



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the Michael E. DeBakey VA Medical Center Houston, Texas

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 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 and benefits services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to OIG.

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

**To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244**

Contents

	Page
Executive Summary	i
Introduction	1
Medical Center Profile	1
Objectives and Scope of the Combined Assessment Program Review	1
Results of Review	3
Opportunities for Improvement	3
Business Rules for Veterans Health Information Systems	3
Contract Community Nursing Home Program	4
Quality Management Program	5
Other Observations	7
Cardiac Catheterization Laboratory Standards	7
Community Based Outpatient Clinics	7
Environment of Care	8
Survey of Healthcare Experiences of Patients	8
Appendixes	
A. VISN Director Comments	10
B. Medical Center Director Comments	11
C. OIG Contact and Staff Acknowledgments	15
D. Report Distribution	16

Executive Summary

Introduction

During the week of January 8–12, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Michael E. DeBakey VA Medical Center (referred to as the medical center). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 355 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 16.

Results of Review

The CAP review focused on seven operational areas. The medical center complied with selected standards in four areas:

- Cardiac Catheterization Laboratory Standards.
- Community Based Outpatient Clinics (CBOCs).
- Environment of Care (EOC).
- Survey of Healthcare Experiences of Patients (SHEP).

We identified three areas that needed additional management attention.

- Business Rules for Veterans Health Information Systems.
- Contract Community Nursing Home (CNH) Program.
- QM Program.

This report was prepared under the direction of Ms. Linda G. DeLong, Director, and Ms. Karen A. Moore, Associate Director, Dallas Regional Office of Healthcare Inspections.

Comments

The VISN 16 and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 10–14, 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.
Assistant Inspector General for
Healthcare Inspections

Introduction

Medical Center Profile

Organization. The medical center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics located in Beaumont, Lufkin, Conroe, Texas City, and Galveston, Texas. The medical center serves a veteran population of about 398,000 in a primary service area that includes 28 counties in southeast Texas.

Programs. The medical center provides care in the areas of medicine, surgery, mental health, spinal cord injury, physical medicine, rehabilitation, and numerous specialty areas. The medical center operates 431 hospital beds, 120 nursing home beds, and several regional referral and treatment programs. Sharing agreements exist with the Department of Defense to provide annual physical exams for local Reserve units.

Affiliations and Research. The medical center is affiliated with Baylor College of Medicine and supports more than 580 medical resident positions in 41 training programs. Other affiliations include 97 clinical and 15 non-clinical program agreements. In fiscal year (FY) 2006, the medical center research program had 563 projects and a budget of \$17 million.

Resources. In FY 2006, medical care expenditures totaled \$491 million. The FY 2006 medical care budget was \$485 million. FY 2006 staffing totaled 2,794 full-time employee equivalents (FTE), including 203 physician and 572 nursing FTE.

Workload. In FY 2006, the medical center treated 83,079 unique patients. The medical center provided 115,285 inpatient days of care in the hospital and 42,271 days of care in the Nursing Home Care Unit. The inpatient care workload totaled 12,913 discharges, and the average daily census, including nursing home patients, was 432. The outpatient workload was 809,485 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 facility operations focusing on patient care administration 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 activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical records. The review covered the following seven programs:

Business Rules for Veterans Health	CNH Program
Information Systems	EOC
Cardiac Catheterization Laboratory	QM Program
Standards	SHEP
CBOCs	

Programs needing improvement are discussed in the Opportunities for Improvement section (beginning on page 3). Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

During this review, we also presented fraud and integrity awareness briefings for 355 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Opportunities for Improvement

Business Rules for Veterans Health Information Systems

We reviewed Veterans Health Administration (VHA) and medical center information and technology policies and interviewed Information Resource Management Service staff. A communication (software informational patch¹ USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers. The communication addressed a number of issues relating to the editing of electronically signed documents in the Veterans Integrated Health Systems Technology and Architecture system. The Information Officer cautioned that “the practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed.” On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

Business rules define what functions certain groups or individuals are allowed to perform in the medical record. The OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the facility’s Privacy Officer.

