Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the North Florida/ South Georgia Veterans Health System Gainesville, Florida

Report No. 07-00542-179

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VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Office 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 March 19, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the North Florida/South Georgia Veterans Health System (the system) located in Gainesville and Lake City, FL. The purpose of the review was to evaluate selected system operations, focusing on quality management (QM) and selected areas of patient care. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 8.

Results of Review

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

- Patient Satisfaction.
- Ocala Community Based Outpatient Clinic (CBOC).

We made recommendations in the four remaining areas reviewed. To improve operations, the system needed to:

- Improve QM processes in patient safety, medication management, peer review, and clinic access.
- Ensure cardiac catheterization laboratory staff comply with policies regarding documentation of informed consents and brief operative notes.
- Ensure staff comply with policies regarding crash cart checks and defibrillator testing, preventive maintenance of biomedical equipment, and infection control practices.
- Ensure that business rules governing electronic medical records (EMRs) comply with Veterans Health Administration (VHA) policy.

During our review, we also identified the system's Chest Pain Center and Teledermatology Program as organizational strengths.

This report was prepared under the direction of Ms. Victoria Coates, Acting Regional Director, and Annette Robinson, CAP Team Leader, St. Petersburg Office of Healthcare Inspections.

Comments

The VISN and Acting System Directors agreed with the CAP review findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 12–20, 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

System Profile

System managers provided the following profile information:

Organization. The system consists of the Malcom Randall VA Medical Center located in Gainesville, FL, and the Lake City VA Medical Center located in Lake City, FL. In addition, the system operates three large multi-specialty outpatient clinics in Daytona Beach, Jacksonville, and Tallahassee, FL, and six CBOCs located in Lecanto, Leesburg, Ocala, St. Augustine, and The Villages in north Florida and Valdosta in south Georgia. The system is part of VISN 8 and serves a veteran population of more than 460,000 in a primary service area that covers 33 counties in northern Florida and 19 counties in southern Georgia.

Programs. The system provides medical, surgical, mental health, and long-term care services. The system has 285 inpatient hospital beds and 264 long-term care beds.

Affiliations and Research. The system is affiliated with the University of Florida and, through this affiliation, supports 127 medical/surgical resident positions. Other affiliations include Florida State University, Santa Fe Community College, Lake City Community College, and Florida A&M University. In fiscal year (FY) 2006, the system supported 316 research projects through its budget of $8 million. Important areas of research include brain diseases, oncology, and rehabilitation.

Resources: In FY 2006, medical care expenditures totaled approximately $603.4 million. Staffing in FY 2006 totaled 3,608 full-time employee equivalents (FTE), which included 252 physician and 1,151 nursing FTE. The FY 2007 budget is approximately $585.4 million.

Workload. In FY 2006, the system treated 122,225 unique patients. The system provided 65,856 inpatient days of care in the hospital and 78,604 inpatient days of care in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 12,071 discharges, and the average daily census, including nursing home patients, was 417. The outpatient workload totaled 1,276,906 visits.

Services for Military Personnel Returning from Iraq and Afghanistan. The system offers a comprehensive program of services to recently discharged veterans of Operation Iraqi Freedom and Operation Enduring Freedom. A Seamless Transition Task Force (STTF) made up of county Veteran Service Officers and medical, mental health, and rehabilitation staff from the system, the Vet Center, and the Florida Department of Veterans Affairs provides outreach and service coordination. The STTF has conducted briefings to National Guard and Reserve units throughout their catchment area, as well as

coordinated Post-Deployment Health Reassessment events with contracted medical teams for more than a dozen military units.

The State of Florida has had approximately 30,000 active duty military personnel deployed to Iraq or Afghanistan. Through its outreach efforts, the system has made initial contact with over 5,000 returning combat veterans and has enrolled more than 3,000 for VA care.

Objectives and Scope of the Combined Assessment Program Review

Objective. 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.

Scope. We reviewed selected clinical activities to evaluate the effectiveness of QM and patient care administration. We also conducted an inspection of the facility's environment of care (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 facility's patient care areas, the condition of equipment, the adherence to clinical standards for infection control and patient safety, and the compliance with patient data and medication security requirements. The previous CAP review (*Combined Assessment Program Review of the North Florida/South Georgia Veterans Health System*, Report No. 04-01718-222, September 29, 2004) had no health care findings requiring follow-up.

