# Department of Veterans Affairs
# Office of Inspector General

# Combined Assessment Program Review of the South Texas Veterans Health Care System San Antonio, Texas

Report No. 07-01158-190

August 21, 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 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 the OIG.

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

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# Contents

# Executive Summary

## Introduction

During the week of March 5–9, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the South Texas Veterans Health Care System (the system). 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 230 employees. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 17.

## Results of Review

The CAP review focused on six operational areas. The system complied with selected standards in four areas:

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

We identified two areas that needed additional management attention. To improve operations, the system needed to:

- Comply with Veterans Health Administration (VHA) Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 VHA Office of Information (OI) guidance.
- Establish a comprehensive and effective QM Program based on reliable data to accurately reflect and improve patient outcomes.

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 and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–24, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

# Introduction

## System Profile

**Organization.** The system is a tertiary care system that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 16 CBOCs with locations including McAllen, Corpus Christi, Harlingen, Victoria, Eagle Pass, Laredo, Alice, Seguin, Beeville, Kingsville, Uvalde, New Braunfels, and several in San Antonio, TX. The system serves a veteran population of 333,000 in a primary service area that includes 62 counties in Texas.

**Programs.** The system provides medical, surgical, mental health, geriatric, and rehabilitation services. It has 296 acute care beds, 40 domiciliary beds, and 244 nursing home beds and operates several regional referral and treatment programs, including the Spinal Cord Injury Center, a bone marrow transplant unit, and an open heart surgery program. The system has sharing agreements with three military bases, the State of Texas, and two community hospitals.

**Affiliations and Research.** The system is affiliated with the University of Texas Health Science Center at San Antonio and supports 187 medical resident positions in 30 training programs. The system also has affiliations that support associate/allied health trainees. In fiscal year (FY) 2006, the system research program had 588 projects and a budget of $8.6 million. Important areas of research include aging, infectious diseases, and health services.

**Resources.** In FY 2006, medical care expenditures totaled $456 million. The FY 2007 medical care budget is $480 million. FY 2006 staffing totaled 2,800 full-time employee equivalents (FTE), including 177 physician and 549 nursing FTE.

**Workload.** In FY 2006, the system treated 80,308 unique patients. The system provided 24,944 inpatient days of care in the hospital and 11,664 inpatient days of care in the Nursing Home Care Unit. The inpatient care workload totaled 10,829 discharges, and the average daily census, including domiciliary and nursing home patients, was 425. The outpatient workload was 854,468 visits.

## Objectives and Scope of the Combined Assessment Program Review

**Objectives.** CAP reviews are one element of 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, employees, and patients; and reviewed clinical records. The review covered the following six programs:

| | |
|---|---|
| Business Rules for Veterans Health Information Systems | CBOC |
| Cardiac Catheterization Laboratory Standards | EOC |
| | QM |
| | SHEP |

The review covered system operations for FYs 2005, 2006, and 2007 through March 5, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, Texas*, Report No. 05-00222-111, March 25, 2005).

During this review, we also presented fraud and integrity awareness briefings for 230 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.

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.

# Results of Review

## Opportunities for Improvement

### Business Rules for Veterans Health Information Systems

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records,* issued August 25, 2006, includes the electronic medical record and the paper record and is also known as the legal health record. It includes items, such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes—all accurately reflecting the times and dates recorded.

A communication (software informational patch[1] USR*1*26) was sent from VHA's OI on October 20, 2004, to all medical centers, providing guidance on a number of issues relating to the editing of signed documents in the electronic medical records system.[2] 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. OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to a medical center's Privacy Officer. We reviewed VHA and system information and technology policies and interviewed Information Resource Management Service staff.

**Condition Needing Improvement**. The system had five business rules that needed to be changed to limit retraction, amendment, or deletion of notes to the Privacy Officer or Chief of Health Information Management Service. System staff took action to edit and remove these business rules while we were onsite.

**Recommendation 1.** We recommended that the VISN Director ensure that the System Director requires compliance with VHA policy and the October 2004 OI guidance.

The VISN and System Directors agreed with the findings and recommendation. The Office of Information Technology will review all business rules on a continuous basis

[1] A patch is a piece of code added to computer software in order to fix a problem.
[2] VA's electronic medical records system is called VistA, which is the acronym for Veterans Health Information Systems and Technology Architecture.

and report their findings quarterly to the Compliance Board. The improvement plans are acceptable, and we will follow up on planned actions until they are completed.

## Quality Management

The purposes of this review were to determine if the system had a comprehensive, effective QM Program designed to monitor patient care activities and coordinate improvement efforts and if the system was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. We found that the system's QM Program did not provide continuous, comprehensive monitoring of important patient care and safety processes and that performance improvement (PI) activities were not consistently initiated when deficiencies were identified.

