Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Maryland Healthcare System, Baltimore, Maryland

Report No. 06-01831-202 **September 11, 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 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

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted a program review of the VA Maryland Healthcare System (the system) during the week of May 8–12, 2006. The purpose of the review was to evaluate selected system operations focusing on patient care administration, quality management (QM), and administrative management controls. During the review, the Office of Investigations provided 9 fraud and integrity awareness briefings to 521 system employees.

Results of Review

This review focused on seven areas. The system complied with selected standards in the following areas:

- All Employee Survey (AES)
- Survey of Healthcare Experiences of Patients (SHEP)

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

- Strengthen internal administrative controls over the Community Nursing Home (CNH) program.
- Complete Peer Review training and improve timeliness of peer reviews.
- Improve and document adverse event disclosure to patients and families.
- Strengthen analysis of Patient Safety Assessment Code (SAC).
- Establish interdisciplinary treatment team plans for breast cancer patients.
- Eliminate atypical antipsychotic drug refills of over 90 days.
- Implement plans to meet performance measures in diabetes, cholesterol, and blood pressure control.
- Strengthen environment of care practices on telemetry unit.

This report was prepared under the direction of Mr. Randall Snow, JD, Associate Director, and Ms. Carol Torczon, RN, MSN, ACNP, Health Systems Specialist, Washington, DC, Office of Healthcare Inspections.

VISN and Medical Center Director Comments

The Veterans Integrated Service Network (VISN) 5 and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. Management will appoint a Safety Officer to the CNH Review Team and establish a CNH oversight committee with appropriate representation. Measures are being taken to improve peer review training, adverse event procedure training, and to improve compliance with the Veterans Health Administration (VHA) breast cancer screening performance measure. A multidisciplinary group is designing a system to improve the care of patients receiving atypical antipsychotic medications, and systems are being put into place to assure cleanliness and safety of patient care areas. (See Appendixes A and B, pages 15–22, 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

Facility Profile

Organization. As one of the most modern health care programs in the country, the VA Maryland Healthcare System offers veterans state-of-the-art medical technology, clinical services, and research programs. The system, part of the VA Capitol Health Care Network (VISN 5), is home to the world's first filmless radiology department, which allows health care providers to have nearly instant access to patient radiology images throughout the system. Outpatient care is also provided through nine community based outpatient clinics located throughout southern Maryland.

Specialized Programs.

- Geriatric Evaluation and Management Program
- Geriatric Research, Education, and Clinical Center
- Home-Based Primary Care Program
- Mental Illness Research, Education, and Clinical Center
- Multiple Sclerosis Center of Excellence
- Outpatient Spinal Cord Injury Program
- Regional Neurosurgery Program
- Refractory Congestive Heart Failure Program
- Women Veterans Evaluation and Treatment Program

Affiliations and Research. The Maryland Healthcare System has one of the largest funded research and development programs in the VA system, including studies in diabetes, immunology, oncology, virology, cellular biology, and infectious diseases. It is affiliated with the University of Maryland School of Medicine in the sharing of staff, resources, and technology.

Resources. In fiscal year (FY) 2005, system medical care expenditures totaled $207,934,781. FY 2005 staffing was 697 full-time equivalent employees, including 80 physicians and 480 nurses.

Workload. In FY 2005, the system treated 50,961 unique patients. The inpatient care workload totaled 8,487 admissions and the average daily census was 424, including long term care patients. The outpatient care workload was 575,278 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 patient care, quality management, 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 and administrative activities to evaluate the effectiveness of patient care administration, QM, and management controls. 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. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

All Employee Survey
Breast Cancer Management
Diabetes and Patients on Atypical Antipsychotic Medications
Contract Nursing Home Program
Environment of Care
Quality Management
Survey of Healthcare Experiences of Patients

The review covered facility operations for FY 2005 through May 8, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Medical Center Baltimore, Maryland,* Report No. 04-00356-130, April 16, 2004).

During this review, we presented 9 fraud and integrity awareness briefings for 521 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, 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. Activities in the section titled "Other Observations" have no reportable conditions.

Results of Review

Organizational Strengths

Top 10 Best Places To Work

In the March 24, 2006, issue of the Baltimore Business Journal, the VA Maryland Health Care System was officially named as 1 of the 10 Best Places to Work in Baltimore for an organization with 500 or more employees.

The 10 finalists for the Best Places to Work competition were selected based on employee responses to an online survey that was conducted by the Baltimore Business Journal for a 3-week period. The VA Maryland Health Care System competed with over 170 other businesses, health care systems, universities, and financial institutions throughout the state for this prestigious honor. Additionally, the health care system has the unique distinction of being the only Federal agency in Maryland to be named as 1 of the 10 Best Places to Work in Baltimore for 2006.

Opportunities for Improvement

Contract Nursing Home Program

Conditions Needing Improvement. CNH Program Managers needed to improve monitoring and oversight of CNH activities and amend local policies to ensure that veterans receive quality care in safe environments.

