



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the Overton Brooks VA Medical Center Shreveport, Louisiana

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 and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, 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 and benefits services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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Executive Summary

Introduction

During the week of August 24, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Overton Brooks VA Medical Center (the medical center), Shreveport, 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 287 employees. The system 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 two areas:

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

We identified the following organizational strengths:

- Advanced Clinic Access.
- Cost Avoidance for Interfacility Transfers.
- Fee Basis Consults.

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

Breast Cancer Management

- Implement a process for communication of suspicious or abnormal mammography reports to patients from offsite affiliates.
- Document patient notification of mammography and biopsy results in medical records.
- Develop and implement a tracking tool to monitor offsite mammography services through the full continuum of care.

Contract Community Nursing Homes

- Appoint representatives from nursing service and the medical staff to the Contract Community Nursing Home (CNH) Oversight Committee.

- Require that the CNH Oversight Committee meet at least quarterly.
- Require that the social worker and registered nurse alternate and document visits and/or monthly monitoring of VA patients in CNH facilities.

Quality Management

- Initiate mortality reviews when indicated and ensure timely completion of peer reviews within 120 days.
- Ensure timely administration and discontinuance of prophylactic antibiotics.
- Implement corrective actions to comply with annual employee tuberculosis screening and fit testing for masks.
- Disclose adverse events.
- Ensure clinical staff maintain current training and certification in advanced cardiac life support and basic life support.

Environment of Care

- Remove pharmacy supplies on top of shelf storage units and take actions to preclude the continued placement of supplies in this area.
- Ensure local corrective actions for maintenance and repair issues are initiated.

We also followed up on recommendations contained in the previous CAP report (*Combined Assessment Program Review of the Overton Brooks VA Medical Center, Shreveport, Louisiana*, Report Number 03-01396-131, issued July 17, 2003), and found that the medical center had satisfactorily resolved all healthcare recommendations contained in that report at the time of this CAP review.

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

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (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 Dana Moore, Deputy,
Assistant Inspector General for Healthcare
Inspections for:)*

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

Introduction

Medical Profile

Organization. The medical center consists of one Veteran Health Administration (VHA) tertiary care facility in Shreveport, Louisiana, and three community based outpatient clinics (CBOCs) in Monroe, Louisiana; Texarkana, Arkansas; and Longview, Texas. The medical center serves 5 counties in Arkansas, 10 counties in Texas, and 15 parishes in Louisiana. The medical center is part of Veterans Integrated Service Network (VISN) 16 and serves a veteran population of 43,394.

Programs. Comprehensive health care is provided through primary and tertiary care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, and dentistry. The medical center is a part of the South Central VA Health Care Network, which includes facilities in Oklahoma, Arkansas, Texas, and Mississippi.

Affiliations and Research. The medical center, affiliated with Louisiana State University Health Sciences Center in Shreveport, is an important training site for residents and medical students. Other academic training affiliations include nursing, pharmacy, social work, respiratory therapy, and numerous other health and allied health-related fields. Major research areas include both clinical and basic science areas. The medical center is a primary receiving center for military casualties in the VA/Department of Defense (DoD) Contingency Plan and is a Federal Coordinating Center for the National Disaster Medical System.

Resources. The medical center's budget was approximately \$160 million in fiscal year (FY) 2005 and \$179 million in FY 2006. FY 2006 staffing is 1,177.5 full-time equivalent employees (FTE), which includes 88.39 physician and 393.5 nursing FTE.

Workload. In FY 2005, the medical center treated 38,197 unique patients. In FY 2006 (through June 2006), it treated 36,623 unique patients. In FY 2005, the average daily census was 87.9, and in FY 2006 (through June 2006), the average daily census was 91.2. The FY 2006 (through June 2006) outpatient workload was 258,375 visits.

Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected health care medical center operations focusing on QM, the medical center'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 medical center'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 medical center's patient care areas, the condition of equipment, adherence to clinical standards for infection control and patient safety, and compliance with patient data and medicine security requirements.

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

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

The review covered medical center operations for FY 2005 and FY 2006 through August and was done in accordance with OIG standard operating procedures for CAP reviews.

During the review, we also presented three fraud and integrity awareness briefings for hospital employees. These briefings, attended by 287 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 medical center during the course of the review, and we have included a brief description of these organizational strengths in this report.

Results of Review

Organizational Strengths

Centralized Scheduling Unit: A Patient Centered Approach to Advanced Clinic Access.

