Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System Biloxi, Mississippi

Report No. 07-00161-159 **July 2, 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 and benefits services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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Executive Summary

Introduction

During the week of January 29, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Gulf Coast Veterans Health Care System (the system) located in Biloxi, MS. The purpose of the review was to evaluate selected system operations, focusing on quality management (QM) and selected areas of patient care. During the review, we also provided fraud and integrity awareness training for 637 employees. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 16.

Results of Review

This CAP review focused on six health care areas. The system complied with selected standards in the following two areas:

- Survey of Healthcare Experiences of Patients (SHEP).
- Community Based Outpatient Clinics (CBOCs).

We identified the following organizational strengths:

- Ventilator Associated Pneumonia Prevention.
- Management of Disruptive Behavior.
- Emergency Preparedness for Hurricanes.

We made recommendations in four of the six activities reviewed. For the activities of QM, contract community nursing homes (CNHs), business rules for veterans health information systems, and environment of care (EOC), the system needed to take action as outlined below and on the next page.

Quality Management

- Implement remedies to ensure root cause analyses (RCAs) are completed in 45 days.
- Ensure the minimum National Center for Patient Safety (NCPS) completion guidelines are met for volume of individual RCAs and aggregate reviews per year.
- Ensure RCAs are properly chartered, and the concurrence page is signed by all team members, including the system Director.
- Execute timely action plans and outcome monitors for all RCAs to mitigate repeat events.
- Ensure senior leadership monitors outcome measures for all RCAs.

- Accurately reconcile medications during admission, transfer, and discharge for all services indicated.
- Standardize the peer review form to capture signatures of all peer review providers and dates of those signatures.
- Define all future Level 3 peer reviews consistent with Veterans Health Administration (VHA) policy.

Contract Community Nursing Homes

- Appoint a representative from QM to the CNH Oversight Committee.
- Ensure the CNH Oversight Committee meets annually with each Ombudsman office and documents the meetings.
- Ensure CNH inspections are completed within the timeframe required.
- Ensure CNH performance improvement activities are integrated into the system's QM Program.

Business Rules for Veterans Health Information Systems

- Ensure compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 Office of Information (OI) guidance.

Environment of Care

- Ensure all areas are cleaned, and compliance is monitored by the Environmental Management Service (EMS) supervisor.
- Ensure the roof and air conditioning units are repaired.

This report was prepared under the direction of Ms. Marisa Casado, Director, St. Petersburg Office of Healthcare Inspections, and Mr. David Griffith, CAP Team Leader, St. Petersburg Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

System Profile

Organization. The system consists of one VHA tertiary care facility located in Biloxi, MS, and three CBOCs located in Pensacola and Panama City, FL, and in Mobile, AL. The system is part of VISN 16 and serves a veteran population of 246,883 in a primary area that includes 18 counties in Alabama, Mississippi, and Florida.

Programs. The system provides nursing home care and medical, surgical, mental health, geriatric, and rehabilitation services. The system has 130 inpatient beds and 81 nursing home beds. The system has sharing agreements with Keesler Air Force Base (AFB), Navy Hospital Pensacola, Eglin AFB, Tyndall AFB, and five community hospitals.

Affiliations and Research. The system is affiliated with Louisiana State University, Keesler AFB, Indiana University School of Optometry, and several other colleges and universities. The system supports 83 medical resident positions in five training programs. Important areas of research include osteoporosis, depression, cancer, tinnitus, and cardiovascular disease.

Resources. In fiscal year (FY) 2006, medical care expenditures totaled $235 million. The FY 2007 medical care budget is projected to be approximately $207.5 million. FY 2006 staffing totaled 1,528 full-time employee equivalents (FTE), including 98 physician and 412 nursing FTE.

Workload. In FY 2006, the system treated 47,182 unique patients and provided 39,420 inpatient days of care in the hospital, 61,832 inpatient days of care in the nursing home, and 53,922 inpatient days of care in the domiciliary. The inpatient care workload totaled 4,195 discharges, and the average daily census, including nursing home patients, was 425. The outpatient workload was 467,977 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 QM, the facility's EOC, and selected areas of patient care.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical activities to evaluate the effectiveness of QM and patient care administration. We also conducted an inspection of the system's EOC. QM is the process of monitoring the quality of patient care to identify and correct harmful and potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. EOC is the cleanliness and condition of the system'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:

Business Rules for Veterans Health Information Systems	EOC
CBOCs	QM
CNHs	SHEP

The review covered select system operations for FYs 2006 and 2007 through December 31, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on the recommendations from our previous CAP review of the system (*Combined Assessment Program Review of the VA Gulf Coast Health Care System, Biloxi, Mississippi*, Report No. 04-01946-188, August 27, 2004).