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

Cardiac Catheterization Laboratory	EOC
Ocala CBOC	Patient Satisfaction
EMR Business Rules	QM Processes

The review covered selected system operations for FYs 2006 and 2007 through March 23, 2007, 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

Organizational Strengths

Chest Pain Center Accreditation. In November 2003, the system established an interdisciplinary task force dedicated to the implementation of processes to improve early diagnosis and treatment of patients presenting with acute coronary syndrome (ACS). In April 2004, the system's Gainesville facility became the first VA medical center in the nation to become accredited as a chest pain center by the Society of Chest Pain Centers. In April 2006, the system's Lake City facility sought and received accreditation as well. Because VHA tracks individual medical center performance related to ACS measures, the system has benefited from the Chest Pain Center's rigorous quality of care standards. Since November 2004, data show that 177 low-risk ACS patients have been successfully treated following the ACS clinical pathway. There have been no missed myocardial infarctions (MI) and no deaths from acute MI in this patient population.

Implementation of Teledermatology. In May 2005, the system implemented a teledermatology pilot program to reduce dermatology waiting times for CBOC patients. Teledermatology allows skin condition images to be digitally recorded and uploaded to the patient's EMR. These images are readily accessible for interpretation by a dermatologist at the Gainesville facility.

Through teledermatology, more patients in remote CBOCs were able to receive timely and high quality dermatology consultation and care. For the period July through December 2005, the teledermatologist made a treatment recommendation in more than 95 percent of cases, and consult waiting times were reduced from 99 days to 5 days.

Opportunities for Improvement

Quality Management Processes

The purposes of this review were to determine if the system (a) had a comprehensive, effective QM Program designed to monitor patient care activities and coordinate improvement efforts and (b) was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations.

Conditions Needing Improvement. Overall, we found that the QM Program was well organized and coordinated. However, we identified some process improvement opportunities related to root cause analyses (RCAs), medication management, peer review, and advanced clinic access that required management attention.

Patient Safety. VHA guidelines and the National Center for Patient Safety outline specific requirements for a comprehensive program. A critical part of any patient safety program is completing RCAs within defined timelines to mitigate risk of repeat events. The system initiated 21 RCAs (12 individual and 9 aggregate) in FY 2006 but failed to complete the RCAs in 45 days, as required. We found that the completion times ranged from 69 days to 157 days. In addition, we reviewed the 12 individual RCAs and found that, on average, it took 18 days to charter RCA teams once the system was aware of the events. We also noted concurrence signatures were incomplete in 5 of the 12 individual cases reviewed. Without timely identification of adverse events, completion of RCAs, and signatures reflecting concurrence with findings, managers could not be assured of comprehensive and efficient patient safety processes.

Medication Management. VHA guidelines, The Joint Commission's[1] National Patient Safety Goals, and system policy define standards for patient identification prior to dispensing medication. Failure to use complete patient names and social security numbers resulted in 68 dispensing errors in the outpatient pharmacy in FY 2006 through the 1st quarter of FY 2007. The system's remedial actions during FY 2006 had not been effective. Without proper controls, managers could not be assured that patients received their prescribed medications.

Peer Review. VHA guidelines specify national program requirements for the peer review process. We reviewed the system's peer review program for FY 2006 and found that the Peer Review Committee (PRC) minutes were not presented quarterly to the Medical Executive Committee (MEC). The PRC trends and evaluates peer review findings and makes recommendations for improvement to the MEC. The MEC has responsibility for acting on PRC recommendations.

[1] Formerly the "Joint Commission on Accreditation of Healthcare Organizations."

In addition, formal training for all peer reviewers was incomplete at the time of our visit. VHA Directive 2004-054, *Peer Review for Quality Management,* dated September 29, 2004, requires formal training for all clinicians performing peer review. We found that the system implemented a new peer review policy on July 1, 2005, but did not complete the training. The system QM staff assumed a formal training program would be released that would meet the requirements. At the time of our review, QM staff had a PowerPoint document printed out for presentation, and rounds were in progress at various service levels to obtain signatures as evidence of training. Without required reports to leadership and formal training of peer reviewers, managers could not be assured that the peer review process was functioning as intended and that quality improvement actions were initiated.