Condition Needing Improvement. The medical center had one business rule that allowed editing of a signed note by someone other than the Privacy Officer. Although the business rule was in place, it is important to note that this did not result in the alteration of a signed note and did not affect the established process that prohibits Clinical Application Coordinators from altering signed notes. Management stated that compliance with VHA Handbook 1907.1 and the October 2004 OI guidance will continue to be integrated into all Information Management and health record operations at the medical center.

Medical center staff took action to remove and/or amend their business rule while we were onsite.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

¹ Patch – a piece of code added to computer software in order to fix a problem.

Contract Community Nursing Home Program

The purpose for the CNH Program review was to assess the medical center's compliance with requirements defined in VHA Handbook 1143.2, which includes the selection, placement, and monitoring of patients in CNHs and the inclusion of patients and family members in the process. Additional purposes included determining if: (1) VHA facilities have improved the oversight of VA patients in CNHs, (2) services contracted for are received, and (3) appropriate actions are taken when problems are identified that adversely affect patient safety and quality of care.

Conditions Needing Improvement. According to VHA standards, CNH staff demonstrated a lack of oversight in monitoring quality indicator deficiencies, monitoring veterans every 30 days, and entering a patient's death into the computerized patient record system (CPRS) in a timely manner.

Monitoring Quality Indicator Deficiencies. CNH staff did not provide documentation that the Centers for Medicare and Medicaid Services quality indicator deficiencies were monitored and reviewed on a consistent basis. The average number of deficiencies for nursing homes in the state of Texas is nine. A sample of five contracted CNHs were reviewed. One CNH in which three veterans resided had 46 deficiencies and was on the National Watch List. The CNH Review Team demonstrated a lack of oversight in the annual evaluation of the nursing home. The CNH Coordinator was unaware of the severity and quantity of deficiencies identified in the State inspection. The CNH Coordinator explained that the medical center performed their annual evaluation on March 23, 2006, and the State conducted an inspection on March 18, 2006. We expressed concerns for the level and number of deficiencies the medical center failed to identify in March.

The CNH Review Team showed inadequate follow-up on the statement of deficiencies and plan of corrections. As a result, the CNH Oversight Committee held no discussion about the evaluation or possible corrective actions. The CNH Coordinator informed us that quality indicator deficiencies were discussed during the CNH Review Team and CNH Oversight Committee meetings. We reviewed all CNH related committee minutes from FY 2006 and found only four documented discussions concerning the scope, severity, and quantity of deficiencies in contracted nursing homes. Neither committee addressed the 46 deficiencies in a nursing home that provided care for three veterans. While we were onsite, the medical center implemented a plan of corrective action.

Monitoring Veterans. VHA policy requires a social worker and registered nurse (RN) to alternate monthly visits in order to see patients every 30 days, unless otherwise indicated in an individual treatment plan. However, documented evidence confirmed that veterans were not monitored in accordance with VHA standards. A review of medical records indicated that 8 of 10 patients were monitored sporadically during the months of September through November 2006. For example, a social worker saw a patient on

August 28, October 20, and December 29, 2006. This same patient was seen by the RN on December 22, 2006. Visits which should have occurred in September and November were not made. The CNH Coordinator reported that clinical staff was in a transitional period. The medical center took corrective action.

Entering Patient's Death. The medical center did not enter a patient's death into CPRS in a timely manner. During a medical record review, a progress note stated that a veteran had died in a nursing home on November 8, 2006. However, CPRS did not indicate that the veteran's records had been closed. On December 22, 2006, an RN went to the nursing home to conduct an initial visit for another veteran and learned of this veteran's death. The RN then documented a progress note in CPRS that the patient had died, but the patient's medical records were not closed to reflect the death. This allowed all aspects of CPRS to remain open, which showed all medications to be active, including morphine sulfate and hydrocodone. The information was not properly entered into CPRS until January 8, 2007, after the issue was brought to the attention of the CNH staff by OIG healthcare inspectors. The medical center did follow-up to ensure that unauthorized access into CPRS did not take place after the patient's death. The corrective action taken by CNH staff while our healthcare inspectors were onsite demonstrated a desire to comply with CPRS standards.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to provide oversight in monitoring quality indicator deficiencies, monitor veterans at least every 30 days in accordance with VHA standards, and enter death notification into CPRS in a timely manner.