During the review, we also presented three fraud and integrity awareness briefings for employees. These briefings, attended by 637 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. We also noted three organizational strengths of the system during the course of the review, and we have included brief descriptions in this report.

Results of Review

Organizational Strengths

Ventilator Associated Pneumonia Prevention. In 2003, the system identified the need to implement measures to reduce the risk for ventilator associated pneumonia (VAP). The VAP infection rate had increased to 11 percent from 7.5 percent in 2001. The system has developed and instituted several measures to reduce VAP. In 2004 and 2005, the system took the following actions: (a) instituted oral care with Sage Care Products (main ingredient is peroxide), (b) designated an intensivist, and (c) developed a Ventilator Care Bundle order set and Ventilator Weaning protocols. As a result, in 2004, the system's VAP infection rate began to decline. In 2006, the VAP infection rate was down to zero.

Management of Disruptive Behavior. The system established a Disruptive Behavior Committee to address problem incidents that may occur in the system. The committee is interdisciplinary and has representatives from Workforce Development, Nursing Service, the Patient Advocate's office, Police Service, Clinical Informatics, Patient Safety, Safety, and the American Federation of Government Employees. A quick response team called the Disruptive Behavior Response Team was developed to respond to reported incidents of disruptive or threatening behavior and to assess the potential for immediate danger. The system provided staff education to help employees minimize and possibly eliminate incidents of anger or disruptive behavior. From FY 2005 to FY 2006 (after the implementation of these measures), there was a 48 percent decrease in the incidence of disruptive behavior.

Emergency Preparedness for Hurricanes. The system has experienced some of the strongest hurricanes ever to hit the continental United States (Camille, Ivan, Dennis, and Katrina). Recognizing the historical significance of these losses, the system set about making changes that would allow efficient operations following a catastrophic hurricane event. The system made preparations with regard to back-up power, improved water systems, the use of a variety of communication systems, and stockpiles of critical supplies. These preparations enabled the system to remain operational and provide service, with little or no impact on care, for the 174 patients retained throughout the landfall of Hurricane Katrina. While sustaining an estimated $11.5 million in damages at the Biloxi facility and experiencing a total loss of the Gulfport facility, the system has continued to operate normally. The exception was the closure of the domiciliary to use as space for mental health and dementia inpatients. The team of core Facilities Management Service staff operated throughout the storm, connected by the radio system. They took measures to provide safety for all and to lessen the damage on the physical structure.

Opportunities for Improvement

Quality Management

Conditions Needing Improvement. The QM program was generally effective in providing oversight of the quality of care. However, the following program areas needed specific improvements:

Patient Safety. We reviewed major components of the program and noted several areas not in compliance with VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, and the VA NCPS modifications in effect since October 1, 2003. A critical part of the Patient Safety Program is properly executing RCA reviews for actual or potential adverse events and implementing action plans with monitors to mitigate risk of repeat events. Although there is no correct number of RCAs that should be completed by a facility, 4 individual RCAs, 8 combined individual RCAs, and 12 aggregated review RCAs are considered a reasonable minimum by the NCPS.

We reviewed all RCAs initiated by the system in FY 2006 and found that only four individual cases were conducted. None of the four RCAs were completed in 45 days, and one case remained open for more than 6 months. We also noted the following deficiencies:

- Two of four did not have concurrence signatures and dates from the system Director and all team members.
- One of four did not have a signed Charter Memorandum from the system Director, as required by NCPS for all RCAs.
- One of four was given an extension beyond 45 days—not permitted by the NCPS—and did not include evidence of action items implemented or outcome measures completed.
- The system has a limited process to monitor RCA actions and outcomes to completion by senior leadership committees. (The process was changed during our review in a draft revision of the system Performance Improvement Policy.)

The system failed to conduct the required 12 aggregate reviews for falls, adverse drug events, missing patients, and parasuicides. Parasuicides and adverse drug events require quarterly reviews. Falls and missing patients require reviews every 6 months.

