Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Tuscaloosa VA Medical Center Tuscaloosa, Alabama

Report No. 07-00157-97 **March 14, 2007**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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Contents

Executive Summary

Introduction

During the week of November 13, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Tuscaloosa VA Medical Center (referred to as the facility or VAMC). The purpose of the review was to evaluate selected facility operations, focusing on quality management (QM) and selected areas of patient care. The facility is under the jurisdiction of Veterans Integrated Service Network (VISN) 7.

Results of Review

This CAP review focused on five health care areas. The facility 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:

- Alabama State Quality Awards.
- Falls and Restraint Reduction.
- Hypertension Management.

We made recommendations in three of the five activities reviewed. For the activities of environment of care (EOC), breast cancer management, and the QM Program, the facility needed to take action as outlined below and on the next page.

Environment of Care

- Ensure all facility fire extinguishers are inspected monthly in accordance with the Life Safety Code.
- Ensure that EOC deficiencies are properly tracked and that data is analyzed, trended, and reported to the EOC Committee monthly.
- Ensure that Facility Management Service (FMS) develops a plan to ensure that the facility is properly maintained.
- Ensure the facility safety manager develops a process to ensure that all construction projects are reviewed for potential Interim Life Safety Measures (ILSM) impact, action plans are developed, and all reviews are reported to the Construction Safety Committee for review by the governing body.

Breast Cancer Management

- Ensure all biopsy results are communicated to patients.
- Ensure a Tumor Registry Program is implemented at the facility.
- Ensure that a tracking mechanism is implemented to follow patients through the continuum of care.

Quality Management Program

- Implement immediate investigations for all safety assessment code (SAC) 3 adverse events and complete individual root cause analyses (RCAs) within 45 days.
- Document peer reviews at the Chief of Staff level or by the Peer Review Committee for all deaths that meet the screening guidelines.
- Ensure that the physician advisor receives appropriate training for the Utilization Management (UM) Program.

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

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–17, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Facility Profile

Organization. The Tuscaloosa VA Medical Center is located in Tuscaloosa, Alabama, and provides a broad range of inpatient and outpatient health care services. There are no current or planned community based outpatient clinics. The facility is part of VISN 7 and serves a veteran population that includes 12 counties in western Alabama.

Programs. The facility provides primary care, mental health, geriatric, and rehabilitation services and provides access to secondary and tertiary care services. The facility operates 146 hospital beds and 198 nursing home beds.

Affiliations and Research. The facility has an active affiliation with the University of Alabama School of Medicine. Over 200 university residents, interns, and students are trained at the facility each year. There are nursing student affiliations with the University of Alabama and the University of Alabama at Birmingham. The facility also has affiliations with colleges and universities for schools of health care administration, business administration, dietetics, occupational therapy, physical therapy, speech-language pathology, telecommunication and film, advertising and public relations, and office administration.

In fiscal year (FY) 2006, the facility's research program had an estimated 44 projects and a budget of $805,907 ($301,304 in VA funding and $504,603 in non-VA funding). Important areas of research include the treatment of post-traumatic stress disorder (PTSD), depression, bipolar disorder, generalized anxiety disorder in persons over age 60, agitation in patients with dementia, vocational rehabilitation for patients with PTSD, palliative care, bereavement, and hospice care.

Resources. In FY 2006, medical care expenditures totaled approximately $85 million. FY 2006 staffing totaled 827.8 full-time employees (FTE), including 27.4 physician and 297 nurse FTE.

Workload. In FY 2006, the facility treated 14,656 unique patients. The facility provided 45,475 inpatient days of care in the hospital and 50,737 inpatient days of care in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 734 discharges, with 640 hospital and 94 nursing home discharges, respectively. The average daily census, including nursing home patients, was 287, with 136 hospital and 151 nursing home patients, respectively. The outpatient workload was 175,327 visits.

Objectives and Scope of the Combined Assessment Program 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 this

CAP review were to conduct recurring evaluations of selected health care facility operations, focusing on QM, the facility's EOC, and selected areas of patient care.

Scope. We reviewed selected clinical activities to evaluate the effectiveness of QM and patient care administration. We also conducted an inspection of the facility's EOC. QM is the process of monitoring the quality of patient care to identify and correct harmful and potentially harmful practices and conditions. Patient care administration is the process of planning and delivering patient care. EOC is the cleanliness and condition of the facility's patient care areas, the condition of equipment, adherence to clinical standards for infection control and patient safety, and compliance with patient data and medicine security requirements.