Quality Management Program

The purposes of this review were to determine whether (1) VHA facilities have comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and (2) VHA facility senior managers actively support and appropriately respond to QM efforts.

Condition Needing Improvement. The QM program was comprehensive and generally effective, with appropriate review structures in place for 14 of the 15 program activities reviewed. However, we identified one program area that needed improvement.

Patient Safety. VHA Handbook 1050.1, *Patient Safety Improvement*, and Medical Center Memorandum No. 00Q-004, *Patient Safety Improvement Plan*, require a root cause analysis (RCA) for an adverse event to be completed within 45 calendar days of the medical center becoming aware that an RCA is required. However, in the review we conducted, RCAs for FY 2006 were not completed within the required timeframe. Without timely completion of RCAs, planning for corrective actions to prevent the occurrence of similar events would be delayed.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that all RCAs are completed within the 45-day timeframe, as specified in VHA Handbook 1050.1, *Patient Safety Improvement*, and Medical Center Memorandum No. 00Q-004, *Patient Safety Improvement Plan*.

Other Observations

Cardiac Catheterization Laboratory Standards

A cardiac catheterization is a specialty procedure performed in a catheterization laboratory to diagnose defects in the heart chambers, valves, and blood vessels. In some cases, the diagnostic procedure may require a therapeutic intervention, commonly known as percutaneous coronary intervention (PCI), to open blockages. The purpose of this review was to determine if the medical center's cardiac catheterization laboratory practices were consistent with VHA Handbook 1004.1 and the American College of Cardiology (ACC) and the Society for Cardiac Angiography and Interventions Laboratory Standards. These standards define requirements for provider procedure volumes, laboratory procedure volumes, cardiac surgery resources, complication rates, QM, the informed consent process, and cardiopulmonary resuscitation (CPR) training. We reviewed these practices and found that the medical center was in compliance with the standards.

The medical center's cardiac catheterization laboratory completed 687 diagnostic coronary and 186 PCI procedures in FY 2005. The volume of PCIs was low due to an attending physician's medical incapacitation that led to the use of contract physicians. These contract physicians continued their outside practices, which satisfied the provider/laboratory procedure volume requirements. The attending physicians privileged in these areas performed the procedures within the acceptable ACC standards, and all had received the required CPR training. The medical center has an ongoing quality improvement process that tracks, trends, and analyzes cardiac catheterization procedures to improve patient outcomes. In addition, we reviewed 10 medical records of patients who had a cardiac catheterization procedure in FY 2005 and found that the informed consent documentation was appropriately completed. We made no recommendations.

Community Based Outpatient Clinics

The purpose of this review was to evaluate the CBOC's compliance with VHA regulations regarding selected standards of operation, such as EOC, patient safety, QM, credentialing and privileging, and emergency plans. The review also assessed if the CBOC improved timely access to health care services and maintained the same standard of care as their parent medical center for primary care and mental health services.

Our inspectors visited the Galveston CBOC and interviewed key individuals at the parent medical center and the CBOC. We reviewed documentation and self-assessment tools on the description of services provided, including Warfarin (an anti-coagulant medication) Clinic services. Documentation related to credentialing and privileging and background investigations were reviewed. Ten patients were interviewed, and an inspection of the clinic's EOC was conducted.

Documentation illustrated that CBOC clinicians managed patients taking warfarin according to current VHA clinical practice guidelines. The review of three CBOC providers' credentialing and privileging files and two CBOC nurses' personnel folders showed the documentation to be in order, with appropriate background screenings. The employees maintained basic life support certification. The emergency management plan was current, and clinical staff were educated in and knowledgeable about rendering emergency care to the patients.