The system's QM Service, with more than 19 FTE, has responsibility for a broad array of program areas, including quality monitoring, patient safety, PI measures, and utilization management. We conducted interviews with clinical QM Service managers and employees and with the system's senior management staff. We also followed up on recommendations concerning the system made in *Healthcare Inspection, Credentialing and Privileging Irregularities at the South Texas Veterans Health Care System, San Antonio, Texas*, Report No. 06-00703-147, issued May 22, 2006, and another review that has not yet been published. We wanted to determine the effectiveness of corrective actions. In addition, we reviewed the self-assessment form completed by clinical QM Service staff regarding the functioning and operations of the QM Program, and we reviewed other relevant QM documents and committee minutes.

The QM Program did not provide sufficient evidence of required monitoring and oversight. Only 7 (54 percent) of 13 QM Program areas effectively monitored criteria and had appropriate review structures established to ensure that patient care and patient safety processes were functioning properly. Various QM functions were not completed consistently, accurately, or timely, and documentation of QM activities, medical staff committees' oversight, and actions follow-up was fragmented, making it difficult to follow the sequence of events and outcomes. In some incidences, committee reports contradicted findings presented by a second committee and subsequently validated by healthcare inspectors. For these reasons, we could not say with certainty that the data we received was valid and represented the full scope of QM problems at the system.

**Conditions Needing Improvement.** The QM Program did not comprehensively plan, monitor, assess, or improve important patient care and organizational functions. During our review, we found the following deficient program areas:

- Adverse event disclosure.
- Medical records.
  - Resident supervision.
- Mortality review and analyses.

- Operative and other invasive procedures.
  - Meeting attendance.
  - Discussions of National Surgical Quality Improvement Program (NSQIP) data.
  - Discussions of peer review.
- Patient safety.
  - Root cause analyses (RCAs).
  - Follow-up of patient falls action plans/staff education.
- Peer review.
  - Timeliness, documentation, tracking, and evaluation of reviews.

Adverse Event Disclosure. The system did not adequately document compliance with VHA policy requiring disclosure of adverse events. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, requires VHA facilities to inform patients and their families of unanticipated outcomes of care. VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, requires clinical disclosure within 24 hours of a practitioner's discovery of an adverse event. Individual providers are obligated to disclose adverse events to patients harmed in the course of their care, including when harm may not be obvious or severe.

Risk Management identified 16 clinical events between December 2005 and October 2006 that required clinical disclosure. We reviewed the patient records for these events, along with supporting documentation provided by Risk Management, and determined that 14 of 16 did not contain adequate documentation of timely clinical disclosure or the reasons that disclosure could not be accomplished.

Risk Management has developed a feedback report for service chiefs when the disclosure template progress note in the computerized patient record system is not being fully utilized by clinicians. This report includes a reminder to encourage discussion of the issue at staff meetings on a regular basis. Additionally, these reports are to be discussed at least quarterly at the Clinical Executive Board (CEB). We reviewed all available CEB minutes from June–November 2006 and found no discussion of adverse event disclosure.

Medical Records/Resident Supervision. We found that documentation of resident supervision did not meet the standards of VHA Handbook 1400.1, *Resident Supervision*. An extensive number of notes, including history and physicals, operative reports, and procedure notes, were not signed by the required faculty member. In addition, the system requires a substantive progress note by faculty twice a week while patients are in intensive care units (Section R.12.7, Medical Records).[3] Despite medical record review audits the system conducted in 2006 demonstrating 100 percent compliance with these directives, we found two peer review cases that did not have the required faculty member

[3] Medical Staff By-Laws, Rules, and Regulations FY 2005 and the system's Bylaws and Rules of the Medical Staff FY 2006.

oversight, documentation, and signatures,[4] and we found 10 medical records with similar deficiencies. In the cases reviewed, we found that faculty notes for general surgery were not completed twice a week, as required.[5]

Mortality Review and Analysis. The system's Medical Staff By-Laws, Rules and Regulations for FY 2005 and 2006 state in Section 4.0, Medical Staff Functions, "important processes and outcomes are monitored on a continuous basis by the medical staff." Our inspection determined that the system did not adequately monitor mortality outcomes. We found that in quarters 1 and 2 of FY 2007, the system reported mortality data collection and trending; however, we identified deficiencies in the mortality review process during the October 1, 2006–February 28, 2007, timeframe that resulted in five case reviews occurring more than 30 days after the veterans' demise. Risk Management informed inspectors that a list of patient deaths is generated monthly by computer in order to identify quality of care issues in a retrospective medical record review. In addition, system staff must report unusual or unexpected deaths as they occur. Occasionally, computer failure to print automated reports or complicated patient care issues can delay reviews beyond the 30 day criteria. We determined that the current process does allow some deaths not to be reviewed within 30 days, as required. Should a patient death require further investigation, it is critical to collect data and conduct interviews promptly so that important information is not lost.

