Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina

Report No. 07-00163-128 **May 10, 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 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 mission of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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Executive Summary

Introduction

During the week of December 4, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the William Jennings Bryan (WJB) Dorn VA Medical Center (the medical center), Columbia, South Carolina. The medical center is part of Veterans Integrated Service Network (VISN) 7. 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 205 employees. In addition, we followed up on selected recommendations from the previous CAP review of the medical center.

Results of Review

The CAP review focused on eight areas. The medical center complied with selected standards in the following areas:

- Environment of Care (EOC).
- Contract Community Nursing Home Program (CNH).
- Community Based Outpatient Clinic (CBOC).
- Diabetes and Atypical Antipsychotic Medications.
- Patient Satisfaction.

We identified conditions in QM, Breast Cancer Management, and the Cardiac Catheterization Program that needed management attention. We made the following recommendations:

- Develop local policies and implement all components of quality care monitoring processes, as required.
- Ensure that suspicious or abnormal mammography results are available to VA providers within the required timeframe.
- Request an exemption to perform percutaneous coronary interventions (PCIs) and formalize the plan for rapid transfer to an open heart surgery program.

Comments

The VISN and Medical Center Directors concurred with the CAP review findings and recommendations and provided acceptable improvement plans. (See pages 12–16 for the full text of the Directors' comments.) We will follow up on planned improvement actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The WJB Dorn VA Medical Center is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six CBOCs located in Anderson, Greenville, Rock Hill, Florence, Sumter, and Orangeburg, South Carolina. The medical center is part of VISN 7 and serves a veteran population of about 68,282 in a primary service area that includes 30 counties in South Carolina.

Programs. The medical center provides medical, surgical, mental health, geriatric, rehabilitative, and home health services. The medical center has 124 hospital beds and 92 nursing home beds and operates several regional referral and treatment programs, including the Health Care for Homeless Veterans Program.

Affiliations and Research. The medical center is affiliated with Palmetto Health and the University of South Carolina School of Medicine and supports 1 dental and 48.6 medical resident positions. The medical center has sharing agreements with Shaw Air Force Base and Fort Jackson Army Base. In fiscal year (FY) 2006, the medical center research program had 260 projects and a budget of $824,257. Important areas of research include oncology, psychology, and pharmacy.

Resources. In FY 2006, medical care expenditures totaled $241 million. The FY 2007 medical care budget is $253 million. FY 2006 staffing totaled 1,318.5 full-time equivalent employees (FTE), including 84 physician and 360 nursing FTE.

Workload. In FY 2006, the medical center treated 55,928 unique patients. The medical center provided 28,283 inpatient days of care in the hospital and 21,100 inpatient days of care in the Nursing Home Care Unit. The inpatient care workload totaled 3,984 discharges, and the average daily census, including nursing home patients, was 139. The outpatient workload was 584,035 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 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 William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina,* Report No. 04-01863-219, September 28, 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:

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

The review covered facility operations for FYs 2004, 2005, 2006, and 2007 through December 8, 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

Opportunities for Improvement

Quality Management – Processes for Monitoring the Quality of Care Needed Strengthening

The purposes of this review were to determine if: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported QM efforts and appropriately responded to QM results; and (c) the medical center was in compliance with Veterans Health Administration (VHA) directives, appropriate accreditation standards, and Federal and local regulations. To evaluate QM processes, we interviewed senior managers and reviewed the self-assessment completed by QM staff regarding the medical center's compliance with QM requirements. We evaluated documents related to the functioning of the Health Systems Council (HSC),[1] as well as other relevant QM documents and committee minutes.

The QM program was generally effective in providing oversight of the quality of patient care in the medical center. Performance improvement (PI) efforts, patient complaints, medication management, blood products usage, resuscitation outcomes, medical records, efficient patient flow, and advanced clinic access (ACA) were monitored effectively. However, we identified several program areas that needed strengthening.

