but did not have any patients in those nursing homes at the time of our review. We reviewed policies, existing contracts, minutes of the CNH Oversight Committee, documentation of inspections for 6 CNHs, and medical records of 10 former CNH patients. We interviewed members of the CNH Inspection Team and the CNH Oversight Committee.

We found that the medical center complied with VHA's requirements for the CNH program.³ The CNH Inspection Team performed initial and annual facility inspections using its own internal forms for administrative, social services, and nursing areas. The CNH program social workers and nurses conducted monthly site visits to monitor the care of CNH patients. The medical center's CNH Oversight Committee provided adequate managerial oversight for the program.

Although the medical center currently does not have any patients in CNHs, we conducted a site visit to Tensas Nursing Home in Newellton, LA, during which we interviewed the Administrator and Director of Nursing (DON) and performed a limited inspection of the facility's environment of care. The Administrator and DON expressed a very high level of satisfaction with the professionalism and thoroughness of the medical center CNH staff with whom they interacted on an ongoing basis. We reviewed the files of two former VA patients during our site visit and found that the care provided by the CNH was well-documented and fulfilled the requirements of the contracts and medical center discharge orders.

Although the medical center complied with VHA requirements in the performance and reporting of initial and annual CNH inspections, we found that the CNH program could be improved if the tools recommended by VHA were utilized. The medical center used separate forms to document the various components of initial and annual inspections, such as social work, engineering, and nursing inspections. The medical center did not use the Exclusion Form recommended on the VHA website to document CNH inspections. The Exclusion Form serves to document all the critical aspects of patient care that, if not provided by the CNH, would exclude that CNH from VA participation. The Exclusion Form would thus provide the needed comprehensive documentation of the facility inspections on a single form. The medical center also did not use the CNH adverse event form to document and report adverse events that occur at CNH facilities.

³ VHA Handbook 1143.2, "VHA Community Nursing Home Oversight Procedures."

Although we did not find that adverse events went unreported, use of the VHA-recommended form would ensure that such occurrences are reported.

During our review, the medical center prepared a draft policy that, once implemented, would require the use of the CNH Exclusion Form and Adverse Event Forms.

Recommended Improvement Action 4. We recommended that the VISN Director require the Medical Center Director to approve and implement the draft policy requiring the use of the VHA-recommended documents and forms for its CNH program.

Other Observations

Diabetes and Atypical Antipsychotic Medications

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 blood pressure monitoring and control, review Fasting Blood Glucose (FBG) test results, and improve prevention counseling for patients without diabetes.

VHA clinical practice guidelines for the management of diabetes suggests that: diabetic patients' hemoglobin A1c (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 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 rating for these diabetes performance measures, the medical center must achieve the following scores:

- HbA1c greater than 9 percent (poor Glycemic control) – Goal is 15 percent or lower (lower percent is better).
- Blood Pressure less than 140/90 mmHg – Goal is 72 percent or higher (higher percent is better).
- Cholesterol (LDL-C) less than 120 mg/dl – Goal is 75 percent or more (higher percent is better).

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggests that FBG is the preferred screening test and should be performed every 1-3 years. A normal FBG is less than 110 mg/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 126 mg/dl on at least two occasions is diagnostic for Diabetes Mellitus.

We reviewed medical records for a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days. Only one of the patients had a diagnosis of diabetes. Our review showed that the medical center met or exceeded VHA performance criteria for this diabetic patient, and the 12 applicable non-diabetic patients were appropriately screened and counseled.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with B/P less than 140/90 mm/Hg	Diabetic patients with LDL-C less than 120mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
100 percent (1/1)	0 percent (0/1)	100 Percent (1/1)	92 percent (11/12)	100 percent (10/10)

SHEP Evaluation

Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. The Performance Analysis Center for Excellence of the Office of Quality and Performance is the analytical, methodological, and reporting staff for SHEP. Measure 21 of the VHA Executive Career Field Performance Plan for FY 2006 states that "In FY06 the percent of patients reporting overall satisfaction as Very Good or Excellent will meet or exceed targets" in:

a. Ambulatory Care:

Performance Period: Patients seen October 05–June 06

Meets Target: 77 percent

Exceeds Target: 80 percent

b. Inpatients:

Performance Period: Cumulative October 05–June 06

Meets Target: 76 percent

Exceeds Target: 79 percent

Following are graphs showing the medical center's SHEP results for inpatients and outpatients.