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

Breast Cancer Management	EOC
Diabetes and Atypical Antipsychotic Medications	QM Program
	SHEP

The review covered facility operations for FYs 2005, 2006, and 2007 through November 13 and was done 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. We also noted several organizational strengths of the facility during the course of the review, and we have included a brief description of these in this report.

Results of Review

Organizational Strengths

We identified the following organizational strengths.

Alabama State Quality Awards. The facility has been the recipient of two consecutive Alabama State Quality Awards that recognized the facility's QM improvement efforts. Specifically:

- The facility received Alabama State's highest and most prestigious award for Healthcare Quality in 2005—the Quality Award in Healthcare in 2005 (Level III). This was the only award to a VA facility in Alabama. The award cited the facility's use of seven Baldrige Boards to implement Baldrige criteria throughout the facility. The facility was also recognized for its work on the transition center for veterans returning from Iraq, as well as for the creation of the Hurricane Katrina Response and Recovery Center for veterans displaced by Hurricane Katrina.

- The facility also received the 2006 Alabama Quality Award of Excellence in Continuous Productivity and Quality Improvement. The award recognized the facility for the development of the Acting to Improve Medical Health Outcomes (AIM-HI). The award acknowledged the significant improvements made by the facility in the care of mental health patients related to cancer screening and diabetes management.

Falls and Restraint Reduction. The facility initiated a major safety initiative for FYs 2002 and 2003 with the goal of reducing falls with major injuries. Actions taken by the facility's team included implementation of the Morse falls scale, acquisition of special equipment for falls prevention (low beds, bed/chair alarms, and hip protector pads), and education of patient/staff on falls reduction. As a result of the facility's efforts, a reduction in rate of falls with and without injury has been sustained for several years. While reducing the injuries related to falls, the facility was able to significantly reduce the total number of restraint events over time from 1,240 events in FY 2000 to 6 events in FY 2006.

Hypertension Management. The process action team on hypertension implemented the following actions, which led to improved compliance on blood pressure (BP) control: (a) conversion to manual BP machines, (b) training and reinforcement of correct BP technique, (c) dispensing of home BP devices to patients, (d) development of clinical reminders and provider report cards on hypertension, and (e) referrals to a pharmacist for difficult to manage patients. As a result of these interventions, the facility improved its BP performance measure (PM) results by 43 percent between FYs 1999 and 2006.

Opportunities for Improvement

Environment of Care

Conditions Needing Improvement. VA policy requires that patient care areas be clean, sanitary, and maintained to optimize patient safety and infection control. We reviewed various facility EOC-related committee minutes for the period March through August 2006. We inspected all patient care areas and found conditions requiring management attention. The facility needs to address life safety and fire safety measures. Also, the facility needs to place increased emphasis on the general interior maintenance and appearance of the facility.

Fire Safety Review and Equipment Inspection Documentation. We conducted a review of fire safety documentation, as submitted to the facility's EOC Committee, for the period March through August 2006. This review included documentation of fire drills and fire safety equipment inspections.

The NHCU fire extinguishers were delinquent in receiving the required monthly inspection. The National Fire Protection Association (NFPA) requires that, "Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals."[1] During a visual review of individual fire extinguisher inspection cards, we found inspection frequency and dates of completion of this inspection during the first week of each month (5th–6th). However, as of the OIG inspection (November 13, 2006), the NHCU's monthly fire extinguisher inspection for November had not been completed, and the fire extinguishers were not in compliance with the NFPA Life Safety Code.

EOC Management Program. We found that the facility used an individualized monthly tracking report rather than a cumulative tracking system. While a "tour date" field is used on the facility's tracking spreadsheet, no "completed date" field is available for comparison against the facility's "14-day completion" PM, as stated in Medical Center Policy (MCP) 001-25, *Environment of Care Management Plan*.

Facility policy[2] requires the Chief of FMS to complete tracking of deficiencies observed by facility staff during scheduled EOC rounds. No review by the EOC Committee of the status of deficiencies (cumulative data, completion rates, and outliers) identified during EOC rounds was found in any EOC minutes.