We found deficiencies in the following areas:

Adverse Event Disclosure. The medical center did not comply with VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*. The medical center had not established a local disclosure policy by April 1, 2006, as required, and did not require clinical disclosure within 24 hours and institutional disclosure within 72 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. QM staff identified one event that required clinical and institutional disclosure during FY 2006. We reviewed the patient record for this event, along with supporting documentation provided by the QM staff, and determined that the clinical and institutional disclosure exceeded the required timeframes. We also noted that the required progress note template for institutional disclosure documentation was not used. Without adequate disclosure processes, managers could not be assured that patients were provided with timely and accurate information needed.

[1] The oversight committee responsible for performance improvement activities.

Peer Review. The medical center had not developed a local peer review policy or established a Peer Review Committee (PRC). Peer review is a confidential, non-punitive, and systematic process to evaluate quality of care at the individual provider level. VHA Directive 2004-054, *Peer Review for Quality Management*, required development of a local policy for protected peer review by March 4, 2005, as well as establishment of a multidisciplinary PRC. We evaluated the peer review activities conducted during FY 2006 and identified the following issues:

- Managers did not complete quarterly tracking of peer review data (including number of reviews, outcomes by level, and number of changes to level) and follow-up of action items and recommendations that resulted from completed peer reviews.
- Managers did not review a representative sample of Level 1[2] peer review cases to ensure reliability of the findings and to evaluate the peer review process.
- The medical center peer review database showed that none of the 16 initial peer reviews were completed within the 45-day timeframe, as required by VHA.

Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual providers' practices. Peer reviews should be conducted in accordance with policy to ensure providers perform according to accepted community standards.

Root Cause Analyses. We found that elements of the root cause analysis (RCA) process did not comply with VHA guidelines. RCAs are designed to identify and resolve the root cause of system and/or process deficiencies involved in an actual or potential adverse event. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, requires that RCAs be conducted within 45 days of the medical center's identification of need. Additionally, the handbook requires a process for identification of adverse events, implementation of action plans designed to prevent future occurrences of similar events, and outcome evaluation to ensure that changes have the desired effect.

Of the 15 RCAs (5 individual and 10 aggregates) conducted for events occurring in FY 2006, we found that 13 were not completed within the 45-day requirement. In addition, no RCA was chartered for one adverse event that involved a death following a medication error. We also found problems with the completion and the evaluation of the effectiveness of many of the recommended actions. For example, at the time of our review, 45 percent of the RCAs had incomplete actions, and 73 percent had incomplete outcome evaluations. Without timely and complete RCAs, managers could not be assured of the effectiveness of the patient safety process and the impact of improvements.

Mortality Review. The mortality review process did not include all screening criteria to identify cases requiring peer review referral, as required by VHA Directive 2005-056,

[2] Level 1 – Most experienced, competent practitioners would have managed the case similarly.

Mortality Assessment. We reviewed the FY 2006 death log maintained by QM staff and found that mortality screening identified deaths from hospital acquired infections and deaths occurring within 30 days of surgery. However, the screening process did not include the other 12 criteria outlined in the directive that require referral for peer review. Since not all screening criteria were used, managers could miss opportunities to refer appropriate cases for peer review.

Utilization Management. The medical center had not implemented a standardized utilization management (UM) plan that included a process for collecting and reporting UM data, as required by VHA Directive 2005-009, *Utilization Management*. During FY 2006, medical center staff conducted admission and continued stay reviews and provided reports containing some data elements to the HSC. However, the reports did not include the following required elements of a continued stay review: (1) data for recommended level of care when criteria are not met, (2) analysis of second level physician reviewer findings, (3) number of and reasons for diversions, and (4) documentation of inter-rater reliability of clinical reviews. Without collecting and reporting all UM review elements, managers could not be assured that trends were identified and actions initiated.

Restraint Review. The medical center restraint review process did not include all elements required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). We found that FY 2006 restraint reports provided to the HSC did not include review of opportunities to reduce restraint use as required by JCAHO. In addition, when the alternatives to restraint usage fell below the 90 percent target during 2 quarters in FY 2006, the HSC minutes did not reflect data review and discussion of the improvement actions. Without thorough review and analysis of restraint data, managers could not be assured that corrective actions were initiated to reduce restraint usage.

