Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Alexandria VA Medical Center Pineville, Louisiana

Report No. 06-01521-229 **September 28, 2006**

VA Office of Inspector General
Washington, DC 20420

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 is 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 and regional offices 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 June 26, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Alexandria VA Medical Center (the medical center), Pineville, LA. 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 for 127 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 16.

Results of Review

This CAP review focused on six healthcare areas. The medical center complied with selected standards in the following three areas:

- Survey of Healthcare Experiences of Patients
- Breast Cancer Management
- Contract Community Nursing Homes

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

Quality Management

- Ensure timely completion of peer reviews and incorporate a formal process for surgical morbidity and mortality review.
- Collect, analyze, and trend data on all operative and invasive procedures.
- Disclose adverse events to patients or representatives and document disclosure.
- Provide and document required training on Advanced Cardiac Life Support.

Environment of Care

- Ensure emergency exits are unobstructed.
- Perform appropriate fire/life safety assessments, including employee and patient assessments, for all planned construction projects.
- Ensure all environment of care (EOC) issues are properly reported to the EOC committee, appropriately reviewed and analyzed, and action plans are developed to timely address deficiencies.

Diabetes and Atypical Antipsychotic Medications

- Review diabetes performance measures and develop action plans to meet target thresholds.
- Ensure all patients receiving atypical antipsychotic medications (AAMs) get routine laboratory work-ups, the results are monitored and reviewed with each patient, and the reviews are documented.
- Initiate clinical reminder options in Computerized Patient Record System to complete any diabetic related screens for non-diabetic patients receiving AAMs.

We also followed up on recommendations contained in the previous CAP report dated March 26, 2003, and found that peer reviews were still not consistently reviewed in a timely manner as recommended in that report. The medical center had satisfactorily resolved all other healthcare recommendations contained in that report by the time of this CAP review.

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 and Medical Center Directors agreed with the CAP findings and provided acceptable improvement plans. (See Appendixes A and B, pages 14–18, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. Located in Pineville, Louisiana, the Alexandria VA Medical Center (the medical center) consists of a tertiary care facility, a long-term care center, and community-based outpatient clinics located in Lafayette and Jennings, Louisiana. The medical center is part of Veterans Integrated Service Network (VISN) 16 and serves a veteran population of 100,000 in Mississippi, Louisiana, Arkansas, Oklahoma, southeast Texas, and northwest Florida.

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, and dentistry. The medical center has 114 hospital beds and 154 nursing home beds. The medical center is one of three specialty referral facilities in the VISN for acute and intermediate psychiatric care, receiving long-term psychiatry referrals from network facilities as well as VA facilities in bordering states.

Affiliations and Research. The medical center is affiliated with Tulane University School of Medicine. It also has affiliations with Louisiana State University School of Medicine and 14 allied health professions in nursing, dentistry, pharmacy, physical and occupational therapy, psychology, social work, speech pathology, and healthcare administration. Currently, no research is conducted at this facility.

Resources. The medical center's budget was approximately $123 million in fiscal year (FY) 2005 and $122 million in FY 2006. FY 2006 staffing is 1,070 full-time equivalent employees (FTE), which includes 52 physician and 320.7 nursing FTE.

Workload. In FY 2005, the medical center treated 30,095 unique patients; in FY 2006 (through May 2006), it treated 32,983 unique patients. In FY 2005, the average daily census was 223, and in FY 2006 (through May 2006), the average daily census was 209. The FY 2006 (through May 2006) outpatient workload was 143,888 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 services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on quality management, the facility's environment of care, and selected areas of patient care.