Lack of reviewable and reliable information inhibits management's ability to attend to and monitor a safe environment for patients, staff, and visitors. The absence of an effective EOC deficiency tracking system, which provides timely and accurate data that

[1] NFPA Code 10-7.2.1.2.
[2] Facility's MCP 001-25, *Environment of Care Management Plan*, paragraph IV.4.

facilitates reviews and corrective action by facility staff and management, may create an environment where unsafe conditions remain uncorrected, thus compromising the safety of patients, staff, and visitors.

Maintenance and Repair Activities. A tour of the facility's NHCU was completed to validate the effectiveness of the facility's EOC rounds system. We documented 30 examples of maintenance and repair lapses in patient-occupied rooms and direct patient support areas. The EOC deficiencies we observed potentially compromised patient safety and health and included light fixtures and lens covers with potential to fall, peeling paint on the dementia unit, unsafe electrical switches, and exposed wiring.[3]

While we found exterior surfaces of the NHCU exhaust fans to be clean, internal control vanes, which are located beyond the exterior surfaces cleaned by housekeeping aids, were obstructed due to accumulated dirt and dust. This provides an environment in which bacteria, mold, and mildew can develop, which could compromise the health of patients and employees.

Construction Safety Committee Minutes. We reviewed the Construction Safety Committee minutes. The facility did not adequately document that they used appropriate criteria to assess life safety/fire safety issues related to construction projects. The Construction Risk Assessment and Fire Safety criteria of the NFPA 101: Life Safety Code[4] should have been discussed, reviewed, and approved by facility management for contractor and patient/employee safety issues. We found no evidence of a review using these criteria in the EOC Committee minutes or in any other facility management report. This is a repeat finding from the facility's FY 2005 Annual Workplace Evaluation.[5]

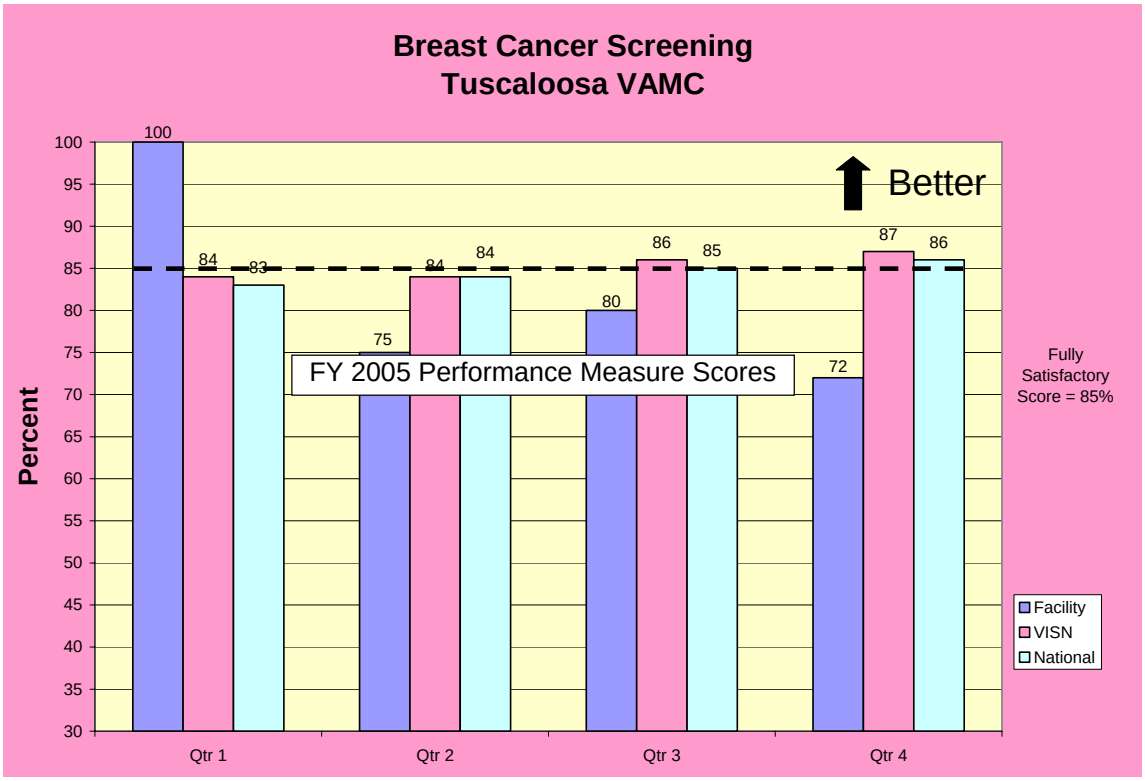
Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Facility Director takes action to ensure that: (a) all facility fire extinguishers are inspected monthly in accordance with the Life Safety Code; (b) EOC deficiencies are properly tracked and data is analyzed, trended, and reported to the EOC Committee monthly; (c) FMS develops a plan to ensure the facility is properly maintained; and (d) the facility safety manager develops a process to ensure that all construction projects are reviewed for potential Interim Life Safety Measures (ILSM) impact, action plans are developed, and all reviews are reported to the Construction Safety Committee for review by the governing body.