FY2005 3rd & 4th Quarter

**Jackson, MS
VA Medical Center**

INPATIENT SHEP RESULTS

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	80.73	78.27	89.40	67.36	65.08	75.37	83.35	73.98	69.52
VISN 16	80.20	77.70	89.20	67.50	65.90	74.60	82.90	75.1+	69.80
JACKSON VAMC	84.2+	81.5+	91+	75.1+	69.9+	79.5+	82.10	77+	74.4+

1st Quarter FY2006

**Jackson, MS
VA Medical Center**

OUTPATIENT SHEP RESULTS

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	81.5	78	95.3	73.1	83.7	76.2	82.6	66.5	82.2	80.7	85.2
VISN	79.4	79.5	94.7	73.1	83.1	76.5	82.2	66.2	81.3	82	84.9
Outpatient Clinics	83.4	68.9	96.8	71.6	85.2	75.6	78.8	75.1	81.7	78	87.5

The medical center formed a work group to analyze the SHEP results and developed action plans for improvements. The Medical Center identified several areas of improvement in inpatient and outpatient settings to improve continuity of care, education and information, transition, pharmacy pickup, overall coordination, and emotional support. The action plans included the following actions.

- Additional positions for a hospitalist, patient advocate, and nursing supervisor position to assist with low score areas of SHEP.
- A position was created for an inpatient ambassador, in which the ambassador visits patients/family to discuss concerns and assist with problem solving in a timely manner.
- Senior managers provide customer service awards to staff members who go over and beyond job requirements to ensure that patient satisfaction is provided.
- The medical center implemented changes in new employee orientation which includes lunch with senior managers and training by the patient advocate to ensure that all employees are acting as an advocate for patient care.
- The facility has incorporated a patient education resource in their high volume patient areas and the pharmacy; they also plan to open one in the near future in the atrium lobby area.

Senior managers have made and continue to strive to meet patients' needs and address their concerns.

Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 19, 2006

From: Network Director, SCVAHCN (10N16)

Subject: Combined Assessment Program Review of the G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi

To: Marisa Casado, Director, St. Petersburg Office of Healthcare Inspections (54SP)

Margaret Seleski, Director, Management Review Service (10B5)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Actions 1. The VISN Director should ensure that the Medical Center Director requires that: (a) appropriate measures are taken to ensure the safety of psychiatric patients until bathrooms are renovated to correct improperly draining showers, (b) ILSM-mandated fire drills are separately identified and reviewed by the EOC Committee, and (c) the AEMS/MERS system remains the primary information and reporting management tool for tracking EOC work orders until it is officially replaced.

Response to 1(a): Appropriate measures are taken to ensure the safety of psychiatric patients until bathrooms are renovated to correct improperly draining showers.

Concur Target Completion Date: 7/31/06

Planned Action: Although a project has been submitted to renovate the ward and abate the shower drainage issues, immediate actions have been taken to procure non-skid mats that will be changed out daily. The new mats should be in place by 7/31/06.

Response to 1(b): ILSM-mandated fire drills are separately identified and reviewed by the EOC Committee.

Concur Target Completion Date: July 2006

VAMC Jackson will revise the reporting matrix in III.B of the EOC minutes to add columns descriptive of ILSM applicability and estimated project duration.

Project Description	Status/Comments	ILSM Criteria In Effect	Duration
		*	

- *Denotes criteria in effect: extra drills, walkthroughs, ICRA's, etc.*

VAMC Jackson will revise the fire drill reporting matrix in VIII of the EOC minutes to include columns descriptive of ILSM – related conditions and associated project.

DATE	SHIFT	LOCATION	DEVICE	RESPONSE	ILSM Required Y/N & Associated Project	PROBLEM /CRITIQUE

VAMC Jackson will expand discussion in section VIII of the EOC minutes to detail any ILSM conditions within any construction area of the medical center.

Recommended Improvement Actions 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) ensure all 30-day mortalities and major morbidities associated with surgical procedures undergo peer review, (b) comply with patient safety goals to ensure correct surgery guidelines are followed for invasive procedures outside the OR setting, and (c) comply with VHA Handbook 1400.1 to ensure surgical resident supervision is properly documented.

Concur See below for target completion dates.

