Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-00558-176

Combined Assessment Program Review of the Southeast Louisiana Veterans Health Care System New Orleans, Louisiana

June 17, 2010

Washington, DC 20420

Why We Did This Review

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 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 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.

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp**)**

Table of Contents

Executive Summary

Introduction

During the week of March 15–19, 2010, the OIG conducted a Combined Assessment Program (CAP) review of the Southeast Louisiana Veterans Health Care System (the facility), New Orleans, LA. 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 314 facility employees. The facility is part of Veterans Integrated Service Network (VISN) 16.

Results of the Review

The CAP review covered eight operational activities. We made recommendations in six of the activities reviewed. For these activities, the facility needed to ensure that:

- Quarterly Peer Review Committee (PRC) reports to the Executive Committee of the Medical Staff (ECMS) reflect all required elements.
- Appropriate staff maintain and the facility monitor required cardiopulmonary resuscitation (CPR) certifications.
- Utilization management and invasive procedure review data are displayed in meeting minutes and analyzed appropriately.
- Clinicians develop comprehensive suicide safety plans for high-risk patients, as required by Veterans Health Administration (VHA) guidelines.
- A suicide prevention coordinator (SPC) is assigned to the Baton Rouge community based outpatient clinic (CBOC).
- Clinical privileges are granted in accordance with VHA requirements.
- Clinical service chiefs define the criteria for delineation of privileges.
- Preventive maintenance (PM) is completed on all sterilizers according to the prescribed schedule.
- Appropriate staff receive annual magnetic resonance imaging (MRI) safety education.
- MRI Zone 3 access is physically restricted and uniquely keyed.

- Medical records include information about patients who have been hospitalized at VA expense and discharged from community hospitals.

The facility complied with selected standards in the following two activities:

- Environment of Care (EOC)
- Medication Management

This report was prepared under the direction of Victoria Coates, Director, Atlanta Office of Healthcare Inspections.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15–21, 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

Profile

Organization. The facility is comprised of five CBOCs located in Baton Rouge, Hammond, Houma, Slidell, and Reserve, LA, and three outpatient clinics located in New Orleans, Metairie, and Mandeville, LA. The facility is part of VISN 16 and serves a veteran population of about 162,500 throughout 23 parishes in southeast Louisiana.

The levee breeches after Hurricane Katrina rendered the original VA medical center unusable. However, CBOCs continued to provide services without interruption. Medical center employees worked out of tents, trailers, and donated space and provided needed services for the area's veterans. Within 100 days, usable sections of the original medical center reopened to provide primary care, limited specialty care, and mental health services.

During the next year, approximately half of the medical center employees returned to the area while the other half relocated to other VA facilities throughout the country. Without a medical center or a full complement of staff, adjustments were made in the care delivery system. The former New Orleans VA Medical Center became a system of clinics and was renamed the Southeast Louisiana Veterans Health Care System.

The facility's recovery has included the opening of new CBOCs; construction of a radiology center; renovation of the pharmacy and the urgent care center; and activation of several leases, including dental and mental health clinics. The facility partners with other VA medical facilities and local hospitals to provide inpatient care. Also, the facility has established its Virtual Inpatient Program partnership with academic affiliate Tulane University, allowing VA medical professionals to care for veteran patients in a hospital setting. A unique Hospital-at-Home program was implemented to allow patients with certain medical conditions to be monitored in-home. In 2006, Congress appropriated funding for a replacement medical center. Construction begins this year and is expected to be completed in late 2013.

Programs. The facility provides outpatient primary, specialty, and mental health care and pharmacy, laboratory, and radiology services.

Affiliations and Research. The facility is affiliated with Tulane University and Louisiana State University and trained approximately 200 residents in fiscal year (FY) 2009. It also provides training for other disciplines, including nursing, psychology, and cardiopulmonary science. In FY 2009, the facility research program had 68 approved active research projects with approximately $2.2 million in funding. Important areas of research included post-traumatic stress disorder, related couples therapy, and heart stent prototype trials for medication delivery.

Resources. In FY 2009, facility expenditures totaled $245 million. The FY 2010 medical care budget is $265 million. FY 2009 staffing was 1,084 full-time employee equivalents (FTE), including 79 physician and 173 nursing FTE.