[3] This is documented in a summary and photographs from our inspection conducted on November 13, 2006.
[4] Joint Commission on Accreditation of Healthcare Organizations, EC.5.50, "Interim Life Safety Measures," *2006 Hospital Accreditation Standards*, page 297.
[5] FY-05 Annual Workplace Evaluation (AWE), Tuscaloosa VAMC, Item 2-7-5A, dated 1/29/06.

Breast Cancer Management

Conditions Needing Improvement. Not all biopsy results were communicated to the patients in accordance with Veteran Health Administration (VHA) Handbook 1104.1.[6] The facility needed to improve their tracking process to monitor patients through the continuum of care and implement a Tumor Registry Program onsite, in accordance with VHA Directive 2003-034.[7]

The VHA breast cancer screening PM assesses the percent of patients screened according to prescribed timeframes. Three of 4 quarters did not meet the required standard, as shown in the chart below.



Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. VHA mammography standards require documentation of normal findings to be included in the medical record within 30 days of the procedure. According to VHA Directive 2003-034, communication of suspicious or abnormal results to the ordering provider is required within 3 working days. Communication can be by telephone contact between the mammography procedure site and the ordering provider. If this is the method adopted, entry into the electronic patient record is required. Timely results need

[6] VHA Handbook 1104.1, *Mammography Standards*, August 6, 2003.
[7] VHA Directive 2003-034, *National Cancer Strategy*, June 29, 2003.

to be available and accessible to guide patient care and treatment. We assessed these items in a review of three patients diagnosed with either breast cancer or an abnormal mammography during FYs 2004 and 2005.

We found that three of three patients (100 percent) were appropriately screened for breast cancer. Mammography results were reported to patients within 30 working days, patients were appropriately notified of their diagnoses, and patients received timely biopsy procedures. Only two patients required consultations for oncology, surgery, and/or radiation therapy; the consultations were done timely. However, we determined that: (a) not all biopsy results were communicated to the patients or documented in medical record, (b) the facility did not have a Tumor Registry onsite as required by the directive, and (c) a tracking process to monitor patients through the continuum of care was not implemented.

Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
3/3	**3/3**	**3/3**	**2/2**	**3/3**

The facility's mammographies and biopsies are performed at community affiliates on a fee-for-service basis. There was a lack of communication and documentation between the fee-basis affiliates and the facility, which precluded verification that biopsy results were reported to the patient as required by VHA Handbook 1104.1.

VHA Directive 2003-034 requires every facility to have a Tumor Registry in place to monitor patients diagnosed with cancer. We were told that the facility does not have a Tumor Registry or a sharing agreement with another local facility. Facility staff reported that the facility is coordinating with local off-site affiliates and other VA medical centers to develop a sharing agreement for Tumor Registry services.

The facility had a tracking system to monitor breast cancer patients once diagnosed, but the facility did not monitor patients through the full continuum of care. Staff reported that the facility was in the process of reconstructing the tracking process. Another FTE had been added to the program to assist with the reconstruction of the tracking system. However, the FTE position was vacant at the time of our site visit.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Facility Director takes action to ensure that: (a) all biopsy results are communicated to patients, (b) a Tumor Registry Program is implemented at the facility, and (c) a tracking mechanism is implemented to follow the patients through the continuum of care.

Quality Management Program

Conditions Needing Improvement. The purpose of this review was to evaluate whether the facility's QM Program provided comprehensive oversight of quality of care and whether senior managers actively supported the program's activities. We interviewed the facility Director, Chief of Staff, Chief Nurse Executive, and QM personnel, and we evaluated plans, policies, and other relevant documents. The facility's QM/Performance Improvement Program was comprehensive and generally effective; however, we found three areas for performance improvement.