Review Team. VHA Handbook 1143.2 requires that a CNH Review Team be established for evaluation of nursing homes that care for veterans. The CNH Review Team must include a registered nurse, a social worker, and other disciplines as appropriate to evaluate areas of non-compliance. Prior to placing a veteran, a Safety Officer must conduct an initial site survey to insure that the nursing home is in compliance with the Life Safety Code. Thereafter, triennial site surveys are conducted unless otherwise indicated by the review process. A Safety Officer was not formally appointed to the CNH Review Team.

Oversight Committee. A CNH Oversight Committee with upper-management level representation needed to be established. VHA policy requires oversight of the CNH Review Team to ensure that veterans receive quality care. Facilities with CNH programs must establish a CNH multidisciplinary oversight committee with upper management representation from social work, nursing, quality management, acquisition, and medical staff, to effectively administer and monitor the program. The committee is established by the Healthcare System Director and is responsible for completing and monitoring

mandated CNH reviews. A draft for the establishment of a CNH Oversight Committee was developed while we were onsite.

Policy. The local policy did not require the frequency of social worker or registered nurse visits mandated by VHA. VHA regulations require monthly visits if patients are within a 50-mile catchment area and biannual visits if beyond the catchment area and no patient/treatment issues are indicated. The local policy only required yearly visits for long term placement patients without regard to any other patient/treatment issues. A draft of the revised local CNH policy was developed while we were onsite.

Reporting Events. VHA policy requires sentinel events or adverse patient occurrences discovered in nursing homes to be immediately reported to the System Director, the Network Geriatrics and Extended Care Office, and the Geriatric and Extended Care Strategic Health Group via the Certification Report on the VA's CNH Website. In two cases where CNH patients experienced adverse events, program managers did not report or document the incidents as required.

Recommended Improvement Action 1: We recommend that the VISN Director ensure that the System Director: (a) formally appoint a Safety Officer to the CNH Review Team, (b) establish a CNH oversight committee with multidisciplinary upper- management level representation, (c) amend local policy to meet VHA requirements for frequency of social work and nurse visits to patients in CNHs, and (d) use VA Nursing Home evaluation tools to report adverse events and improve communication between nursing homes and CNH program managers.

Quality Management

Conditions Needing Improvement. The QM program was generally effective, with appropriate review structures in place for 12 of the 14 program activities reviewed. However the peer review process, disclosure of adverse events to patients, and the Safety Assessment Code (SAC) scoring of adverse events needed improvement.

Peer Review Process. Peer review is the ongoing evaluation of a provider's professional performance by their colleagues. VHA policy requires adverse events be peer reviewed by healthcare providers within 45 days of discovery of an event and that Peer Review Committee members receive specialized training to perform peer review duties. The majority of peer review cases did not meet the timeliness standard, nor was peer review training accomplished. We reviewed 23 cases identified for peer review in Calendar Year 2005. Four cases were reviewed within the 45-day standard, while 19 were not. Of these 19 reviews, 3 were unfinished after 8 months and 1 was unfinished after 2 years.

Adverse Event Disclosure. When serious adverse events occur as a result of patient care, VHA policy requires staff to discuss the events with patients, inform them of their right to file tort or benefit claims, and document the notification in the patient's medical

record. In a sample of 27 patients who experienced adverse events from January 2005 through May 2006, we found 15 patient medical records with no documentation of patient notification, 12 patient records with minimal notification documentation, and only 2 of these 12 documented advisement of the right to file tort or benefit claims. Documentation of patient notification separate from the patient medical record was included on the system's Incident Report form. However, this documentation was incomplete and did not meet VHA standards.

Safety Assessment Code.[1] In accordance with VHA Policy, QM staff investigate adverse events and assign a SAC score, which dictates whether any further definitive action (peer review, patient notification, or initiation of a root cause analysis) is required concerning a particular incident. Eight adverse events that resulted in hip fractures were reviewed. Four of the eight were assigned a SAC score that was too low for the adverse event experienced.

Recommended Improvement Action 2: We recommend that the VISN Director ensure that the System Director requires: (a) implementation and completion of a peer reviewing training program for providers and Peer Review Committee members, (b) providers performing peer review meet the 45-day completion requirement, (c) responsible clinicians to fully inform patients who experience adverse events, and (d) QM Staff to completely review adverse events and the recommended patient treatment plan prior to assigning the SAC score.

Breast Cancer Management

Conditions Needing Improvement. Clinicians need to ensure that the number of women receiving breast cancer screening (mammography) services meets or exceeds VHA's established performance target of 85 percent. In addition responsible clinicians needed to document the interdisciplinary treatment plan in each patient's VA medical record.