Advanced Clinic Access. VHA guidelines and system performance measures set standards to meet the demand for patient services within defined timeframes. In FY 2006, the system did not meet target expectations to see new patients within 30 days in all clinics measured. In the 1st quarter of FY 2007, we found improvement for one data measure in the Cardiology Clinic; however, performance in the other nine clinics had not improved. The system acknowledged that some clinics could not schedule patients to be seen within 30 days and reported that they were working on approaches to improve access.

Recommendation 1. We recommended that the VISN Director ensure that the Acting System Director requires that RCAs are completed in accordance with the guidance outlined in the VHA National Patient Safety Improvement Handbook.

Recommendation 2. We recommended that the VISN Director ensure that the Acting System Director requires that corrective actions are taken to eliminate medication dispensing errors in the outpatient pharmacy and that the effectiveness of those actions is monitored.

Recommendation 3. We recommended that the VISN Director ensure that the Acting System Director requires that peer review results are reported quarterly to the MEC.

Recommendation 4. We recommended that the VISN Director ensure that the Acting System Director requires that formal training is completed for all peer reviewers.

Recommendation 5. We recommended that the VISN Director ensure that the Acting System Director requires that processes are implemented to improve access to specified clinics.

The VISN and Acting System Directors agreed with the findings and recommendations. They reported that a new process will be implemented to ensure completion of RCAs within 45 days, and status of RCAs will be monitored by top management. A new software program, currently in beta testing, will allow bar code scanning of patient

medication to be confirmed with patients' Veteran Identification Cards. In the meantime, staff will use two patient identifiers prior to dispensing medications, and effectiveness will be monitored through the medication error reporting process. It has been indicated on the agenda calendar that PRC results will be reported to the MEC quarterly, and the results are not to be deferred. Staff will receive formal training on peer reviews, and the system will implement processes to improve access to specified clinics. We will follow up on the planned actions until they are completed.

Cardiac Catheterization Laboratory

Conditions Needing Improvement. The system did not meet VHA policy requirements for documentation of informed consents for cardiac catheterization procedures (specialty procedures used to diagnose and treat defects in the heart chambers, valves, and blood vessels). In addition, procedure reports were not always timely.

The purpose of this review was to determine if the system's cardiac catheterization laboratory practices were consistent with the American College of Cardiology and the Society for Cardiac Angiography and Interventions *Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards* and with VHA policy. The standards define requirements for provider procedure volumes, laboratory procedure volumes, cardiac surgery resources, QM, and the informed consent process. VHA policy requires that informed consents include the names of all practitioners involved in the procedure and contain documentation of possible complications.

We determined that physicians performed an acceptable volume of procedures and had low complication rates. In addition, cardiac surgery was readily available for patients in the event of an emergency. However, based on our review of 10 medical records of patients who received cardiac catheterizations during FY 2005, we found that informed consents and procedure reports were incomplete.

Informed Consents. Ten of 10 (100 percent) informed consent forms failed to list all providers who participated in the procedure; one of these consent forms did not identify the attending physician. In addition, 4 of 10 (40 percent) consent forms did not list possible major complications. Without completed consent forms, managers could not be assured that the patients were adequately informed of the names of the clinicians performing any part of their procedure or of the possible complications associated with the procedure.

Procedure Reports. The Joint Commission[2] and system policy require entry of a brief procedure report in the medical record immediately after any invasive procedure, with a final operative report to be dictated the same day. We found that 3 of the 10 (30 percent)

[2] *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*, Update 2, Joint Commission Resources, Inc., September 2006, Standard IM.6.30, "Management of Information."

medical records reviewed did not contain the required procedure reports. Without completed brief procedure notes, providers may not have access to important clinical information needed to care for the patient.

The system reported that they altered the consent form in late FY 2005 to include a preprinted list of possible complications. We confirmed that complications are now properly recorded on the consent forms.

Recommendation 6. We recommended that the VISN Director ensure that the Acting System Director requires that informed consent forms reflect the names of all physicians participating in cardiac catheterization procedures and that brief procedure notes are documented immediately following the catheterizations.