Workload. In FY 2009, the facility treated 34,505 unique veterans for a total of 378,362 outpatient visits.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

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

- Coordination of Care
- EOC
- Medication Management
- MRI Safety
- Physician Credentialing and Privileging (C&P)
- QM
- Reusable Medical Equipment (RME)
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through March 15, 2010, 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 (*Combined Assessment Program Review of the VA Medical Center, New Orleans, Louisiana,* Report No. 02-03264-148, August 7, 2003). The facility had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 314 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no findings requiring corrective actions.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the facility had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, performance improvement (PI) data, and other relevant documents, and we interviewed appropriate senior managers and the QM Coordinator.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate structures were in place for 8 of the 12 program activities reviewed; however, we identified deficiencies in the following areas.

PRC. VHA policy[1] requires that the PRC provide quarterly reports of specified data elements to the ECMS. We found that the PRC completed the required quarterly reports; however, some data elements were not included. We found that quarterly reports did not include tracking and trending of the aspects of care for peer reviews determined to be a Level 2 or Level 3, identified facility issues or actions completed, or tracking of actions completed by each service.

CPR and Its Outcomes. VHA policy[2] requires implementation of a monitoring system to ensure current CPR certification for designated clinically active staff. Prior to December 2009, the facility did not have a system to monitor and report expiration dates nor did local policy identify the actions to be taken if appropriate training was not completed.

In December 2009, local policy was updated to incorporate the consequences for expired certifications, and the facility implemented a monitoring and reporting system. However, we found that at the time of our visit, there were 31 clinical staff who had expired CPR certifications. In addition, local policy was not followed regarding consequences for expired certifications.

Data Display and Analysis. Joint Commission (JC) standards require data display and analysis for specific PI activities. Facility reports did not reflect data trends or document analysis of utilization management or invasive procedures review data in meeting minutes for the 12 months prior to our site visit.

Recommendation 1 We recommended that the VISN Director ensure that the Facility Director requires that quarterly PRC reports to the ECMS include all required elements.

[1] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[2] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

The VISN and Facility Directors concurred with the findings and recommendation. A new report format was created, and the first quarterly report was presented to the ECMS in May 2010. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director ensure that the Facility Director requires that the facility monitor CPR certifications and that appropriate staff maintain this credential.

The VISN and Facility Directors concurred with the findings and recommendation. A weekly CPR certification compliance monitoring report is being forwarded to each service. In addition, staff and executive leadership are being notified of pending expiration dates. An expired certification results in the removal of the non-compliant employee from patient care responsibilities until completion of the required CPR certification. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the Facility Director requires display and analysis of utilization management and invasive procedure review data in meeting minutes.

The VISN and Facility Directors concurred with the finding and recommendation. Monitoring reports, which include data display and analysis, are now being provided to leadership and appropriate committees. The implementation plans are acceptable, and we will follow up until the planned actions are completed.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how

patients can access professional help 24 hours a day, 7 days a week.[3]

A previous OIG review of suicide prevention programs in VHA facilities[4] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide in the past 6 months. We eliminated two of those records from further review as clinicians were unable, despite repeated attempts, to contact these outpatients to complete the safety plans. Of the eight remaining records, six patients were or should have been followed exclusively by facility staff. The other two patients were hospitalized at the Alexandria VA Medical Center; thus, both facilities shared responsibility for coordination of care and patient safety.

Because the facility does not operate inpatient beds, clinical staff must rely on other VISN and private sector hospitals to provide psychiatric hospitalization when needed. Thus, communication and coordination are critically important to assure the safety of suicidal or potentially suicidal patients. The facility's managers agreed to discuss the issue with other VISN facility managers to assure appropriate coordination of services; therefore, we made no recommendations related to communication and coordination. However, we identified the following areas that needed improvement.

Safety Plans. In three of the six facility-specific records, we found that safety plans were not completed, as required. The other three records contained suicide safety plans that addressed appropriate elements. Of the two patients shared with the Alexandria VA Medical Center, one had a safety plan in the medical record while the other did not. Facility staff explained that other VISN facilities may not always agree with their suicide risk assessment and patient record

[3] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[4] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009*; Report No. 09-00326-223; September 22, 2009.

flag; therefore, those facilities don't necessarily complete safety plans.