Patient Safety. VHA Handbook 1050.1[8] defines requirements for facility patient safety programs to effectively manage adverse events. We reviewed major components of the program and found areas needing attention. A critical part of the Patient Safety Program is properly executing the individual RCA process for adverse events.

We reviewed a total of five RCAs, which by VHA guidelines require investigation and completion within 45 days. We found one RCA with an SAC score of 3 (indicating a major injury from a fall that requires surgical repair and extended days of acute hospital care). We found that the RCA team was not chartered until 78 days after the facility became aware of the event, and the team did not complete the investigation until 157 days had transpired. In the four additional RCAs, we found that none of the four were completed within 45 days; all four remained in progress at the time of our review.

Peer Review. VHA Directive 2004-054[9] delineates an important process of mortality assessment screening to identify cases that require peer review. We reviewed 1st quarter FY 2006 mortality data and found one case that met screening guidelines for peer review. Although QM staff told us that this case was discussed with and reviewed by the Chief of Staff, no documentation of his review was available. If the decision is made not to proceed with a formal review by the Peer Review Committee, VHA Directive 2004-054 requires documentation of that decision. We found no such documentation.

Utilization Management. VHA Directive 2005-040[10] defines program components that must be in place to perform UM functions. We found that most areas were in compliance with the intent of VHA Directive 2005-040. However, the Chief of Staff did not appoint a Physician Advisor until November 14, 2006, and no documentation of the Physician Advisor's required training[11] could be produced.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Facility Director takes action to (a) implement immediate investigations

[8] VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, January 30, 2002.
[9] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004.
[10] VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.
[11] The Physician Advisor must have training for physicians in Utilization Management, which is available from a variety of sources.

for all SAC 3 adverse events and complete individual RCAs within 45 days, (b) document peer reviews at the Chief of Staff level or by the Peer Review Committee for all deaths that meet the screening guidelines, and (c) ensure that the Physician Advisor receives appropriate training for the UM Program.

Other Observations

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 for improving the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that in FY 2006, at least 77 percent of ambulatory care patients and 76 percent of inpatients discharged during a specified date range will report their experiences as Very Good or Excellent. The following graphs show the facility's performance in relation to national and VISN performance for inpatients and outpatients. Medical centers are expected to address areas in which they are underperforming. In the following two charts, note that "+" indicates results that are significantly better than the national average and "-" indicates scores that are significantly worse than the national average.

Inpatient SHEP Results – Q3 and Q4 FY 2005

INPATIENT – Q3 and Q4 FY 2005	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	**80.73**	**78.27**	**89.40**	**67.36**	**65.08**	**75.37**	**83.35**	**73.98**	**69.52**
VISN	80.70	78.70	89.30	68.4+	66.00	74.90	81.5-	74.30	69.30
Tuscaloosa	80.50	77.80	81.9-	64-	57.7-	59.9-	78.1-	64.8-	60.7-

Outpatient SHEP Results – Q3 FY 2006

Outpatient – Q3 FY 2006	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Transition	Specialist Care	Visit Coordination
National	**80.9**	**77**	**94.6**	**72**	**83**	**75.1**	**81.1**	**64.4**	**81.3**	**80.5**	**84.1**
VISN	75.5	76	92.1	69.7	79.9	74.6	82.1	58.1	79.7	79.9	80.9
Tuscaloosa	81.5	84	96.9	74.4	81.9	75.7	75.3	*	81	82.9	89.4

***** *signifies fewer than 30 respondents*

The facility has a Customer Service Subcouncil that meets monthly and a designated Customer Service Coordinator. SHEP results were analyzed and action plans developed to address areas needing improvement. Ongoing facility initiatives to maintain and improve current levels of customer service include a "Service Recovery" program that permits timely resolution of complaints and a "QuickCard" survey in the outpatient clinics that provides daily customer feedback for service in the facility.

Diabetes and Atypical Antipsychotic Medications

The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes).

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

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

We reviewed the facility's four diabetes-related PMs for FY 2005. We found that the facility met 31 percent (4/13) of VHA FY 2005 quarterly PM goals related to diabetes for which data was reported. Specifically, we found:

- HbA1c greater than 9 percent – The facility did not meet any PM thresholds for FY 2005.
- BP less than or equal to 140/90mmHg – The facility met or exceeded PM thresholds for quarter (Q)1, Q3, and Q4.
- BP greater than or equal to 160/100mmHg – The facility did not meet any PM threshold for FY 2005. In fact, no data was reflected for Q1, Q3, or Q4 for this PM.
- LDL-C less than 120mg/dL – The facility met or exceeded the PM threshold only for Q1.