The VISN and Acting System Directors agreed with the findings and recommendations and reported that all participating physicians' names are now listed on consent forms. They also reported that a process is now implemented requiring the fellow and attending physician to review, discuss, and document the procedure immediately after the procedure and requiring the fellow to complete the CART-CL (Cardiac Assessment Reporting and Tracking System for Cardiac Catheterization Laboratories) database report for the attending physician to co-sign. We will follow up on the planned actions until they are completed.

Environment of Care

VHA requires that health care facilities have a comprehensive EOC program that complies with VHA policy, Occupational Safety and Health Administration regulations, and Joint Commission standards. We inspected selected clinical and non-clinical areas at both the Gainesville and Lake City facilities for cleanliness, safety, privacy, infection control, and general maintenance. We followed up on EOC concerns cited on the Annual Workplace Evaluation and found that those issues were resolved. Our inspection revealed that the system maintained a safe and clean environment. However, patient privacy at the Gainesville facility was a concern. Many of the inpatient rooms on the medical units were crowded with five beds, which did not allow for auditory and visual privacy. We were informed by management that the system has submitted a plan for construction of a bed tower that will offer private rooms.

Conditions Needing Improvement. We found a few minor maintenance issues that were corrected while we were onsite. However, we identified deficiencies related to crash cart checks and defibrillator testing, preventive maintenance of biomedical equipment, and infection control practices that required management attention.

Equipment Testing. Crash carts and defibrillators are life saving equipment that must be tested daily to ensure readiness in case of an emergency. In March 2007, the crash cart and defibrillator located in the Eye Clinic were not tested for 7 days, and the ones located

in the NHCU were not tested for 2 days. In addition, one of three eyewash stations in the Laboratory had not been inspected since February 16, 2007. According to local policy, the pressure of the eyewash stations should be inspected weekly.

Preventive Maintenance. Three pieces of biomedical equipment were outdated, and one piece of equipment (a blood pressure machine) did not have an inspection sticker. An oxygen purifier and a suction machine had inspection stickers that expired in August and November 2006, respectively. Another suction machine's inspection sticker expired in February 2007.

Infection Control. On one of the medical units, used patient care equipment was stored in the clean supply room. We were informed by the Nurse Manager that the unit was being renovated, and there was no place to store equipment. Although space was clearly an issue, used equipment should be segregated from clean supplies and equipment to avoid the risk of contamination.

The system corrected the preventive maintenance and infection control deficiencies while healthcare inspectors were onsite.

Recommendation 7. We recommended that the VISN Director ensure that the Acting System Director requires that crash carts and defibrillators are tested according to policy and, results are appropriately documented and monitored; preventive maintenance on all equipment is performed according to schedule; and used equipment is clearly identified and stored separately from clean supplies and equipment.

The VISN and Acting System Directors agreed with the findings and recommendations. They reported that documentation of defibrillator check sheets will be forwarded to Biomedical Engineering at the end of each month for review and sent to the EOC Committee on a monthly basis. Preventative maintenance on all equipment will be performed as scheduled and sent to the EOC Committee on a monthly basis. Used equipment will be clearly identified and stored separately from clean supplies and equipment. We will follow up on the planned actions until they are completed.

Electronic Medical Record Business Rules

Conditions Needing Improvement. The system had two business rules that allowed editing of a signed note by users other than the author and about 150 rules that allowed amendment of notes by staff other than the author. Business rules define which groups or individuals are allowed to edit, amend, or delete documentation in EMRs. The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, includes the electronic and paper medical record. It includes items such as physician orders, progress notes, and examination and test results. In general, once notes are signed, they should not be altered.

On October 20, 2004, the VHA Office of Information (OI) sent software informational patch USR*1*26 to all medical centers to assure that business rules complied with VHA regulations. The guidance 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." In January 2006, the OIG identified a VA facility where progress notes could be improperly altered and recommended that VHA address the issue on a national basis. On June 7, 2006, VHA issued a memorandum to VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

During our review, we found that the system still had some business rules that did not comply with VHA policy. System staff took action to remove these business rules while we were onsite.

Recommendation 8. We recommended that the VISN Director ensure that the Acting System Director requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance related to the altering of signed notes in the health record.