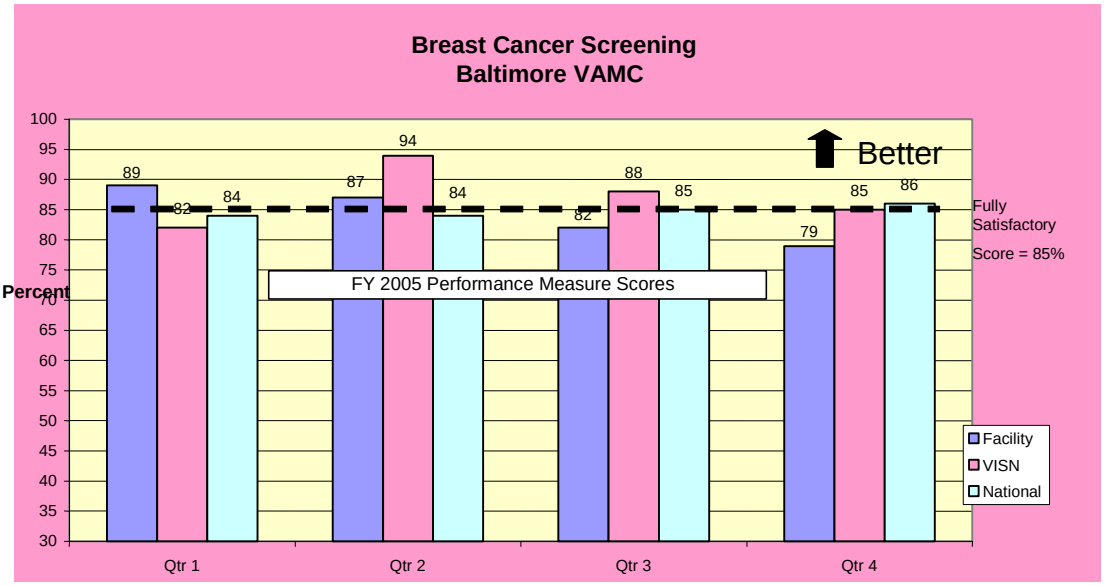
VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a sample of eight patients who were newly diagnosed with breast cancer. To determine compliance we used standards outlined in VHA and local policies.

Screening and Referral. The system did not meet the VHA performance measure for breast cancer screening in 2 of the 4 quarters for FY 2005, as indicated in the following

[1] The SAC score determines the severity of the adverse event and the probability of the event occurring again. SAC scores include a severity category with a probability category for either an actual event or close call, with a ranked matrix score of 3 (highest risk), 2 (intermediate risk), and 1(lowest risk). This SAC score is used for comparative analysis and determining whom to notify about the event.

graph. However, seven of the eight cases we reviewed received appropriate screening, with one case not receiving appropriate screening due to patient issues such as missing scheduled appointments.

Seven of the eight patients received their mammography results within 30 days; one did not, due to difficulty in locating the patient. Six of the eight patients received timely biopsy procedures; two patients did not, due to the system's inability to contact the patient via phone or certified letters. All eight patients received timely consultations for general surgery, hematology/oncology, and radiation therapy; however, none of the eight patients had an interdisciplinary treatment plan documented in their medical record.



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	Documentation of interdisciplinary treatment plan
7/8	7/8	8/8	8/8	6/8	0/8

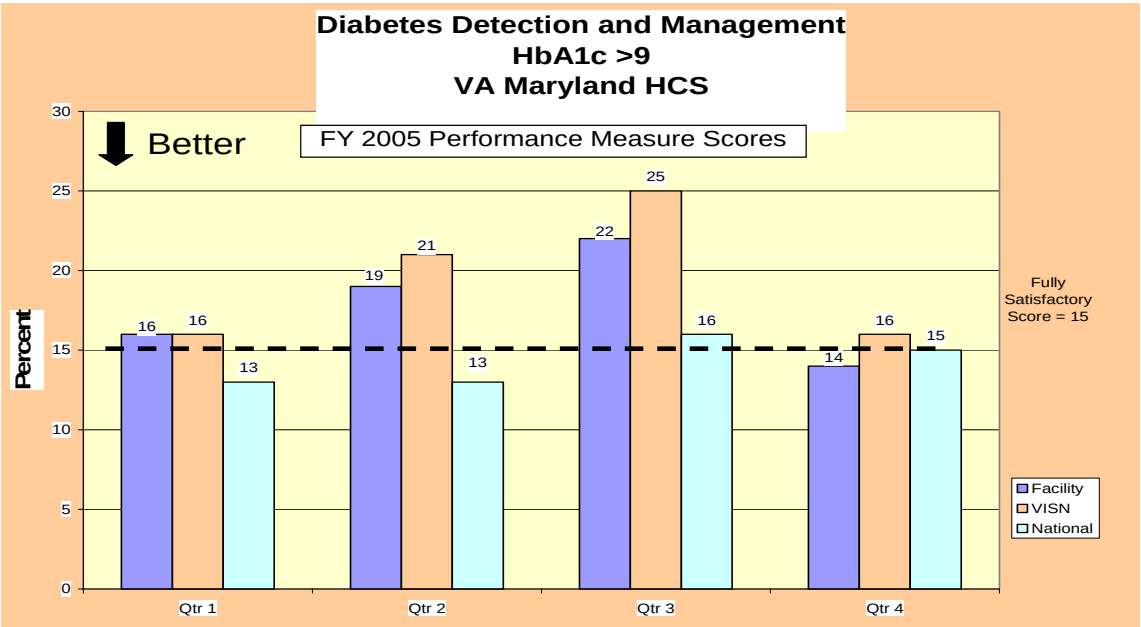
Recommended Improvement Action 3: We recommend that the VISN Director ensure that the System Director take action to (a) improve compliance with VHA's breast cancer screening performance measure and (b) ensure that responsible clinicians document an interdisciplinary treatment plan in each patient's medical record.