The CBOC patients interviewed expressed satisfaction with the clinic's services and the timeliness of access to care. The clinic's EOC was safe and clean. Clinical managers also provided adequate patient privacy during the clinic check-in process. We made no recommendations.

Environment of Care

The purpose of the evaluation was to determine if the medical center maintains a safe and clean health care environment. The medical center is required to establish a comprehensive EOC program that fully meets the National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Healthcare Organizations standards. The Infection Control Program was evaluated to determine compliance with VHA directives based on the medical center's management of data collected and the processes in which that data is used to improve performance. The medical center maintained a generally clean and safe environment. The Infection Control Program monitored, trended, and analyzed the data and reported the results to clinicians for implementation of quality improvements. We made no recommendations.

Survey of Healthcare Experiences of Patients

Presidential Executive Order 12862 requires agencies to publish customer service standards, survey their respective customers, and use customer feedback information to manage the agency. The Executive Career Field Performance Plan for FY 2006 established that 77 percent of ambulatory care patients and 76 percent of discharged inpatients must report overall satisfaction of "very good" or "excellent" in order to meet or exceed target goals.

The graphs on the next page show the medical center's SHEP results for inpatients and outpatients.

Michael E. DeBakey VA Medical Center											
INPATIENT SHEP RESULTS											
FY 2006 Quarters 1 and 2		Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	
National		81.31	78.63	89.95	68.02	65.8	75.85	83.41	74.49	70.03	
VISN		79.6-	77.3-	88.8-	66.6-	64.3-	74.7-	82-	75.30	69.10	
Medical Center		76.4-	75.2-	86.5-	63.8-	61.1-	75.30	81.4-	70.7-	65.9-	
OUTPATIENT SHEP RESULTS											
FY 2006 Quarter 3	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	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	80.2	79.3	94.1	70.4	81.2	75.1	80.7	65	80.4	83.1	82.9
Medical Center Clinics	71.5	78.9	91.6	66.9	80.3	71.2	76.1	58.6	76.9	82.4	83.4
Legend: "+" Indicate results significantly better than the National Average "-" Indicate results worse than national average											

The medical center Director was aware of the SHEP report results for FY 2006, and results had been communicated to the employees. Medical center analysis of the survey results identified areas targeted for improvement. The medical center developed action plans based on these results to improve patient access to appointments, coordination of care, emotional support, education and information, transition, family involvement, and pharmacy pick-up services.

The medical center is in the process of implementing the Press Ganey strategic initiative in the Primary Care Clinics. Press Ganey will survey the patients, provide real time responses regarding veteran satisfaction, and compare the medical center's performance with the private sector. Because specific information, such as clinic area and providers, will be available, it will be easier to identify and address problem areas. We made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 28, 2007

From: Network Director, South Central VA Health Care Network (10N16)

Subject: CAP Response - Michael E. DeBakey VA Medical Center, Houston, TX

To: Medical Center Directors (00)

1. The SCVAHCN 16 has reviewed the response to the CAP Report for the Michael E. DeBakey VAMC, Houston, TX, and concur.
2. If you have questions or need additional information, please contact Mr. Edgar Tucker, Center Director, at Houston, at 713.194.7100.



Robert Lynch, M.D.

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: 2/27/2007

From: Medical Center Director

Subject: **Combined Assessment Program Review, Michael E. DeBakey VA Medical Center, Houston, Texas**

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to respond to this draft Office of Inspector General Report. We concur with the report's recommendations for improvement. Attached is information on actions taken to address the findings.

2. Please contact me at 713-794-7100 if you have questions regarding the attached response or if I may be of further assistance.

(originals signed by:)

EDGAR L. TUCKER

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

The following Medical Center Director's comments² 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 requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

Concur **Target Completion Date:** Complete

As noted in this report, the MEDVAMC corrected the finding while the review team was on site.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director requires clinicians to provide oversight in monitoring quality indicator deficiencies, monitor veterans at least every 30 days in accordance with VHA standards, and enter death notification into CPRS in a timely manner.