The VISN and Acting System Directors agreed with the finding and recommendation and reported that amending or editing of records will be limited to certain users and situations, and will be approved by the Chief, Clinical Informatics Service, and/or the Operations Manager. We will follow up on the planned actions until they are completed.

Other Observations

Patient Satisfaction

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 survey 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." The graphs on the next page show the system's performance in relation to national and VISN performance for inpatients and outpatients. Medical centers and health care systems are expected to address areas in which they are underperforming.

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	78.6	77.7	90.20	68.10	66.70	75.50	83.60	74.80	69.80	**
System	76.7	75.5	89.80	66.70	64.70	72.9	82.70	73.90	70.50	**

*** Less than 30 Respondents*

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	80.2	83.7	95.1	75.7	85.4	78.1	80.5	60.4	82.4	82.7	84.2
System	81.8	80.7	96.1	77.7	86.6	80.3	81.5	69	84.1	83.6	86.4

We reviewed the system's SHEP results and compared them to the national and VISN results. The inpatient SHEP scores for the 3rd and 4th quarters of FY 2006 were below the target of 76 percent in the areas of coordination of care, education and information, emotional support, family involvement, preferences, and transition. The outpatient SHEP scores for the 4th quarter of FY 2006 were below the target of 77 percent in the area of pharmacy pick-up.

The system had a designated Customer Service Representative who reported to the Executive Leadership Council. The system analyzed the SHEP results and developed action plans to address areas needing improvement. Managers have shared results with employees at service level meetings and stressed the importance of customer service. Ongoing system initiatives to maintain and improve current levels of customer service include implementation of advanced clinic access, performance improvement teams in pharmacy pick-up, courtesy training using the CARE (Connect, Appreciate, Respond, Empower) approach, and patient education brochures. We made no recommendations.

Ocala Community Based Outpatient Clinic

The purpose of this review was to assess CBOC operations and delivery of health care services. 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 Ocala CBOC, located about 40 miles from the Gainesville campus, was staffed by VA employees and served 9,160 veterans in FY 2006.

We reviewed Ocala CBOC policies, performance documents, provider credentialing and privileging (C&P) files, and nurses' training records. We conducted an EOC inspection to assess compliance with environmental standards. To determine if patients received the same standard of care relative to medications, we compared the management of patients receiving warfarin[3] at the parent facility with those receiving warfarin at the Ocala CBOC. We also interviewed six patients about their perceptions of care.

We found that Ocala CBOC providers' C&P files contained appropriate background screening and professional practice documentation. Clinical staff were knowledgeable about rendering emergency care, were certified in Basic Life Support, and received training on the automated external defibrillator. The CBOC emergency management plan was current, and the facility was clean and well maintained. The Ocala CBOC met Joint Commission, Health Insurance Portability and Accountability Act, and Life Safety requirements.

Patients on warfarin received the same standard of care at the Ocala CBOC as patients at the parent facility. Pharmacists managed the warfarin clinics at both sites, and providers conducted patient education regarding warfarin use and side effects. Patients were given emergency contact numbers if they had problems or concerns related to their medication. The Ocala CBOC patients we interviewed reported being satisfied with their care. We made no recommendations.

[3] Medication used to prevent blood clots.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 10, 2007

From: Director, VA Sunshine Network (10N8)

Subject: **Combined Assessment Program Review of the North Florida/South Georgia Health System Gainesville, Florida, Project Number 2007-00542-HI-0226**

To: Director, Management Review Service (10B5)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the North Florida/South Georgia Veterans Health Service.

2. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(original signed by:)

George H. Gray, Jr.

Appendix B

Acting System Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 9, 2007

From: Acting System Director, North Florida/South Georgia Health System (573/00)

Subject: **Combined Assessment Program Review of the North Florida/South Georgia Health System Gainesville, Florida, Project Number 2007-00542-HI-0226**

To: Director, VA Sunshine Network (10N8)

(original signed by:)
THOMAS SUTTON

Acting System Director's Comments to Office of Inspector General's Report[4]

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

OIG Recommendations

Recommendation. We recommended that the VISN Director ensure that the Acting System Director requires that:

(1) RCAs are completed in accordance with the guidance outlined in the VHA National Patient Safety Improvement Handbook.