Without proper identification, reporting, documentation, and follow-up of adverse events, system-wide patient safety efforts can not be assured. Without action plans and monitors for improvement, risk for repeat events exists.

Medication Safety. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has established a National Patient Safety Goal to improve medication safety.

We found that JCAHO and local policy standards for patient safety in medication reconciliation were not met in multiple service areas for September–December 2006. Reconciliation is done to avoid medication errors, such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten.

We reviewed Medicine, Surgery, and Psychiatry Service data for all opportunities to reconcile medications during admission, transfer, and discharge. We found Pharmacy Service performance improvement monitors showing the following compliance:

Medicine Service	496 (58 percent) of 855 encounters
Surgery Service	208 (40 percent) of 519 encounters
Psychiatry Service	104 (31 percent) of 336 encounters

The system needs to improve compliance with the National Patient Safety Goal.

Peer Review. We reviewed the system's peer review process for compliance with VHA Directive 2004-054, *Peer Review for Quality Management*. We requested peer reviews for all Level 3[1] determinations for FY 2006 and received 11 cases meeting that criterion. We found that 9 of 11 cases were either not signed and/or dated by the initial peer reviewer.

We also found that the system's local policy, *Memorandum No. 11.25.06, Attachment A-9*, defined Level 3 as most experienced, competent practitioners would have managed the case differently in ***all*** of the respects listed. The VHA directive only requires ***one or more*** aspects to apply for the reviewer to make a determination of Level 3. During our review on January 31, 2007, the system revised their local policy to comply with the VHA directive.

Recommendation 1.[2] We recommended that the VISN Director ensure that the System Director takes action to implement remedies to ensure RCAs are completed in 45 days.

Recommendation 2. We recommended that the VISN Director ensure that the System Director takes action to ensure that the minimum NCPS completion guidelines are met for volume of individual RCAs and aggregate reviews per year.

[1] Peer Review Level 3 means that most experienced, competent practitioners would have managed the case differently in one of more aspects of care.

[2] After comments were received from the system, but before the report was published, the OIG made a policy decision to no longer use multi-part recommendations. 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.

Recommendation 3. We recommended that the VISN Director ensure that the System Director takes action to ensure RCAs are properly chartered, and the concurrence page is signed by all team members, including the system's Director.

Recommendation 4. We recommended that the VISN Director ensure that the System Director takes action to execute timely action plans and outcome monitors for all RCAs to mitigate repeat events.

Recommendation 5. We recommended that the VISN Director ensure that the System Director takes action to ensure senior leadership monitors outcome measures for all RCAs.

Recommendation 6. We recommended that the VISN Director ensure that the System Director takes action to accurately reconcile medications during admission, transfer, and discharge for all services indicated.

Recommendation 7. We recommended that the VISN Director ensure that the System Director takes action to standardize the peer review form to capture signatures of all peer review providers and dates of those signatures.

Recommendation 8. We recommended that the VISN Director ensure that the System Director takes action to define all future Level 3 peer reviews consistent with VHA policy.

The VISN and System Directors agreed with the findings and recommendations. The system created an Excel spreadsheet to track due dates for the required 45-day completion. The system also created a new RCA standard operating procedure and presented it to the Quality and Performance Management Committee for approval. Current RCA volume requirements set by NCPS for FY 2007 have been met. Measures have been initiated to complete charters and obtain concurrence page signatures for new RCAs. RCA action plans and outcome monitors are now added to the Quality and Performance Management Committee agenda, with senior leadership monitoring in the morning report. Medication reconciliation is ongoing, with specific target goals set for compliance. Peer reviews will be on a standardized form, with monitors in place to captures dates and signatures of all peer review providers. All future Level 3 reviews will comply with the new revised policy. The improvement actions are acceptable, and we consider recommendations 1, 2, 4, 5, and 8 closed. We will follow up on reported implementation actions for recommendations 3, 6, and 7 to ensure they have been completed.

Contract Community Nursing Homes

Conditions Needing Improvement. The CNH Oversight Committee needed to have representation from QM and meet with the Ombudsman offices at least yearly. The CNH

Review Team needed to conduct CNH inspections within the required timeframes. The CNH Oversight Committee also needed to integrate the CNH performance improvement activities into the system's QM Program. We identified the following areas needing improvement:

CNH Oversight Committee. The CNH Oversight Committee did not have a representative from QM. According to VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, the CNH Oversight Committee includes multidisciplinary management-level representatives from Social Work, Nursing, QM, Acquisition, and the medical staff. The system reported that they appointed a QM representative to the committee while we were onsite.