A key component of Advanced Clinic Access is for veterans to be able to make appointments at their convenience, as well as have a mechanism to call, cancel, or reschedule an appointment as desired. Another factor for starting the call center was the large number of complaints made by patients about the lack of returned calls and letters. The unit is operational Monday–Friday during administrative work hours. For patients who call after hours, the unit has a call back system the next business day. The medical center experienced a 43 percent drop in patient complaints after being open for only 4 months, and the no show rates dropped in most clinics. Also the SHEP new and established appointments survey results improved and were meeting and/or exceeding the performance measure goal.

Cost Avoidance for Interfacility Transfers. Senior managers appointed a Utilization Management (UM) Interfacility Transfer Clinical Coordinator in 2005 for the purpose of determining the appropriateness of veteran admissions to outside facilities. They wanted to ensure that patients admitted to private sector facilities were transferred back to the medical center in a timely manner. The UM Transfer Coordinator developed a variety of alerts in the computerized patient record system (CPRS) to assist with the transfer process. Guidelines on bed availability and a proposal for an overflow unit to assist in decreasing the number of patients hospitalized in private sector facilities were also developed. The Interfacility Physicians were provided with clear guidelines on procedures for transferring patients back to the medical center. A bed huddle process was developed where key nursing, Business Office, medical staff, and the UM staff meet to discuss bed availability and bed flow throughout the medical center. In FY 06 (through June 2006), the medical center had a cost avoidance of 1,537 patient days from transfers back to the medical center. Senior managers estimated a cost savings of over \$3 million dollars due to the UM Transfer Program.

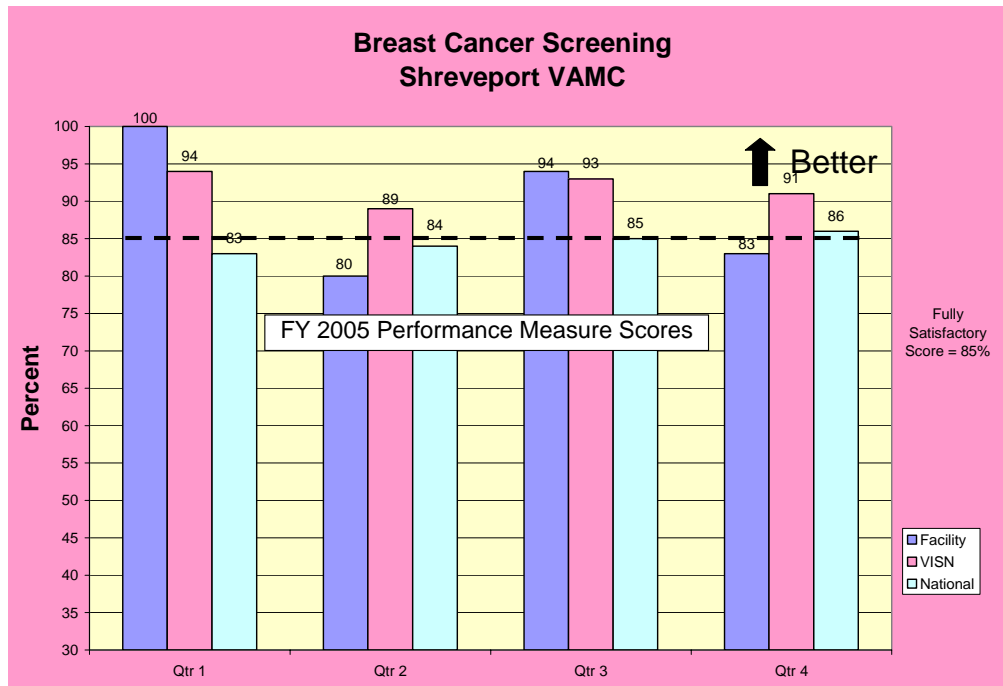
Fee Basis Consults. Senior managers identified an opportunity to decrease a large volume of unmonitored referrals for non-VA care. In many cases, a patient was referred out for care before the appropriate administrative funding approval/authorization had been made. As a result, the Fee Basis Unit was not aware of the referral until the claim was received for payment. A process action team was chartered to improve the processes and financial accountability for patients referred out for services. A consult template was developed to include fields that mimic the authorization form for patient care. This process and report results are reviewed with staff at all levels. In reviewing the data, senior managers determined that it was more cost effective to establish a contract for some services and/or perform others in house. For example, a third Gastro-intestinal suite was opened, which senior managers estimate saved approximately \$500,000 in FY 2005.

