Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA North Texas Health Care System Dallas, Texas

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Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- 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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Introduction

During the week of October 30, 2006, the Office of the Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA North Texas Health Care System (the System) in Dallas and Bonham, Texas. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and integrity awareness training to 967 employees. In addition, we followed up on QM and Environment of Care (EOC) recommendations from the previous CAP review of the System.

Results of Review

The CAP review focused on nine areas. The System complied with standards in the following areas:

- EOC.
- Diabetes and Atypical Antipsychotic Medications.
- Breast Cancer Management.
- Patient Satisfaction.
- All Employee Survey (AES).

We identified conditions in QM, the Contract Nursing Home (CNH) Program, a Community Based Outpatient Clinic (CBOC), and the Cardiac Catheterization Program that needed management attention. We made the following recommendations:

- Construct a comprehensive, effective QM program that includes all appropriate patient care and patient safety elements.
- Appoint and train the Utilization Management (UM) physician advisor.
- Improve veteran visitation, medical record and travel documentation, and contract home oversight in the CNH Program.
- Improve administrative operations and oversight at the Greenville CBOC (GCBOC).
- Require completed informed consents for cardiac catheterization procedures.

Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 20–33, for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
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Introduction

System Profile

Organization. The System is comprised of two divisions—the Dallas VA Medical Center and the Sam Rayburn Memorial Veterans Center in Bonham, Texas. The System is a tertiary care health care system that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at the VA-operated Fort Worth outpatient clinic (OPC), and at 11 contracted CBOCs. The System is part of Veterans Integrated Service Network (VISN) 17 and serves a veteran population of about 500,000 in a primary service area that includes 38 counties in Texas and 2 counties in southern Oklahoma.

Programs. The System provides medical, surgical, mental health, geriatric, rehabilitation, and homeless services. The System has 299 hospital beds, 255 nursing home beds, and 264 domiciliary beds, and operates several regional referral and treatment programs, including polytrauma and spinal cord injury. The System also has sharing agreements with TRICARE[1] and ChampVA[2].

Affiliations and Research. The System is affiliated with the University of Texas Southwestern Medical Center at Dallas and the Baylor College of Dentistry, and supports 575 residents and 554 medical student positions. Other affiliations include the University of North Texas, University of Texas at Arlington, and Texas Tech University. In fiscal year (FY) 2006, the System research program had 330 active projects including $3.1 million in VA and $2.9 million in Research Corporation[3] funding. Important areas of research included rapid eye movement (REM) sleep and spinal cord injury rehabilitation.

Resources. In FY 2006, medical care expenditures totaled $532.9 million. FY 2006 staffing totaled 3,647 full-time equivalent (FTE) employees, including 253 physician and 916 nursing FTE.

Workload. In FY 2006, the System treated 103,126 unique patients. The System provided 75,961 inpatient days of care in the hospital, 68,133 inpatient days of care in the Nursing Home Care Unit (NHCU), and 83,840 days of care in the domiciliary. The inpatient care workload totaled 11,976 discharges; the average daily census was 208 in the hospital, 187 in the NHCU, and 198 in the domiciliary. The outpatient workload was 1,040,347 visits.

[1] TRICARE is the health insurance program for military personnel and their families.

[2] ChampVA is the Civilian Health and Medical Program of the Department of Veterans Affairs, a cost-sharing health plan for the dependents of qualifying disabled veterans.

[3] A private foundation that aids basic research in the sciences.

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 facilities focusing on patient care and QM.
- 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 QM and patient care administration. QM is the process of monitoring the quality of care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. In addition, we conducted follow-up on selected aspects of our previous CAP review (*Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas*, Report No. 04-01878-34, November 26, 2004).

In performing the review, we inspected work areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered selected aspects of the following programs and activities:

AES	Diabetes and Atypical Antipsychotic Medications
Breast Cancer Management	EOC
Cardiac Catheterization	Patient Satisfaction
CBOC	QM
CNH Program	

The review covered facility operations for FY 2005, FY 2006, and FY 2007 through November 3, 2006, and was completed in accordance with OIG standard operating procedures for CAP reviews.

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.

Results of Review

Since January 2005, the System has experienced a complete turnover of top managers, many of whom told us that redirecting the organizational culture and acknowledging staff efforts to improve patient care were a top priority. We reviewed staffing, workload, patient and employee satisfaction, and performance measure data to assess the overall quality of patient care. While patient and employee surveys reflect the need for continued improvement, the System was taking actions to enhance satisfaction scores. In addition, the System is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and has demonstrated progress towards meeting Veterans Health Administration's (VHA's) clinical performance measures.

Opportunities for Improvement

Quality Management – Processes To Promote Quality Care and Patient Safety Needed Significant Improvement.

Despite multiple external reviews and recommendations for corrective actions, the System's QM Program did not provide continuous, comprehensive monitoring of important patient care and safety processes, and performance improvement activities were not consistently initiated when deficiencies were identified.

The System's Clinical QM Service, with 27 FTE, has responsibility for a broad array of QM Program areas including quality monitoring, patient safety, performance improvement (PI), performance measures, and UM. We conducted interviews with Clinical QM Service managers and employees, and with the System's senior management staff. We reviewed an external report of QM operations completed by VISN 21 in June 2004, and another report completed by a System-wide Ongoing Assessment and Review Strategy (SOARS) team in April 2006. We also followed up on recommendations made in the 2004 OIG CAP report to determine the effectiveness of corrective actions. In addition, we reviewed the self-assessment completed by Clinical QM Service staff regarding the functioning and operations of the QM Program, as well as other relevant QM documents and committee minutes. The purposes of this review were to determine if (a) the System had a comprehensive, effective QM Program designed to monitor patient care activities and coordinate improvement efforts and (b) the System was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations.

Overall, we found the QM Program did not provide the necessary monitoring and oversight to ensure that patient care and patient safety processes were functioning properly. The various QM functions were not completed consistently, accurately, or timely; and the QM activities documentation, medical staff committees' oversight, and actions follow-up were fragmented, making it difficult to follow the sequence of events

and outcomes. In addition, the System's QM self-assessment reported full or substantial compliance with all preselected standards; however, we found effective QM monitoring and compliance in only 33 percent of the program areas (patient complaints, resuscitation outcomes, credentialing and privileging (C&P), efficient patient flow, and advanced clinic access). For these reasons, we could not say with certainty that the data we received was valid and represented the full scope of QM problems at the System.

Conditions Needing Improvement. The QM Program did not comprehensively plan, monitor, assess, or improve important patient care and organizational functions. We noted that many of the deficiencies listed below were previously identified in the 2004 CAP report, and again in the VISN 21 and SOARS reviews; yet the conditions, in whole or in part, continued to exist at the time of our review. During our review, we found the following deficient program areas:

- QM oversight.
- Mortality review and analysis.
- Patient safety.
  - Root cause analyses (RCAs).
  - Patient safety alerts.
- Data tracking, trending, analysis, and reporting.
  - Blood usage.
  - Restraints.
  - Medical records.
- Peer review.
- Adverse event disclosure.
- Operative and other invasive procedure review.
- UM.