SPC. VHA policy[5] requires that very large CBOCs[6] designate a full-time SPC committed to suicide prevention activities. The Baton Rouge CBOC, which served approximately 11,000 unique patients in FY 2009, meets the size criteria for assignment of its own SPC. At the time of our visit, the Baton Rouge CBOC did not have an SPC assigned.

Recommendation 4 We recommended that the VISN Director ensure that the Facility Director requires that clinicians develop comprehensive suicide prevention safety plans for patients identified as at high risk for suicide, as required by VHA guidelines.

The VISN and Facility Directors concurred with the findings and recommendation. A safety plan template has been developed, and training regarding safety plan implementation has been provided to appropriate staff. The implementation plans are acceptable, and we will follow up until the planned actions are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Facility Director assigns an SPC for the Baton Rouge CBOC.

The VISN and Facility Directors concurred with the finding and recommendation. An SPC for Baton Rouge CBOC will be assigned. The implementation plan is acceptable, and we will follow up until the planned action is completed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether the facility has consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles[7] and evaluated the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes. We also reviewed meeting minutes during which discussions about the physicians took place.

[5] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
[6] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[7] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

We reviewed the C&P files and profiles of 10 physicians who were granted initial privileges or renewal of privileges in the past 12 months. We found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

FPPE. VHA policy[8] requires the evaluation of the privilege-specific competence of a practitioner (such as a newly hired physician) who does not have documented evidence of competently performing the requested privileges at the facility. FPPE should be considered at the time of initial appointment or when new privileges are requested. We reviewed documentation for four newly hired physicians and one existing physician who was granted new privileges and found that:

- None of the C&P and profile folders contained evidence of FPPE.
- Professional Standards Board (PSB) minutes did not reflect 6-month FPPE follow-up as defined and agreed upon by PSB members during meeting deliberations.
- One new provider was granted privileges for procedures not performed at the facility.

OPPE. VHA policy[9] requires reevaluation of privilege-specific competence for all existing privileged physicians. We found that one of six physician profiles did not contain any OPPE data for the 2-year period prior to reprivileging.

Also, we noted that service chiefs did not consistently define criteria for assessing an individual's capacity to perform specified privileges. Of the five clinical services represented in our sample, three had not designated criteria or PI monitors to determine provider ability and competence relative to specified privileges.

Recommendation 6 We recommended that the VISN Director ensure that the Facility Director requires that privileges are granted in accordance with VHA requirements.

[8] VHA Handbook 1100.19.
[9] VHA Handbook 1100.19.

The VISN and Facility Directors concurred with the findings and recommendation. A database is being created to track and trend OPPE data over time. Information gained from an OPPE and FPPE training program will be used to improve the current competency process. The implementation plans are acceptable, and we will follow up until the planned actions are completed.

Recommendation 7 We recommended that the VISN Director ensure that the Facility Director requires that clinical service chiefs define the criteria for delineation of privileges, as required by VHA policy.

The VISN and Facility Directors concurred with the finding and recommendation. Service chiefs are in the process of defining privileging criteria, which will be submitted to the PSB for approval. The implementation plans are acceptable, and we will follow up until the planned actions are completed.

Reusable Medical Equipment

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and JC standards.

We inspected the Supply, Processing, and Distribution clean room and the decontamination reprocessing rooms. We determined that the facility had appropriate policies and procedures and consistently monitored compliance with established guidelines. Also, the facility had a process in place to track RME should a sterilization failure occur.

For three pieces of RME, we reviewed the standard operating procedures (SOPs) for reprocessing. In general, we found that SOPs were current and consistent with the manufacturers' instructions and that the employees we observed followed SOPs. We reviewed the competency folders and training records of the staff we observed and found that annual competencies and training were current

and consistently documented. However, we identified the following area that needed improvement.

PM. VA requires[10] that PM is done on a scheduled basis and that detailed information is maintained by biomedical engineering for all sterilizers and washers. We reviewed the repair history of the three steam sterilizers and found that PM was performed inconsistently and did not adhere to the facility-defined semi-annual schedule. All three sterilizers had at least one PM gap of 10 months or more.

Recommendation 8 We recommended that the VISN Director ensure that the Facility Director requires PM to be completed on all sterilizers according to the prescribed schedule.