Operative and Other Invasive Procedures Committee. The Operative and Other Invasive Procedures Committee has a monitoring and review function, reporting to the CEB at least quarterly. According to system Policy Memorandum 11-04-20, *Operative and Other Procedures Review*, the committee systematically measures the performance of operative and other invasive and non-invasive procedures that place patients at risk. Data are collected, organized, aggregated, compared (as applicable), and presented to and reviewed by the committee.

A review of committee activities for FY 2006 found that the committee met nine times, exceeding the quarterly minimum established by local policy. Quorums, however, were not met in seven (77 percent) of the nine meetings held in FY 2006. Minutes did not routinely reflect discussion of procedure complications or NSQIP and Continuous Improvement in Cardiac Surgery Program statistics but did reflect discussion and decisions approving peer review outcomes, review of mortality and autopsy data, as well as changes in polices and procedures. Healthcare inspectors requested information concerning what constitutes a quorum for the committee and were told that *Robert's Rules of Order* was used as guidance. According to *Robert's Rule of Order*, a quorum is defined, in the absence of bylaws, as a majority of all the members. Therefore, none of

[4] Compliance with Section R6, Supervision; Section R7, Admissions Discharges and Patient Care; Section R8, Patient Orders; and Section R9, General Rules.
[5] Compliance with Section R6, Supervision; Section R7, Admissions Discharges and Patient Care; Section R8, Patient Orders; and Section R9, General Rules.

the actions taken in seven of the nine meetings could be justified.

Patient Safety. VHA Handbook 1050.1 and system Memorandum No. 002-06-08, *Patient Safety Improvement (Risk Management) Program*, require an RCA for adverse events to be completed within 45 calendar days of the system becoming aware that a review is required. Without timely completion of RCAs, planning for corrective actions to prevent the occurrence of similar events would be delayed.

When RCAs were initiated during FY 2006, only 4 of 14 were completed within the required 45-day timeframe. Twelve RCAs had been chartered in FY 2007 by the time of our review. Two of the 12 RCAs were not yet required to be completed. Of the remaining 10 RCAs, we found that 3 were successfully processed, as required, while 7 RCAs requiring completion were not finalized in a timely manner. Of the RCAs identified in FY 2007, 5 (50 percent) of the 10 were chartered 30 to 150 days after the clinical event occurred. The system was aware of some adverse events in FYs 2006 and 2007 (up to the time of our review) for as long as 8 months before chartering the RCAs.

Although 22 of 24 RCAs that required completion between October 1, 2005, and March 1, 2007, were finalized at the time of our review, several had incomplete action plan elements and outcomes that had not been monitored for effectiveness. For example, an enhanced training program for staff to ensure safe patient movement resulted from an RCA action plan and was recorded in Patient Safety Committee meeting minutes. The plan required staff training to be accomplished and documented in competency records. When asked to supply training records for three nurses in designated clinical areas, no personnel competency documentation could be provided. Although mention of the new policy was found in staff meeting minutes for three other clinical care areas, this did not meet the intent of the action plan, and no follow-up had been implemented.

The VISN and the National Center for Patient Safety (NCPS) had oversight responsibility but had not recognized that the RCAs were not complete or timely.

Peer Review. The peer review process did not include all components required by VHA Directive 2004-054, *Peer Review for Quality Management*. Peer review is a confidential, non-punitive, and systematic process to evaluate quality of care at the individual provider level.

The directive states:

- Protected peer review for quality improvement always starts with an "initial review," which must be completed within 45 days.