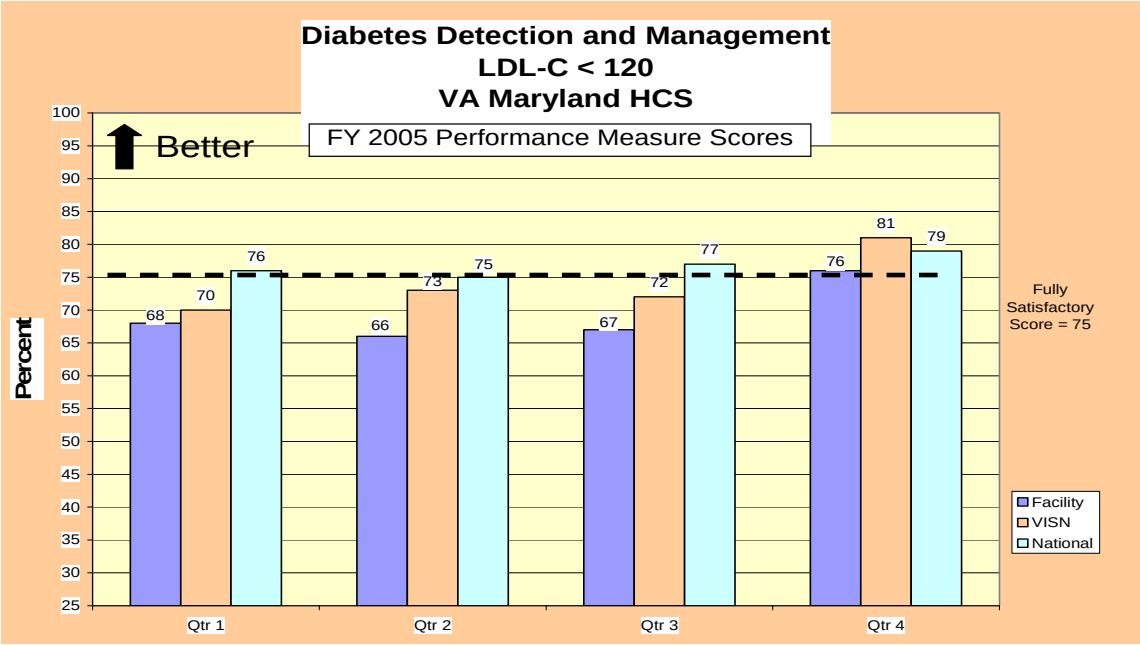
Diabetes and Atypical Antipsychotic Medications

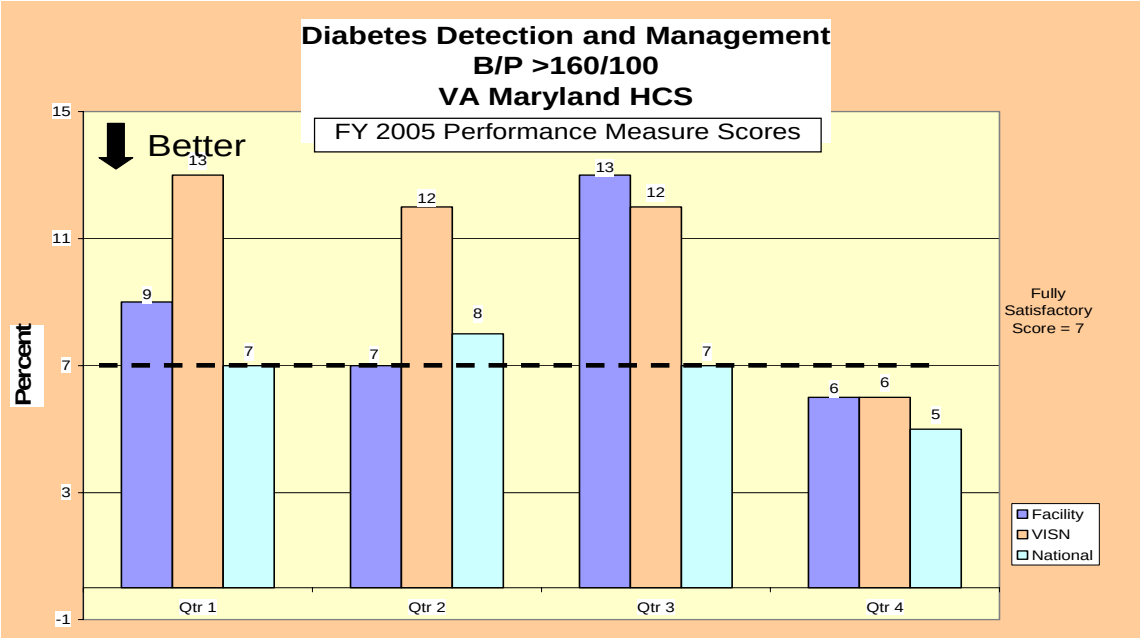
Conditions Needing Improvement. Mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes) require effective diabetes screening, monitoring, and treatment. Clinicians needed to improve the regularity by which the patients are screened and take a more aggressive, organized approach to management of patients with elevated blood pressures, hyperglycemia, and hyperlipidemia.