Ombudsman Relationship. VHA policy requires that each CNH Review Team and Oversight Committee establish a working relationship with the appropriate State Ombudsman offices to discuss subjects of mutual interest and concern. At a minimum, a yearly meeting is held with each office. The system reported their first meeting with two of the three Ombudsman offices in 2006 but had not met with the third office, as required.

CNH Inspections. The system did not conduct the CNH inspections, as required by policy. VHA policy requires the system to complete and document inspections every 12 months. At the time of our review, the system had seven CNH contracts. Three of the CNHs were not inspected within the timeframe required. VHA policy also requires that CNH inspections be completed no more than 90 days prior to the expiration of the contract. We found one CNH contract that was not in compliance with this regulation. While we were onsite, the system provided us with copies of a tracking form and a draft policy that they plan to implement to ensure future compliance.

Performance Improvement. The system did not integrate the CNH Program into its QM Program. The intent is for employees to use the results of improvement activities to strengthen the CNH Program. We did not find evidence that quality data were collected, analyzed, and integrated into the system's QM Program.

Recommendation 9. We recommended that the VISN Director ensure that the System Director takes action to appoint a representative from QM to the CNH Oversight Committee.

Recommendation 10. We recommended that the VISN Director ensure that the System Director takes action to ensure the CNH Oversight Committee meets annually with each Ombudsman office and documents the meetings.

Recommendation 11. We recommended that the VISN Director ensure that the System Director takes action to ensure CNH inspections are completed within the timeframe required.

Recommendation 12. We recommended that the VISN Director ensure that the System Director takes action to ensure CNH performance improvement activities are integrated into the system's QM Program.

The VISN and System Directors agreed with the findings and recommendations. A QM representative was appointed to the CNH Oversight Committee and will attend future meetings. The committee will document annual meetings with each Ombudsman office, and CNH inspections will meet the 90-day requirement. The CNH performance improvement activities will be integrated into the system's QM Program and reported to the appropriate committees. The improvement actions are acceptable, and we consider recommendation 9 closed. We will follow up on reported implementation actions for recommendations 10, 11, and 12 to ensure they have been completed.

Business Rules for Veterans Health Information Systems

Condition Needing Improvement. Business rules define what functions certain groups or individuals are allowed to perform in the electronic medical record. We reviewed VHA and system information and technology policies and interviewed Information Resource Management Service staff. We found that the system had 25 business rules that allowed editing or amendment of signed notes by users other than the author. Seventeen additional rules needed to be changed to limit retraction or deletion of notes to the Privacy Officer only.

On October 20, 2004, VHA's OI sent guidance to all medical centers to assure that business rules complied with VHA regulations. 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.

OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the system's Privacy Officer. System staff took action to edit and remove the business rules identified as inappropriate while we were onsite.

Recommendation 13. We recommended that the VISN Director ensure that the System Director takes action to ensure compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

The VISN and System Directors agreed with the finding and recommendation. The Privacy Officer will review all business rules annually to ensure compliance with VHA Handbook 1907.1 and the OI guidance. The improvement action is acceptable, and we consider this recommendation closed.

Environment of Care

Conditions Needing Improvement. Some patient care areas needed improvement. The system is required to establish a comprehensive EOC program that fully meets the NCPS, Occupational Safety and Health Administration, and JCAHO standards. The infection control program is evaluated by medical center staff to determine compliance with VHA directives by reviewing the management of data collected and the processes in which the data is used to improve performance. The system maintained a generally clean and sanitary environment. The infection control program monitored, trended, analyzed, and reported the data to clinicians for implementation of quality improvements. However, some areas needed management attention.

We randomly selected 12 areas throughout the system to inspect. We found stained ceiling tiles; stained sinks and corroded faucets in the medication rooms; damaged basins; air conditioning units repaired with duct tape; dirty air vents in some areas; and holes in the walls.

We were told that during Hurricane Katrina, the system's parent facility sustained damage to the roof in Building 1, which caused leakage problems. We were also told that after Katrina, there were issues in obtaining funds to make the necessary repairs. System staff took corrective actions while we were onsite to replace ceiling tiles and clean the sinks. System staff also provided us with their plans to repair the roof and the air conditioning units.