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

- The facility developed an internal PM database to more effectively monitor diabetes-related measures. The database facilitated weekly reviews by the facility rather than waiting for quarterly results. This allowed the facility to respond to PM shortcomings and adjust corrective actions to meet PM thresholds.
- The facility analyzed patient workload to identify any patient population that was not being effectively serviced or monitored. The analysis identified a single patient

population and allowed the facility to adjust providers and treatment protocols to more effectively meet patient care needs and improve PM outcomes.

- The facility continuously monitored progress monthly through two committees—the Process Management Committee and the AIM-HI Committee. Additionally, facility managers meet weekly to review data and make any adjustments to ensure continuous improvement.

We reviewed medical records for a sample of 13 randomly selected patients who were on one or more atypical antipsychotic medications for at least 90 days in FY 2005. None of the patients reviewed had a diagnosis of diabetes. Nine patients had clinical indicators indicative of a predisposition to diabetes; they received prevention counseling.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with BP less than or equal to 140/90mm/Hg	Diabetic patients with LDL-C less than 120mg/dL	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
0/0	0/0	0/0	13/13	9/9

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 6, 2006

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

Subj: **Combined Assessment Program Review of the Tuscaloosa VA Medical Center**

To: Director, St. Petersburg Office of Healthcare Inspections (54SP)

1. Attached is Tuscaloosa's response to the Office of Inspector General (OIG) Combined Assessment Program Review Site Visit during the week of November 13, 2006. I have reviewed the CAP recommendations, which have been individually addressed.

2. I understand recommendations (1b) ensure documentation of required extinguisher annual safety inspections and (1c) quarterly fire drill data is reported to and reviewed by the facilities EOC committee, have been dropped along with the findings.

3. I concur with the comments and actions taken by the Medical Center Director as outlined in the comments and implementation plan to improve processes at the Tuscaloosa VA Medical Center.

(original signed by:)

Thomas A. Cappello, MPH, FACHE

Attachments

Tuscaloosa VA Medical Center
Response to the Office of Inspector General Combined Assessment Program Review Report

Comments and Implementation Plan

1. Environment of Care

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Facility Director takes action to ensure that: (a) all facility fire extinguishers are inspected monthly in accordance with the Life Safety Code; (b) EOC deficiencies are properly tracked and data is analyzed, trended, and reported to the EOC Committee monthly; (c) FMS develops a plan to ensure the facility is properly maintained; and (d) the facility safety manager documents all ILSM safety reviews and outcomes to the Construction Safety Committee.

Concur with recommended improvement actions

a. Ensure all facility fire extinguishers are inspected monthly in accordance with the Life Safety Code.

Planned Action: Medical Center will ensure that all fire extinguishers are inspected and documented monthly in accordance with the Life Safety Code. **(Completed: November 2006)**

b. EOC deficiencies are properly tracked; data is analyzed, trended, and reported to the EOC Committee monthly.

Planned Action: EOC deficiencies shall be tracked and that data analyzed, trended, and reported to the EOC Committee monthly. **(Target Date: December 2006)**

c. Ensure that Facility Management Service develops a plan to ensure that the facility is properly maintained.

Planned Action: A process action team will be established to evaluate our current maintenance system and make recommendations for a more proactive approach. **(Target Date: February 2007)** Until improved processes are in place, the maintenance staff will conduct weekly rounds to ensure like items do not reoccur. **(Target Date: December 2006)**

d. Ensure the facility safety manager develops a process to ensure that all construction projects are reviewed for potential Interim Life Safety Measures impact, action plans are developed, and all reviews are reported to the Construction Safety Committee for review by the governing body.

Planned Action: Interim Life Safety Measures will be evaluated and documented in the Construction Safety Committee minutes. **(Target Date: December 2006)**

2. Breast Cancer

Recommended Improvement Action 2: We recommended that the VISN Director ensure that the facility Director takes action to ensure that: (a) all biopsy results are communicated to patients, (b) a Tumor Registry Program is implemented at the facility, and (c) a tracking mechanism is implemented to follow the patients through the continuum of care.

Concur with recommended improvement actions

a. Ensure all biopsy results are communicated to patients.