VHA clinical practice guidelines suggest that diabetic patients' blood glucose levels be at a therapeutically acceptable level (Hemoglobin A1c below 9 percent) to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90; and low density lipoprotein cholesterol (LDL-C) should be less than 120. The system must meet these standards to receive fully satisfactory ratings for these performance measures.

The system did not meet the VHA performance measures, as shown in the following graphs, for blood pressure, glycemic, or cholesterol control in diabetic patients for FY 2005.







We reviewed a sample of 13 patients who were on 1 or more atypical antipsychotic medications for at least 90 days. Three of the 13 patients had diabetes. Two patients with poor glycemic control (Hemoglobin A1c greater than 9), one patient with a blood pressure of greater than 140/90, and two patients with LDL-C greater than 120 did receive appropriate clinical care to address their conditions.

Seven patients had not been seen by a Primary Care provider for 6 months or more, and two patients had not been seen by a Primary Care provider for at least 2 years.

Four of the 13 patients received 11 prescription refills for the atypical antipsychotic medications. This enabled the patients to continue taking medications without appropriate medical monitoring or interventions. See the table below for a summary of the results of the medical record review.

Diabetic patients with HbA1c > 9 percent	Diabetic patients with B/P > 140/90 mm/Hg	Diabetic patients with LDL-C > 120mg/dl	Non-diabetic patients appropriately screened
2/3	1/3	2/3	10/10

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the System Director requires clinicians to: (a) establish a system for assuring that patients receiving atypical antipsychotic medications are appropriately monitored for the development of diabetes and other drug related complications, such as weight gain; (b) limit the number of allowable refills to prompt the veteran to timely return for evaluation, treatment, and services; and (c) ensure that Mental Health patients are provided with the opportunity to be followed in Primary Care.

Environment of Care

Conditions Needing Improvement. VHA regulations require that the hospital environment present minimal risk to patients, employees, and visitors, and that infection control practices are employed to reduce the risk of hospital-acquired infections. We inspected the system medical facilities in Baltimore, Perry Point, and the Baltimore Rehabilitation and Extended Care Center facility.

Unit 3B, the Telemetry Unit at the main Baltimore facility, required management attention for the following:

- Cleanliness and infection control measures needed monitoring in occupied patient rooms and patient rooms prepared for new admissions—furniture, walls, floor, and bathrooms needed cleaning.

- Unattended, stored equipment blocked the emergency egress corridors. The Joint Commission on Accreditation of Healthcare Organizations identified the same condition during an October 2005 inspection.

- Protection of patient confidentiality in accordance with the Privacy Act and Health Insurance Portability and Accountability Act needed strengthening. Sensitive patient information was displayed on an unattended computer terminal.

Recommended Improvement Action 5. We recommend that the VISN Director ensure that the System Director requires that: (a) patient areas are clean, (b) egress corridors remain open and unobstructed, and (c) computer terminals are secured when left unattended.

Other Observations

All Employee Survey

The Executive Career Field (ECF) Performance Plan for FY 2005 directs that the VISN will ensure that results from the 2004 AES are widely disseminated throughout the network by, at a minimum, conducting a town hall meeting open to all employees at each facility during the rating period. VISNs are to have analysis of the 2004 AES results, with formulation of plans to address action items for improvements, completed by September 30, 2004. Plans must demonstrate milestones that include time lines and measures that assess achievement.

The system met all requirements of this performance measure in the ECF performance plan for FY 2005. The AES site coordinator obtained survey results, and analyzed them with the assistance of the National Center for Organizational Development. The results were distributed throughout the system by hard copy and email. System analysis of the survey results included review of low scores on a facility and service line level. An action plan was developed by the deadline of September 30, 2004. Three areas needing improvement were identified for the system, and more areas were identified on the service line and unit level. The action plans, developed by the service line managers and designated work groups, have measurable objectives with identified timelines and milestones. Actions taken to improve the work environment are well documented.

