Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Central Alabama Veterans Health Care System Montgomery, Alabama

Report No. 06-02822-45 **December 15, 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.
- 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 September 25, 2006, the Office of Inspector General conducted a Combined Assessment Program (CAP) review of the Central Alabama Veterans Health Care System (the system), Montgomery, Alabama. 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 142 employees. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 7.

Results of Review

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

- Survey of Healthcare Experiences of Patients
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care

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

QM

- Complete peer reviews within 120 days and ensure quality improvement actions are initiated and measured to achieve goals.
- Disclose and document significant adverse events.
- Implement documentation of the time-out briefing for all required operative and invasive procedures outside the operating room.
- Accurately reconcile medications across the continuum of care.
- Ensure root cause analysis review action items are fully implemented and monitored for process improvement.

Breast Cancer Management

- Implement a process for communication of suspicious or abnormal mammography reports to ordering providers within 3 work days.
- Ensure that the Tumor Registry is maintained.

- Ensure that patients at the contract clinic are monitored by the system.
- Ensure that documentation of all procedures is available in the electronic medical record.

Contract Community Nursing Home

- The Contract Community Nursing Home (CNH) Program will cease operations effective October 1, 2006; therefore, we made no recommendations.

This report was prepared under the direction of Ms. Marisa Casado, Director, St. Petersburg Office of Healthcare Inspections.

VISN Director's Comments

The VISN Director agreed with the CAP review findings and provided acceptable improvement plans (see Appendix A, pages 13–17, for the full text of the VISN 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

System Profile

Organization. The Central Alabama Veterans Health Care System (the system) is a two-division, comprehensive health care system, located in Montgomery and Tuskegee, Alabama. The system provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics located in Dothan, Alabama; and Columbus, Georgia. The system is part of VISN 7 and serves a veteran population of about 134,000 in a primary service area that includes 43 counties in the central and southeastern portions of Alabama and in western Georgia.

Programs. The system provides medical, surgical, mental health, geriatric and rehabilitation services, and nursing home care. The system has 85 hospital beds and 160 nursing home beds, and operates several regional referral and treatment programs, including the Psychosocial Residential Rehabilitation Program, the Post-Traumatic Stress Disorder Program, Substance Abuse Outpatient Program, and the Homeless Domiciliary. The system has sharing agreements with the 42nd Medical Group, Maxwell Air Force Base in Montgomery, Alabama; and Lyster Army Outpatient Clinic in Fort Rucker, Alabama.

Affiliations and Research. The system is affiliated with the Morehouse School of Medicine, an historically black college located in Atlanta, Georgia, and supports three medical resident positions in two training programs. Other affiliations include nursing, podiatry, pharmacy, medical technology, medical records, recreation therapy, social work, psychology, occupational and physical therapy, nutrition and food, audiology and speech pathology, phlebotomy, and imaging. The system does not participate in research activities.

Resources. In fiscal year (FY) 2005, medical care expenditures totaled $146.6 million. The FY 2006 medical care budget was $153.7 million. FY 2006 staffing totaled 1,384.1 full-time equivalent employees (FTE), including 79.4 physician and 382.3 nurse FTE.

Workload. In FY 2005, the system treated 36,547 unique patients. In FY 2006 (through July 2006), the system treated 34,772 unique patients. In FY 2005, the average daily census was 61.4. In FY 2006 (through June 2006), the average daily census was 50.8. The FY 2006 (through June 2006) outpatient workload was 230,748 visits.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the Office of Inspector General's (OIG) 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 (QM), the facility's environment of care (EOC), 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 medication 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	EOC
Contract Community Nursing Homes (CNH)	QM Program
Diabetes and Atypical Antipsychotic Medications	Survey of Healthcare Experiences of Patients (SHEP)

The review covered facility operations for FY 2004, FY 2005, and FY 2006 (through June 2006), 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 health care system employees. These briefings, attended by 142 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 one organizational strength of the system during the course of the review, and we have included a brief description in this report.