Recommendation 14. We recommended that the VISN Director ensure that the System Director takes action to ensure all areas are cleaned, and compliance is monitored by the EMS supervisor.

Recommendation 15. We recommended that the VISN Director ensure that the System Director takes action to ensure the roof and air conditioning units are repaired.

The VISN and System Directors agreed with the findings and recommendations. The Chief of EMS will ensure all areas are cleaned, with particular attention to baseboards and stainless steel sinks. Daily inspections will continue, and baseboard replacement will begin in March 2007. A project is in place to replace air conditioning and heating units in the Nursing Home Care Unit and in Buildings 1, 2, and 19 by May 2007. Interim painting and repairs will be initiated by March 2007. The improvement actions are acceptable. We will follow up on reported implementation actions to ensure completion.

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 uses the data to improve 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." Medical centers are expected to address areas in which they are underperforming. The following tables show the system's performance in relation to national and VISN performance for inpatients and outpatients. In the tables, note that "+" indicates results that are significantly better than the national average, and "-" indicates the score is significantly worse than the national average.

Inpatient SHEP Results
Quarter 3 and Quarter 4, FY 2006

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	**81.35**	**78.90**	**89.90**	**67.92**	**65.97**	**75.95**	**83.43**	**74.66**	**70.11**	**
VISN	79.5-	77.6-	89.30	67.20	65.00	74.2-	82.3-	75.7+	69.40	**
VA Gulf Coast	83.20	79.60	89.90	72.8+	69.00	81.6+	81.80	80.7+	72.80	**

*** Overall Quality is not reported by ALL BED SECTIONS*

Outpatient SHEP Results
Quarter 4, FY 2006

Facility Name	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	**81.1**	**77.9**	**94.7**	**72.8**	**83.1**	**75.6**	**81.9**	**65.9**	**81.4**	**80.7**	**84.4**
VISN	77.9 -	80.9	94.1	71.0	81.1	74.5	83.0	67.3	80.5	78.6	83.6
VA Gulf Coast	81.5	81.7	94.3	69.9	82.4	73.1	84.5	60.4	79.2	78.3	81.5

We reviewed the system's SHEP results and compared them to the national and VISN results. The inpatient SHEP scores for quarters 3 and 4 of FY 2006 were below the target

of 76 percent in the areas of education and information, emotional support, and transition. The outpatient SHEP scores for quarter 4 of FY 2006 were below the target of 77 percent in the areas of education and information, overall coordination, and pharmacy pick-up.

The system has a SHEP Coordinator and a Patient Satisfaction Committee that meets monthly. Managers analyzed the scores and provided documentation of improvement strategies. Some of the strategies included conducting inpatient and outpatient surveys, conducting customer service training for all staff, hiring a Patient Education Coordinator, and designating service level patient advocates to permit timely resolution of complaints. The system had taken appropriate actions, and we made no recommendations.

Community Based Outpatient Clinics

The purpose of this review was to assess the effectiveness of CBOC operations and VHA oversight to determine whether CBOCs are in compliance with selected standards of operations, such as patient safety, QM, credentialing and privileging, and emergency planning.

VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, establishes consistent planning criteria and standardized expectations for CBOC operations. It defines the CBOC, the options for staffing, and the services provided. VHA Directive 2002-074, *VHA National Dual Care Policy*, establishes a system-wide approach to the coordination and provision of medical care that optimizes the quality, appropriateness, and efficacy of care and medications provided to eligible veterans who are seen by both VA and community providers. VHA Handbook 1100.19, *Credentialing and Privileging*, defines the process for all individuals who are permitted by law and the facility to provide patient care services independently. VHA Directive 0710, *Personnel Suitability and Security Program*, establishes requirements to perform background checks or, at a minimum, a Special Agreement Check on all appointees, health care contractors, and most volunteers prior to their entry on duty at a VHA facility.

We interviewed key personnel and patients at the parent facility and the Mobile CBOC. We reviewed documentation and self-assessment tools on descriptions of services provided, including Warfarin Clinic services. We determined that the parent facility Warfarin Clinic, managed by two pharmacists, and the CBOC Warfarin Clinic, managed by one pharmacist, maintain the same standards and expectations. Patients attended an initial education class at the parent facility or the CBOC before they received their first dose of warfarin. Patients received a handbook that contained a toll-free telephone number to call if they had questions.