The VISN and Facility Directors concurred with the findings and recommendation. Modifications have been made to the PM monitoring process, including implementation of a log book to document the PM schedule and the completion dates for sterilizers and other equipment. The implementation plan is acceptable, and we will follow up until the action is completed.

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the facility maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined patient medical records and staff training records, reviewed relevant policies, and interviewed key staff. We determined that the facility had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC. Patients in the magnet room were directly observed at all times and had access to a push-button call system while in the scanner. Additionally, mock fire and emergency response drills had been conducted in the MRI area.

We reviewed the medical records of 10 patients who underwent MRIs during February 2010 and found that all had received appropriate screening. However, we identified two areas that needed improvement.

[10] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.

Safety Education. The JC recommends annual MRI safety education to be provided to all staff who may enter the MRI area, including housekeepers and police officers. Managers confirmed that the required annual Level 1 (basic) MRI safety education had not been provided to non-MRI staff.

Security and Safety. The JC recommends Zone 3 (control room for the magnet) access to be physically restricted by a method that can differentiate between MRI and non-MRI staff. We were told that Zone 3 was usually kept unlocked and was not uniquely keyed for MRI employees; therefore, unauthorized staff or patients could enter Zone 3.

Recommendation 9 We recommended that the VISN Director ensure that the Facility Director requires annual MRI safety education to be provided to appropriate staff.

The VISN and Facility Directors concurred with the finding and recommendation. Training for all appropriate staff has either been completed or is planned. The implementation plan is acceptable, and we will follow up until the planned action is completed.

Recommendation 10 We recommended that the VISN Director ensure that the Facility Director requires Zone 3 access to be physically restricted and uniquely keyed, in accordance with JC guidance.

The VISN and Facility Directors concurred with the finding and recommendation. A punch key pad, which requires staff to enter a code to access the MRI control room, has been installed. The corrective action is acceptable, and we consider this recommendation closed.

Coordination of Care

The purpose of this review was to evaluate whether inter-facility transfers and discharge communication between the facility's primary care physicians (PCPs) were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharge communication are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA requires[11] that the facility have a local policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of

[11] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

the QM program. We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place. However, we identified the following area that needed improvement.

Medical Record Documentation. The JC requires the medical record to include all available information for the practitioner responsible for providing follow-up care, treatment, or services. We reviewed the medical records of 10 patients who had been hospitalized at VA expense and discharged from community hospitals from May through July 2009. We assessed whether information was available to PCPs for the clinic visit subsequent to the hospitalization. We found that documentation reflecting the recent hospitalization was lacking in 3 (30 percent) of the 10 patients' medical records. In addition, we found that in 2 (20 percent) of the 10 records, the discharge summary was not available in the medical record.

Recommendation 11 We recommended that the VISN Director ensure that the Facility Director requires that medical records include information about patients who have been hospitalized at VA expense and discharged from community hospitals.

The VISN and Facility Directors concurred with the findings and recommendation. Processes to obtain, scan, and review discharge summary documents have been implemented to ensure that medical records include the required information. The implementation plans are acceptable, and we will follow up until the planned actions are completed.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

We inspected the Hammond, Slidell, and Reserve CBOCs and two primary care (green and yellow) clinics at the New Orleans outpatient clinic. The facility maintained a generally clean and safe environment. The infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met,

and risk assessments complied with VHA standards. We made no recommendations.