Results of Review

Organizational Strength

Surgical Instrument Tracking. The system implemented the use of the Censtitrac System, in which all surgical instruments are laser barcoded and tracked. The Censtitrac System tracks the location of the surgical tray, who assembled the tray, and the instruments assigned to each tray. Additionally, the Censtitrac System produces electronic count sheets and instrument images and flags instruments that are incorrect, missing, or in need of maintenance. Since the implementation of the Censtitrac System, the instrument trays have arrived in the operating room with 100 percent accuracy.

Opportunities for Improvement

QM Program Review

Conditions Needing Improvement. The QM/performance improvement program was comprehensive and generally effective. We found four areas for performance improvement.

Peer Review. Veterans Health Administration (VHA) Directive 2004-054[1] requires that initial peer reviews be completed within 45 days and final reviews closed by the peer review committee in 120 days. We reviewed peer reviews completed during the first, second, and third quarters of FY 2006. We found the average number of days to complete the reviews was 195 days in the first quarter, 84 days in the second quarter, and 139 days in the third quarter. Without timely peer reviews, the system cannot implement required quality and performance improvement measures.

Adverse Event Disclosure. The VHA Directive 2004-049[2] requires prompt disclosure to patients or their representatives regarding adverse events, generally within 24 hours but not later than 72 hours after the practitioner's discovery of the events. We reviewed adverse event reports and found one surgical case that resulted in a significant bladder laceration that required additional emergent surgery and treatment. We found no documentation in the medical record of the required disclosure to the patient.

Patient Safety Goals. We reviewed reports for evidence of compliance with the National Patient Safety Goals. We found two areas needing improvement: (1) the time-out[3] briefing for invasive procedures outside of the operating room (OR) and (2) the medication reconciliation process. We found that the system conducted a time-out

[1] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.
[2] VHA Directive 2005-049, *Disclosure of an Adverse Event*, October 27, 2005.
[3] Procedure in place that requires verification of the correct patient, the correct procedure, the correct site, and the correct implant (where applicable) by personnel prior to the start of the procedure.

briefing for only 63 of 72 invasive procedures (87.5 percent) performed from January through August 2006. VHA Directive 2004-028[4] requires 100 percent compliance to ensure that the correct procedure is performed on the correct patient and site.

Patient Safety Goal number "8" requires that hospitals accurately and completely reconcile all medications across the continuum of care. The system must implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization with the involvement of the patient. This process includes a comparison of the medications the organization provides compared to those on the patient's list. A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization. For calendar year 2006, the system self-reported meeting the goal 50 percent of the time. Just prior to our review, the system published a new medication management policy. No other documentation was produced by the system to show any additional corrective action(s) initiated to meet the goal.

Root Cause Analysis. Using the Severity and Probability Matrix provided by the National Center for Patient Safety,[5] we reviewed two root cause analysis (RCA) reports that received a Safety Assessment Code (SAC) score of "3" from the system's QM staff. A SAC-3 score indicates the existence of an environment in which a patient is vulnerable to actual or potential adverse events described as death, permanent loss of function, or permanent lessening of bodily functions that are not related to the natural course of the patient's illness or underlying condition(s) being treated. In both cases, we found that the RCA reports were not completed in the required 45-day time period, and follow-up actions were incomplete. In addition, one did not include the concurrence signatures. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, requires that once an action plan is implemented, there must be a plan for evaluating the effectiveness to assure that changes have the desired effect. Also, the handbook requires that completion of the RCA should be documented by the concurrence signatures of all appropriate staff. Without evaluation of outcomes, patient safety effectiveness and improvement cannot be determined. Without signatures by all appropriate staff, there cannot be assurance of concurrence with the RCA findings or the action plan for improvement.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Health Care System Director takes action to: (a) complete peer reviews within 120 days and ensure actions for quality improvement are initiated and measured to achieve goals, (b) disclose and document significant adverse events, (c) implement documentation of the time-out briefings for all required operative and invasive procedures outside the OR, (d) accurately reconcile medications across the continuum of