Response to 2(a): Ensure all 30-day mortalities and major morbidities associated with surgical procedures undergo peer review. **Target Completion Date:** Complete May 2006: Monitoring is ongoing.

Planned Action: The cause of the discrepancy was determined to be due to the method utilized to pull surgical deaths. A canned report existed in the surgical package that Quality Management (QM) was unaware of. Immediately upon being made aware of the report, QM staff obtained access and began utilizing it to ensure that all deaths within 30 days of any procedure including tracheotomies will be peer reviewed.

Response to 2(b): Comply with patient safety goals to ensure correct surgery guidelines are followed for invasive procedures outside the OR setting

Planned Action: Areas performing procedures outside the OR submit a list of procedures to be performed daily to QM. QM reviews procedures for appropriate documentation in the medical record and randomly observes the timeout procedure to ensure the process is done appropriately. Currently, leadership is evaluating further actions to increase compliance. Ongoing monitoring is in place. Current compliance for period of 5/16/06 to 6/17/06 is 91%. **Target Completion Date:** Target met for time period stated above. Monitoring and continuous improvement efforts are ongoing.

Response to 2(c): Comply with VHA Handbook 1400.1 to ensure surgical resident supervision is properly documented.

Planned Action: Concurrent chart reviews are being conducted to ensure that documentation is completed as required. Providers are contacted by chart reviewers if deficiencies are noted that can be corrected timely. Deficiencies not corrected within required timelines are reported to the Director at morning report. The Director meets with individual providers as appropriate.

Compliance rates are as follows:

May: 95% June: 96%

Complete May 2006: Monitoring is ongoing.

Recommended Improvement Actions 3. We recommend that the VISN Director ensure that the Medical Center Director takes action to (a) implement a process for communication of suspicious or abnormal mammography reports to patients and from off-site affiliates as required in VHA Handbook 1104.1 and (b) document patient notification of mammography and biopsy results in medical records.

Concur Target Completion Date: See Below

Response to 3(a): Implement a process for communication of suspicious or abnormal mammography reports to patients and from off-site affiliates as required in VHA Handbook 1104.1

Planned Action: Complete Prior to the IG visit, the medical center had completed a time study on the mammography process. As a result of that study, an additional FTE was added as a Mammography Program Coordinator (MPC). The mammography program coordinator tracks the turnaround time for all mammography procedures including breast biopsies. The off-site affiliate faxes the radiology reports to MPC within 72 hours of procedure date. The MPC scans and codes the reports into Vista Imaging within 24 hours of receipt (or on the same day for Bi Rad 4 and 5 results). Bi Rad reports 3-5 are coded as an abnormality which sends an alert to the provider.

The MPC enters a CPRS note regarding the abnormality and notifies the provider by phone with results.

The MPC sends a patient notification letter for all abnormal and normal reports. The patient is notified of abnormal results, via certified mail, within five business days of mammogram procedure, and of negative results, via regular mail, within 30 business days. The provider also attempts to call the patient with abnormal results and documents such communication in CPRS.

Response to 3(b): Document patient notification of mammography and biopsy results in medical records.

Planned Action: The MPC sends a patient notification letter for all abnormal and normal reports. The patient is notified of abnormal results, via certified mail, within five business days of mammogram procedure, and of negative results, via regular mail, within 30 business days. The provider also attempts to call the patient with abnormal results and documents such communication in CPRS.

The MPC has written an amendment to the letter of agreement (contract) with off-site affiliate to require mammography services be performed in accordance to VHA Handbook 1104.1. Contract is still being negotiated. During the interim, the MPC receives a copy of the certified receipt for VA documentation of patient notification of abnormal results. Negotiations are in progress.

Target Completion Date: 8/15/06

Recommended Improvement Action 4. We recommended that the VISN Director require the Medical Center Director to approve and implement the draft policy requiring the use of the VHA-recommended documents and forms for its CNH program.

Concur **Target Completion Date:** Complete

Response to 4: Planned Action: Complete The Community Nursing Home policy which requires the use of the VHA-recommended documents and forms has been approved and implemented by the Director. One Nursing Home inspection has occurred since the IG visit. The recommended documents and forms outlined in the policy were used during this inspection, and the up-dated information has been entered into the website as required.

(original signed by:)

Robert Lynch, MD

OIG Contact and Staff Acknowledgments

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