Opportunities for Improvement

Breast Cancer Management

Condition Needing Improvement. The medical center met the VHA performance measures (PM) for breast cancer screening; provided timely Radiology, Surgery and Oncology consultative and treatment services. However, the oversight of offsite mammography facilities was not monitored appropriately.

The VHA breast cancer screening PM assesses the percent of patients screened according to prescribed timeframes. The medical center's mean PM score for FY 2005 was 89 percent, which meets the fully satisfactory level. The chart below shows VHA's breast cancer management quarterly PM 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 during FY 2005. The chart below shows the medical center's outcomes from this review:

Patients appropriately screened	Mammography results reported to patient within 30 days	Patients received timely consultations	Patients received timely biopsy procedure	Patients appropriately notified of their diagnoses
*8/10	9/10	3/3	**4/7	4/10

* We determined that one patient did not require screening because she did not meet the age requirement.

**Providers decided that 3 of 10 patients did not require biopsies, but could be followed with an annual mammography.

VHA Handbook 1104.1¹ requires that offsite facilities communicate results of referred patients' results to the referring physician within 30 days of the date of mammographic procedure, and send suspicious or highly suggestive results to the referring VA physician within 3 business days. The medical center did not have mammography services on site; therefore, services were provided by contract and/or fee basis facilities in the community. Patients receiving mammography services were not monitored by the medical center effectively to ensure that the appropriate care was provided by the offsite facilities. Documentation of provider and patient notification as required by VHA directive was deficient.

Medical record review did not consistently reveal that offsite mammography facilities reported "Suspicious" or "Highly Suggestive of Malignancy" results to the medical center within 3 business days, and some patients were not notified within 5 business days as required in the VHA handbook. Also, biopsy results were not accessible in the patients' medical records and 43 percent (3/7) of the patients were not notified of their biopsy results. The facilities were aware of these issues and were in the process of (a) developing a tracking tool that would monitor the mammography process from start to finish, and (b) establishing a full-time employee position for a Mammography Coordinator.

Recommended Improvement Actions 1. We recommend that the VISN Director ensure that the Medical Center Director takes action to: (a) implement a process for communication of suspicious or abnormal mammography reports to patients and from offsite affiliates as required in VHA Handbook 1104.1, (b) document patient notification of mammography and biopsy results in medical records, and (c) develop and implement a tracking tool to monitor offsite mammography services through the full continuum of care.

Contract Community Nursing Homes

Condition Needing Improvement. The medical center's Contract Community Nursing Home (CNH) Program was generally effectively managed. The medical center had 11 contracts with CNHs and 25 patients in those nursing homes at the time of our review.

¹ VHA Handbook 1104.1 is *Mamography Standards*, issued August 6, 2003.

We reviewed policies, existing contracts, minutes of the CNH Oversight Committee, documentation of inspections for 5 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 Shreveport Manor in Shreveport, LA, and Pilgrim Manor in Bossier, LA, during which we interviewed the Administrator and Director of Nursing (DON) and performed a limited inspection of each facility's environment of care.

VHA Handbook 1143.2² provides guidelines for the VA CNH Program, to include oversight and monitoring of patients who have been placed in CNHs by VA facilities. The medical center's CNH Oversight Committee provided oversight of the CNH Review Team efforts; however, their oversight responsibilities should be strengthened. VHA policy requires that the membership of the oversight committee include a registered nurse, physician, social worker, and representatives from QM and Acquisitions. The medical center's CNH Oversight Committee membership did not include a registered nurse or a physician. The handbook also requires that the committee meet at least quarterly. The medical center's local policy stated that the chairman will call a meeting at the chairman's discretion and under special circumstances. Review of the committee minutes demonstrated that the committee was not in compliance with the VHA handbook. We also found that the committee did not review annual CNHs inspections or document meeting with the 11 CNHs' Ombudsmen.

The CNH team did not renew three CNH contract in calendar year 2005. The CNH Team reported that the contracts were not renewed because of patient dissatisfaction with two of the CNHs and a third CNH had not renewed its liability insurance. We reviewed the termination letters and found the reasons stated were budget constraints (for two CNHs) and circumstances beyond the medical center's control.

We reviewed the medical records of 10 VA patients who were placed in CNH facilities. Seven of the 10 patients did not receive VA staff monthly visits and/or demonstrate alternate visits by the social worker and registered nurse as required by VHA policy.