Operative and Other Invasive Procedure Review. The medical center PI process did not include all elements of the operative and other invasive procedure review, as required by JCAHO. Reports presented to the HSC did not include evaluations of problem-prone cases or complications. In addition, there were no documented reviews of major discrepancies between pre- and post-operative diagnoses. JCAHO requires data aggregation and analysis, identification of trends, and tracking of actions to resolution. Without appropriate evaluation, managers could not be assured that PI activities were initiated when indicated.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director develops local policies and implements all components of quality care monitoring processes, as required.

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. Medical center managers implemented an action plan to ensure quality care monitoring processes. The medical center will

(1) finalize a policy on Adverse Event Disclosure, educate the staff, and monitor compliance; (2) implement a PRC policy and have the PRC review all 1st quarter FY 2007 cases for timeliness and reliability of findings; (3) improve the RCA process by tracking timeliness of RCA completion and action items completion rates and by completing outcome evaluations; (4) improve death review screening by using all 16 criteria; (5) implement a UM policy, collect data on recommended levels of care (for example, physician reviewer analysis, numbers and reasons for diversion), and present monthly reports to the HSC; (6) make recommendations regarding the use of restraints and alternatives; and (7) improve the operative and invasive procedure review process by reporting on complications and discrepant diagnoses.

Breast Cancer Management – Communication of Suspicious or Abnormal Mammogram Results Needed Improvement

Timely diagnosis, patient notification, and treatment are essential elements for optimal patient outcomes. We assessed these items in a sample of six female patients who were diagnosed with breast cancer during FYs 2004 and 2005. One of the six came to the medical center for care after already receiving a screening mammogram at a private facility. We found that four of the five remaining patients received screening mammograms by the medical center. All six women received biopsies, consultations, and appropriate treatments. Clinicians communicated well with patients and involved them in the treatment planning process. However, we found that communication of abnormal results to providers needed improvement.

Condition Needing Improvement. We found that suspicious or abnormal mammography results were not available to ordering providers within the required timeframe in FY 2005. The medical center refers all patients to community facilities for mammography procedures. VHA mammography standards require reporting of suspicious or abnormal mammography results to the ordering providers within 3 working days. As these outside reports had to be mailed, reviewed by the Radiology Department, and then scanned into the medical record, results were not available to the ordering providers within 3 days. In addition, radiology staff told us that when patients required additional procedures to confirm abnormal results, radiology staff waited until all of the follow-up testing and reporting was completed before scanning reports. We found that for four of the five patients reviewed, abnormal results were not available in the medical record for anywhere from 8 to 246[3] days post mammogram. Without knowledge of abnormal results, clinicians could not plan and provide timely treatment. Managers told us that a new process is in place whereby the contractor sends electronic reports, which are scanned into the VA medical record the next working day.

[3] The 246-day delay involved one patient who could not be contacted to schedule follow-up.

Recommendation 2. We recommended that the VISN Director require that the Medical Center Director ensures that suspicious or abnormal mammography results are available to VA providers within the required timeframe.

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. Medical center managers will develop a templated progress note for abnormal mammogram reports, which will generate an electronic message to the providers. Timeliness of reporting will be monitored.

Cardiac Catheterization Program – Exemption Should Be Requested

The purpose of this review was to determine if the medical center's cardiac catheterization laboratory (CCL) practices were consistent with VHA policy and the 2001 American College of Cardiology/Society for Cardiac Angiography and Interventions *Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards*.

We reviewed the medical records of five patients who had undergone a diagnostic cardiac catheterization procedure and five who had undergone an interventional procedure known as a PCI[4] in FY 2005. We found appropriately completed informed consents for all 10 patients. We reviewed provider credentialing and privileging (C&P) files and found that providers were current in their cardiopulmonary resuscitation certifications. Although the CCL performed 569 diagnostic procedures and 15 low-risk PCIs in FY 2005 and reported no major complications, we found an issue requiring management attention.