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 & Performance is the analytical, methodological, and reporting staff for SHEP. Measure 21 of the VHA ECF Performance Plan for FY 2006 requires that in FY06 the percent of patients reporting overall satisfaction of Very Good or Excellent will meet or exceed targets in:

Ambulatory Care
Performance Period: Patients seen October 05–June 06
Meets Target: 77%
Exceeds Target: 80%

Inpatients: For Inpatients discharged October 04–June 05
Performance Period: Cumulative October 05–June 06
Meets Target: 76%
Exceeds Target: 79%

The following graphs show the system's SHEP results for inpatients and outpatients.

Dates of Survey Reporting period:
Q3, Q4 2005

VA Maryland Healthcare System

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	75.8-	74.5-	85.1-	63.2-	60.1-	74.40	79.6-	69-	66.9-
Medical Center	70.4-	71.1-	83.8-	59.7-	57.6-	73.00	77.9-	67.7-	66.70

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

Dates of survey reporting period:
Q1 2006

VA Maryland Healthcare System

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	**81.2**	**76.4**	**95.1**	**71.5**	**82.6**	**76.6**	**76.5**	**63.7**	**81.3**	**77.9**	**85.1**
Outpatient Clinics	77.3	68.1	93.9	68.7	79.2	74.7	71.1	61.8	79.1	73.3	82.7
_ BALTIMORE OUTPATIENT CLINIC	71.6	61	94.1	65	75.2	71	69.8	*	76.2	71.6	79.6
_ PERRY POINT OUTPATIENT CLINIC	78.8	71.3	88.5	61	74.8	73.7	*	77	73.8	*	85.5
_ CAMBRIDGE OUTPATIENT CLINIC	84.3	80.9	98.8 +	78.4	86.3	82.4	69	*	86.8	79	88.8
_ GLEN BURNIE OUTPATIENT CLINIC	91.1 +	87.2	97.5	82.2	91.5 +	84.5 +	93.7	*	88.9 +	82.5	89.3
_ LOCH RAVEN VA OUTPATIENT CLINIC	83.8	71.4	91.9	75.1	86.5	81.1	76.5	*	85.7	71.6	85.9
_ POCOMOKE CITY CBOC	88.7 +	62.9	94.8	73.4	86.4	79.4	76.7	*	85.2	*	87.8
_ FORT HOWARD OUTPATIENT CLINIC	86.9	83.5	95	79.5	89.4	78.1	67.4	*	83.3	82	81.3

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

The system has a Veterans Satisfaction Committee and a Customer Service Advisory Council that analyzes survey data on a current, comprehensive, and continuing basis, identify needed improvement, formulate plans and provide education and support to the service lines. Actions taken include customer service training, Service Recovery Script instruction, and unit and service line specific initiatives. The system continuously conducts inpatient and outpatient surveys.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 13, 2006

From: Network Director, VA Capitol Healthcare Network (10N5)

Subject: **Combined Assessment Program Review of the VA Maryland Healthcare System Baltimore, Maryland**

To: Assistant Inspector General, Office of Healthcare Inspections through: Director, Management Review Service (10B5)

1. Attached please find the action plan for the recommendations from the Office of the Inspector General Combined Assessment Program Review conducted May 8-12, 2006.

2. We appreciate the professionalism demonstrated by your team during this review process.

3. If you have any questions regarding this report, please contact Mr. Dennis H. Smith, Director of the VAMHCS, at 410-605-7016.

(original signed by:)

James J. Nocks, M.D., M.S.H.A.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 11, 2006

From: Medical Center Director

Subject: **Combined Assessment Program Review of the VA Maryland Healthcare System Baltimore, Maryland**

To: Director, Management Review Service (10b5)

1. Attached please find the action plans for the five (5) recommendations from the Office of the Inspector General Combined Assessment Program Review conducted May 8-12, 2006.

2. The professionalism and cooperative manner demonstrated by your team during this review process was appreciated by all.

3. If you have any questions regarding this report, please contact Iris E. Pettigrew, Director, Accreditation and Performance Improvement at 410-605-7009.

(original signed by:)
Dennis H. Smith

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) 1 The VISN Director ensures that the System Director:

(a) Formally appoint a Safety Officer to the CNH Review Team,

(b) Establish a CNH oversight committee with multidisciplinary upper- management level representation,

(c) Amend local policy to meet VHA requirements for frequency of social work and nurse visits to patients in CNH's, and

(d) Use VA Nursing Home evaluation tools to report adverse events and improve communication between nursing homes and CNH program managers.