- 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 QM and patient care administration. We also conducted an inspection of the facility's EOC. 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. EOC 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 we reviewed clinical and administrative records. This review covered the following activities:

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

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

During the review, we also presented four fraud and integrity awareness briefings for hospital employees. These briefings, attended by 127 employees, 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 facility 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 assistance in response to Hurricane Katrina's impact on the Gulf Coast in August 2005, primarily by providing pharmacy support for VA facilities incapacitated during the disaster. The medical center's pharmacy workload increased from a monthly average of about 75,000 prescriptions before August 2005 to over 104,000 in October 2005. The increased pharmacy workload continued through January 2006. The pharmacy activated longer outpatient hours and remained open on weekends to serve New Orleans area patients. The pharmacy and other medical center staff worked extended hours and shared duties under difficult circumstances in order to ensure medications were delivered as timely as possible.

Survey of Healthcare Experiences of Patients. As described more fully in the body of this report, the medical center has undertaken commendable efforts in response to the Survey of Healthcare Experiences of Patients (SHEP). The medical center identified five areas needing improvement in both outpatient and inpatient Veterans Health Service Standards (VHSS) scores. Areas of concerns were access, education and information, pharmacy pick-up times, emotional support, and transition. The medical center analyzed the data and implemented effective improvement actions, including several initiatives to decrease wait times, provide educational resources to patients, and improve patient access to care. The medical center has also effectively included SHEP data and improvement measures into their strategic plan.

Community Involvement and Cooperation. The medical center is very involved in community activities. Employees are encouraged to support and become involved in local charities. In 2005, the medical center was awarded the Donor Group of the Year Award for its highly successful blood drives throughout the year. The medical center participates in the Leadership Central Louisiana program sponsored by Louisiana State University and organized the Central Louisiana Healthcare Ethics Coalition to focus on healthcare ethics and establishing ethical standards within the community. The medical center also entered a mutual support agreement with a local fire department to provide coordinated disaster planning and support A successful combined mass disaster drill was held in June 2006.

Opportunities for Improvement

Quality Management Program Review

Conditions Needing Improvement. The QM/Performance Improvement Program was comprehensive and generally effective. However, we found four areas needing improvement.

Peer Review. Veterans Health Administration (VHA) policy[1] requires a formal peer review of all mortalities and major morbidities associated with any surgical procedures within 30 days. We reviewed reports from March 2005 through March 2006 and found that the medical center had 17 surgical deaths within 30 days of the surgical procedures. The staff told us that surgical morbidity and mortality is discussed in the surgical staff meetings and is included in the minutes. However, the minutes do not represent a formal peer review process. The minutes did not indicate the level of care rendered, document whether a consensus of opinion was reached, identify the staff who performed the peer review, or include corrective actions and follow-up monitors for quality improvement.

VHA policy requires that initial review be completed within 45 days and that the peer review committee complete the final review within 120 days. The medical center completed 49 peer reviews from March 2005 through March 2006. We sampled 11 peer reviews and found that all missed one or both timeline requirements. Additionally, we found that four of the peer reviews took over 200 days to complete.

Without timely peer review, the medical center cannot implement required quality and performance improvement measures. The lack of timely peer reviews was also a finding in the previous March 26, 2003, CAP review.

Operative and Invasive Procedure Reviews. The Joint Commission on Accreditation of Healthcare Organizations requires that operative and invasive procedure data be collected and monitored for performance improvement opportunities. In addition, performance measures are used to trend outcomes and to measure whether or not changes are needed to the system-wide process of surgical care.

The medical center did not collect comprehensive data that measured the performance of all operative and invasive procedures over time. They did not critically analyze data or compare the data with internal or external benchmarks. Problems or opportunities were not identified so that specific actions could be implemented. Instead, the medical center relied on surgical infection prevention monitors required for a national VHA project, which did not provide sufficient data for critical analysis of surgical and invasive procedures.

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

Adverse Event Disclosure. VHA policy[2] requires prompt disclosure to patients or their representatives regarding adverse events that occur in the medical center. We reviewed incident reports for the period October 2005 through June 2006 and surgical reports for the period January 2006 through March 2006. We found three adverse events for which there was no documentation in the medical records of required disclosures to patients or their representatives. Two of the adverse events involved medication errors, and one involved a surgical procedure with complications that required further surgery.