Concur **Target Completion Date:** 5/1/07

Effective immediately, upon notification of an adverse event, "Action Items" will be created by the Performance Improvement Secretary. Action items with due dates and responsible individuals will be established for the charter date (within 3 days of the event), and for the completion date (not to exceed 45 days). Weekly, staff assigned to RCAs will provide an update of the status of each RCA to the Chief, Performance Improvement, or designee. At day 30, if an RCA is not going to meet the 45 day completion time, the Chief, Performance Improvement, and Quadrad will be informed by the PI Specialist and a meeting will be scheduled with the RCA team. At that time, an action plan to ensure the completion of the RCA will be developed.

(2) Corrective actions are taken to eliminate medication dispensing errors in the outpatient pharmacy and that the effectiveness of those actions is monitored.

[4] After comments were received from the system, 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 appearance of the recommendations in the body of the report and in the Directors' comments is the result of this action.

Concur **Target Completion Date:** 7/1/07

Automated (automation for Optifill) software is in beta testing that will allow the bar code scan of the patient medication to be confirmed with the patient VIC card at the pick-up window. We are expecting this process to be fully implemented July 1, 2007. In the meantime, staff has been educated to use full name and full Social Security number to identify patients. Effectiveness will be monitored thru medication error reporting process.

(3) Peer review results are reported quarterly to the MEC.

Concur **Target Completion Date:** 4/2/07

During FY 2006, Peer Review Committee (PRC) results are to be presented quarterly. During FY 2006, results were presented 3 out of the 4 quarters. For the 4th and final reporting period of the FY, the Medical Executive Committee had a full agenda and insufficient time to review results. The report was delayed until the next meeting (FY 2007). The Chief of Staff's office has indicated on the agenda calendar, that PRC results are not to be deferred. Thus far, FY 2007 reports have been presented as expected.

(4) Formal training is completed for all peer reviewers.

Concur **Target Completion Date:** 5/1/07

Prior to 2007, informal peer review training was provided without documentation of the training. As noted in the findings, a formal training plan for Peer Review Education was developed and reviewed by the OIG during the survey. Performance Improvement staff have implemented training to clinical services and documents training. As of this date, 41 staff have participated in Peer Review training.

(5) Processes are implemented to improve access to specified clinics.

Concur **Target Completion Date:** 10/1/07

The following plans are in place to improve access to the specified clinics.

Audiology – Short term – Will increase the number of consults sent to fee services. Intermediate term – Will open additional Audiology Clinic within the Ocala CBOC to reduce demand on Gainesville clinic. The bulk of consults for Audiology come from the southern tier CBOCs. This clinic will have two Audiologists and two acoustic sound booths. Long Term – Summerfield OPC planned to open in FY 2009 and will include Audiology services to handle the consult demands from the southern tier CBOCs.

Cardiology – Short Term – No actions required. Intermediate term – Add additional echo cardiology technician and machines. Process improvement in Cardiology referral process. Long Term – New office spaces and equipment, including 3rd Cath lab and procedure area will be available if Bed Tower is funded.

Dermatology – Short Term – Resuming Saturday clinics to reduce backlog. Intermediate term – Add Mid level provider and RN support to increase capacity within Gainesville Primary Care environment. Hire additional dermatology provider at Jacksonville OPC. Long Term – Perform process redesign of consult process to improve efficiency of process and remove non-value added steps.

Eye Care – Short Term – Increase contract for fee eye care services for Gainesville. Intermediate Term – Add eye care services to Ocala CBOC to reduce demand on Gainesville. The bulk of consults for eye care come from the Southern Tier CBOCs. This clinic will have two Optometrists and five eye lanes. In addition, will add contract for fee service eye care near the Tallahassee OPC until their expansion site is remodeled. Upon completion add two Optometrists and seven eye lanes. Add one additional eye lane at the Jacksonville OPC. Long Term – Summerfield OPC planned to open in FY 2009 and will include Optometry services to handle the consult demands from the southern tier CBOCs.