Concur **Target Completion Date:** Complete

Finding "A" Corrective Action: A staff member has been assigned to check the Medicare website each month to document the latest State survey for contract nursing homes (CNH). The assigned staff member is also calling contract nursing homes weekly to obtain the following information for patients on VA contract:

² **Note:** After comments were received from the medical center, but before the report was published, the OIG made a policy decision to no longer have any multi-part recommendations. Separate recommendations will be numbered and tracked separately; any recommendations with more than one element will not be closed until all implementation actions have been taken. This will improve the tracking and reporting of recommendations. Any disparity in this report between the numbering of the recommendations in the body of the report and in the Directors' comments is the result of this action.

1. Name and number of patients on VA contract:
 - a. Patient(s) admitted to a private hospital;
 - b. Patient(s) who have expired;
 - c. Patient(s) discharged or left the facility;
 - d. Patient(s) experiencing unusual medical/psychiatric issues.

2. Recent State survey and date.

Finding "B" Corrective Action: All CNH patients will be seen every 30 days by a nurse or social worker. To ensure this occurs, the following process has been implemented:

1. Each week, the social worker and nurse submit a "Documentation of Monthly Follow-up Form" to the CNH program manager on completed visits.
2. The supervisor compares information on the form to documentation in CPRS.
3. A master spreadsheet with all veterans on contract is reviewed by the program manager not later than 4 business days before the end of the month to ensure all visits are completed and documented. In the absence of the CNH nurse or social worker, coverage is provided.

Finding "C" Corrective Action: The CNH clerk notifies the MEDVAMC Decedent Affairs office of all deaths by "receipt acknowledged" message and then checks CPRS within 72 hours to ensure the death notice is posted. If receipt of the death notification is not acknowledged within 72 hours, the CNH clerk contacts the Decedent Affairs office by telephone and verifies that the death notice is posted in CPRS within 24 hours.

Recommendation 3. We recommend that the VISN Director ensure that the Medical Center Director requires that all RCAs are completed within the 45-day timeframe as specified in VHA Handbook 1050.1, *Patient Safety Improvement*, and Medical Center Memorandum No. 00Q-004, *Patient Safety Improvement Plan*.

Concur

Target Completion Date: 3/31/07

The following improvements are being implemented to achieve the 45-day mandate for completion of RCAs: RCA Teams will be appointed by the Medical Center Director; supervisors will allocate adequate time for RCA participation by assigned staff; the RCA Team's Quadrad briefing will be scheduled at the time an RCA is appointed; staff will be advised that RCAs are important and that the RCA Team will discuss its findings and recommendations with the Quadrad (Director, Associate Director, Chief of Staff, and Chief Nurse Executive); Quality Managers will facilitate RCAs in addition to Patient Safety staff; leaders involved in corrective actions will attend the Quadrad briefing; and recommendations will be salient, measurable, and attainable to avoid lengthy rework.

Please note that MEDVAMC's last five RCAs have been completed within 45 days and all of our RCAs currently in progress are projected to meet the 45-day mandate.

OIG Contact and Staff Acknowledgments

OIG Contact	Linda G. DeLong, Director Dallas Regional Office of Healthcare Inspections (214) 253-3331
Acknowledgments	Karen Moore, Associate Director Shirley Carlile Roxanna Osegueda Wilma Reyes Marilyn Walls

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 16 (10N16)
Director, Michael E. DeBakey VA Medical Center (580/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction and Veterans Affairs
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
 John Cornyn
 Kay Bailey-Hutchison
U.S. House of Representatives:
 Kevin Brady
 John Abney Culberson
 Al Green
 Gene Green
 Nick Lampson
 Sheila Jackson Lee
 Michael T. McCaul
 Ted Poe
 Ron Paul

This report is available at <http://www.va.gov/oig/publications/reports-list.asp>.