Patient Safety. VHA policy[3] requires the medical center to identify those providers who require advanced cardiac life support (ACLS) training and to ensure training of those providers is current. The medical center has an internal policy that requires ACLS training every 2 years and that the training be documented in VHA's Training and Education Management Program (TEMPO) system. We reviewed the training records for 30 Medical Service and Specialty Service clinicians who were required to receive ACLS training every 2 years. We found that for 6 of the 30 (20 percent) providers, ACLS training was not documented in TEMPO; 3 of the 30 (10 percent) providers were beyond the 2-year renewal date.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) ensure timely completion of peer reviews and incorporate a formal process for surgical morbidity and mortality review; (b) collect, analyze, and trend data on all operative and invasive procedures; (c) ensure adverse events are disclosed to patients or family members and the disclosures are documented in the medical records; and (d) improve patient safety by ensuring designated providers are provided ACLS training and the completed training is documented according to medical center policy.

Environment of Care

Conditions 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 numerous conditions requiring management attention. The medical center needs to address life safety and fire safety measures. Also, the medical center needs to place increased emphasis on the general interior cleanliness and appearance of the facility.

Life Safety/Fire Safety Measures. We found two 1st floor stairwell fire exits (North and South stairwells) in the Nursing Home Care Unit (NHCU) that did not provide fire egress because of a major construction project. Both stairwells had 1st floor exterior exits, originally leading to the outside, but the exits were now compromised because of the

[2] Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.
[3] VHA Directive 2002-046, *Staff Training in Cardiopulmonary Resuscitation and Advance Cardiac Life Support*, July 31, 2002.

ongoing NHCU project. Neither exterior exit offered a safe exit pathway for fire or other emergency conditions necessitating evacuation. Signage did not exist on either interior door surface to alert people that the exit was not available. The 1st floor South stairwell was totally blocked, and the 1st floor North stairwell opened into a major construction area, posing significant danger to NHCU patients and staff entering the area. Neither interior door was otherwise secured to prevent evacuees from entering the blocked or unavailable stairwells at the 1st floor level.

The medical center did not sufficiently document life safety/fire safety issues related to the NHCU project. A patient/employee safety review and assessment was required prior to the start of the NHCU expansion project in order to identify the project's impact, explore alternative strategies, and develop training. Medical center staff could not provide documentation of this review.

The medical center did not adequately document that they used appropriate criteria to assess life safety/fire safety issues related to the NHCU expansion project. The Construction Risk Assessment and Fire Safety criteria of the National Fire Protection Association 101, Life Safety Code should have been discussed, reviewed, and approved by medical center management for contractor and patient/employee safety issues. We found no evidence of a review using these criteria in the EOC Committee minutes or in any other medical center management report.

General Environmental Conditions. We toured all inpatient and outpatient operational areas and observed numerous environmental concerns related to cleanliness, maintenance, and appearance, including:

- *Obstructed exhaust vents in patient rooms and clinical examination rooms*. Environmental Management Service and Engineering need to work in concert to clean secondary grids, internal control vanes, and/or dampers to remove built-up dirt and dust. The current condition presents an environment conducive to the growth and development of infection-related organisms.

- *Stained or broken ceiling tiles in outpatient and inpatient areas*. Stained ceiling tile presents an environment permitting the growth of mold and mildew within the moist material of the ceiling tile. This is caused by increased warmth emanating from the non-air conditioned overhead crawl space. Broken ceiling tile permits vector pathways for pests such as ants, fleas, roaches, and/or rodents into patient occupied areas.

- *Damaged plaster/paint at the base of windows and/or below windows in inpatient and outpatient clinical areas.* The type of plaster/paint damage observed indicates a long-term pattern of exposure to water migrating through the exterior walls around windows, across any interior insulation, such as fiberglass, foam, mineral wool, and into interior wall materials. The long-term exposure, combined with

seasonal high temperatures and exterior high humidity, creates an environment highly conducive to the development and growth of mold and mildew. The medical center has identified this as a maintenance issue and developed a Non-Recurring Maintenance project that is awaiting VISN 16 funding approval.