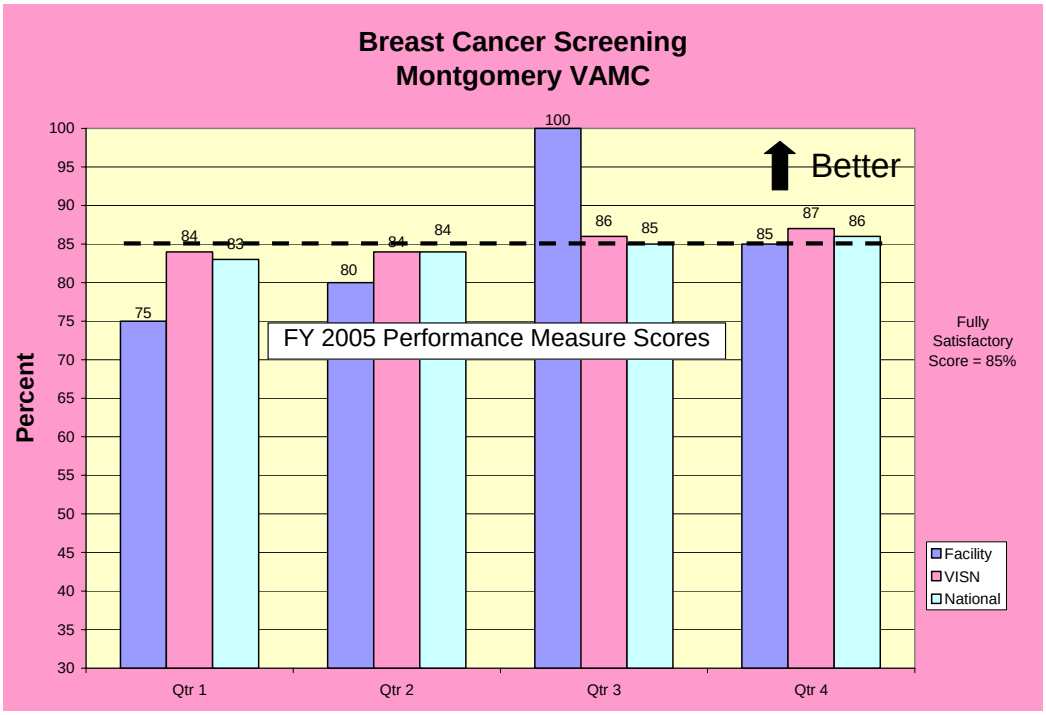
[4] VHA Directive 2004-028, *Ensuring Correct Surgery and Invasive Procedures*, June 25, 2004.
[5] http://vaww.ncps.med.va.gov/Education/PS101/SafetyAssessmentCode.doc

care, and (e) ensure RCA review action items are fully implemented and monitored for process improvement.

Breast Cancer Management

Condition Needing Improvement. According to the VHA Handbook 1104.1,[6] fee-basis and contract clinic facilities need to report suspicious or abnormal mammography results to system providers. We found that the tumor registry did not contain all patients diagnosed with breast cancer; the system did not monitor patients' mammograms and/or breast biopsy procedures; and documentation of procedures was not available in patients' medical records from the contract clinic.

The VHA breast cancer screening performance measures (PMs) assess 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. The VHA Handbook requires documentation of normal findings to be included in the medical record within 30 days of the procedure. According to the VHA Directive, communication of suspicious or abnormal results to the ordering provider is required within 3 working days. Communication can be by telephone contact between the mammography procedure site and the ordering provider. If this is the method adopted, entry into the electronic medical record is required. Timely results need to be available and accessible to guide patient care and treatment.



[6] VHA Handbook 1104.1, Mammography *Standards*, August 6, 2003.

We reviewed the electronic medical records for two patients diagnosed with breast cancer or an abnormal mammography during FYs 2004 and 2005. The results of this review are shown 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
2/2	2/2	2/2	1/1	2/2

Although the system did meet the VHA performance measure for breast cancer screening for FY 2005 (85 percent), there were areas in which the off-site contract affiliate did not provide results to the providers as required in the VHA Handbook. Our review found fee-basis, contract-for-services, and contract clinic affiliates did not forward mammography results to the system within 3 days when the results were suggestive or highly suggestive of malignancy.

The system's Tumor Registry log was incomplete. The log did not include the contract clinic's malignant cases. We also found the system did not monitor the contract clinic's breast cancer cases. During our visit, staff reported that the system does not follow up with contract clinic mammographies because these services are included in the contract with the clinic. Staff reported that mammogram entries from the contract clinic were not available in the patients' electronic medical records.