Condition Needing Improvement. The medical center had not requested an exemption from VHA to perform PCIs. VHA requires that medical centers formally request an exemption to perform PCIs if the medical center does not have an onsite cardiac surgery program. American College of Cardiology guidelines state that a facility performing PCIs in the absence of onsite cardiac surgery should have a formal, written agreement with a nearby institution with cardiac surgical services and a proven plan for rapid transport (within 1 hour) from the CCL to the operating room at the nearby facility. The Chief of Cardiology told us that only a verbal agreement existed between the medical center and a local hospital for emergent transfer and that the process was not formally monitored or tested for timeliness.

The interventional cardiologist who performed PCIs is no longer on staff, and PCIs are not performed at the present time. The medical center would like to reinstitute this program when an interventional cardiologist is hired; therefore, the medical center should formalize their agreement with the local hospital, test ambulance response times, and request an exemption from VHA.

[4] Percutaneous Coronary Interventional (PCI) procedures – These non-surgical procedures are performed in the cardiac catheterization laboratory by a specialized cardiologist and a cardiovascular team of nurses and technicians. The procedures utilize special catheters to 'open' blocked arteries that supply blood to the heart.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requests an exemption from VHA and develops a plan for rapid access to open heart surgery before resuming PCI procedures in the CCL.

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. Medical center managers will request an exemption from VHA and will formalize the agreement with a local facility to provide rapid open heart surgery.

Other Focused Review Results

Environment of Care – The Facility Was Clean and Well Maintained

VHA requires that health care facilities have a comprehensive EOC program that complies with VHA policy, Occupational Safety and Health Administration regulations, and JCAHO standards.

We inspected 12 clinical areas for cleanliness, safety, infection control, and general maintenance. The inspection showed that the medical center maintained a clean and safe environment, secured medications, and regularly monitored infection rates. We also followed up on EOC concerns reported in the previous CAP report and found that those issues were resolved.

The medical center's infection control and patient safety managers collaborated to expand the hand hygiene program and increase compliance with Centers for Disease Control guidelines, which is a patient safety goal. The medical center received funding from the National Center for Patient Safety to improve patient outcomes by decreasing hospital acquired infection rates. The program includes staff education, active surveillance of employee hand washing techniques, and the purchase of hand sanitizers that attach to belts, making them readily available and easy to use.

Contract Community Nursing Home Program – Oversight Was Comprehensive

CNH Program staff provided appropriate and comprehensive oversight of the community nursing facilities caring for veterans. We reviewed the CNH Program to assess compliance with local and national policies regarding the selection of contract facilities, the review process for contract renewal, and the monitoring of patients in community nursing facilities. We evaluated whether patients received rehabilitation services (speech, physical, or occupational therapy) when ordered and whether there were effective processes in place to more closely monitor the community nursing facilities where deficiencies had been identified.

At the time of our visit, the medical center had 60 veterans in 23 contract community nursing facilities in South Carolina. We selected five community nursing facilities for review and visited two of those five. We interviewed the administrators at these two sites, toured the facilities, and visited the veterans under contract there. We conducted 10 patient record reviews and interviewed 4 patients and 3 family members.

The CNH Program complied with local and VHA policy. The Community Care Council met regularly to discuss inspection results and contract renewal recommendations. The CNH review team utilized the exclusion report (which summarizes quality indicators and results of state and other inspections) to complete their annual review of each facility. Contract renewal recommendations were based on these reviews. We found that CNH Program staff recommended increased monitoring, suspension of placements, or contract termination, when appropriate.

Community nursing facility staff told us, and we confirmed by medical record review, that a CNH Program nurse or social worker visited at least monthly. We found documentation of these visits in the patients' VA medical records, and visit notes contained evidence of patient assessment and discussion of concerns with the facility staff or administrator, when indicated. We found that families were involved in the community nursing facility selection process, and Program staff accommodated their preferences, when possible. The administrators told us that CNH Program staff were accessible and responsive to their needs and concerns. We also confirmed that patients received contracted services, as ordered.

Community Based Outpatient Clinic – Patients Received the Same Standard of Care

The purpose of this review was to assess operations and delivery of health care services at CBOCs. CBOCs were designed to improve veterans' access to care by offering primary care in local communities while delivering the same standard of care as the parent facility. The Sumter CBOC, located in leased space about 40 miles from the medical center, is staffed by VA employees. The CBOC served 2,437 veterans in FY 2006.