We found that deficiencies identified during EOC rounds were reported to the EOC Committee but lacked detailed deficiency descriptions. The identified deficiencies were not trended or analyzed. Consequently, the EOC Committee did not have sufficient data to review the current ongoing status of identified deficiencies, completed items, and open items.

Recommended Improvement Actions 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) fire exits are unobstructed, unusable exits are clearly marked and secured, and alternative emergency exit procedures are documented through the EOC Committee; (b) comprehensive life safety/fire safety assessments for patients and employees are documented prior to the start of new construction projects; and (c) EOC issues are reported to the EOC Committee, appropriately reviewed and analyzed, and action plans are developed to address deficiencies in a timely manner.

Diabetes and Atypical Antipsychotic Medications

Conditions 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 (AAMs) (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes). Clinicians needed to improve the medical center's diabetes-related performance measures (PMs), monitoring of patients, and counseling for patients without diabetes.

VHA clinical practice guidelines for the management of diabetes suggest that: (a) 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; (b) blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and (c) low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl). To receive a fully satisfactory rating for these diabetes PMs, the medical center 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 140/90 mmHg – 72 percent (higher percent is better)
- Cholesterol (LDL-C) less than 120 mg/dl – 75 percent (higher percent is better)

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (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 the facility's four diabetes-related PMs for 2005. We reviewed medical records for a sample of 13 patients who were on one or more AAMs for at least 90 days in 2005. Only two patients had a diagnosis of diabetes.

Performance Measures. We found the medical center met only 46 percent (6/13) of VHA quarterly PM goals related to diabetes. The PM data showed 3 quarters with "0" data reported. The medical center was unable to indicate whether there were no patients to report or if data were not entered for those 3 quarters. Specifically we found:

- **HbA1c less than 9:** The medical center did not meet PM thresholds for 3 out of 4 quarters (25 percent met); the 4th quarter, "0" data was recorded.
- **LDL-C less than 120:** The medical center did not meet PM thresholds for 4 out of 4 quarters (0 percent met).
- **B/P less than or equal to 140/90:** The medical center did not meet PM thresholds for 1 out of 4 quarters (75 percent met).
- **BP greater than or equal to 160/100:** The medical center did not meet PM thresholds for 2 out of 4 quarters (50 percent met); 2nd and 4th quarters, "0" data was recorded.

Diabetes-Related Testing and Clinical Reminders. We found no evidence the medical center used the date-driven clinical reminder options to complete any diabetic-related screens or laboratory orders such as FBG, HbA1c, LDL-C/D, for routine periodic monitoring of values for non-diabetic patients receiving AAMs. However, the clinical staff were able to demonstrate effective and proactive processes they were planning to initiate within the Computer Patient Record System (CPRS) package to inform clinicians of the need to order both baseline and routine follow-up laboratory tests.

We reviewed medical records for a sample of 13 patients who were on one or more AAMs for at least 90 days in 2005. Only two patients had a diagnosis of diabetes. Our review showed that the medical center met or exceeded VHA performance criteria for these diabetic patients; also the medical center provided diabetes prevention counseling, such as diet and exercise, to 8 of 11 non-diabetic patients reviewed.

Diabetic patients with HbA1c less than 9 percent	Diabetic patients with B/P less or equal to 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 (2/2)	**100 percent (2/2)**	**50 percent (1/2)**	**55 percent (6/11)**	**73 percent (8/11)**