Recommended Improvement Actions 2. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) a representative from nursing service and the medical staff be appointed to the CNH Oversight Committee, (b) CNH Oversight Committee meet at least quarterly, (c) CNH Oversight Committee provide appropriate supervision of CNH team activities, and (d) CNH staff complete and document visits and/or monthly monitoring of VA patients in CNH facilities as required.

² VHA Handbook 1143.2 is *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

Quality Management Program Review

Condition Needing Improvement. The quality management/performance improvement program was comprehensive and generally effective. However, we found four areas needing improvement.

Peer Review. VHA policy³ 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 the medical center had 22 surgical deaths within 30 days of the surgical procedure. We found that mortality peer reviews were not initiated when indicated. The medical center only reviewed 10 (45 percent) of the deaths.

VHA policy requires that initial peer review be completed within 45 days and that the peer review committee completes the final review within 120 days. We reviewed all peer reviews for FY 2005 and found only 66 percent (23/35) were completed by the peer review committee within the required 120 day time period. Further review of 1st quarter FY 2006 showed 14 of 21 (67 percent) peer review cases were completed as required. We found peer reviews were not closed within the required 120-day timeframe; however, the peer review committee recently began holding bimonthly meetings in order to improve the timeliness of the peer review process.

Infection Control. National guidelines for prevention of surgical site infections call for timely administration and discontinuance of prophylactic antibiotics. The aim is to meet 87 percent compliance with the above guidelines. We reviewed both measures during the first 3 quarters of FY 2006 and found the compliance for administration within 1 hour of surgery at 75 percent (60/80) and discontinuance of antibiotics within 24 hours of surgery at only 32 percent (24/76).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) sets a 95 percent target for annual employee health Tuberculosis Skin Test (TBST) for both new and existing employees. The medical center's new and annual employee TBST screening was below the JCAHO standard at 76 percent in FY 2005. In FY 2006 (through June 2006) the medical center's compliance rate was 58 percent.

Occupational Safety and Health Administration (OSHA) standards require an annual qualitative fit testing (QLFT) for clinical staff/direct patient care givers who may come into contact with patients who have undiagnosed or untreated tuberculosis. In FY 2005, the medical center was aware they were not in compliance with the OSHA standard, and they could not determine which services were compliant with the standard.

³ VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.

OSHA requires N-95 masks be fit tested for each employee on an annual basis. We found the medical center's process for annual QLFT ineffective, and the compliance rate (at the time of our inspection) was only 8 percent of the required employees.

Adverse Event Disclosure. According to VHA Directive 2005-049,⁴ adverse events require disclosure to patient or family members generally within 24 hours but not later than 72 hours after the practitioner's discovery of the event. We reviewed adverse event reports from July 1, 2005, to July 31, 2006, and found three sentinel events⁵ that required institutional disclosure. We found the medical center did not make timely disclosures at times, because providers did not notify senior level management when adverse events occurred.

In the first case, the patient developed bilateral lower extremity paraplegia.⁶ The disclosure was documented 3 months after the surgery. In a second case, the patient developed quadriplegia.⁷ The disclosure was not documented until 14 days later. In the third case, the patient presented to the emergency room with seizures. The patient had an intracranial bleed that was not diagnosed until neurological tests revealed brain death. The disclosure was not documented until 15 days later. We were told the family requested that the disclosure meeting occur on a specific date, thus causing the delay.

Patient Safety. VHA policy requires medical centers to delineate those providers who require advanced cardiac life support (ACLS) certification and basic life support (BLS) training. The training must be current in the procedures for patient safety. We reviewed medical center policy and training records for both ACLS and BLS. We found that 8 providers had expired ACLS certification and 65 providers required BLS training. The medical center did not have a system to track when renewals were due and relied on providers to self-report. Also the medical center did not have a formal reporting process to the Cardiopulmonary Resuscitation Committee to ensure that appropriate training status and needs could be identified in a timely fashion.

Recommended Improvement Actions 3. We recommended that the VISN Director ensure that the Medical Director takes action to: (a) initiate mortality reviews when indicated and ensure timely completion of peer reviews within 120 days, (b) ensure timely administration and discontinuance of prophylactic antibiotics, (c) implement corrective actions to comply with annual employee TBST screening and QLFT for N-95 masks per OSHA guidelines, (d) disclose adverse events as required in VHA Directive 2005-049, and (e) ensure clinical staff maintain current training and certification in ACLS and BLS.

⁴ VHA Directive 2005-049 is *Disclosure of Adverse Events to Patients*, October 27, 2005.

⁵ Unexpected occurrences involving death or serious physical or psychological injury, or risk thereof.