Medication Management

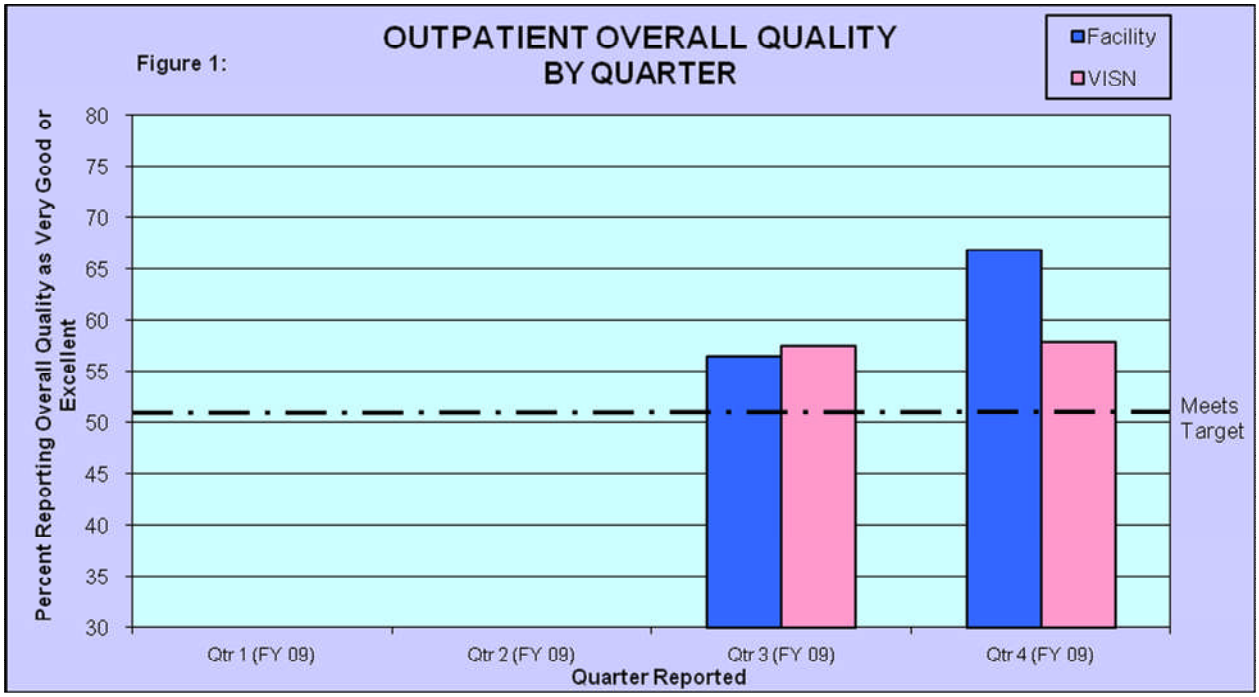
The purpose of this review was to evaluate whether the facility had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients.

The facility had established practices to govern the maintenance of chronic renal disease patients who receive erythropoiesis-stimulating agents.[12] We found that clinical staff had appropriately identified and addressed elevated hemoglobin levels in the 10 patients whose medical records we reviewed. Also, although the pharmacy is closed on weekends and from 7:00 p.m. to 7:30 a.m. on business days, the facility had appropriately provided a qualified pharmacist to answer questions during those hours. We made no recommendations.

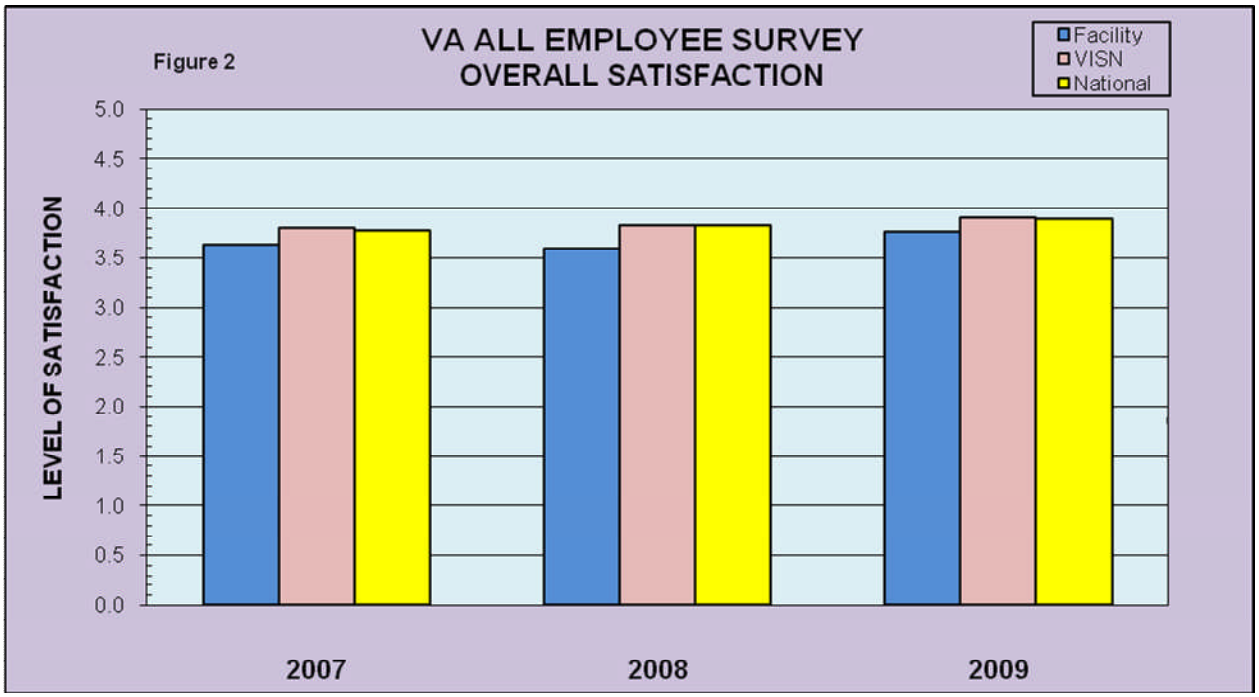
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. The facility has not offered any onsite inpatient services since 2005. Figure 1 on the next page shows the facility's and VISN's overall outpatient satisfaction scores for quarters 3 and 4 of FY 2009.[13] The target score is noted on the graph.