QM Oversight. In the 2004 CAP report, we noted that the QM Program was not planned, systematic, or coordinated on an organization-wide level. The System reported taking corrective actions including: completion of an external review to assess and evaluate the QM Program; reorganization of the QM program; allocation of adequate resources; review and modification of existing committee structure and communication; development and implementation of staff PI education programs; and incorporation of outcomes and accomplishments into the PI annual report to management.

In 2006, we found that corrective actions taken after the last visit had not fully resolved identified conditions and that major QM program areas continued to be inefficient or ineffective. The System underwent two external reviews after the 2004 OIG CAP review, yet conditions identified were not adequately addressed. While the QM Service was reorganized and staff were added, we found no apparent improvement in QM Service efficiency or effectiveness. Committee structure and communication may have been modified, but documentation in committee minutes was often poor and did not reflect quality oversight in important patient care areas. We confirmed that staff received PI

education, and PI activities were occurring in other clinical service areas; however, we did not find any evidence that the QM Service submitted an annual report to management. As a result, System managers could not be assured of a comprehensive, effective QM oversight process capable of identifying and resolving quality and patient safety issues.

Mortality Review and Analysis. In the 2004 CAP report, we noted that the QM managers did not collect, trend, or analyze mortality data. The System's corrective actions included improved data collection with subsequent reporting and analysis of mortality data.

We found, in 2006, that the System made some improvements in mortality data collection and trending; however, we identified deficiencies in the mortality review process that could delay identification of adverse events. The Risk Manager told us that, at the end of each month, he generates a list of patient deaths from the previous month and completes a retrospective medical record review to identify quality of care issues. In addition, System staff must report unusual or unexpected deaths as they occur. We determined that the current process could allow some deaths not to be reviewed for 30 days or longer. Should a patient death require further investigation, it is critical to collect data and conduct interviews promptly so that important information is not lost.

Additionally, we found that since mortality reviews were not always conducted immediately after the deaths, managers could not be assured that potential or actual adverse events were identified timely, or that peer reviews were initiated according to policy. Failure to conduct timely mortality reviews can result in missed opportunities to improve patient care.

Patient Safety – RCAs. In the 2004 CAP report, we noted that patient safety processes were insufficient to assure safe patient care. Specifically, we reported delays in identification of adverse events and inadequate trending and analysis of adverse event information. The System reported corrective actions that included hiring a patient safety officer in September 2004,[4] revising processes for RCA presentation beginning in August 2004, and improved entry of adverse event data.

We found, in 2006, that significant elements of the patient safety process did not comply with VHA guidelines. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*,[5] specifies the identification, evaluation, reporting, documentation, and follow-up requirements for potential and actual adverse events. When appropriate, action plans should be implemented to prevent future occurrences of similar events, and outcomes should be measured to ensure that corrective actions have the desired effect.

[4] A patient safety specialist was also hired in October 2005.
[5] Issued January 30, 2002.

We found deficiencies in all 19 RCAs (9 individual and 10 aggregates[6]) that should have been chartered or completed in FY 2006. We found that four aggregate RCAs were not processed as required. Of the remaining 15 RCAs, we found that none were completed within the 45-day requirement, and only 6 (40 percent) had been finalized at the time of our review. The System was aware of some adverse events for as long as 9 months before chartering the RCAs. In addition to the 19 RCAs we reviewed, we also identified two adverse events detailed in patient incident reports where RCAs could have provided meaningful information, but those RCAs were not chartered.

Although six RCAs had been completed, they all lacked the required team member and management signatures. In addition, all six completed RCAs had some incomplete action plan elements, and all had some outcomes that had not been evaluated for effectiveness. The VISN and the National Center for Patient Safety had oversight responsibility but had not recognized that the RCAs were not complete or timely. Without identification, reporting, documentation, and follow-up of significant patient outcomes and events, managers could not be assured of comprehensive and efficient patient safety processes.

Data Tracking, Trending, Analysis, and Reporting. In the 2004 CAP report, we noted that System staff collected QM data but did not consistently conduct analysis or trending, recommend corrective actions, or assign time frames for the completion of actions. The System reported corrective actions including increased tracking and trending of information by various medical staff committees.

However, in 2006, we did not find evidence that data was consistently collected, trended, or analyzed, or that corrective actions were taken for high-risk processes. Further, medical staff committee minutes lacked documented discussion of data on a routine, consistent basis for many program areas, as follows:

- The System did not continue to monitor blood and blood component request data, even though reports showed that between 31 and 75 percent of the request forms were incomplete for January 2005 through August 2005.

- Transfusion Review Workgroup minutes did not include blood usage reports from February 2006 through June 2006.

- The Executive Committee of the Medical Staff (ECMS) did not address a Medical Records Committee recommendation to administratively close delinquent medical records.

- The Medical Records Committee did not follow up on deficiencies identified in the Inpatient and Outpatient Medical Record Audits for September 2005 through

[6] Based on VHA requirements, there should have been 12 aggregate reviews completed for FY 2006. However, 2 quarterly medication event aggregate reviews included data covering more than 1 quarter.

September 2006. Reports showed consent forms were absent in 5 percent of the medical records reviewed and that pain assessments were incomplete 22 percent of the time.

- Patient Safety Committee meeting minutes from February 2005 through September 2006 reflected the identical restraint usage report for 15 of 19 months and did not document follow-up action based on the data.

- ECMS and Quality Council meeting minutes during FY 2006 did not reflect mortality data analysis or discussion.

- ECMS minutes for FY 2006 did not include review or analysis of UM data.

- ECMS minutes for FY 2006 did not reflect review of Peer Review Committee (PRC) meeting minutes.

- The Operative and Other Invasive Procedures Committee met only four times in 2006 rather than monthly, as required by local policy. In addition, minutes did not routinely reflect discussion of procedure complications or of National Surgical Quality Improvement Program (NSQIP) and Continuous Improvement in Cardiac Surgery Program (CICSP) statistics.

JCAHO requires data aggregation and analysis to identify patterns and trends and determine variability or unacceptable levels of performance. System policy requires reporting of data to responsible medical center committees for review, analysis, and action, as appropriate. Without appropriate data management and follow-up activities, managers could not be assured that patient care and patient safety processes were functioning effectively, or that PI activities were initiated when indicated.

During our 2006 CAP review, we found the following conditions that had not been previously identified:

Peer Review. The peer review process did not include all components required by VHA Directive 2004-054, *Peer Review for Quality Management*.[7] Peer review is a confidential, non-punitive, and systematic process to evaluate quality of care at the individual provider level. The peer review process includes an initial review by a peer of the same discipline to determine the level of care,[8] with subsequent PRC evaluation and concurrence with the findings. We reviewed the FY 2006 peer review database (the database) and identified issues relating to timeliness, documentation, tracking, and evaluation of reviews.

[7] Issued September 24, 2004.
[8] Peer review levels: Level 1 – Most experienced, competent practitioners would have managed the case similarly; Level 2 – Most experienced, competent practitioners might have handled the case differently; and Level 3 – Most experienced, competent practitioners would have managed the case differently.

Timeliness: Once the need for peer review is determined, VHA requires initial reviews to be completed within 45 days and PRC evaluations within 120 days. The database showed that 22 (35 percent) of 63 initial reviews were not completed within the required 45 days, and 21 (33 percent) of 63 final peer reviews were not completed by the PRC within the required 120 days.