⁶ Paralysis of the lower half of the body with involvement of both legs usually due to disease of or injury to the spinal cord.

⁷ Paralysis of all four limbs.

Environment of Care

Condition Needing Improvement. VA policy requires that patient care areas be clean, sanitary, and maintained to optimize patient safety and infection control. The medical center needed to address life safety and fire safety measures. We inspected all patient care areas and found some conditions requiring management attention.

Life Safety/Fire Safety Measures. We found Pharmacy Service placing supplies on top of storage units throughout the pharmacy area in violation of the National Fire Protection Association (NFPA) standards.⁸ Storage may not be placed on the top of shelving units creating an obstruction to each sprinkler's water discharge pattern described by a horizontal plane extending from the sprinkler deflector down 18 inches. Interviews with medical center staff confirmed the recurring nature of the observed condition.

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

- We observed moisture control problems throughout the outpatient clinic area (northeast quadrant) of Building 1. We found mold/mildew on heating, ventilation, and air conditioning (HVAC) strip supply diffusers and overhead fluorescent light fixture support frames (rooms 1E52, 1E55, 1E13).
- We observed rust residue on the surface of five HVAC supply air diffusers in the Emergency Room (1E4).
- We observed mold/mildew on ceiling tile over the outpatient clinic check-in desk (1E21).
- We found damaged ceramic tile in a male restroom, rusted privacy panel, and corroded/decaying water supply escutcheon (1E85).

These observations showed an environment potentially unsafe for both patients and staff through long-term exposure to airborne mold/mildew spores, falling paint particles, and damaged ceramic tile. Additionally, pharmacy storage practices compromise fire and employee safety within the work space.

Recommended Improvement Actions 4. The VISN Director should ensure that the Medical Center Director requires that (a) storage of pharmacy supplies on top of shelf storage units are removed and actions are taken to preclude the continued placement of supplies in this area, and (b) ensure local corrective actions for maintenance and repair issues are initiated.

⁸ NFPA 2002 Edition, Part 13, *Standard for Installation of Sprinkler Systems*, Chapter 8, Installation Requirements, Section 8.5, Position, Location, Spacing and Use of Sprinklers, Paragraphs 5.21, 5.3 and 6.1.

Other Observations

Diabetes and Atypical Antipsychotic Medications

The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes). Clinicians needed to improve the medical center's diabetes related performance measures, monitoring of patients, and counseling for patients without diabetes.

VHA clinical practice guidelines for the management of diabetes suggests that diabetic patients' hemoglobin A1c (HbA1c), which reflects the average blood glucose level over a period of time, should be less than ($<$) 9 percent to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to (\leq) 140/90 millimeters of mercury (mmHg); and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl). To receive fully satisfactory rating for these diabetes performance measures (PMs), the medical center must achieve the following scores:

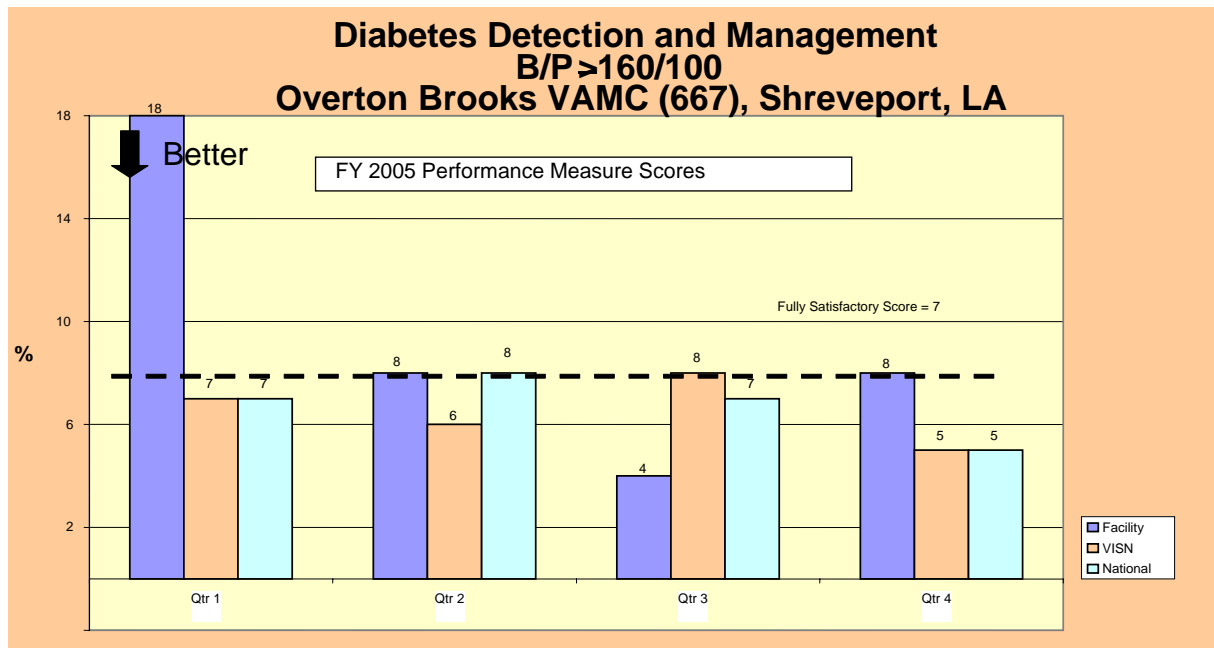
- HbA1c greater than 9 percent– 15 percent (lower percent is better).
- Blood Pressure less than or equal to 140/90 mmHg – 72 percent (higher percent is better).
- Cholesterol (LDL-C) less than 120 mg/dl – 75 percent (higher percent is better).