VAMHCS Concurs - Corrective Actions Follow:

(a) A memorandum from the Medical Center Director was be forwarded to Darwin Benedict and Emmanuel Mbong, Perry Point and Baltimore Safety Managers, appointing them as members of the CNH Review Team. **Completed: June 19, 2006.**

(b) The CNH Oversight Committee has formally been in place since April 2006. Current membership will be expanded to include additional upper management staff. A memorandum from the MC Director was forwarded to the following upper management staff appointing them to the committee:

Iris Hernandez, Associate Chief Nurse, GLTC
Richard Iafolla, Chief, Engineering Service
John O'Brien, Social Work Executive

Completed: June 19, 2006

(c) VAMHCS SOP 102/GLTC – 053, "Community Care – Contract Nursing Home Program" will be revised to amend the frequency of social work and nurse visits to patients in CNHs located more than 50 miles from the VA facility. A draft policy was developed and reviewed for accuracy, while the OIG staff was on-site. The

current SOP will be distributed as a VAMHCS Policy. **Target Date: July 24, 2006.**

(d) The CNH Program staff will adhere to VAMHCS Policy 512-14/RM-006, "Patient Incident Reporting Program" to report any adverse and/or sentinel events. The VA Nursing Home Sentinel and Adverse Event Form, available on the VA Community Nursing Home Web Page, will be used to report sentinel and adverse events to VISN and GEC Strategic Planning Group. **Completed: June 15, 2006**.

OIG Recommendation(s) 2 The VISN Director ensures that the System Director requires:

(a) Implementation and completion of a peer reviewing training program for providers and Peer Review Committee members,

(b) Providers performing peer review meet the 45-day completion requirement,

(c) Responsible clinicians to fully inform patient's who experience adverse events, and,

(d) QM Staff to completely review adverse events and the recommended patient treatment plan prior to assigning the SAC score.

VAMHCS Concurs - Corrective Actions Follow:

(a) All members of the Peer Review Committee have received the training and/or training packet, thus accomplishing the goal of 100% on June 16, 2006. In addition, the Risk Management and Legal Departments presented a widely attended Peer Review training on June 12, 2006. This training will be available as a web-based training on or about July 17, 2006 for individuals that did not attend. As new members are selected they will be required to complete the web-based training if they have not done so previously. TEMPO monitoring will also be used to assure that providers asked to do a review have received the training. The responsible Clinical Center Director will be accountable for determining compliance via TEMPO. If provider has not completed the training the Clinical Center Director is responsible to ensure the requested reviewing provider does so prior to the review. **Target Date: July 17, 2006**

(b) In order to facilitate providers meeting the 45 day review requirement, this information was provided during a training held on June 12, 2006 which will also be available as a web based training. Monthly reminders are sent to Clinical Center Directors concerning pending reviews not yet completed by the initial due date. The current monitoring process will be expanded to include a Pending

Report presented to ECMS monthly, including the compliance within 45 days by month, YTD, and Clinical Center beginning the July 2006 meeting. The level of compliance with this requirement will be added as an evaluative criteria for Clinical Center Director's annual evaluation. **Target Date: Sept. 30, 2006**

(c) Clinicians have previously been made aware that in addition to informing patients of an adverse event, this must specifically be documented in the medical record. The facility included the reinforcement of this requirement at a training held June 12, 2006. The entire training as previously stated will be available as a web based training for those who were unable to attend. The revised disclosure policy is available on the VAMHCS web site. The Adverse Event Template for use in CPRS is activated for use by practitioners for institutional and severe adverse events disclosure. To determine ongoing compliance there will be quarterly monitoring of the need for disclosure for severe adverse events to include CPRS documentation of information concerning filing of tort or benefit claims beginning 4th quarter FY06. The providers are instructed to document on the template or in a progress note in CPRS. Risk Management/Patient Safety will monitor and provide reports to the ECMS. If incomplete documentation is identified, the provider or Clinical Center Director will be notified to determine rationale and have complete documentation entered in CPRS. **Target Date: July 1, 2006**

(d) All patient adverse events are reviewed in conjunction with their treatment plan. To increase the accuracy of the SAC scoring, incident reports will be held until the patient outcome and treatment plan implementation allows for a more complete assessment for questionable patient outcomes. The maximum amount of time they will be held before scoring will be 30 days. For patients already scored during this period, the SAC score will be adjusted if the patient deteriorates or dies. **Completed: June 1, 2006**

OIG Recommendation(s) 3 The VISN Director ensures that the System Director takes action to:

(a) Improve compliance with VHA's breast cancer screening performance measure and,

(b) Ensure that responsible clinicians document an interdisciplinary treatment plan in the patients' medical record.

VAMHCS Concurs - Corrective Actions Follow:

(a) The facility introduced an action plan the beginning of FY06 that included three primary initiatives. The first was the identification and contact of "missed

opportunities", women eligible for breast CA screening but had not received it. On a monthly basis Women's Health reviews future appointment listings for all women to determine if they have received the screening. Those without documented screening are contacted to encourage appointment scheduling or document if screening was performed elsewhere. The second action is to improve provider documentation by educating them in the use of reminders and obtaining information on outside screening performed. The third action is to implement education and discussion with patients to avoid refusal or reverse a refusal. The action plan is reported to and monitored routinely by the EPRP Committee and this process is ongoing. Since the introduction of the Action Plan, results are as follows: 1st quarter 06 - 95.4%, 2nd quarter 06 - 89 % and the first 2 months of 3rd quarter 06 - 86% (preliminary). **Completed: Sept. 2005**