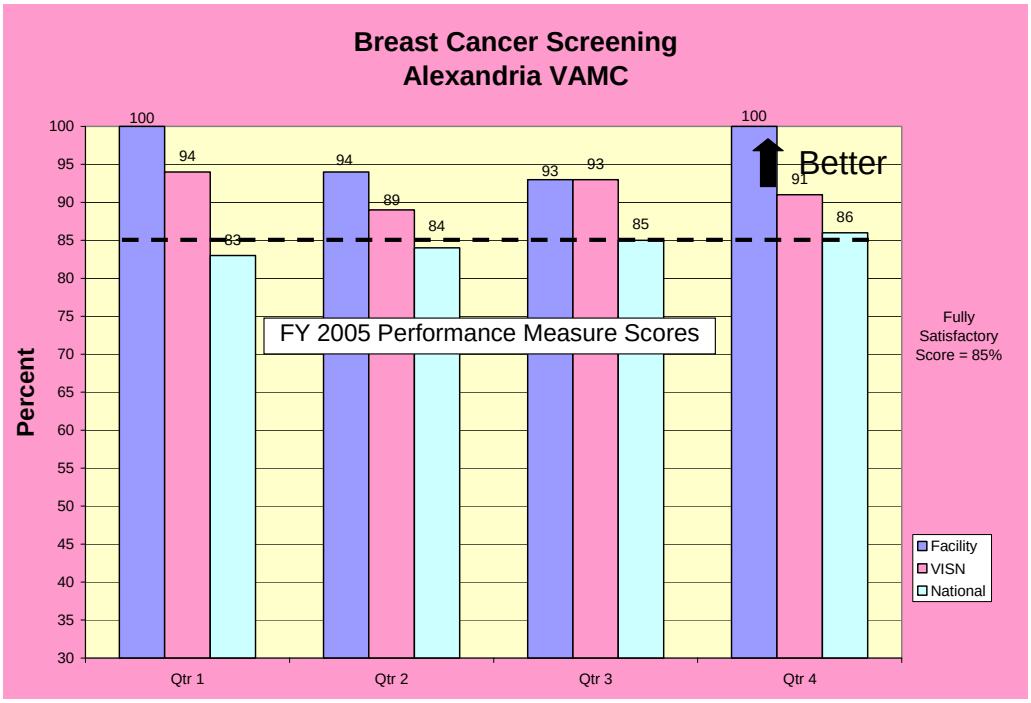
Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to: (a) review PMs related to diabetes and develop an action plan to meet all assigned PM thresholds; (b) initiate the date-driven clinical reminder options in CPRS to complete any diabetic-related screens for non-diabetic patients receiving AAMs; and (c) ensure all patients receiving AAMs get routine laboratory work-ups such as LDL-C, HbA1c, and FBG; the results are monitored and reviewed with each patient; and the reviews are documented.

Other Observations

Breast Cancer Management

The medical center met the VHA PM for breast cancer screening; provided timely Radiology, Surgery, and Oncology consultative and treatment services; promptly informed patients of diagnoses and treatment options; and developed coordinated interdisciplinary treatment plans.

The VHA breast cancer screening PM assesses the percent of patients screened according to prescribed timeframes. The medical center achieved the fully satisfactory level in all 4 quarters in FY 2005. The chart below shows the VHA's breast cancer management performance for FY 2005:



Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We reviewed these items in a random sample of 10 patients who were diagnosed with breast cancer or had abnormal mammography results during FYs 2004 and 2005. The chart on the next page shows the medical center's outcomes from this review:

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
10/10	**10/10**	**10/10**	**3/3**	**7/7**

All 10 patients were screened appropriately, received mammogram results within 30 days, and were notified of their diagnoses. Three of the 10 patients were referred and evaluated for surgery, oncology, and/or radiology consultations in a timely manner. Seven of the 10 patients received timely biopsy procedures after suspicious or highly suspicious mammograms were performed, averaging 10 days from mammography results to biopsy procedure.