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

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

Performance Measures: We found the medical center met 56 percent (9/16) of VHA quarterly PM goals related to diabetes. The PM data showed 1 quarter where the reported data exceeded the PM threshold (quarter 1, B/P greater than 160/100). Specifically we found:

- HbA1c greater than 9: The medical center met or exceeded the PM threshold for quarters 1, 2, and 4.
- LDL-C less than 120: The medical center met or exceeded the PM threshold for quarters 1, 2, and 4.
- B/P less than or equal to 140/90: The medical center met or exceeded the PM threshold for quarters 3 and 4.
- BP greater than or equal to 160/100: The medical center met only the 3rd quarter's PM threshold and the 1st quarter's data (18) exceeded the PM threshold, as shown below.



Medical center clinical staff recognized the 1st quarter FY 2005 diabetes-related PM deficiency. They identified and implemented aggressive actions in the inpatient and outpatient settings that addressed diabetes-related outliers. They implemented the following:

- A diabetes therapy group for patients taking atypical antipsychotic medications.
- Clinic reminder telephone calls to ensure patients take medications prior to laboratory blood draws.
- Immediate referrals for either consults or appropriate face-to-face interventions with patient education specialists.

The results of their efforts are indicated in the 2nd–4th quarter PM data where outliers, if any, were reduced.

Of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days in 2005, 12 patients had a diagnosis of diabetes. Our review showed that after the 1st quarter the medical center met or exceeded VHA performance criteria for these diabetic patients; and the medical center provided diabetes prevention counseling and interventions, such as diet modification education and exercise education, to all 12 diabetic patients when appropriate.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with B/P less than 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
42 percent (5/12)	58 percent (7/12)	75 percent (9/12)	100 percent (1/1)	100 percent (1/1)

Survey of Healthcare Experiences of Patients

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

- Ambulatory Care
 - Performance Period: Patients seen October 05–June 06
 - Meets Target: 77 percent
 - Exceeds Target: 80 percent
- Inpatients: For inpatients discharged October 04–June 05
 - Performance Period: Cumulative October 05–June 06
 - Meets Target: 76 percent
 - Exceeds Target: 79 percent

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

Shreveport VAMC									
INPATIENT SHEP RESULTS									
FY 2006 Quarter 1 and 2	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03
VISN	81.21	79.37	88.43	68.18	65.50	78.39	77.10	73.60	64.89
Medical Center	78.6-	74.1-	88.50	65.80	64.10	75.10	82.40	74.70	73.7+

OUTPATIENT SHEP RESULTS											
FY 2006 Quarter 2	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	78.8	78.6	94.7	72.5	82.6	76.3	85.1	72.7	80.5	81	83.5
Outpatient Clinics Overall	73.3	72.1	90.1	69.4	80.2	74.5	78.5	55.9	78.3	80.7	77
Legend: "+" Indicates results that are significantly better than national average "-" Indicates results that are significantly worse than national average											

The medical center identified six inpatient and five outpatient areas needing improvement in Veterans Health Service Standards (VHSS) scores and implemented the following actions to increase their VHSS scores:

- Implemented Advanced Clinic Access to enhance timely scheduling of appointments.
- Recruitment for new Primary Care vacancies; hired temporary staff for recent vacancies.
- Developed service agreements between subspecialty areas and Primary Care to avoid unnecessary consults and improve time management of specialists.