The CBOC EOC inspection demonstrated a clean facility that meets JCAHO, Health Insurance Portability and Accountability Act, and Life Safety requirements. The emergency management plan was current, and all clinical staff were educated in and knowledgeable about rendering emergency care to the veterans. The two nurses

interviewed were certified in automated external defibrillator (AED)/cardiopulmonary resuscitation. Medical center staff inspected the AED and documented results of the inspection. Our review of three CBOC providers' credentialing and privileging files and two CBOC nurses' personnel folders showed that background screening documentation was appropriate. The CBOC met all criteria for inspection; therefore, we made no recommendations.

Follow-Up of Previous Combined Assessment Program Review Recommendations

As part of this review, we followed up on recommendations resulting from a prior CAP review of the system. In June 2004, the OIG found patient safety and EOC issues that needed management attention. The previous findings in patient safety involved reduced visibility in the locked psychiatry unit and loose ceiling panels in hallways. The previous findings in EOC involved medication security, storage of outdated supplies, signage, obstruction of a fire exit, and cleanliness of bathrooms.

We found that system managers had adequately addressed recommendations made in the prior CAP report. The previously cited patient safety conditions were corrected with the relocation of the locked psychiatry unit from Gulfport to the Biloxi campus. The previous EOC issues had also been resolved. We consider both the patient safety and the EOC issues closed.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 26, 2007

From: Director, Veterans Integrated Service Network 16 (10N16)

Subject: Draft Report: Combined Assessment Program Review, VA Gulf Coast Veterans Health Care System (Project No. 2007-00161-HI-0191)

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

1. Enclosed is the response to the Combined Assessment Program (CAP) review of the VA Gulf Coast Veterans Health Care System.

2. If you have any questions, please contact Mary Jones, VISN 16, at 601-364-7871.

(original signed by:)
Robert Lynch, M.D.

Attachment

Appendix B

Health Care System Director Comments

VA Gulf Coast Veterans Health Care System (520) Response to the Office of Inspector General Combined Assessment Program Review Report

Comments and Implementation Plan

1. Quality Management

Recommendation 1. We recommend that the VISN Director ensure that the System Director take action to: (a) implement remedies to ensure RCAs are completed in 45 days; (b) ensure the minimum NCPS completion guidelines are met for volume of individual RCAs and aggregate reviews per year; (c) ensure RCAs are properly chartered, and the concurrence page is signed by all team members, including the system's Director; (d) execute timely action plans and outcome monitors for all RCAs to mitigate repeat events; (e) ensure senior leadership monitors outcome measures for all RCAs; (f) accurately reconcile medications during admission, transfer, and discharge for all services indicated; (g) standardize the peer review form to capture signatures of all peer review providers and dates of those signatures; and (h) define all future Level 3 peer reviews consistent with VHA policy.

Concur with recommended improvement actions

(a) Implement remedies to ensure Root Cause Analysis (RCAs) are completed in 45 days:

Planned Action: Create an Excel spreadsheet with associated tickler files documenting the RCA Charter date, interim departmental due date set at 30 days from charter, and required 45-day RCA completion date. The spreadsheet will be updated and reviewed weekly by the Patient Safety Manager. The above actions were taken **November 1, 2006**. Weekly RCA updates have been added to the Quality and Performance Management (Q & PM) staff meeting agenda. This action was taken **November 1, 2006**. A RCA Standard Operating Procedure (SOP) was created on **January 10, 2007**. The RCA SOP was presented and approved by the Q & PM Committee on **January 17, 2007**.

(b) Ensure the minimum National Center for Patient Safety (NCPS) completion guidelines are met for volume of individual RCAs and aggregate reviews per year:

Planned Action: Current FY 07 number of RCAs have met the minimum volume set by the NCPS. The VISN has sent action items to the Director for every aggregate RCA due FY 07. These actions were forwarded to the Patient Safety Manager on **December 12, 2006**. The due dates were added to the Excel spreadsheet being monitored by Q & PM Service on **December 12, 2006**.

(c) Ensure RCAs are properly chartered, and the concurrence page is signed by all team members including the Health Care System Director:

Planned Action: The Patient Safety Manager reviewed RCA process (in accordance with the VHA Handbook 1050.1 and the VHA National Patient Safety Improvement Handbook 2007) with the Health Care System Director and Executive Leadership staff on **February 21, 2007**.