Gastroenterology – Short Term – Use fee services to see upper endoscopy cases to increase capacity for colonoscopy in Gainesville. Intermediate Term – Increase colonoscopy capacity at Jacksonville OPC through contract with Shands Healthcare Jacksonville. Increase capacity of Lake City hospital upon return of surgeon on military active duty and add a part time surgeon to add additional capacity. Long Term – Redesign GI spaces to allow increased capacity if new bed tower is funded. Increase capacity when Jacksonville OPC clinic is built FY 2010. Increase GI capacity when Summerfield OPC is planned to open in FY 2009.

Mental Health (individual) – Short Term – Facilitate hiring of position vacancies in the Mental Health services. Approved additional staff for the MHICM and SATT programs. Intermediate Term – Expand Group clinics and Tele-health visits in Mental Health. Long Term – Acquire additional space for Mental Health Clinics (new lease space for Gainesville, Summerfield OPC).

Orthopedics – Short Term – Using fee services to reduce backlog. Intermediate Term – Hiring additional physician and midlevel provider to handle increased demand for services. Long Term – Provide same day consultation clinic visits.

Podiatry – Short Term – Have added fee providers to eliminate backlog. Intermediate term – Add FTEE to podiatry to increase capacity. Long Term – Will add podiatry to Summerfield OPC to better serve southern tier patients.

Primary Care – Short Term – Add locum tenens at clinics with backlogs if space is available. Intermediate term – Lease additional space for Jacksonville OPC, Tallahassee OPC, and Ocala CBOC. This will allow additional Primary Care teams to be added at each location. Long Term – Replacement clinic for Jacksonville will be constructed. This will provide the needed additional space for providers.

Urology – Short Term – Expand capacity for Urology Clinic in Lake City. Redesign existing clinic space in Gainesville to improve capacity. Intermediate Term – Additional providers to handle increased demand for services. Long Term – Provide same day consultation clinic visits. National reporting available from VSSC [Veterans Support Service Center] will be used to track progress.

Recommendation 6. We recommended that the VISN Director ensure that the Acting System Director requires that informed consent forms reflect the names of all physicians participating in cardiac catheterization procedures and that brief procedure notes are documented immediately following the catheterizations.

Concur **Target Completion Date:** 3/23/07

All physicians participating in a procedure are now listed on the consent. This is verified by cath lab staff immediately prior to the start of the procedure.

The process is the fellow and attending will review and discuss the procedure immediately after. The fellow completes the CART-CL report for the attending to co-sign.

Recommendation 7. We recommended that the VISN Director ensure that the Acting System Director requires that:

Crash carts and defibrillators are tested according to policy, and the results are appropriately documented and monitored;

Concur **Target Completion Date:** 3/26/07

Documentation of daily defibrillator check sheets will be forwarded to Biomedical Engineering at the end of each month where they will be reviewed for completion and accuracy. An analysis of all sheets will be reported to the EOC on a monthly basis.

Preventive maintenance on all equipment is performed according to schedule;

Concur **Target Completion Date:** 3/23/07

Functional checks and preventive maintenance were completed on all items the day of the inspection. Work orders were generated to provide documentation of the work completed.

Preventive maintenance completion rates for Life Support and Non-Life Support Medical Equipment will be reported to the EOC committee on a quarterly basis.

Used equipment is clearly identified and stored separately from clean supplies and equipment.

Concur **Target Completion Date:** 4/23/07

Beginning 4/9/07 the Nurse Manager/designee will begin daily inspections of the unit to ensure clean and contaminated equipment are stored separately. After 14 days, the inspections will be monthly. Nurse managers will reinforce policy with staff in the monthly staff meeting and will reinforce one-on-one when deficits are identified.

Recommendation 8. We recommended that the VISN Director ensure that the Acting System Director requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records* and the October 2004 OI guidance related to the altering of signed notes in the health record.

Concur **Target Completion Date:** 3/29/07

During review, actions were taken to remove non-compliant business rules. Future business rules with actions of amending or editing will only be approved by the Chief of Clinical Informatics Service and/or Operations Manager, as appropriate for certain users and/or situations.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria Coates, Acting Regional Director St. Petersburg Office of Healthcare Inspections (404) 929-5961
Acknowledgments	Annette Robinson, Healthcare Inspections Team Leader David Griffith Deborah Howard

Appendix D

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