- Conducted Bayer program training “Clinician-Patient Communication to Enhance Health Outcomes” for physicians and physician extenders to provide opportunities to practice skills and techniques.
- Established Surgical Service Goal Sharing Team to monitor arrival times for surgeons to begin first case surgery.
- Remodeled the pharmacy to improve patient flow area.
- Implemented weekly group patient education on End Stage Renal Disease, thus affording an opportunity for informing patient/family regarding choices with kidney disease progression.
- Increased clinic space for chemotherapy treatment.

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 9, 2006
From: VISN Director
Subject: **Combined Assessment Review of the Overton Brooks
VA Medical Center, Shreveport, Louisiana**
To: Office of Inspector General (OIG)

The South Central VA Health Care Network concurs with the Medical Center Director's response and implementation plan regarding the draft report Combined Assessment Review of the Overton Brooks VA Medical Center.

If you have any questions, please contact Mary Jones, HHS, at 601-364-7871.

(original signed by:)

Robert Lynch, MD

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 31, 2006

From: Medical Center Director

Subject: **Combined Assessment Review of the Overton Brooks
VA Medical Center, Shreveport, Louisiana**

To: Director, Veteran Integrated Service Network (10N16)

1. Medical Center Director concurs with the Combined Assessment Program Review Recommendations for Overton Brooks VA Medical Center, Shreveport, Louisiana.
2. Attached are the medical center's Planned Actions to the recommendations.

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

The following Medical Center Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

Recommended Improvement Actions 1. We recommend that the VISN Director ensure that the Medical Center Director takes action to (a) implement a process for communication of suspicious or abnormal mammography reports to patients and from offsite affiliates as required in VHA Directive 1104.1, (b) document patient notification of mammography and biopsy results in medical records, and (c) develop and implement a tracking tool to monitor offsite mammography services through the full continuum of care.

Concur

a. Implement a process for communication of suspicious or abnormal mammography reports to patients and from offsite affiliates as required in VHA Directive 1104.1:

Planned Action: Implemented process by which mammography coordinator monitors compliance with documentation of communication of suspicious or abnormal reports to patients and from off-site facilities.

Target Completion Date: **Completed**

b. Document patient notification of mammography and biopsy results in medical records:

Planned Action: Implemented process of faxed patient notification of mammography and biopsy results from off-site facilities which are scanned into the patient electronic medical record under the supervision of the mammography coordinator. Compliance will be monitored and reported to the Medical Executive Committee quarterly.

Target Completion Date: **January 31, 2007**

c. Develop and implement a tracking tool to monitor offsite mammography services through the full continuum of care:

Planned Action: Implemented a centralized process by which the mammography coordinator uses the breast imaging tracking tool to monitor mammography services through the full continuum of care.

Target Completion Date: **Completed**

Recommended Improvement Actions 2. We recommend that the VISN Director ensure that the Medical Center Director requires that (a) a representative from nursing service and the medical staff be appointed to the CNH Oversight Committee, (b) CNH Oversight Committee meet at least quarterly, (c) CNH Oversight Committee provide appropriate supervision of CNH team activities, and (d) CNH staff complete and document visits and/or monthly monitoring of VA patients in CNH facilities as required.

Concur

a. Representative from nursing service and the medical staff be appointed to the CNH Oversight Committee:

Planned Action: Nurse Executive or designee and Chief, Primary Care Service or physician designee, have been appointed to the Community Nursing Home Oversight Committee.

Target Completion Date: **October 26, 2006**

b. CNH Oversight Committee meet at least quarterly:

Planned Action: The CNH Oversight Committee will meet quarterly in January, April, July, and October as noted in the CNH Oversight Committee policy.

Target Completion Date: **October 26, 2006**

c. CNH Oversight Committee provide appropriate supervision of CNH team activities:

Planned Action: The CNH Oversight Committee will review CNH team activities to include: initial reviews, annual reviews, complaints, recommendations, adverse and sentinel events, trending and analysis of QM data, exclusion criteria reports, contracts, annual Ombudsmen meetings, and appropriateness of resident placement. Team activities will be reported at quarterly CNH Oversight Committee meeting.

Target Completion Date: **January 31, 2007**

d. CNH staff complete and document visits and/or monthly monitoring of VA patients in CNH facilities as required.