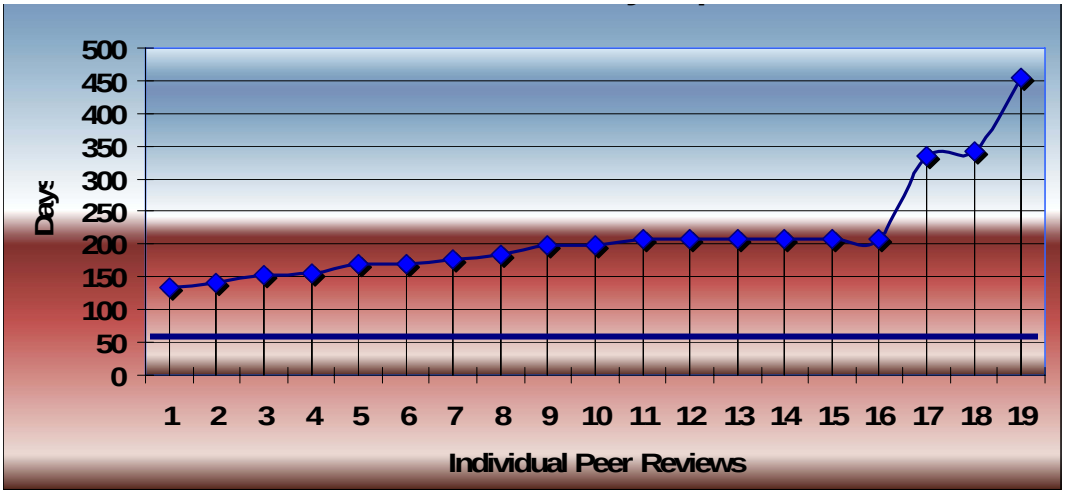
- The initial review results in determination of a Level 1, Level 2, or Level 3.[6] Completed initial protected peer reviews for quality improvement that were conducted by an individual reviewer must be sent to a multi-disciplinary Peer Review Committee (PRC) or subcommittee chaired by the Chief of Staff, or designee.
- The PRC then reconsiders all protected peer review cases within the system completed by the individual initial peer reviewers when the level of review is determined to be a Level 2 or Level 3. Since the PRC oversees all peer reviews, a sufficient and representative sample of Level 1 peer review cases need to be reviewed to ensure the validity and reliability of the findings and to evaluate the peer review process.
- A system-level policy for protected peer review is developed and approved by the VISN Director by March 4, 2005. At a minimum, this policy must require protected peer review (conducted for quality improvement purposes, including resource utilization) occur as described in this directive.

The system conducted a total of 54 peer reviews in FYs 2005 and 2006. Twenty-seven were identified as Level 1, 15 were identified as Level 2, and 12 were identified as Level 3. Fifty-nine percent of Level 1 cases were reviewed by a multidisciplinary Peer Review Panel (PRP). Initial reviews were conducted by a registered nurse, who forwarded cases that did not meet established criteria to the appropriate service chief for evaluation and grading. However, only 3 of 11 initial peer review cases inspected by the PRP fully documented the initial peer evaluation and level of care determinations to be consistent with the requirements of VHA Directive 2004-054 and system Policy Memorandum 11-04-35.

The peer review process includes an initial review by a peer of the same discipline to determine the level of care, with subsequent PRC evaluation and concurrence with the findings. We reviewed the peer review database for FYs 2005 and 2006 and identified issues related to timeliness, documentation, tracking, and evaluation of reviews. Additionally, the CEB did not address discrepancies reported in peer review findings concerning resident supervision and data reported in CEB minutes, which reflects 100 percent resident supervision compliance. We are concerned that discrepancies in reporting activities are neither identified nor responded to and that data reported to oversight committees does not reflect the actual state of patient care and outcomes.

[6] Level 1 – Most experienced, competent practitioners would have managed the case similarly in all of the aspects listed.
Level 2 – Most experienced, competent practitioners might have managed the case differently in one or more of the aspects.
Level 3 – Most experienced, competent practitioners would have managed the case differently in one or more of the aspects.

**Number of Days to Complete Peer Review Beyond the 120-Day Requirement**




*Timeliness*. Once the need for peer review is determined, VHA requires initial reviews to be completed within 45 days and PRC evaluations within 120 days. The database showed that 13 (24 percent) of 54 initial reviews were not completed within the required 45 days, and 19 (46 percent) of 41 final peer reviews were not completed by the PRC within the required 120 days.

*Documentation*. VHA requires documentation of discussion and recommendations resulting from final peer review in meeting minutes. According to the database healthcare inspectors reviewed, the PRC changed 18 (25 percent) of 71 initial peer review levels from a Level 3 to a lower severity level. However, PRC meeting minutes for the same period did not reflect the discussion or rationale for changing any of the initial peer review levels.

*Quarterly Tracking*. VHA requires quarterly tracking of peer review activity, including information on number of reviews, outcomes by level, number of changes to level, follow-up of action items, and recommendations that result from completed peer reviews. System policy requires reporting of data to responsible system committees for review, analysis, and appropriate action. During FYs 2005 and 2006, there was no consistent documentation of the required quarterly tracking in the PRC meeting minutes. No documented discussion of PRC outcomes was reported at the CEB or Quality Executive Board (QEB), which may have provided oversight of the PRC. The CEB minutes from June–December 2006 contained only one reference to peer review, reminding all staff that Level 2 findings must be reviewed. Likewise, meetings of the QEB during July–December 2006 contained no discussion of peer review activity, outcomes, or plans for continuous improvement.