The Patient Safety Manager and the Patient Safety Specialist will ensure that the RCA processes are strictly adhered to (i.e., chartered, and the concurrence page is signed by required staff).

(d) Execute timely action plans and outcome monitors for all RCAs to mitigate repeat events:

Planned Action: The Patient Safety Manager and/or the Patient Safety Specialist will present the status of RCA action plans and outcome monitors to the Q & PM Committee. Presentation of RCA action plans and outcome of monitors is a standing Q & PM Committee agenda item; initial reporting date, **January 17, 2007**.

(e) Ensure senior leadership monitors outcome measures for all RCAs:

Planned Action: The Patient Safety Excel spreadsheet contains updates on all RCAs. The Director's administrative staff was given access to the spreadsheet on **February 2, 2007**. The Acting Chief, Q & PM presents all charters, recommendations, and actions to the Director and the Quadrad during the Director's "Second Morning Report." This action was implemented **January 10, 2007**, and will be ongoing.

(f) Accurately reconcile medications during admission, transfer, and discharge for all services indicated:

Planned Action: A medication reconciliation process has been developed and implemented since **January 2006**. We continue to improve documentation and capture of documentation by reviewing our processes and identifying opportunities to improve. Provider training and feedback is continuous. Pharmacy Service is monitoring the documentation and is reporting compliance rates to the Q & PM Service, Pharmacy and Therapeutics Committee, and to the Chief of Staff. Performance monitoring data is used to provide feedback to the providers as to their progress and to identify areas needing improvement. Administrative Officers from each service are also privy to the performance monitoring data in order for them to keep the service chiefs up to date on their respective service. Documentation of greater than 90 percent compliance is expected by **April 1, 2007**, and documentation of greater than 100 percent compliance is expected by **June 1, 2007**.

(g) Standardize the peer review form to capture dates and signatures of all peer review providers:

Planned Action: The standardized peer review form will be utilized, signed, and dated at the completion of the typed review by all peer reviewers. Monitoring of this action will be done monthly by the Program Manager, Risk Management & Medical Legal Affairs, starting **February 26, 2007**. Findings of the monitoring will be reported at the **March 19, 2007,** Peer Review Committee meeting, and, thereafter for **3 months (April, May, June 2007)**. If a compliance rate of 100 percent is sustained for 90 days, monitoring will be randomly completed quarterly by the committee/chair.

(h) Ensure all future Level 3 peer reviews are consistent with VHA policy:

Planned Action: The Associate Chief of Staff for Clinical Guidelines and Performance Measures will continue to send electronically the peer review Level 3 definition consistent with the VHA policy to each assigned peer reviewer. Action was taken on **January 31, 2007**, which revised the peer review local policy attachment A-9 Level 3 definition to read as it was written on page two of the local policy (Memorandum No. 11-25-06, Peer Review for Quality Management) and the VHA policy.

2. Contract Community Nursing Homes (CNH)

Recommendation 2. We recommend that the VISN Director ensure that the System Director take action to: (a) appoint a representative from QM to the CNH Oversight Committee, (b) ensure the CNH Oversight Committee meets annually with each Ombudsman office and documents the meetings, (c) ensure CNH inspections are completed with the timeframe required, and (d) ensure CNH performance improvement activities are integrated into the system's QM program.

Concur with recommended improvement actions

(a) Appoint a representative from QM to the CNH Oversight Committee:

Planned Action: A representative from QM had been appointed to the CNH Oversight Committee on **December 13, 2006**. The Acting Chief, Q & PM Service, will ensure that a QM representative attends the **March 22, 2007**, and all subsequent meetings of the CNH Oversight Committee.

(b) Ensure the CNH Oversight Committee meets and documents annual meetings with each Ombudsman office:

Planned Action: Although representatives from the three state Ombudsman offices had been contacted individually over the past year, each will now be invited to all quarterly meetings of the CNH Oversight Committee by **February 23, 2007**. In the event that any one of them cannot personally attend, teleconference equipment will be utilized. Attendance of these meetings with the Ombudsmen will be documented in the CNH Oversight Committee minutes. The target completion date is **March 22, 2007**.