Documentation: VHA requires documentation of discussion and recommendations resulting from final peer review to be documented in meeting minutes. According to the database, the PRC changed 23 (37 percent) of 63 initial peer review levels from a Level 3 to a lower severity level. However, PRC meeting minutes for the same period did not reflect the discussion or rationale for changing any of the initial peer review levels.

Quarterly Tracking: VHA requires quarterly tracking of peer review activity including information on number of reviews, outcomes by level, number of changes to level, follow-up of action items, and recommendations that result from completed peer reviews. During FY 2006, there was no documentation of the required quarterly tracking in the PRC meeting minutes.

Level 1 Evaluation: VHA requires review of a representative sample of Level 1 peer review cases to ensure reliability of the findings and to evaluate the peer review process. We found that the PRC did not complete required reviews for the Level 1 cases during FY 2006.

When conducted systematically and credibly, peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual providers' practices. When peer review is not conducted in accordance with policy, managers cannot be assured that patients consistently receive treatment and services according to accepted community standards.

Adverse Event Disclosure. The System did not adequately document compliance with VHA policy requiring disclosure of adverse events. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, requires VHA facilities to inform patients and their families of unanticipated outcomes of care. VHA Directive 2005-049, *Disclosure of Adverse Events to Patients,*[9] requires clinical disclosure within 24 hours of a practitioner's discovery of an adverse event. Individual providers are obligated to disclose adverse events to patients harmed in the course of their care, including when harm may not be obvious or severe.

The System Risk Manager identified five events between July 2005 and September 2006 that required clinical disclosure. We reviewed the patient records for these events, along with supporting documentation provided by the Risk Manager, and determined that three

[9] Issued October 27, 2005.

of five did not contain adequate documentation of clinical disclosure or the reasons that disclosure could not be accomplished.

During our review of one of these cases, we could not locate results of the Ethics Committee consultation, documentation of autopsy, or the coroner referral for this unexpected death. We have referred the case to System management for further review.

Without adequate disclosure practices, managers could not be assured that patients were provided with timely and accurate information needed to make decisions.

Operative Reports. The Medical Records Committee identified 220 delinquent operative reports and 15 delinquent brief post-operative notes dating back to January 31, 2006. Medical staff bylaws require operative reports be dictated or written immediately after any invasive procedure. The bylaws further require that when an operative report is not placed in the medical record immediately following an invasive procedure, a brief post-operative note should be entered into the medical record. The volume of delinquent operative reports, spanning a 9-month period, should have prompted corrective actions earlier; however, Surgical Service did not present an action plan until October 29, 2006. Without the immediate documentation of a brief post-operative progress note and immediate dictation of the operative report, managers cannot be assured that important clinical information is available should complications arise.

Patient Safety Alerts. Follow-up actions were not adequately documented in 6 of 23 (26 percent) of the patient safety alerts and advisories issued by JCAHO and VHA during FY 2006. The patient safety alerts and advisories where follow-up actions were not documented included a tissue recall, potential fire risks, and medical equipment concerns. The *National Center for Patient Safety Quick Reference Guide for Patient Safety Officers and Patient Safety Managers* states that the patient safety officer serves as the point of contact for patient safety alerts and advisories and has responsibility for tracking of corrective actions. Without adequate follow-up and completion of required actions, managers could not be assured that avoidable risks had been mitigated.

UM. The System did not comply with VHA Directive 2005-009, *Utilization Management Policy*,[10] to officially appoint or train the physician advisor, who serves as a third party reviewer of all cases referred by the UM staff. It is important for the physician advisor to understand the responsibilities of the UM advisor role and be viewed by other clinical staff as credible and authoritative.

Recommended Improvement Action(s) 1. We recommend that the VISN Director and the System Director take action to ensure that a comprehensive, effective QM Program capable of identifying and resolving quality and patient safety issues is constructed at the System.

[10] Issued March 7, 2005.

The VISN and System Directors agreed with the findings and recommendations and reported that actions are being taken to recruit a skilled and experienced Quality Manager. In addition, an expert team of Quality Managers, along with Office of Quality Performance staff and National Center for Organizational Development staff are training System Quality Management staff. A skilled Patient Safety Manager has been recruited and will enter on duty in early February 2007, and the Risk Manager has been detailed to the Chief of Staff's office to improve visibility and monitoring. New or revised processes and committee oversight will assure that important QM and patient safety functions are completed appropriately and timely. The System addressed individual findings highlighted in the report and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Recommended Improvement Action(s) 2. We recommend that the VISN Director ensure that the System Director takes action to officially appoint and train the UM physician advisor.

The VISN and System Directors agreed with the finding and recommendation and reported that a physician advisor has been appointed and trained. Documentation is on file in the Chief of Staff's office. We consider this issue resolved and plan no further action.

Contract Nursing Home Program – Operations Needed Improvement

We reviewed the CNH Program to assess compliance with national policies regarding program management, the review process for contract renewal, and the monitoring of veterans in contract nursing facilities. We evaluated whether there were effective processes in place to more closely monitor the contract nursing facilities where deficiencies had been identified.

The System currently has 128 veterans in 51 contract nursing facilities. We selected five contract nursing facilities for review and visited two of them. We interviewed the administrators at these two sites. We conducted 10 medical record reviews and interviewed 8 veterans and 4 family members. Although CNH inspection teams conducted annual inspections, and the contract nursing facility administrators felt the CNH Program staff was accessible and responsive, we found several conditions requiring management attention.

Conditions Needing Improvement. Monitoring of veterans in contract nursing facilities, oversight of contract nursing facilities with deficiencies, and management of the CNH Program Review Team performance needed improvement to ensure that veterans in contract nursing facilities receive quality care in safe environments. We identified problems in the following Program components:

Ongoing Monitoring and Follow-Up Visits. CNH Program staff visited only 4 of 10 veterans in our sample monthly as required. One of the CNH Program nurses often missed visits, frequently failed to document visits, and regularly entered late entry progress notes regarding visits conducted a month earlier. VHA Handbook 1143.2[11] requires that a social worker or registered nurse visit every VA patient under contract in a nursing home at least every 30 days. Social workers and nurses are to alternate monthly visits. Although the CNH social worker visited the veterans under contract every other month, we found many instances where veterans were not visited during alternate months by the CNH Program nurse.

The CNH Program nurse at times wrote one progress note to cover more than one previous visit. For example, on November 14, 2005, she documented that she had also made visits to the veteran in August and October. Most of her progress notes were entered 1 month after the visit date; however, some were entered even later. We found a progress note entered on August 30, 2004, where she wrote "Late entry. CNH visit also made in May. Patient was stable. Charting and coding inadvertently omitted." The veteran's medical record reflected that in May the contract nursing facility had contacted the CNH Program social worker to report that the veteran's skin wound was worsening. He was seen at the medical center later in May, where physicians considered surgery for an infected wound. It did not appear that the veteran's condition was "stable" in May. Clinical information that is 3 months old is no longer useful in monitoring a patient's status.