**Recommendation 2.** We recommended that the VISN Director require that the System Director establishes a comprehensive and effective QM Program based on reliable data to accurately reflect and improve patient outcomes in the following areas:

- Adverse event disclosure is conducted and documented in accordance with VHA Handbook 1050.1.
- Medical records documentation of resident supervision is in accordance with VHA Handbook 1400.1.
- Mortality reviews are identified and conducted in accordance with VHA Directive 2005-056, *Mortality Assessment,* December 1, 2005.
- Operative and Other Invasive Procedures Committee meets established quorum requirements and provides documented discussions of NSQIP data and peer review.
- Patient safety RCAs are timely, and follow-up of action plans is accomplished as specified in VHA Handbook 1050.1.
- Peer review timeliness, documentation, tracking, and evaluations meet the intent of VHA Directive 2004-054.

The VISN and System Directors agreed with the findings and recommendation. The system has revised local policies to meet VHA directives, developed monthly data dashboards for review by appropriate committees, enhanced staff training, and implemented a reorganization process to improve oversight of QM Program areas. The improvement plans are acceptable, and we will follow up on planned actions until all of them are completed.

# Other Observations

## Cardiac Catheterization Laboratory Standards

The purpose of this review was to determine if the system's cardiac catheterization laboratory practices were consistent with VHA Handbook 1004.1, *VHA Informed Consent For Clinical Treatments and Procedures*, and with the American College of Cardiology (ACC) and the Society for Cardiac Angiography and Interventions (SCA&I) *Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards.* A cardiac catheterization is a specialty procedure performed in catheterization laboratories to diagnose defects in the heart chambers, valves, and blood vessels. In some cases, the diagnostic procedure may indicate a need for a therapeutic intervention to open blockages. This procedure is commonly known as percutaneous coronary intervention (PCI). The above standards define requirements for provider procedure volumes, laboratory procedure volumes, cardiac surgery resources, complication rates,

QM, the informed consent process, and cardiac pulmonary resuscitation (CPR) training. We reviewed these practices and found the system in compliance with required standards.

The system's cardiac catheterization laboratory completed 1,073 diagnostic coronary and 408 PCI procedures in FY 2005, which satisfied the laboratory procedure volume requirements. The interventionalists are part-time physicians with joint appointments at both the system and the University of Texas Health Science Center. One interventionalist physician is a contract provider and provides coverage as needed. All interventionalist physicians satisfied the provider procedure volume requirements and performed the procedures within the acceptable ACC/SCA&I standards.

The system has an ongoing quality improvement process that tracks, trends, and analyzes cardiac catheterization procedures to improve patient outcomes. The attending physicians privileged in these areas had received the required CPR training. In addition, we reviewed 10 medical records of patients who had a cardiac catheterization procedure and found that the informed consent documentation was appropriately completed.

## Community Based Outpatient Clinic

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 plan; and to assess whether CBOCs improve access, convenience, and timeliness of VA health care services.

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 staffing options, and the services provided. VHA Directive 2002-074, *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, Special Agreement Checks on all appointees, health care contractors, and most volunteers prior to their entry on duty at a VHA facility.

We conducted an onsite visit at the Frank M. Tejeda VA Outpatient Clinic in San Antonio, TX. We interviewed key individuals at the parent facility and the CBOC. We reviewed documentation and self-assessment tools on descriptions of services provided, including warfarin clinic services. The parent facility and the CBOC warfarin clinics are managed by pharmacists and maintain the same standards of care. The patients receive initial education at the parent facility or CBOC clinics before they

receive their first dose of warfarin. Patients are provided a toll-free telephone number to help facilitate prompt reporting of new medications or other vital information.

We found that the CBOC EOC was generally clean and met Joint Commission,[7] Health Insurance Portability and Accountability Act, and Life Safety requirements. The emergency management plan was current, all clinical staff were educated in and knowledgeable about rendering emergency care to veterans, and all clinical staff were basic life support certified. Documentation in three CBOC providers' credentialing and privileging files and two CBOC nurses' personnel folders was complete and included appropriate background screenings.

## Environment of Care

The purpose of the evaluation was to determine if the system maintained a safe and clean health care environment. The system is required to establish a comprehensive EOC program that fully meets NCPS, Occupational Safety and Health Administration, and Joint Commission standards. We also evaluated the infection control program to determine compliance with VHA directives based on management of data collected and processes in which the data is used to improve performance. The system maintained a generally clean and safe environment. The infection control program monitored, trended, analyzed, and reported the data to clinicians for implementation of quality improvements. We found that the system maintained accurate inventories of tritium, a substance that emits low levels of radiation, in a manner consistent with VA policies.