Planned Action: Chief, Social Work Service, and Nurse Executive or designee will ensure that CNH Review Team staff complete and document visits and/or monthly monitoring of VA patients in community nursing homes. Chief, Social Work Service and Nurse Executive or designee will report compliance at the CNH Oversight Committee quarterly meetings.

Target Completion Date: **January 31, 2007**

Recommended Improvement Actions 3. We recommended that the VISN Director ensure that the Medical Director takes action to (a) initiate mortality reviews when indicated and ensure timely completion of peer reviews within 120 days, (b) ensure timely administration and discontinuance of prophylactic antibiotics, (c) implement corrective actions to comply with annual employee TBST screening and QLFT for N-95 masks per OSHA guidelines, (d) disclose adverse events as required in VHA Directive 2005-049, and (e) ensure clinical staff maintain current training and certification in ACLS and BLS.

Concur

a. Initiate mortality reviews when indicated and ensure timely completion of peer reviews within 120 days:

Planned Action: Risk Manager has developed a process for peer review of all morbidities and mortalities to meet requirement of VHA Directive 2005-056.

Target Completion Date: **May 30, 2006.**

Risk Manager has developed a process of weekly peer review completion monitoring to meet 120-day requirement per VHA Directive 2004-054.

Target Completion Date: **July 20, 2006**

b. Ensure timely administration and discontinuance of prophylactic antibiotics:

Planned Action: Anesthesia Section, Surgical Service, has developed a process for review of appropriateness of antibiotic orders, informing surgeon if no antibiotic is ordered, and administering antibiotics at time of intubation. Compliance is reported to Leadership Board.

Target Completion Date: **September 28, 2006**

c. Implement corrective actions to comply with annual employee TBST screening and QLFT for N-95 masks per OSHA guidelines:

Planned Action: Implement a TBST program in which Employee Health Nurse and Service Chiefs identify high risk employees for annual screening. Employee Health Nurse will establish TB Skin Test Clinics and monitor employee TBST compliance. TBST compliance will be reported monthly by the Employee Health Nurse to the Infection Control Committee.

Target Completion Date: **January 31, 2007**

Engineering Service has implemented an ongoing process for compliance with Qualitative Fit Testing for N-95 respirators. Category 1 staff requiring immediate fit testing are identified and fit tested. Industrial Hygienist, Engineering Service, notifies service chiefs of staff requiring annual QLFT. Industrial Hygienist reports QLFT compliance to Infection Control Committee.

Target Completion Date: **August 21, 2006**

d. Disclose adverse events as required in VHA Directive 2005-049:

Planned Action: Risk Manager and Chief of Staff have implemented a complications and adverse event tracking and reporting process for clinical services performing operative and invasive procedures. Risk Manager is notified of events by clinical service chiefs ensure timeliness of clinical and institutional disclosures. Risk Manager documents inability to disclose an adverse event in the patient electronic medical record when time requirements for disclosure are not able to be met because of patient/family issues.

Target Completion Date: **November 3, 2006**

e. Ensure clinical staff maintain current training and certification in ACLS and BLS:

Planned Action: Clinical service chiefs and Nursing Service will assess staff training needs for Basic Life Support and Advanced Cardiac Life Support and will submit a report to the medical center Education Committee.

Target Completion Date: **January 31, 2007**

The Cardiopulmonary Resuscitation (CPR) Committee will monitor BLS and ACLS compliance of clinical and nursing staff and will report compliance to individual services and at quarterly Medical Executive Committee.

Target Completion Date: **January 31, 2007**

Recommended Improvement Actions 4. The VISN Director should ensure that the Medical Center Director requires that (a) storage of pharmacy supplies on top of shelf storage units are removed and actions are taken to preclude the continued placement of supplies in this area, and (b) ensure local corrective actions for maintenance and repair issues are initiated.

Concur

a. Storage of pharmacy supplies on top of shelf storage units are removed and actions are taken to preclude the continued placement of supplies in this area:

Planned Action: Pharmacy Service has removed items. Pharmacy Service area will be inspected during Environment of Care biannual rounds and during unannounced tracers for compliance.

Target Completion Date: **August 25, 2006**

b. Ensure local corrective actions for maintenance and repair issues are initiated:

Planned Action: All identified maintenance and repair issues have been corrected by Engineering Service with the exception of two diffusers that have been ordered and will be replaced by November 30, 2006.

Target Completion Date: **November 30, 2006**

OIG Contact and Staff Acknowledgments

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Acknowledgments	Charles Cook David Griffith Annette Robinson Roxanna Osegueda

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