It also appeared the CNH Program nurse inaccurately documented clinical information. For example, in one case, the nurse reported a veteran's weight and then later amended the note, documenting the veteran was a new admission and no weights were available. In another case, the nurse assessed that a veteran with multiple sclerosis was continent of bladder, and entered N/A [not applicable] where catheter use was to be documented. However, the veteran had been using a catheter for 2 years.

As the purpose of these visits is to monitor the medical conditions of these veterans and ensure they are receiving adequate care, it is imperative that information regarding their current status is accurate and is documented in their medical records.

Oversight of CNH with Deficiencies. Although four of the five contract facilities in our sample failed the quality measures criteria in their last state inspection, and three of five failed the exclusion review, we found action plans (a hold on placements or increased monitoring) in response to these deficiencies for only two of the contract facilities. The CNH Program utilized the "exclusion review" form as part of their initial and annual review. CNHs are to be excluded from the Program when they fail a certain number of factors considered to be indicators of quality. When this occurs, a waiver is required to renew a contract. When a facility fails, CNH Program managers can terminate the

[11] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, issued June 4, 2004.

contract, suspend admissions, require more frequent inspections, and increase veteran monitoring. We found that the CNH Program Review Team completed lengthy annual inspections, yet did not appear to use this information in their deliberation over contract renewal. Contracts were usually renewed for facilities that failed the exclusion review, but the rationales for renewal were not documented, and waivers were not requested.

Oversight of CNH Review Team. We identified other areas of program operation requiring improved oversight, as follows:

- CNH Program nurses and social workers used different billing codes for the same procedure.
- We found little accountability for a Government vehicle provided to a CNH Program nurse for facility visits. The nurse was not required to submit trip tickets signed by a supervisor and did not provide monthly accountability logs to the Motor Pool.
- CNH Program nurses may have violated patient privacy by reviewing non-veteran patients' medical records and by physically examining non-veteran patients at the contract facility without authority or consent.

CNH Program staff told us the nurses thought it was appropriate to review a percentage of all records during the inspection process. In reviewing wound care management, one CNH Program nurse examined all veteran and non-veteran patients at the facility with skin integrity issues. We brought this issue to management's attention for immediate corrective action.

The System did not establish an Oversight Committee until February 2006 although this was a VHA requirement since 2004. We learned that the System Director established the Oversight Committee due to "significant concerns about the ability of the CNH Review Team to provide appropriate oversight." This committee has met monthly since that time to implement a PI program and to bring the CNH Program into compliance. As our review covered only 5 of the 51 contract nursing facilities, and 10 of the 128 veterans under contract, we suggested the System Director request an external review of the CNH Program to determine if the issues we identified exist throughout the program.

Recommended Improvement Action(s) 3. We recommend that the VISN Director ensure that the System Director requires:

a. CNH Program nurses to visit veterans in contract nursing facilities and document veterans' medical records as required.
b. CNH Program staff to increase monitoring of contract nursing facilities not meeting quality or exclusion criteria and document the rationale(s) for contract renewal.
c. CNH Program staff to enter the appropriate range of billing codes for facility visits.
d. CNH Program staff to follow standard procedures when using a Government vehicle.
e. Appropriate action is taken regarding nurses who violated the privacy of non-veteran nursing home patients.

The VISN and System Directors agreed with the findings and recommendations and reported that CNH Program staff are entering appropriate notes in both CNH and VA medical records, and compliance is being tracked monthly. All CNHs have corrective action plans that require increased VA monitoring, with quarterly reporting to the CNH Oversight Committee. Staff have been trained and are using consistent, appropriate procedure codes; the most recent audit found 100 percent compliance. CNH employees are following procedures for use of Government vehicles. The CNH Program nurse who introduced the VA-private pay comparison is no longer employed at the System, and staff have been advised that evaluation of private pay nursing home patients is improper. The System provided acceptable improvement plans to address the identified issues. We will follow up on the planned actions until they are completed.

Community Based Outpatient Clinics – Some Administrative Functions Could Be Improved

Condition Needing Improvement. CBOCs were designed to improve veteran access to health care by offering primary care in local communities. CBOCs are supposed to meet standards of care and contract requirements. At the GCBOC, we found hard-copy medical records were not always secured, the contractor's annual performance reports did not contain all reporting elements, and the System's oversight of GCBOC operations was not always sufficient to ensure that veterans received care according to the contract.

Greenville is a rural community about 60 miles from the Dallas facility. The GCBOC is staffed by subcontractors of a nationally recognized health care provider that was awarded multiple VA CBOC contracts across the country. The GCBOC served 302 unique veterans in FY 2006. We interviewed key individuals at the Dallas facility and the GCBOC; we also reviewed GCBOC policies, service provision and performance documents, and provider C&P files. We also conducted an EOC inspection in the CBOC. The purpose of this review was to assess CBOC operations and compliance with contract requirements, and to examine VHA oversight of CBOC activities and services in relation to the contract. We found the following deficiencies requiring management attention:

- The contract requires use of the Computerized Patient Record System (CPRS) in the GCBOC; however, due to some hardware and access issues, hard-copy records were still being used. During our environment of care inspection, we found stacks of unsecured hard-copy medical records in two providers' unlocked and unoccupied offices; we did not determine whether any were veterans' records. The System's policy on medical records management[12] states that medical records are confidential and will be safeguarded from disclosure at all times. While we did not find any evidence that patient information was improperly accessed or compromised, we found

[12] System Memorandum No. MR-1, *Medical Records Management Committee*, March 9, 2004.

the practice of leaving medical records unsecured unacceptable. CPRS will be implemented at GCBOC by late November 2006, an action that should largely eliminate the need to maintain hard-copy medical records on veteran patients.

- Per the contract, the contractor is required to submit an annual report to the System that outlines their performance in 11 areas. While the contractor completed annual reports, those reports did not contain data on all required performance elements, such as emergency room visits, grievances, and release of information times. The contractor agreed to modify the annual report format to include all required performance elements.

- In December 2004, the System inspection team noted that GCBOC records did not contain documentation of Advance Directive discussions or needs assessments for patient education. This report recommended that the GCBOC be given 30 days to submit a plan of correction. We found no evidence of a corrective action plan, and these documentation deficiencies were identified again in January and September 2006.

Despite the above deficiencies, we found that other areas of the CBOC were functioning satisfactorily. For example, C&P files were in order, policies were in place, staff was knowledgeable about the clinic and its services, and patient satisfaction scores were improving.

Recommended Improvement Action(s) 4. We recommend that the VISN Director ensure that the System Director requires:

a. Timely implementation of CPRS at all CBOCs.
b. CBOC staff to properly secure veterans' medical information.
c. Designated System staff to review the contractor's annual report for all appropriate performance elements.
d. Designated System inspection team members to follow up on inspection deficiencies and assure completion of corrective actions.

The VISN and System Directors agreed with the findings and recommendations and reported that CPRS has been implemented at all but one CBOC; the remaining CBOC anticipates full implementation by mid-February 2007. Privacy and security training has been completed by CBOC staff, and medical record security is included in the annual CBOC inspection. Annual reports must now be completed using a template that includes all performance elements, and inspection deficiencies will be followed up to ensure appropriate resolution. The System provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Cardiac Catheterization – Informed Consents Needed Improvement

Condition Needing Improvement. System clinicians did not document informed consents for cardiac catheterization procedures in accordance with VHA policy. The purpose of this review was to determine if the System's cardiac catheterization laboratory practices were consistent with professional association standards[13] and VHA policy.