We interviewed key individuals from the medical center and the CBOC. We reviewed CBOC policies, performance documents, and provider C&P files. We also conducted an EOC inspection in the CBOC. To determine if patients received the same standard of care, we compared the management of patients receiving warfarin[5] at the parent facility and the CBOC.

CBOC providers' C&P files and CBOC nurses' personnel folders contained evidence of background screenings and other appropriate documentation. We found that the

[5] A medication used to prevent blood clots.

emergency management plan was current, and clinical staff were certified in basic life support and educated in and knowledgeable about rendering emergency care. The CBOC was a clean facility that met JCAHO, Health Insurance Portability and Accountability Act, and Life Safety requirements.

We determined that a pharmacist managed the warfarin clinic at the parent facility, but the primary care provider managed patients on warfarin at the CBOC, as the CBOC did not have an assigned pharmacist. Managers told us that the CBOC switched from a contracted staff clinic to a VA-staffed clinic in September 2006 and is recruiting for a pharmacist. We found that patient education regarding warfarin use and side effects was one-on-one and individualized at both the parent facility and the CBOC. Patients at both sites are given the same 800 number if they have problems or concerns related to their medication. Patients on warfarin received the same level of care at the CBOC as patients at the parent facility.

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) 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 each diabetic mental health patient in our sample.

We found that medical center clinicians effectively monitored and treated the five diabetic patients in our sample. Clinicians appropriately educated the patients, consulted nutrition, and/or changed medications, as indicated. Non-diabetics were appropriately screened for diabetes and counseled about diabetes prevention.

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 graphs on the next page show the medical center'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. Medical centers are expected to address areas in which they are underperforming.

WJB Dorn Outpatient SHEP Results

Q3 FY 2006

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	80.90	77.00	94.60	72.00	83.00	75.10	81.10	64.40	81.30	80.50	84.10
VISN 7	Overall	75.50	76.00	92.10	69.70	79.90	74.60	82.10	58.10	79.70	79.90	80.90
Outpatient clinics and WJB Dorn CBOCs- Overall	544	82.20	73.10	92.50	69.90	82.90	78.30	86.50	58.00	81.30	83.60	84.40

WJB Dorn Inpatient SHEP Results
Q1 and Q2 FY 2006

Facility Name	Facility Numbers	Bed Section	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	National	All Bed Sections	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03
VISN 7	Overall	All	80.60	77.90	88.30	70.10	66.60	76.10	81.80	73.80	70.90
WJB Dorn VA	544	All	82.60	77.10	89.90	69.80	66.90	75.80	85.40	76.60	75.60

The medical center's Customer Service Council identified several areas for improvement and developed action plans to address deficiencies. To address patient dissatisfaction with outpatient pharmacy pick-up times, the medical center consolidated pharmacy locations for medication pick-up, which resulted in outpatient pharmacy wait times decreasing from 30 minutes to 17 minutes in FY 2006. Other examples of the improvement initiatives included Health Benefits Seminars for new outpatients, ACA appointment postcard reminders, inpatient information booklets, the inpatient Proactive Visit program, and the 48-hour discharge telephone follow-up program. We found that the most recent outpatient and inpatient scores showed improvement in eight areas.

Appendix A

VISN Director's Comments

Department of Veterans Affairs **Memorandum**

Date: January 4, 2007

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

Subject: **Draft Report –** Combined Assessment Program Review William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina – Project Number 2007-00163-HI-0192

To: Assistant Inspector General, Office of Healthcare Inspections

Thru: Director, Management Review Service (10B5)

1. Attached is Columbia's response to the Office of Inspector General (OIG) site visit 2007-00163-HI-0192.

2. 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 Columbia VA Medical Center.

(original signed by:)

Thomas A. Cappello, MPH, FACHE

Appendix B

Medical Center Director's Comments

Department of Veterans Affairs **Memorandum**

Date: December 29, 2006

From: Director, WJB Dorn VA Medical Center (544/00)

Subject: **Draft Report –** Combined Assessment Program Review William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina - Project Number 2007-00163-HI-0192

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

1. We have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the William Jennings Bryan Dorn VA Medical Center. We concur with the findings and recommendations.