The system has a contract with offsite affiliates who provide mammograms for their patients. We found there was a lack of communication between the affiliate and the system that would have ensured that the mammography procedures were completed and reported back to the system as required by the VHA Handbook. The system also monitored fee-basis and contract-for-services sites but not the contract clinic. The contract clinic was not required to provide copies of mammography or biopsy results to the system.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Health Care System Director takes action to: (a) implement a process for communication of suspicious or abnormal mammography reports to ordering providers within 3 work days, (b) ensure that the Tumor Registry is maintained, (c) ensure that patients at the contract clinic are monitored by the system, and (d) ensure that documentation of all procedures is available in the electronic patient medical record.

Contract Community Nursing Homes

Condition Needing Improvement: The Contract Community Nursing Homes (CNH) Program needed to improve monitoring and oversight of CNH activities to ensure that veterans in these facilities received quality care in safe environments. We identified several areas needing improvement.

CNH Oversight Committee. Managers had not established a CNH Oversight Committee, and the CNH Program coordinator did not meet with local Ombudsmen as required. VHA Handbook 1143.2[7] mandates that a CNH Oversight Committee be established by the Health Care System Director and that it report to the chief clinical officer. The committee should include a multidisciplinary management-level representative from social work, nursing, quality management, acquisition, and medical staff, and it should meet at least quarterly. Although the system had established an inspection team, they had no Oversight Committee established to review inspection results, discuss contract renewals, and monitor clinical and billing concerns until March 2006.

Ombudsman Relationships. VHA policy also requires that each CNH review team and Oversight Committee establish a working relationship with the appropriate Veterans Benefits Office and the local Ombudsman office to discuss subjects of mutual interest and concern. At minimum, a yearly meeting is to be held with each office. The CNH Coordinator reported she had her first meeting with the Ombudsman representatives in March 2006.

Performance Improvement. The system did not integrate the CNH Program into its QM Program. The intent is for employees to use the results of improvement activities to strengthen the program. We did not find evidence that quality data were collected, analyzed, and integrated into the system's QM program.

CNH Inspections. The CNH review team did not complete CNH inspections every 12 months as required by policy. At the time of our review, the system had nine contracts with CNHs. None of the CNHs were inspected within the timeframe required. We also found that the system used an internal form to document annual inspections which did not provide a comprehensive assessment of the CNH. Several critical elements, such as the Centers for Medicare and Medicaid Quality Measures, were not included on the form. The CNH Coordinator reported that the review team discussed the quality measures during their meetings; however, documentation of these meetings could not be produced.

Policy requires that that the system exclude CNHs from the program when any facility fails four of seven quality evaluation factors.[8] One nursing home did not meet 5 of 7 indicators and had 19 deficiencies on the state inspection. Alabama's state average was

[7] VHA Handbook 1143.2, *Community Nursing Home Oversight*, June 4, 2004
[8] VHA Handbook 1132.2, *Community Nursing Home Oversight*, Paragraph 11.b(1), Exclusion Criteria, Page 11, dated June 4, 2004

nine. Two other nursing homes failed the Life and Safety Code inspections. The system has several options when a facility is not in compliance. These options include termination of the contract, suspension of veteran admissions, more frequent inspections, and increased patient monitoring. The system chose not to terminate any contract, but allowed contracts to expire, and suspended further placement of patients in those CNHs because placement of patients in the community had decreased and the system had sufficient space at the Tuskegee Nursing Home Unit to meet veteran need. Two CNHs were no longer utilized prior to our visit. One CNH did not have the appropriate liability insurance, and the other CNH's contract expired on May 31, 2006, and was not renewed.

In a memorandum dated September 5, 2006, the CNH Oversight Committee Chair, recommended closure of the CNH Program. The Health Care System Director concurred with the recommendation and notified the VISN 7 Network Contracting Officer to close the contracts for three facilities, one ending December 2006 and two ending February 2007. He also requested not to exercise the option year for four CNHs so that the contracts would self-terminate in September 2006.

The program was no longer effective after October 1, 2006; therefore, we made no recommendations.