We reviewed the medical records of 10 patients who underwent cardiac catheterizations in FY 2005. Three of the informed consents lacked the name of the attending physician, and six lacked the names of the participating fellows. VHA policy requires that informed consents include the names of all practitioners in the performance of the procedure. As a result, managers could not be assured that the patients were adequately informed of the names of the clinicians performing any part of their procedure.

Recommended Improvement Action(s) 5. We recommend that the VISN Director ensure that the System Director requires staff to complete informed consents for cardiac catheterization procedures consistent with VHA policy.

The VISN and System Directors agreed with the findings and recommendations and reported that the cardiac catheterization laboratory has implemented the iMed electronic consent form which requires the completion of mandatory information fields. The process will be audited for compliance. The System provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Other Focused Review Results

Environment of Care – Facilities Were Clean and Well Maintained

The purpose of the evaluation was to determine whether the System established a comprehensive EOC program that met selected VHA, Occupational Safety and Health Administration (OSHA), and JCAHO standards and to follow up on issues identified during the 2004 CAP review. To evaluate EOC, we inspected selected clinical and non-clinical areas at both the Dallas and Bonham facilities, paying particular attention to those issues noted in the 2004 report. We inspected units for cleanliness, safety, infection control, and general maintenance. Overall, we found System facilities to be clean and well-maintained and previously identified issues to be resolved. Managers provided excellent documentation of EOC rounds and timely abatement of identified conditions. Nurse managers reported that housekeeping staff assigned to their units were conscientious and that Engineering Service's Quick Response team was fast and effective.

[13] *American College of Cardiology and the Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards*, June 2001.

We noted an Environmental Management Service initiative that enhanced employee safety. Managers provided an alternative to fabric bags for soiled (sometimes wet) linen by purchasing well-built rolling frames that held a supply of disposable plastic bags. The large step-on bar that opened the lid was designed to promote hands-free use, while the attached lid meant that soiled linen was always covered. The filled leak-proof bags, smaller and lighter than fabric bags, were rolled, not carried, to the linen chute, which decreased the possibility of employee back injuries.

Diabetes and Atypical Antipsychotic Medications – Monitoring and Treatment Were Appropriate

We reviewed the medical records of 13 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) who were on these medications for at least 90 days in FY 2005. We evaluated the effectiveness of diabetes screening, monitoring, and treatment by reviewing the hemoglobin A1c (HbA1c - the average blood glucose level over a period of time), the blood pressure, and the cholesterol level of diabetic mental health patients receiving these medications.

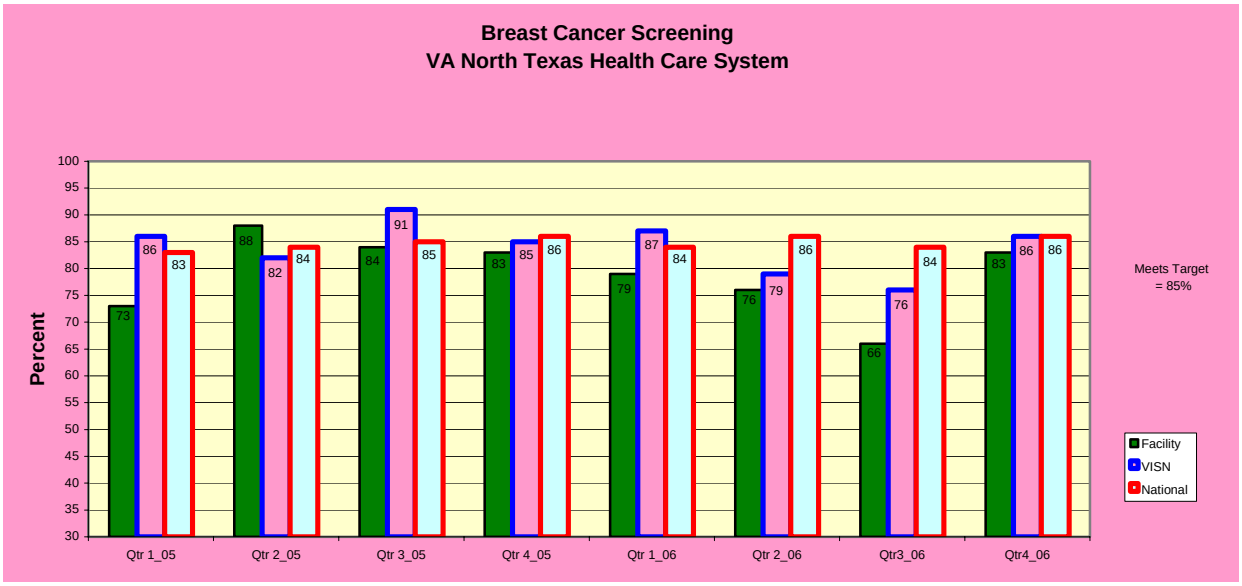
We found that clinicians performed effective monitoring and treatment of the four diabetic patients in our sample. The nine non-diabetic patients were appropriately screened for diabetes and counseled about diabetes prevention.

We noted that the System's clinicians collaborated with several other VHA clinicians studying atypical antipsychotic medications and side effects and published results in a professional journal in July 2006.[14]

Breast Cancer Management – Corrective Actions Were Implemented

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed time frames. Timely screening, diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to appropriate management of breast cancer patients and optimal patient outcomes. The following table illustrates the System's breast cancer screening performance.

[14] M. Lambert, L. Copeland, N. Sampson, and S. Duffy, *New-onset type-2 diabetes associated with atypical antipsychotic medications*, Progress in Neuro-Psychopharmacology and Biological Psychiatry, Volume 30, Issue 5, July 2006, pp. 919–923.



While the System met the performance measure target score (85 percent) for only 1 quarter in FYs 2005 and 2006, System managers had recognized the deficiencies in breast cancer screening and implemented corrective actions. Those actions included reducing no show rates, identifying patients due for screening, provider education on the breast cancer screening process, expanding the Well Women's Clinic to 5 days a week, and the purchase of a second mammography unit, which will be in place in January 2007.

We reviewed the medical records of female veterans diagnosed with breast cancer in FY 2005 and found that, in general, women received screening mammograms, timely biopsies, consultations, and treatments. Clinicians communicated well with patients, keeping them informed of test results and involving them in the treatment planning process. We found patient care was well coordinated.

Patient Satisfaction – Managers Were Addressing Deficiencies

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in 12 service areas including access to care, coordination of care, and courtesy. VHA relies on the analyses, interpretations, and delivery of the survey data for making administrative and clinical decisions to improve the quality of care delivered to patients. The following tables show the System's performance in relation to national and VISN performance. VHA's Executive Career Field Performance Plan states that in FY 2006, at least 77 percent of ambulatory care patients treated and 76 percent of inpatients discharged during a specified date range will report their experiences as very good or excellent. Healthcare systems are expected to address areas in which they are under performing.