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

(original signed by:)
Brian Heckert

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 Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director develops local policies and implements all components of quality care monitoring processes, as required.

Concur **Target Completion Date:** April 30, 2007

Adverse Event Disclosure: Approval of policy to be completed by 1/31/07. Staff education about adverse event disclosure to be completed by April 2007. The Patient Safety Officer or designee will monitor timely adverse event disclosure monthly to ensure compliance. Reports of timely disclosure will be presented to the Health Systems Council quarterly beginning April 2007.

Peer Review: A Peer Review Committee policy has been developed, completed initial review by Medical Executive Sub-Council, with final approval at the January 2007 Medical Executive Sub-Council meeting. The Peer Review Committee will meet by 2/28/07 to review all Level 1 - Level 3 peer reviews completed during 1st Quarter FY 07. The committee will review the reliability of findings, timeliness of peer review completion, and make recommendations to the Medical Executive Sub-Council from completed peer reviews beginning March 2007.

Root Cause Analyses (RCA): The medical center root cause analysis process will include tracking of timely completion of aggregate and individual root cause analyses. Reports to senior medical center leaders will be presented monthly by the individual or aggregate RCA team members at the Director's Staff Meeting and will include timely completion rates for action items and outcome evaluation for RCAs to date.

Mortality Review: The screening data base tool will include all 16 criteria for initiating a peer review beginning January 2007 for first quarter FY 07 deaths and will be reported quarterly to Health Systems Council beginning March 2007.

Utilization Management: Medical Center Memoranda describing utilization management policy and procedure will be approved by 2/28/07. Monthly data collection and quarterly reports to the Health Systems Council will include recommended levels of care, analysis by a physician reviewer for approval and denials of patients not meeting first level reviews, number and reasons for diversion and documentation of inter-rater reliability of clinical reviews beginning March 2007.

Restraint Review: Health Systems Council minutes will reflect discussion, recommendations for action and analysis of alternatives to restraint usage beginning January 2007.

Operative and Other Invasive Procedure Review: Beginning in February 2007, a prospective review of Thoracic Surgery cases for morbidity and mortality will be conducted with quarterly reports to HSC in the mid month of the quarter (Feb/May/Aug/Nov) for the previous quarter. Major discrepancies between pre-and post-operative diagnoses will be reported quarterly to the Health Systems Council beginning March 2007. Surgical mortality reviews within 30 days of an operative procedure will continue to be presented quarterly to the Health Systems Council. NSQIP morbidity, mortality and post-op complication summary report will be presented to HSC in May. Corrective actions based on reported data will be provided at that time for identified outliers.

Recommendation 2. We recommend that the VISN Director requires that the Medical Center Director ensures that suspicious or abnormal mammography results are available to VA providers within the required timeframe.

Concur **Target Completion Date:** April 30, 2007

A templated progress note entry will be entered by the PACS/ADPA Coordinator for Radiology or designee when abnormal or suspicious for malignancy mammogram reports are received. These notes will result in electronic notification to the ordering and primary care provider, and the Chief of Oncology services to meet 72 hour notification requirements and a second level review. A third level review by quality management and quarterly reporting to the Health Systems Council will continue of all abnormal or suspicious for malignancy radiology reports. The PACS/ADPA Coordinator for Radilogy will track, trend, analyze, and report timely reporting to providers to the Cancer Care Sub-Council and Health Systems Council beginning April 2007.

Recommendation 3. We recommend that the VISN Director ensure that the Medical Center Director requests an exemption from VHA and develops a plan for rapid access to open heart surgery before resuming PCI procedures in the CCL.

Concur **Target Completion Date:** February 28, 2007

The Medical Center Director will request an exemption from VHA by 1/31/07. The current verbal agreement for rapid access will be formalized through a memoranda of understanding by March 2007 with test of the agreement by April 2007.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Christa Sisterhen, Associate Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	Susan Zarter, Healthcare Inspections Team Leader Bertha Clarke Victoria Coates Paul Norris Toni Woodard

Appendix D

Report Distribution

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