(c) Ensure CNH inspections are completed with the timeframe required:

Planned Action: A CNH Coordinator was appointed by the Acting Chief, Social Work Service, on **February 13, 2007**. The CNH Coordinator's responsibilities include ensuring all inspections are completed within the set timeframe by utilizing the appropriate spreadsheet. The spreadsheet will identify the vendor, services, and contract expiration dates to ensure the 90-day requirement is met. In addition, the CNH Coordinator will maintain and update the CNH Inspection Tracking form for deficiencies

and, when appropriate, re-inspection dates. The target completion date for these actions is **March 22, 2007**.

(d) Ensure CNH performance improvement activities are integrated into the system's QM Program:

Planned Action: The CNH performance improvement activities will continue to be reported to the CNH Oversight Committee, Geriatric and Extended Care Patient Team (GECPT), Clinical Executive Committee (CEC) and the Executive Leadership Board (ELB). The next CNH Oversight Committee meeting will be held on **March 22, 2007**, and that data will be reported to the Q & PM Committee on **April 18, 2007**.

3. Business Rules for Veterans Health Information Systems

Recommendation 3. We recommend that the VISN Director ensure that the System Director takes action to ensure compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

Concur with recommended improvement action

Planned Action: The USR*1*26 was discussed in Clinical Informatics Committee and complied with by **July 1, 2006**, by removal of the ability to edit a signed document by expected cosigners. The Privacy Officer will review all Business Rules annually (each **January 25th**) to ensure compliance with VHA Handbook 1907.1, Health Information Management and Health Records; October 2004 Information Letter Office of Information guidance; and future VA/VHA Requirements/instructions. The Privacy Officer and Chief, Clinical Informatics Section, will be notified when new business rules are written. **(Effective January 25, 2007)**

4. Environment of Care

Recommendation 4. We recommend that the VISN Director ensure that the System Director takes action to (a) ensure all areas are cleaned, and compliance is monitored by the EMS supervisor and (b) ensure the roof and air conditioning units are repaired.

Concur with recommended improvement actions

(a) Ensure all areas are cleaned and monitored by the Environment Management Service supervisor for compliance:

Planned Action: The Chief, Facilities Management Service, has reviewed current Environmental Management Section (EMS) inspection procedures with the Chief, EMS, to ensure that all areas are appropriately cleaned and monitored. Particular attention will be paid to baseboards and stainless steel sinks. Actions were taken **February 9, 2007**.

EMS Supervisors will continue to conduct daily sanitation inspections and will report stained ceiling tiles and other routine maintenance needs to the Facilities Management Service (FMS) Customer Service Center. Baseboards in all areas will be inspected by FMS to determine the need for cleaning or replacement. A list of areas where baseboards need replacement will be compiled and FMS will begin replacement by **March 16, 2007**.

All areas will continue to be monitored through Environmental Rounds, with special attention given to the items noted during the IG inspection.

(b) Ensure the roof and air conditioning/heating units are repaired:

Planned Action: A project to replace the fan coil (air-conditioning/heating units) in Building #2, the NHCU, is in progress with an estimated completion date of **May 4, 2007**. This is project #520-06-120. Buildings 1 and 19 also have fan coil units that will be replaced through renovation projects #520-317 and #520-321. In the interim, FMS will inspect all fan coil units and initiate painting or other necessary repairs by **March 16, 2007**.

Attachment A

Project Information

#	Project Title and Tracking Number	Original Budget, Program, Fiscal Year, & Quarter	Construction Plan Projected Completion Date
1	Project ACORN (Major) (520-317)	$310,000,000 Budget FY 2005 Major	3/1/10
2	Hurricane Renovation Building-19 (D/B Minor) (520-321)	$6,400,000 Minor FY 2005 Minor	8/15/08
3	Replace Roof Building-3 (NRM) (520-02-104)	$1,432,114 Actual FY 2006 NRM	8/1/07
4	Replace Fan Coils Building-2 (520-06-120)	$350,600 Actual FY 2006 NRM	5/4/07
5	Repair/Replace Roofs Building 1, 17, & 53 (520-06-200H)	$2,262,000 Budget FY 2006 NRM	12/1/07
6	Repair/Replace Roofs Building 2, 19, & 21 (520-06-201H)	$2,565,000 Budget FY 2006 NRM	12/1/07

Appendix C

OIG Contact and Staff Acknowledgments

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Acknowledgments	David Griffith Deborah Howard Annette Robinson Idell Graham Elizabeth Bullock

Appendix D

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