Other Observations

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 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," as shown below;

a. Ambulatory Care
   Performance Period: Patients seen October 2005 – June 2006
   Meets Target: 77%
   Exceeds Target: 80%

b. Inpatients: For Inpatients discharged October 2004 – June 2005
   Performance Period: Cumulative October 2005 – June 2006
   Meets Target: 76%
   Exceeds Target: 79%

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

Dates of Survey Reporting period: Qtr. 1 & Qtr. 2 2006

Central Alabama VA Health Care System

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

INPATIENT SHEP RESULTS

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	**81.31**	**78.63**	**89.95**	**68.02**	**65.80**	**75.85**	**83.41**	**74.49**	**70.03**	**
VISN	80.60	77.90	88.3-	70.1+	66.60	76.10	81.8-	73.80	70.90	**
Health Care System	76.5-	78.70	84.4-	64.4-	60.4-	69.4-	80.6-	70.5-	65.8-	**

Dates of survey reporting period: Qtr. 2 2006

Central Alabama VA Health Care System

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

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	**80.7**	**78.1**	**94.8**	**72.6**	**83.3**	**75.8**	**81.5**	**65.5**	**81.7**	**80.8**	**84.7**
VISN	**78.1**	**81.6**	**93.7**	**73.4**	**84.7**	**75.8**	**82.3**	**63.7**	**81**	**78.3**	**83.5**
Outpatient Clinics - Overall	74.8	78.5	93.8	72.6	83.2	77.6	76.5	64.5	79.2	81	84.7

The system identified several areas needing improvement in inpatient and outpatient settings, including emotional support, family involvement, preferences, transition, access, and mailed and pick-up pharmacy. The following corrective actions were initiated:

- Conducted exit interviews with patients at conclusion of provider appointments and prior to discharge to ensure that patients are not experiencing anxiety, fears, or concerns.
- Increased contact between treatment team and family members.
- Implemented the "Hostess Cart" to provide a broader selection of snacks for veterans.
- Revised policy on patient hand-off from one level of care to another.
- Implemented a monitoring process for pharmacy wait times.
- Educated and encouraged patients to refill prescriptions in a timely manner by one of three methods: ordering using MyHealtheVet, Phone Pharmacy Refill line, or Consolidated Mailed Outpatient Pharmacy.

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).

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 or equal to 140/90 millimeters of mercury (mmHg); and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl). To receive a fully satisfactory rating for these diabetes PMs, the system must achieve the following scores:

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

We reviewed the system's four diabetes-related PMs for FY 2005. We reviewed medical records for a sample of 13 patients who were on 1 or more atypical antipsychotic medications for at least 90 days in FY 2005. Two patients had a diagnosis of diabetes.

We found the facility met 64 percent (9/14) of VHA FY 2005 quarterly PM goals related to diabetes (reported data). Specifically we found:

- **HbA1c greater than 9:** The system met or exceeded PM threshold only for quarter (Q)2, Q3, and Q4.
- **B/P less than or equal to 140/90:** The system met or exceeded PM threshold for Q1, Q3 and Q4.
- **BP greater than or equal to 160/100:** The system met or exceeded PM threshold for Q2 and Q4. No data was reflected for Q1 or Q3 for this PM, or patients were 0 percent for this measure.
- **LDL-C less than 120:** The system met or exceeded PM threshold only for Q1.

The system had a proactive, outcome-focused approach to address improvement. The system's corrective efforts for the diabetes-related PMs include the following:

- The Diabetes Clinic has posted diabetes-related PM outcomes for FY 2005 and FY 2006 through June 2006 on its patient information board.
- The system aggressively reviews all PM data and, in consultation with VISN 7 managers, conducts ongoing bi-weekly telephonic reviews of PM data.
- The Performance Improvement office, working with each responding service, has developed action plans for all PMs that fall below assigned thresholds.