VA North Texas Health Care System Outpatient SHEP Results Q2 FY06

Facility Name	Facility Number	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	**National**	**80.7**	**78.1**	**94.8**	**72.6**	**83.3**	**75.8**	**81.5**	**65.5**	**81.7**	**80.8**	**84.7**
VISN	Overall	72.7	73.1	91.4	68	79.2	71.6	78.2	59.7	76.9	77.8	79.7
System OPC Clinics – Overall	549	69.1	65.4	89.6	66.8	78.3	69.7	74.1	51.2	74.1	77.7	76.8

VA North Texas Health Care System Inpatient SHEP Results Q1 & Q2 FY 06

Facility Name	Facility No.	Bed Section	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	**National**	**All**	**81.31**	**78.63**	**89.95**	**68.02**	**65.80**	**75.85**	**83.41**	**74.49**	**70.03**
VISN 17	Overall	ALL	77.3	76.4	87.5	65.3	63.2	74.9	81.4	72.8	66.9
System	549	ALL	71.7	70.3	86.2	63	61	71.9	81.8	70.2	61.9

The System had a designated SHEP Coordinator who completed a sophisticated analysis of SHEP results and reported this data to top management and Service chiefs. In addition, the System's Customer Service Council was active and engaged in multiple initiatives including an Ambassador/Greeter program, "mystery shoppers,"[15] Quick Cards (feedback cards), and Service Recovery. Action plans were developed for those areas needing improvement. For example, to reduce pharmacy wait times, Pharmacy Service was encouraging patients to refill their medications by mail. Requesting medication refills at the window is unplanned work which delays completion of other medication orders. System managers were also taking action to revise CBOC contracts to reflect more specific patient satisfaction performance requirements. SHEP scores and performance improvement initiatives were adequately communicated and documented, and the effectiveness of corrective actions was evaluated.

While the System's SHEP scores often fell below the established goals, we found that appropriate actions were being taken to address patient satisfaction issues.

[15] Someone who investigates customer service while pretending to be a customer or potential customer.

All Employee Survey – Managers Were Taking Appropriate Actions To Improve Employee Satisfaction

The System utilized AES data to improve employee satisfaction. VHA administers the AES to assess employee satisfaction in three dimensions: job satisfaction index, organizational assessment inventory, and culture. Healthcare systems use the results to target areas for improvement.

Prior to implementation of the 2006 survey, the new AES Coordinator "mapped" staff to individual units so that pertinent survey results could be unbundled and sent to individual Service chiefs or work units for follow up action. Staff were reminded of the upcoming survey and encouraged to participate. The System's AES employee response rate was 80.4 percent, more than 15 percentage points higher than the average of the response rates for other VISN 17 facilities.[16]

The AES Coordinator conducted a sophisticated analysis of the 2006 AES scores. The results showed that employee satisfaction scores at the Bonham facility were consistently higher than VISN 17 mean scores, and scores at the Dallas facility were consistently lower than VISN 17 mean scores in all three dimensions. The Fort Worth OPC scores were not significantly different from VISN 17 mean scores. System managers communicated results through Town Hall meetings, staff meetings, and e-mailed bulletins. The System's overall AES action plan for 2006 was comprehensive and targeted three priority areas for improvement: praise, customer satisfaction, and rewards. Specific actions, target dates, and outcomes for each priority had been established. In addition, all Services developed action plans to address deficiencies in their areas.

Two of the three facilities that comprise the System generally met or exceeded goals for employee satisfaction. While the Dallas facility's 2006 AES scores fell below expectations, it is our opinion that the management team is making efforts to improve employee satisfaction and organizational culture.

[16] The calculation excluded the VISN 17 Office, which is primarily administrative.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 16, 2007

From: Director, VA Heart of Texas Network (10N17)

Subject: **Draft Report –** Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas MCI #2006-03482-HI-0426

To: Assistant Inspector General, Office of Healthcare Inspections

1. Network 17 appreciates the OIG's review and recommendations concerning the VA North Texas Health Care System. Each action plan has been designed to completely address all issues identified within the recommendations. The VISN office is taking both the recommendations and the corrective actions very seriously. We will continue to monitor and ensure all recommendations are completely satisfied by the Target Completion Dates.

2. Shoud you have any questions or require additional information, please contact Ms. Maureen Washburn, VISN 17 Continuous Readiness Officer, 817-385-3793.

//s//

Thomas J. Stranova

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 16, 2007

From: Director, VA North Texas Health Care System (549/00)

Subject: **Draft Report –** Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas MCI #2006-03482-HI-0426

To: Director, VA Heart of Texas Health Care Network

1. I want to express my appreciation to the Office of the Inspector General (OIG) Review Team for their professional and comprehensive Combined Assessment Program (CAP) review conducted October 30 - November 3, 2006. I have reviewed the draft report for VA North Texas Health Care System. I concur with the findings, recommendations, all comments, and planned actions.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

//s//

Betty Bolin Brown

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

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

OIG Recommendation(s)

Recommended Improvement Action(s) 1. We recommend that the VISN Director and the System Director take action to ensure that a comprehensive, effective QM Program capable of identifying and resolving quality and patient safety issues is constructed at the System.

Concur **Target Completion Date:** July 31, 2007

VISN 17 is working with VA North Texas Health Care System (VANTHCS) to ensure a comprehensive and effective Quality Management Program. VANTHCS continues its extended recruitment effort to acquire an experienced, skilled Quality Manager. While recruitment proceeds, an expert team of Quality Managers, along with the Office of Quality Performance and the National Committee on Organizational Development, are assisting with the support and training of the VANTHCS Quality Management staff. VANTHCS has appointed an Acting Quality Manager. An experienced Patient Safety Manager has been hired and is scheduled to report for duty Feb 2, 2007. A permanent Chief of Staff was appointed in November 2006. The Chief of Staff, his Administrative Assistant and his Secretary are working with the Acting Quality Manager to ensure tracking, trending, analysis, and reporting of medical staff functions. Processes have been established that ensure RCAs, Peer Reviews, and other required activities will be documented within specified timeframes and provide readily available documentation of outcomes and actions. Regarding the program areas identified as deficient during the review:

- QM oversight

Quality management staff, working with the Office of the Chief of Staff and other senior leaders, will provide oversight of compliance with medical staff monitoring and other required functions. Committee charters are being reviewed and revised when indicated. QM staff are taking measures to ensure a more proactive involvement in the work processes of committees. Tracking mechanisms (grids) specific to each committee will prompt QM oversight to ensure strategic alignment with HCS goals, appropriate support of patient care and safety processes, and tracking of recommended actions to completion. The Executive Committee of the Medical Staff (ECMS) agenda has been revised to include the review of deficient program areas as recurring items. All minutes and monitoring of required activities are now required to be transmitted electronically to QM and must include electronically imbedded attachments and data to avoid detached and lost paper copies.

- Mortality review and analysis

All deaths continue to be reported each morning to senior leaders, the Quality Manager, and Patient Safety Manager so that unusual deaths or issues requiring follow-up are identified in a timely manner. This was the VANTHCS practice prior to the OIG visit and will continue. Mortality reviews of all unusual deaths are conducted immediately. Mortality reviews of expected deaths are initiated within four business days. The Risk Manager has been detailed to the Office of the Chief of Staff. This increased visibility will ensure that this activity is closely monitored. Additional QM staff members are working with the Risk Manager on mortality reviews to ensure timeliness. All mortality reviews are current at this time.