Survey of Healthcare Experiences of Patients

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 FY 2006, 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 2005 – June 2006

Meets Target: 77 %

Exceeds Target: 80 %

b. Inpatients

Performance Period: Cumulative October 2005 – June 2006

Meets Target: 76 %

Exceeds Target: 79 %

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

Dates of Survey Reporting period: **Quarter 3, Quarter 4, FY 2005**

Alexandria VA Medical Center

INPATIENT SHEP RESULTS

	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	80.20	77.70	89.20	67.50	65.90	74.60	82.90	75.1+	69.80
Medical Center	82.60	81+	90.90	70.4+	70.2+	78.7+	86.6+	76.7+	73.5+

* Less than 30 Respondents
"+" "-" Indicate Results that are Significantly Better "+" or Worse "-" than the National Average

Dates of survey reporting period: **Quarter 1, FY 2006**

Alexandria 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	72.4 -	78.7	92.3	72.5	83	77.7	79.7	64.6	81.2	83.9	83.5

* Less than 30 Respondents
"+" "-" Indicate Results that are Significantly Better "+" or Worse "-" than the National Average

The medical center identified five areas needing improvement in both outpatient and inpatient VHSS scores. Areas of concerns are access, education and information, pharmacy pick-up times, emotional support, and transition. The medical center analyzed the data and implemented the following actions to increase their VHSS scores:

- Implementing a scripting pilot to decrease wait times in the Primary Care Clinic.
- Following up with access to care by mailing surveys to the patients and analyzing the results.
- Implementing a Drop In Group Medical Appointment clinic that has no waiting list and is available 1 day a week from 8:00 a.m.–12 p.m.
- Educating patients on the automated pharmacy refill process to decrease the wait times for prescription pick-up.
- Providing educational handbooks to patients and families.
- Implementing a "Tell the Director" tool that gives the patients an opportunity to comment on how they feel about the facility and the staff.
- Including SHEP in their strategic plan.

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

Contract Community Nursing Homes

The medical center's Contract Community Nursing Home (CNH) Program complied with VHA policies and was generally effectively managed. The medical center has 18 contracts with CNHs, with 52 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 five CNHs, and medical records of 10 CNH patients. We interviewed members of the CNH Inspection Team and the CNH Oversight Committee. We conducted site visits to Lexington House in Alexandria, LA, and Hilltop in Pineville, LA, during which we interviewed the Administrator and Director of Nursing (DON) and performed a limited inspection of the facility's environment of care.

During our site visits to two CNHs, the Administrator and DON at each facility expressed a very high level of satisfaction with the professionalism and thoroughness of the facility CNH staff with whom they interacted on an ongoing basis. We reviewed facility patient files of six VA patients during our site visits and found that the care provided by the CNHs was well-documented and fulfilled the requirements of the contracts and medical center discharge orders.

The CNH review team completed initial and annual reviews of each facility under contract, which included an analysis of the Centers for Medicare and Medicaid Services Quality Measures. The review team followed the care provided to veteran residents on a monthly basis.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 25, 2006

From: VISN Director

Subject: **Alexandria VA Medical Center, Pineville, Louisiana**

To: John D. Daigh, Jr., M.D, Assistant Inspector General for Healthcare Inspections

Enclosed is the subject draft report. I have reviewed the report and concur with recommendations and actions. If you have any questions regarding the proposed action plans please contact Mary Jones, HSS, at 601-364-7871.

(original signed by:)

Robert Lynch, M.D.,

Network Director, SCVAHCN

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 25, 2006

From: Medical Center Director

Subject: **Alexandria VA Medical Center, Pineville, Louisiana**

To: Network Director, SCVAHCN

Enclosed is the response to the Office of Inspector General Report. I concur with the findings and have provided action plans.

Medical Center 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 Report:

OIG Recommendation(s)

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) ensure timely completion of peer reviews and incorporate a formal process for surgical morbidity and mortality review; (b) collect, analyze, and trend data on all operative and invasive procedures; (c) ensure adverse events are disclosed to patients or family members and the disclosures are documented in the medical records; and (d) improve patient safety by ensuring designated providers are provided ACLS training and the completed training is documented according to medical center policy.

Concur **Target Completion Date:** Date 9/06

(a) Peer Reviews will be monitored on an individual basis to ensure compliance with medical center policy. Peer review timeliness will be tracked utilizing the Peer Review case log. The revised process began in July of 2006. In addition to the implementation of a tracking log and monitoring or peer review status, timeliness of peer review completion will now be a part of all provider's performance appraisals effective July, 2006. The facility's surgical morbidity and mortality review will incorporate the medical centers' Peer Focused Review Process.