Of the 13 patients who were on 1 or more atypical antipsychotic medications for at least 90 days in FY 2005, 2 patients had a diagnosis of diabetes. Our review showed that the system met or exceeded VHA performance criteria for these diabetic patients and provided diabetes prevention counseling and interventions (such as diet modification education, exercise education, etc.,) to the two diabetic patients when appropriate. Of the

eight patients without diabetes but having laboratory values exceeding normal thresholds, 75 percent received appropriate counseling, education, or other interventions.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with B/P less than or equal to 140/90 mm/Hg	Diabetic patients LDL-C less than 120 mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients received diabetes prevention counseling
0 percent (0/2)	**0 percent (0/2)**	**100 percent (2/2)**	**100 percent (12/12)**	**75 percent (6/8)**

Environment of Care

The purpose of the evaluation is to determine if the system maintains a safe and clean healthcare environment. The system must establish a comprehensive EOC program that fully meets all VHA, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Healthcare Organizations standards. To evaluate EOC, clinical and non-clinical areas at both divisions were inspected for cleanliness, safety, infection control, and general maintenance. The system maintained a clean and safe environment with no reportable findings or recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 1, 2006

From: Acting Director, VA Southeast Network (10N7)

Subject: Response to Combined Assessment Program Review – CAVHCS

To: Director, OIG (54SP)

The following VISN Director's comments are submitted in response to the recommendations in the Office of Inspector General report.

Comments and Implementation Plan

1. Quality Management Program Review

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Health Care System Director takes action to: (a) complete peer reviews within 120 days and ensure actions for quality improvement are initiated and measured to achieve goals, (b) disclose and document significant adverse events, (c) implement documentation of the time-out briefings for all required operative and invasive procedures outside the OR, (d) accurately reconcile medications across the continuum of care, and (e) ensure RCA review action items are fully implemented and monitored for process improvement.

Concur with recommended improvement actions

a. Complete peer reviews within 120 days and ensure actions for quality improvement are initiated and measured to achieve goals:

Planned Action: The following corrective actions have been initiated: (1) Completion of all clinical reviews by staff in the Office of Performance Improvement. This strategy has significantly improved compliance with the local policy that requires that the initial peer reviews will be completed within 45 days from the determination that a peer review is necessary.

Currently the time span for completion of the initial peer review ranges from 2 to 20 days. (2) Administrative nurse has been assigned as co-chair to the Peer Review Panel to facilitate timely completion of nursing-related actions. This change has resulted in a decrease in the time span between distributions of letters citing required action to response to request. (3) The Peer Review Panel Data Manager, the Chief of Staff and the Associate Director for Patient Care Services now meet monthly to discuss issues related to the Peer Review process (including timeliness of completion of Peer Reviews). This process has shown an initial improvement trend in compliance with the overall 120 day requirement. For the month of August there were a total of 6 cases reviewed. Three of the six cases have been completed with good timeliness results (5 days, 20 days, and 69 days). (4) Monitoring of action outcomes is completed with tracking and trending, and a report identifying trends and strategies for improvement is presented quarterly to the Executive Committee of the Medical Staff.

b. Disclose and document significant adverse events:

Planned Action: Immediate corrective action was taken with regard to the case cited. The patient was contacted by the Chief of Surgery to determine the status of disclosure. The patient acknowledged being informed of the adverse event at the time of the occurrence. An addendum was added to the patient's record documenting the disclosure. The medical staff is being re-educated on the requirement to document disclosure of adverse events as outlined in the local policy today October 20, 2006. The Risk Manager will monitor for compliance with documentation of the institutional disclosure procedures and will report findings to the Executive Committee of the Medical Staff. All perioperative occurrences are reviewed by the Surgical Case Review Committee. All future cases reviewed will also include a determination of whether or not disclosure took place. Appropriate corrective action will be taken when indicated.

c. Implement documentation of the time-out briefings for all required operative and invasive procedures outside the OR:

Planned Action: The need for improvement of compliance with the time-out process for procedures performed outside of the OR was identified prior to the OIG/CAP review and corrective actions were underway. While the cumulative compliance rate for the time frame reviewed by the OIG/CAP team was 87.7%, this number was a significant improvement in the facility's compliance rate from the time of initial identification of the need for improvement. For the month of August the compliance rate was 100%. As an added measure, shortly following the OIG/CAP review, the Chief of

Surgery re-educated staff on requirement for documentation of time out for procedures conducted outside of the OR.

d. Accurately reconcile medications across the continuum of care:

Planned Action: At the time of the OIG/CAP review, CAVHCS had recently updated the revised medication reconciliation policy (completed August 28, 2006). To assure appropriate implementation of the process, a Medication Reconciliation computer based training course was disseminated and staff informed of requirement to complete the module. The current compliance rate for the training completion is 94.7%. Additionally, Clinical Reminders have been integrated into CPRS to assist staff with completion of the reconciliation process. The CAVHCS Office of Performance Improvement in collaboration with the Pharmacy & Therapeutics Committee are monitoring compliance with the process through random chart review, making recommendations for improvement, and tracking outcomes. The findings and trended recommendations are reported to service managers and the senior leadership team. Corrective actions are identified and tracked as appropriate.

e. Ensure RCA review action items are fully implemented and monitored for process improvement:

Planned Action: Immediate corrective action was taken regarding the RCA referenced in the OIG/CAP Report. Services with outstanding actions were contacted and requested to provide an immediate response. All actions are closed with the exception of one that involves development of algorithm to be included in the suicide policy (target completion October 26, 2006). Other corrective actions that have been taken are as follows: (1) the amount of time elapsing between identification of the need for an RCA and chartering of the team has been identified as a contributing factor to RCAs not being completed in a timely manner. To remedy this, the RCA team will be chartered within 5 days of the determination that an RCA is required. (2) A Performance Improvement staff member will be assigned to each RCA. This individual will serve as a member of the RCA and will also be responsible for ensuring that all actions are implemented. (3) The Risk Manger will monitor, track and trend the outcomes for all actions. Findings from the monitoring process will be disseminated to the appropriate leadership committee. (4) A log will be maintained delineating date of determination of need for RCA, date of RCA team charter, date of presentation of RCA to management, date concurrence signatures obtained, date actions disseminated to services, date actions completed. This information will be reviewed by the Quality Manager and Quadad weekly to ensure compliance.

2. Breast Cancer Management Review

Recommended Improvement Action 2: We recommend that the VISN Director ensure that the Health Care System Director takes action to: (a) implement a process for communication of suspicious or abnormal mammography reports to ordering providers within 3 work days, (b) ensure that the Tumor Registry is maintained, (c) ensure that patients at the contract clinic are monitored by the system, and (d) ensure that documentation of all procedures is available in the electronic patient medical record.

Concur with recommended improvement actions

a. Implement a process for communication of suspicious or abnormal mammography reports to ordering providers within 3 work days:

Planned Action: CAVHCS purchases mammography services via the Fee Program. Fee Basis Authorizations will be updated to request that all highly suspicious/abnormal mammogram reports be faxed to CAVHCS Imaging Services on the same day as the exam is performed. The CAVHCS staff have communicated with the Fee vendors regarding this requirement and received assurances that this will be integrated into the process. Upon receipt of the reports, CAVHCS Imaging Services will alert ordering provider, the Women Veteran's Program Manager (WVPM), and ACOS for Ambulatory Care of highly suspicious/abnormal report within 3 work days.

b. Ensure that the Tumor Registry is maintained:

Planned Action: The Women Veteran's Program Manager (WVPM) or designee will notify tumor registrar of all abnormal biopsy reports. Tumor registrar will enter results into tumor registry.

c. Ensure that patients at the contract clinic are monitored by the system:

Planned Action: The Dothan Community Based Outpatient Clinic contract includes mammogram studies within the contracted services package. The Clinic utilizes a local vendor to provide these services. CAVHCS staff have assured the same process as now used in the facility is also implemented for Dothan CBOC patients. All mammogram and biopsy

reports will be faxed to CAVHCS Imaging Services by the vendor. Additionally, the WVPM will maintain a tracking log to monitor compliance with mammogram and mammogram follow-up requirements. The Dothan CBOC will forward mammogram referral information for their patients to the WVPM on a weekly basis.

d. Ensure that documentation of all procedures is available in the electronic patient medical record:

Planned Action: All mammogram and biopsy reports (inclusive of Dothan CBOC) will be faxed to CAVHCS Imaging Services. CAVHCS Imaging Service will be responsible for scanning reports into CPRS. The Women Veterans Program Policy is under development to include the procedures as described herein; target completion date is October 26, 2006.

(original signed by:)
Thomas A. Cappello, MPH, FACHE

Appendix B

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Appendix C

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