- Patient safety
    - root cause analyses
    - patient safety alerts

All RCAs reviewed at the time of the CAP review now include signatures and have been completed. Since the OIG CAP review, all RCAs are chartered within 24 hours and tracked to ensure completion within the required time frame.

VANTHCS concurs that the supporting documentation for some of the Patient Safety Alerts was not organized in advance and was not adequately presented during the review; however, follow-up actions were documented for all Patient Safety Alerts. The new Patient Safety Manager is now accountable for Patient Safety Advisories and Alerts and has the responsibility for tracking corrective actions to assure avoidable risks are mitigated. The Patient Safety Advisories/Alerts where follow-up actions were not adequately presented included the following:

- The VHA Patient Safety Advisory (#AD 06-06, dated August 24, 2006) concerning the shutdown of Donor Referral Services Tissue Harvesting Co. by the FDA was actually addressed prior to the issue date. The VISN 17 Network Patient Safety Manager contacted VANTHCS on July 11, 2006, inquiring if any patients had received tissue from companies listed in the VHA advisory. VANTHCS identified three patients who received tissue from these companies. The three patients were sent letters of notification on August 17, 2007. Two of the three patients received testing as directed in the advisory, one on September 5, 2006 and the other on November 15, 2007). Both patients' tests were negative. The third patient has not been seen at the VA since September 2005. Since the review, attempts to notify the third patient and next of kin have been unsuccessful. The case was referred to the VA police for assistance with locating the patient. The patient was located and has an appointment to come in for lab work on January 24, 2007.

- Designation of a specific location requested in Patient Safety Advisory (#AD06-04) dated March 16, 2006, concerning liquid oxygen and potential fire risks, was accomplished on April 11, 2006. The required training for all respiratory therapists was not complete at the time of the review; however, it is scheduled for completion by the end of January 2007.

- Patient Safety Alerts concerning medical equipment, Alaris IV tubing (#AL06-10, dated March 6, 2006) and Alaris Infusion Pumps (#AL06-16, dated August 30, 2006) were addressed by providing appropriate training for the nurses and affixing the required labels to the infusion pumps. The nurses were trained between March 1, 2006 and March 31, 2006, before the review. The labels were affixed to the Alaris Pumps over a period of three months, between September 5, 2006 and December 15, 2006.

- Data tracking, trending, analysis, and reporting

  - blood usage

  - restraints

  - medical records

Blood usage has been meticulously monitored on a monthly basis for many years. The Chief of Pathology and Laboratory Medicine has mandated inclusion of blood usage reports as a recurring agenda item for the Transfusion Review Workgroup. The minutes of the Transfusion Review Workgroup are forwarded to the ECMS.

VANTHCS has been selected as a beta test site, and is one of the first sites scheduled to go live, with the VHA bar code expansion project. As a result, Nursing Service has initiated a process for monitoring blood order request forms. The improved process is designed to monitor 100% of the forms concurrently in patient care areas. (The previous monitoring system reviewed a sample of approximately 50 forms per quarter). This new process models the bar code expansion project. Results of the monitoring indicated a significant improvement in completion of the forms used to order blood with an 89.5% completion rate of 361 forms from August through December 2006. Under the new system, two areas of the medical center needing improvement have been identified and PI activities are underway.

It was the Nurse Manager Council, not the Patient Safety Committee, that monitored and took action to reduce restraint usage. The Patient Safety Committee received restraint data from the Nurse Manager Council through the Quality Management Service biannually. The electronic format of the Patient Safety Committee minutes template was set to repeat the same data until the next due date for the report. Unfortunately, even though data had been forwarded to the committee, the data had not been rolled over into the template by the due date. Thus, current restraint usage data was not reflected in the templated report. VANTHCS is proud of the 50+% reduction in restraint usage documented from September 2005 through September 2006. Effective immediately, monthly reports will be sent directly to the ECMS for review.

A different physician has been assigned Chair of the Medical Records Committee and a second physician with a keen interest in medical record review as a means of validating appropriateness of patient care joined the committee in January 2007. The following process improvements are underway:

- The IMED consent process will be universally implemented by September 2007 which should ensure universal availability of consent forms. In those interim instances when paper consents are used, any paper consent form completed must be hand-carried to the Medical Records Department for scanning. VANTHCS initiated a 100% audit of the consent process. This audit will continue through January 2007 to validate performance in accordance with VHA policy and is reported to the Medical Records Committee. The Medical Records Committee minutes are forwarded to the ECMS for further action as appropriate. After January 2007, a random sample of consents will be monitored on a monthly basis and reported to the Medical Records Committee to ensure ongoing compliance with VHA policy.

- A Pain Management Workgroup was chartered November 21, 2006, to ensure consistent definition, monitoring, and documentation of pain management throughout the medical center. The workgroup includes representatives from Nursing Service, Quality Management, and the Medical Records Committee. The workgroup will develop audit tools for use by the Medical Records Committee for assessing and reporting the efficiency of the pain management program.

- The ECMS approved the local policy, "Closure of Incomplete Delinquent Medical Records," during its November 2006 meeting to ensure compliance with VHA Handbook 1907.1, Health Information Management and Health Records.

- Peer review

The reporting of Peer Review Committee minutes has been made a recurring ECMS agenda item to ensure regular review by the ECMS.

The Risk Manager has been detailed to the Office of the Chief of Staff. Peer reviews are now being completed in a timely manner and currently all initial reviews have been completed in 45 days and all final reviews have been completed in 120 days. First Qtr FY07 tracking data was presented at the January PRC and at the ECMS meeting and the data were included in the minutes of both. Changes to a lower level now include discussion and documentation in the minutes.

- Adverse event disclosure

The VANTHCS Adverse Event Disclosure policy, revised to be consistent with the VHA Directive 2005-049, has been approved. Renewed efforts are underway to ensure a clear understanding of facility expectations regarding the requirements for the reporting of adverse events.

- Operative and other invasive procedure review

The Operative and Other Invasive Procedure Committee (OOPC) met a total of six times in FY 06. At the March 16, 2005 meeting, the OOPC documented the decision to meet quarterly after the November 2005 JCAHO Review. Unfortunately, the policy was removed from the webpage, but not rescinded. The policy will be updated. The OOPC developed a schedule for reporting complication rates for the year at the March 22, 2006 meeting. Prior to that meeting, the data reported included bronchoscopy complication reports, resuscitation data, blood usage reports, moderate sedation complications, NSQIP and CSQIP data, universal protocol, performance measures (particularly the SIP measures) and delays in the operating room. The need for additional data will be discussed at the January 2007 meeting. CSQIP and NSQIP data have been routinely reported for the past year and the committee minutes will be made more comprehensive to reflect the discussion about this and other data. The reporting of OOPC minutes has been made a recurring ECMS agenda item.