(b) The Women's Health Program will have the primary responsibility for assuring that clinicians document an interdisciplinary treatment plan in the patient's medical record. All women with a diagnosis of breast CA will be seen at UMMS or a provider of their choice and evaluated by a breast interdisciplinary team. Results of this evaluation will be included in the patient's medical record (paper copy). A quarterly sample of these women will be selected for chart review to determine compliance with inclusion of the interdisciplinary treatment plan. **Target Date: August 2006.**

OIG Recommendation(s) 4 The VISN Director ensures that the System Director requires clinicians to:

(a) Establish a system for assuring that patients receiving atypical antipsychotic medications are appropriately monitored for the development of diabetes and other drug related complications, such as weight gain,

(b) Limit the number of allowable refills to prompt the veteran to timely return for evaluation, treatment, and services, and

(c) Ensure that Mental Health patients are provided with the opportunity to be followed in Primary Care.

VAMHCS Concurs - Corrective Actions Follow:

(a) A group consisting of representatives from Performance Improvement, Psychiatry, Managed Care, Pharmacy, and Endocrinology has been established to design a system to monitor the physical health of patients receiving atypical antipsychotics. The workgroup has developed a computerized template called a Medication Use Evaluation (MUE) which will be required to be used when

prescribing an atypical antipsychotic. The MUE follows the clinical guidelines for monitoring these patients and is mandatory; the atypical medication cannot be ordered without filling out the MUE. The MUE is scheduled to be presented for approval by the Pharmacy and Therapeutics Committee at the July, 2006 meeting. Target Date for implementing the MUE is Aug.1st 2006. Education on the use of the MUE will be provided to those prescribing practitioners who are not already familiar with it. The target date for the completion of the education is July 24, 2006. A chart review will be undertaken quarterly to determine whether the clinical guidelines have been followed. The date of the first review will be November, 2006 and quarterly thereafter. Results of chart review will be shared with involved Service Chiefs and individual providers. This report will occur during the month following the review. A policy outlining the monitoring levels has been drafted and will be published by Aug.1st 2006. **Target Date: Aug. 1, 2006**

(b) Prescription and refills are not to exceed 180 days. This will be accomplished by pharmacy service via an automatic stop order. **Target Date: Aug. 1, 2006.**

(c) All patients are encouraged to enroll in Primary Care. However, since many Mental Health patients may be reluctant to do that, or may be noncompliant with Primary Care appointments, a Mental Health workgroup is in the process of designing a process whereby every Mental Health patient will be able to have certain health parameters such as vital signs and weights checked. The implementation target date is Aug.1st 2006. We are also looking in to the feasibility of doing a mailing to these patients encouraging them to enroll in Primary Care and providing instructions on how to do that. The monitor will be a quarterly chart review to look at whether patients are having their weight and VS taken, and are enrolled in Primary Care. **Target Date: Aug.1, 2006**

OIG Recommendation(s) 5 The VISN Director ensure that the System Director requires that:

(a) Patient areas are clean;

(b) Egress corridors remain open and unobstructed; and

(c) Computer terminals are secured when left unattended.

VAMHCS Concurs - Corrective Actions Follow:

(a) Cleanliness and infection control measure monitoring for occupied and unoccupied patient rooms will be enhanced for 3B and the entire organization. The Facility Administrative Rounds conducts monthly and the weekly EMS rounds will identify rooms/areas that need additional cleaning or detailing. These rounds are conducted throughout the facility at all sites including 3B unit at Baltimore. The weekly rounds have been expanded to include more individuals. The areas identified will be tracked via established system to determine if cleaning requests are accomplished in established time frames. Additionally, EMS is completing a schedule of detailing all rooms on 3B by August 1, 2006 based on availability. All rooms in the facility are scheduled to be detailed quarterly based on room availability. Lastly, Performance Improvement will include in their July newsletter to all staff a reminder concerning everyone's role in environmental cleanliness and safety. **Target Date: August 1, 2006**

(b) The importance of open and unobstructed egress will be reinforced to all staff in the July edition of the Performance Improvement newsletter. Equipment storage is a challenge and reminders will be more frequent. Weekly Administrative and EMS Rounds are conducted and include observation and reporting of any items that obstruct egress throughout the facility. Additionally, egress areas will be added to the charge nurse's checklist for review daily effective July 1, 2006. Monitoring will be accomplished using the findings from the Administrative and EMS rounds to identify individual and recurring problems on an ongoing basis. **Target Date: July 1, 2006**

(c) All employees with computer access are required to review the training for the VHA Privacy Policy and Cyber Security. Supervisors will be held accountable for assuring that their staff has completed the training. Monitoring will again be accomplished during Administrative Rounds as well as during nursing supervisory rounds effective immediately. For repeat offenders disciplinary action will result from responsible supervisors. **Target Date: June 30, 2006**

Appendix C

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Appendix D

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