(b) Surgical case review for operative and invasive procedures will be review and reported on a quarterly basis and documented in the Quality Leadership Board. Criteria and trending forms will be developed and utilized to document the process.

(c) The medical center has a policy on reporting adverse events that include prompt notification to patients and/or their representative. To enhance compliance, an adverse event disclosure template is available in CPRS to document disclosure. Re-education of staff has been completed.

A tracking mechanism has been developed to assist in identification of non-compliance.

(d) A procedure for recording ACLS/BLS documentation in Tempo is clearly defined. A monthly tracking system has been implemented to track compliance.

Recommended Improvement Actions 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) fire exits are unobstructed, unusable exits are clearly marked and secured, and alternative emergency exit procedures are documented through the EOC Committee; (b) comprehensive life safety/fire safety assessments for patients and employees are documented prior to the start of new construction projects; and (c) EOC issues are reported to the EOC Committee, appropriately reviewed and analyzed, and action plans are developed to address deficiencies in a timely manner.

Concur **Target Completion Date:** Date 9/06

(a) The exit in question has been marked as being "not for fire exit". The distance to nearest alternate fire exit is under 150 feet and meets NFPA 101 criteria. ILSMs are in effect and staff/patients have received training and drills on evacuating the building via the existing alternate exits. Documentation is contained in the July EOC committee minutes.

(b) A comprehensive life safety/fire safety assessment for patients and employees has been implemented and will be accomplished and documented prior to the start of new construction projects.

(c) A formalized aggregate report of environmental deficiencies is being developed and will be documented in the EOC minutes effective September 2006. The report will provide more detailed deficiencies and will establish a mechanism for reviewing, analyzing and correcting trends.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to: (a) review PMs related to diabetes and develop an action plan to meet all assigned PM thresholds; (b) initiate the date-driven clinical reminder options in CPRS to complete any diabetic-related screens for non-diabetic patients receiving AAMs; and (c) ensure all patients receiving AAMs get routine laboratory work-ups such as LDL-C, HbA1c, FBG, the results are monitored and reviewed with each patient, and the reviews are documented.

Concur **Target Completion Date:** Date 10/06

(a) All patients whose 1st blood pressure reading is elevated will have the reading retaken and recorded in the vital sign package. If the 2nd reading is also elevated the provider will be notified for possible intervention. After intervention the blood pressure is reevaluated and recorded.

Patients with LDL-C greater than 120 will have a statin added to their treatment plan or if they are currently on a statin the dosage will be evaluated by the provider and the use of combination drug therapy considered.

Patients with an elevated Hemoglobin A1C will have their compliance to mediation and diet evaluated with appropriate interventions. Patient experiencing difficulty reaching therapeutic levels will be referred as appropriate to the dietitian and, or referral will be sent to the care coordination tele-health program for evaluation for more structured management. Providers have been reminded to utilize the clinical reminders in CPRS

(b) As directed, the data-driven atypical antipsychotic clinical reminder in CPRS was implemented July 1, 2006. This reminder makes available to the provider the most recent weight, height, calculated body mass index, blood pressure, pulse, respiration and lipid profile. The patient is then screened regarding sexual dysfunction and applicable labs/diagnostic tests are ordered for baseline as well as routine follow-up on an annual basis.

(c) The AAMS clinical reminder in CPRS has been in place since July 1, 2006. Testing results are reviewed as soon as available and documented by the provider. Results are reviewed and documented with the patient at the next scheduled visit or sooner should it be warranted. A performance improvement monitor is in place to assess compliance.

Appendix C

OIG Contact and Staff Acknowledgments

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Acknowledgments	Raymond Tuenge, Team Leader Charles Cook David Griffith Annette Robinson Elizabeth Bullock

Appendix D

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