From January 31, 2006 to October 31, 2006, 4,851 surgical cases were performed at VANTHCS. There were 220 incomplete Operative Reports at the time of the OIG CAP review. This 4.5% incomplete rate is unacceptable. A newly assigned employee is now compiling the Medical Records Delinquency Reports in a timely and accurate manner. The majority of the delinquent operative reports can be attributed to contract physicians from the affiliate. The Dean of the affiliate has pledged his support to ensure records are complete. Of the 220 delinquent operative notes, only 10 notes are currently outstanding as of December 12, 2006.

- Utilization Management (UM)

While the UM review and reporting process information may not have been adequately conveyed to the OIG reviewers, a process was in place to provide for the ECMS review of UM data and analysis. Quarterly presentations regarding UM were made to the ECMS as well as to the semi-annual meetings of the entire medical staff. Utilization Management Reporting has been made a recurring ECMS agenda item to ensure regular review or analysis of UM data.

Recommended Improvement Action(s) 2. We recommend that the VISN Director ensure that the System Director takes action to officially appoint and train the UM physician advisor.

Concur **Target Completion Date:** Completed

The System Director signed an official document appointing the UM physician advisor who had been serving in that capacity. Official training for the UM physician advisor has been accomplished and certification of the training is on file in the Office of the Chief of Staff.

Recommended Improvement Action(s) 3. We recommend that the VISN Director ensure that the System Director requires:

a. CNH Program nurses to visit veterans in contract nursing facilities and document veterans' medical records as required.

Concur **Target Completion Date:** Completed

Nurses and social workers assigned to the CNH program are now entering a Progress Note in each patient's NH medical record (at the CNH) and CPRS for each visit. Notes are placed in the NH record at the time of the visit and in CPRS within 7 days. The CNH Program Coordinator is monitoring compliance monthly and reporting quarterly to the CNH Oversight Committee. Spot checks have recently been made to compare notes in CPRS with documentation at nursing homes and compliance was at 100%.

b. CNH Program staff to increase monitoring of contract nursing facilities not meeting quality or exclusion criteria and document the rationale(s) for contract renewal.

Concur **Target Completion Date:** Completed

At the time of the CAP review, 13 CNHs did not meet the exclusion criteria. VANTHCS had six of these homes on corrective action plans that increased monitoring at the time of review. Currently, all 13 CNHs are on corrective action plans. The CNH Program Coordinator monitors progress monthly and reports on the status of action plans to the CNH Oversight Committee quarterly.

The CNH Program Coordinator has instituted a process for consulting with the CNH Oversight Committee prior to any decision to renew a contract nursing home that fails exclusion criteria. The rationale for contract renewal will be clearly documented and a specific, individualized corrective action plan implemented to address the deficiencies.

c. CNH Program staff to enter the appropriate range of billing codes for facility visits.

Concur **Target Completion Date:** Completed

CNH program nurses and social workers were trained to use proper procedure codes on November 28, 2006. The CNH Program Coordinator is monitoring compliance and reporting quarterly to the CNH Oversight Committee. The CNH Program Coordinator has audited use of the codes to ensure appropriate codes are being used and has found 100% compliance.

d. CNH Program staff to follow standard procedures when using a government vehicle.

Concur **Target Completion Date:** Completed

All CNH employees have been trained on appropriate use of government vehicles. Trip tickets are completed every time a government vehicle is used. Engineering Service monitors use of government vehicles on a weekly basis and is in the process of converting the manual trip tickets to a computerized log which will make monitoring easier and increase accountability.

e. Appropriate action is taken regarding nurses who violated the privacy of non-veteran nursing home patients.

Concur **Target Completion Date:** Completed

The nurse who introduced the Medicare/Medicaid concept of comparing levels of care between government and private pay patients no longer works at VANTHCS. All CNH staff were instructed that such comparisons between veterans and private pay patients are inappropriate and will not be tolerated. A letter confirming this direction was sent to each employee. The practice of comparing levels of care has ceased.

Recommended Improvement Action(s) 4. We recommend that the VISN Director ensure that the System Director requires:

a. Timely implementation of CPRS at all CBOCs.

Concur **Target Completion Date:** February 16, 2007

VANTHCS had 10 contract CBOCs at the time of the CAP review. Since the review, one CBOC elected to allow its contract to expire on December 31, 2006. Of the remaining nine CBOCs, eight have fully implemented CPRS, which includes the CBOC visited during the OIG CAP review. The one remaining CBOC anticipates full implementation of CPRS by February 16, 2007.

b. CBOC staff to properly secure veterans' medical information.

Concur **Target Completion Date:** Completed

CBOC staff completed mandatory VANTHCS privacy and security training during FY 2006. The contractor conducted additional privacy and security training on November 9, 2006, following the CAP review. VANTHCS staff conducted a follow-up site visit on November 29, 2006 and found that all medical records (electronic and paper) were properly secured. Security of electronic medical records is a component of the annual CBOC review tool. The tool has been amended to include review of the security of paper records as well.

Information security and patient privacy has been added as a recurring agenda item on monthly CBOC conference calls.

c. Designated System staff to review the contractor's annual report for all appropriate performance elements.

Concur **Target Completion Date:** July 31, 2007

The CBOC coordinator has provided the contractor with a modified template that addresses each quality element outlined in the CBOC contract. This template will be used by the contractor when submitting the annual report. The CBOC contract(s) will be modified so that annual reports will be due 90-days prior to contract expiration for use in the contract renewal process.

d. Designated System inspection team members to follow-up on inspection deficiencies and assure completion of corrective actions.

Concur **Target Completion Date:** July 31, 2007

The CBOC Program Coordinator will coordinate and participate in annual CBOC inspections with QM, Safety, and the Medical Records Reviewer not less than 90-days prior to contract expiration. An inspection process has been clarified:

o A written report with deficiencies and recommendations will be submitted to the contractor and CBOC Program Coordinator within two weeks of the inspection.

o The contractor will then have two weeks to submit their plan of correction to the CBOC Program Coordinator.

o Based on the nature of the deficiency and/or whether it is a recurring deficiency, VA staff will make an unannounced follow-up site visit to assess compliance.

o Information obtained during the inspection process will be used in the contract renewal process.

Recommended Improvement Action(s) 5. We recommend that the VISN Director ensure that the System Director requires staff to complete informed consents for cardiac catheterization procedures consistent with VHA policy.

Concur **Target Completion Date:** July 31, 2007

The Cardiac Catheterization Lab implemented the iMed consent process after the referenced 2005 incomplete consent forms referred to in the review. Since the iMed consent process does not allow for completion of the consent form absent the appropriate providers' signatures, this recommendation has been addressed. In those rare instances when paper consents must be used (i.e., equipment malfunction), any paper consent must be hand-carried to the Medical Records Department for scanning. VANTHCS initiated a 100% audit of the consent process and this audit will continue through January 2007 to validate performance in accordance with VHA policy. After January 2007, a random sample of at least 20% of consents will be monitored and reported on a monthly basis to ensure ongoing compliance with VHA policy.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	Bertie Clarke, Healthcare Inspections Team Leader Patricia Conliss, Audit Manager John McDermott, Special Agent in Charge David Griffith John Houston Christa Sisterhen Toni Woodard Susan Zarter

Appendix D

Report Distribution

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