Planned Action: (Target Date: February 2007)

- Oncology Care Coordination Program Implemented November 2006. Data which is being case managed, tracked, and reported include:

- Ensuring normal findings are documented in the medical record and communicated to patient within 30 days.

- Ensuring abnormal test results are communicated to the ordering provider and documented in the medical record within 3 days.

- Ensuring abnormal test results are communicated to the patient and documented in the medical record within 5 days.

b. Ensure a Tumor Registry Program is implemented at the facility.

Planned Action: A meeting has been scheduled with TVAMC Chief of Staff and BVAMC Chief of Staff on December 12, 2006. Also in attendance will be the Director of the Office of Care Coordination from TVAMC and Primary Care Physician who specializes in Oncology from TVAMC. The meeting is to discuss a shared tumor registry between BVAMC and TVAMC. **(Target Date: December 2006)**

Suspicious Lesion – Screening, Early Detection, Diagnosis, and Tumor Registry –Consists of time from original abnormal test (suspicious lesion identified by physical, radiological, or laboratory evaluation) or positive cancer screening test that raises reasonable possibility of cancer, to the point of cancer diagnosis or exclusion. During this phase the Suspicious Lesion Case Manager serves as a facilitator to ensure timely care is provided:

- Utilizing a standardized process to identify all suspicious lesion reports and provide ongoing management of the tumor registry.
- Ensuring the Primary Care Provider is notified of suspicious lesion and a plan of care is implemented in a timely manner.
- Assisting in coordinating any additional diagnostic testing in a timely manner.
- Ensuring the Primary Care Provider is notified of suspicious lesion and a plan of care is implemented in a timely manner.
- Assisting in coordinating any additional diagnostic testing in a timely manner
- Providing on-going case management until confirmation or exclusion of malignancy.

c. Ensure that a tracking mechanism is implemented to follow the patients through the continuum of care.

Planned Action: The Oncology Care Coordination Program will ensure that a tracking mechanism is implemented to follow the patients through the continuum of care by focusing on the coordination and management of services for patients through all phases of cancer treatment. These elements incorporate the eight VHA national strategies for oncology care. **(Target Date: February 2007)**

Prevention and education: The Oncology Case Manager(s) will collaborate with patients, health care providers, TVAMC Patient Health Education Resource Center, and community vendors to ensure that TVAMC patients are well informed about the processes of care required for their medical treatment from the identification of a suspicious lesion or positive screening test through diagnosis and treatment.

Treatment – Active Treatment Phase: In addition to the Prevention and education, the case manager will continue case management services

throughout the active treatment and/or palliative care phases until confirmation or exclusion of malignancy.

3. Quality Management

Recommended Improvement Action 3: We recommended that the VISN Director ensure that the facility Director takes action to (a) implement immediate investigations for all SAC 3 adverse events and complete individual RCAs within 45 days, (b) document peer reviews at the Chief of Staff level or by the Peer Review Committee for all deaths that meet the screening guidelines, (c) ensure that the Physician Advisor receives appropriate training for the UM Program.

Concur with recommended improvement actions

a. Implement immediate investigations for all safety assessment code [SAC] 3 adverse events and complete individual Root Cause Analyses within 45 days;

Planned Action: Revise current process to ensure the immediate RCA teams are appointed for all safety assessment code [SAC] 3 adverse events and complete individual Root Cause Analyses within 45 days. Specifically the process for implementing RCAs has been changed to ensure the RCA process for [SAC] 3 adverse events is immediate. **(Completed November 17, 2006.)**

b. Document peer reviews at Chief of Staff level and/or Peer Review Committee for all deaths that meet the screening guidelines.

Planned Action: Revise current peer review process to ensure the Chief of Staff level or Peer Review Committee reviews all deaths that meet the screening guidelines. Specifically the Chief of Staff will sign all cases documenting that he has reviewed and concurs with action. **(Completed November 14, 2006.)**

c. Ensure that the Physician Advisor receive appropriate training for the UM program.

Planned Action: The Physician Advisor will attend additional training of utilization management and this training will be documented in his competency files. This training will incorporate the required InterQual criteria for admission and continued stay and be implemented by February 2007. **(Target Date: February 2007)**

Appendix C

OIG Contact and Staff Acknowledgments

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Acknowledgments	Charles Cook, Team Leader David Griffith Deborah Howard Annette Robinson Idell Graham Elizabeth Bullock

Appendix D

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