## 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 for satisfaction.

[7] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

The following graph shows the system's SHEP results for inpatients and outpatients:

**South Texas Veterans Health Care System (San Antonio, TX)**

**INPATIENT SHEP RESULTS**

| *FY 2006 Quarters 3 and 4* | Access | Coordination of Care | Courtesy | Education & Information | Emotional Support | Family Involvement | Physical Comfort | Preferences | Transition |
|---|---|---|---|---|---|---|---|---|---|
| National | 81.35 | 78.9 | 89.90 | 67.92 | 65.97 | 75.95 | 83.43 | 74.66 | 70.11 |
| VISN | 78.2- | 77- | 88- | 67.80 | 66.70 | 76.00 | 82.50 | 75.30 | 71.30 |
| System | 81.4 | 79.2 | 89.10 | 70.00 | 69.4+ | 78.7+ | 82.10 | 76.20 | 73.2+ |

**OUTPATIENT SHEP RESULTS**

| *FY 2006 Quarter 4* | 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 | 75.6 - | 77.5 | 92.2 | 70.3 | 80.6 | 72.5 | 79.7 | 66.9 | 78.6 | 79.2 | 81 |
| System Clinics | 82.2 | 79.7 | 93.5 | 70.8 | 82.4 | 76.9 | * | * | 79.7 | 74 | 78.3 |

***Legend***: "+" Indicate results significantly better than the national average
"-" Indicate results worse than national average
* Less than 30 respondents

The system Director was aware of the SHEP results for FY 2006, and those results had been communicated to employees. System analysis of the survey results identified areas targeted for improvement. The system developed action plans based on these results to improve patient access to appointments in specialty clinics for new and established patients, improve communication to address patient concerns, and train nursing staff on the inpatient units to better provide emotional support.

In FY 2007, the system initiated their "Go for the Blue" campaign, which includes key drivers, such as access, quality, satisfaction, and cost. All service areas are scored monthly for each key driver with a color-coded score card. "Blue" exceeds the target, "green" meets the target, and "red" indicates the target was not met. This score card is shared with all staff at the system and displayed in the different service areas. Staff recognition and positive reinforcement is provided when services improve their patient satisfaction scores to reach "blue."

**Appendix A**

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 15, 2007

**From:** VISN Director

**Subject:** **Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, Texas**

**To:** VHA Management Review Service (10B5), VA Central Office, Washington, DC

THRU: Director, Dallas Regional Office of Healthcare Inspections

1. I have reviewed the document and concur with the actions proposed by the Health Care System Director. Recommendations will be completed by July 13, 2007. See Medical Director's Comments for specific actions. We will reassess strategies for oversight of RCAs at the Network and contact the National RCA point of contact to modify as needed to ensure future compliance.

2. For questions, please contact Deborah Antai-Otong, Continuous Readiness Officer, VISN 17 at 817 385 3794.

*(original signed by:)*

Thomas J. Stranova, MPH, CRA, FACHE

## VISN Director's Comments to Office of Inspector General's Report

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

**OIG Recommendations**

**Recommendation 1**. We recommended that the VISN Director ensure that the System Director requires compliance with VHA policy and the October 2004 OI guidance.

Concur **Target Completion Date:** July 13, 2007

The Office of Information Technology will review all business rules on a continuous basis and report their findings quarterly to the Compliance Board. The Compliance Board will track these findings on their dashboard. Dashboard results will be reported monthly to the Health Care System's Quality Executive Board (QEB), Clinical Executive Board (CEB), and Joint Leadership. This report will also be tracked and reported to the VISN 17 leadership through a monthly action plan.

**Recommendation 2**. We recommended that the VISN Director require that the System Director establishes a comprehensive and effective QM Program based on reliable data to accurately reflect and improve patient outcomes in the following areas:

- Adverse event disclosure is conducted and documented in accordance with VHA Handbook 1050.1.
- Medical records documentation of resident supervision is in accordance with VHA Handbook 1400.1.
- Mortality reviews are identified and conducted in accordance with VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005.

- Operative and Other Invasive Procedures Committee meets established quorum requirements and provides documented discussions of NSQIP data and peer review.

- Patient safety RCAs are timely, and follow-up of action plans is accomplished as specified in VHA Handbook 1050.1.

- Peer review timeliness, documentation, tracking, and evaluations meet the intent of VHA Directive 2004-054.

Concur **Target Completion Date:** July 13, 2007

Please see System Director comments for response.

**Appendix B**

# System Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** June 11, 2007

**From:** System Director

**Subject:** **Combined Assessment Program Review of the South Texas Veterans Health Care System, San Antonio, Texas**

**To:** VHA Management Review Service (10B5), VA Central Office, Washington, DC

Network, Director, VA Heart Of Texas Network (10N17), Dallas, Texas

1. The recommendations made during the Office Of Inspector General Combined Assessment Program Review conducted March 5–9, 2007, have been reviewed, and our comments and implementation plan are noted below. All action plans will be completed by July 13, 2007.

2. I would like to take this opportunity to commend the OIG CAP Review Team for both their thoroughness and professionalism. This review provides us with the opportunity to continue improving care to our veterans.

3. If you have any questions, please contact Donna Gladstone, Compliance Officer, at 210-617-5300 ext.16167.

*(original signed by:)*

TIMOTHY P. SHEA, FACHE

## System Director's Comments to Office of Inspector General's Report

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

**OIG Recommendations**

**Recommendation 1**. We recommended that the VISN Director ensure that the System Director requires compliance with VHA policy and the October 2004 OI guidance.

Concur **Target Completion Date:** July 13, 2007

The Office of Information Technology will review all business rules on a continuous basis and report their findings quarterly to the Compliance Board. The Compliance Board will track these findings on their Dashboard.

**Recommendation 2**. We recommended that the VISN Director require that the System Director establishes a comprehensive and effective QM Program based on reliable data to accurately reflect and improve patient outcomes in the following areas:

- Adverse event disclosure is conducted and documented in accordance with VHA Handbook 1050.1.
- Medical records documentation of resident supervision is in accordance with VHA Handbook 1400.1.
- Mortality reviews are identified and conducted in accordance with VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005.
- Operative and Other Invasive Procedures Committee meets established quorum requirements and provides documented discussions of NSQIP data and peer review.

- Patient safety RCAs are timely, and follow-up of action plans is accomplished as specified in VHA Handbook 1050.1.

- Peer review timeliness, documentation, tracking, and evaluations meet the intent of VHA Directive 2004-054.

Concur **Target Completion Date:** July 13, 2007

**Adverse event disclosure is conducted and documented in accordance with VHA Handbook 1050.1.**

1. VHA Directive 2005-049, Disclosure of Adverse Events to Patients, has been reviewed and compared to local policy memorandum 002-07-05, "Disclosure of Adverse Events," and all VHA requirements have been included in the local policy. Revised local policy was approved by CEB in May 2007.

2. Three separate education curriculums will be developed, which will provide training at House Staff Orientation, New Employee Orientation, Fee Provider/Without Compensation Orientation, Service Level training, and online training to include information on VHA Directives and STVHCS policies related to disclosure, apology, and civil behavior in general. Training will be tracked in TEMPO.

3. The Employee Assistance Program Chair will develop program guidance for dealing with unresolved emotional impact of medical error.

4. A dashboard will be developed to include house staff trained on policies and on documenting and conducting an appropriate disclosure in clinical areas of the facility. Dashboard results will be reported monthly to the Quality Executive Board (QEB), Clinical Executive Board (CEB), and to the Joint Leadership Council (JLC). Adverse event disclosure is conducted and documented in accordance with VHA Handbook 1050.1.

**Medical records documentation of resident supervision is in accordance with VHA Handbook 1400.1.**

1. Attending staff in ALMD will be directed by their section chiefs that the Medical Staff By-Laws (page 47, R.12.7) will be enforced.

2. Monitoring of compliance with the Medical Staff By-Laws will be performed monthly during Open Records Review by Quality Management personnel.

3. Results of this data will be reported in dashboard format to the Medical Records Committee monthly.

**Mortality reviews are identified and conducted in accordance with VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005.**

1. Local policy will be written in accordance with VHA Directive 2005-056, Mortality Assessment, December 2005, and will clearly identify and describe the process used by STVHCS to conduct these reviews. This policy will be submitted to the Clinical Executive Board (CEB) in July for review and approval.

2. A parameter was added to the STVHCS Mortality Report Database to track deaths that are reviewed outside of the 30-day parameter and will be reported quarterly to CEB and the VISN.

3. Quality Management will track on their monthly dashboard the number of death reviews that were not completed within 30 days and submit their findings to CEB and VISN.

4. The Quality Management Office will be restructured to identify a clinician to manage the review and report of Mortalities and Peer Review.

5. The local Operative and Other Invasive Procedure (OOP) Policy and Peer Review Policy will be revised so that all surgical mortalities will flow directly to the Peer Review Committee rather than through the OOP process to expedite these reviews.

**Operative and Other Invasive Procedures Committee meets established quorum requirements and provide documented discussions of NSQIP data and peer review.**

1. The OOP Review Committee Policy, 11-04-20, was reviewed and revised, and a draft document will be submitted to the CEB in July of 2007. This policy includes the addition of NSQIP reporting, tracking of training and ACLS certification of moderate sedation providers, change in frequency of meetings from "at least quarterly" to "at least 10 times per year," determination of a quorum, and deletion of Peer Review function.

2. The NSQIP Nurse Reviewer has been added to the membership roster of the OOP Committee; NSQIP has been added to the OOP Committee agenda as a standing item. Quarterly reports of NSQIP data will be presented (beginning June 26, 2007) and biannual reports of CICSP (cardiac) data will be presented upon release by the program.

3. Committee membership has been enhanced to include medical staff representation from operative, invasive, and non-invasive procedure sites. The Chief of Surgery and/or designee will attend meetings monthly. Consideration will be given to including Pulmonary Bronchoscopy Faculty and Nursing representatives from Radiology Special Procedures and Surgical Clinics. Changes will be incorporated into the OOP Committee Bulletin and forwarded to CEB for approval.

4. Number of OOP Committee attendees and quorum compliance have been added to the OOP Committee dashboard, and results will be reported monthly to the CEB.

**Patient safety RCAs are timely and follow-up of action plans is accomplished as specified in VHA Handbook 1050.1.**

1. A new procedure has been implemented to insure completion of RCAs within 45 days of the facility awareness date. (Since implementation, all RCAs have been completed within mandated time parameters.)

2. The day the RCA is requested, the Patient Safety Officer sends an electronic request to appropriate leadership, requesting selection of appropriate staff to participate as team members.

3. The following day, the RCA charter is prepared and hand-carried to the Director's Office for approval and signature.

4. The RCA is convened within 1 week, and the RCA team proceeds with their task.

5. No later than the second week, a briefing date is established with senior leadership (within the required 45-day timeframe), and the Director's signature is obtained upon completion of the briefing.

6. The RCA information is entered into SPOT immediately thereafter.

7. Timeliness of RCAs are tracked on a dashboard and are reported to QEB and JLC.

8. RCA recommendations are assigned to appropriate staff by formal document prepared by Patient Safety staff and approved and signed by the Director.

9. Timelines for implementation are specified.

10. Patient Safety Officer tracks implementation.

11. Documentation is required to be submitted to the Patient Safety Officer to provide assurance that actions have been completed.

12. Completion and implementation of RCA recommendations are tracked by dashboard and reported to QEB and JLC, respectively.

**Peer review timeliness, documentation, tracking, and evaluations meet the intent of VHA Directive 2004-054.**

1. Local policy will be revised to include changes to the Protected Peer Review Program that will be initiated to correct deficiencies and initiate recommendations related to Surgical Death reviews and the Operative and Other Procedure Process.

2. The current Medical Staff Bylaws in Article VIII Committees on page 24 defines the quorum for Medical Staff committees as 50 percent. In addition, Article X, Item 8, identifies a quorum as 50 percent or more of the membership. (This policy will be strictly adhered to unless there is not the presence of a member of the specialty for which a review is conducted.) If a member of the specialty is not present, the case will be referred to the next meeting. If the case is reaching the 120-day requirement, an ad hoc meeting will be coordinated for the Chief of Staff and/or an extension will be approved.

3. The CEB Dashboard has been amended to monitor and report medical staff meeting attendance quorum compliance and timeliness of peer reviews. This data will be reviewed by CEB monthly and reported.

4. The Peer Review Committee will improve the current minutes documentation process and format to ensure that the reasons for the change of Level of Care determination are clear. This parameter will be added to the PRC minutes format and the PRC Case Review Sheet.

5. The current QM Protected Peer Review Summary Reports will be improved to identify monitoring results to include the number of PR cases that are not completed in the required timeframe. Currently, the QM Protected Peer Review Summary Reports for each quarter monitor and report the following monitoring parameters: total number of reviews completed, number of reviews completed by the PRC, number of Level 1 cases reviewed, number of Level 2 cases reviewed, number of Level 3 cases reviewed. The outcomes monitored and reported include the number of levels that remained the same, the number of levels that changed, the

number of levels that were increased, and the number of levels that were decreased by the PRC. The recommendations and follow-ups monitored on the report include the number of recommendations, the number of completed actions, the number of follow-ups in progress, and the percent of completed action items. (Careful monitoring of these reports will be conducted to ensure that all required data is present and complete.)

6. The new process will ensure that the PRC charges the CEB with all action items requiring medical staff leadership review, approval, and action.

7. The PR reporting process will be enhanced by requiring the PRC to forward approved reports to the appropriate services and committees beginning with the next quarterly report.

8. The Quality Management Office will be restructured to identify a clinician to manage the review and report of Mortalities and Peer Review.

9. The local Operative and Other Invasive Procedure (OOP) Policy and Peer Review Policy will be revised so that all surgical mortalities will flow directly to the Peer Review Committee rather than through the OOP process to expedite these reviews.

**Appendix C**

# OIG Contact and Staff Acknowledgments

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

**Appendix D**

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