[12] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[13] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.



Employees are surveyed annually. Figure 2 below shows the facility's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 1, 2010

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

Subject: **Combined Assessment Program Review of the Southeast Louisiana Veterans Health Care System, New Orleans, LA**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA CO 10B5 Staff)

1. The SCVAHCN 16 has reviewed the response to the CAP Report for the Southeast Louisiana Veterans Health Care System and concur.

2. If you have questions or need additional information, please contact Gwendolyn Lemaire, RN, ACOS of Quality Management, at 504-565-4937.

(original signed by:)
George H. Gray, Jr.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 26, 2010

From: Director, Southeast Louisiana Veterans Health Care System (629/00)

Subject: **Combined Assessment Program Review of the Southeast Louisiana Veterans Health Care System, New Orleans, LA**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA CO 10B5 Staff)

Per your request, attached is the response to the CAP review draft report from the Southeast Louisiana Veterans Health Care system.

The visit was helpful, productive and the team was cordial. All recommendations have been implemented.

We thank you for this opportunity to improve our health care system and our care to our Veterans.

(original signed by:)
Julie A. Catellier
Director

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Facility Director requires that quarterly PRC reports to the ECMS include all required elements.

Concur

The Peer Review quarterly report was amended during the CAP visit and shared with the inspector who stated that the new format satisfied the requirements. The new report is in place and the first quarterly review was presented to the Executive Committee of the Medical Staff on May 3, 2010 and included all required elements per VHA Policy.

Recommendation 2. We recommended that the VISN Director ensure that the Facility Director requires that the facility monitor CPR certifications and that appropriate staff maintain this credential.

Concur

Workforce Development (WFD) has improved its monitoring process of facility compliance with CPR certifications. Currently, reports generated through the LMS database are sent weekly to the Administrative Officers of each Service identifying the compliance as well as deficiency of appropriate staff. Individual names with expiration dates appear on these weekly reports to facilitate the monitoring process at the Service level. Providers failing to renew their CPR certification are reported to the Service Chief through the Service administrative staff.

In addition, electronic reminders are sent via LMS to identified staff notifying them of their pending expiration date. Electronic reminders are automatically generated throughout a 90 day period, prior to their expiration date, prompting the individual to schedule a CPR class to renew their certification. On a monthly basis (when the dash board is due) WFD generates a list of non-compliant staff which is submitted to Nurse Executive. The Nurse Executive then sends a list of people who's BLS will expire in the coming 30 days to the Executive Leadership/Pentad. The Chief of Staff receives that list and then sends the notifications to each Service Line Director that those non-compliant employees will be removed from patient care responsibilities unless they present a valid BLS

card to WFD and their Service Line by the date of the expiration of their BLS credentials.

Recommendation 3. We recommended that the VISN Director ensure that the Facility Director requires display and analysis of utilization management and invasive procedure review data in meeting minutes.

Concur

Utilization Management monitors the patients' perception of care for those patients admitted to SLVHCS' VIP Unit. The results of this monitor are presented weekly at the Director's Board on Boards Meeting and a monthly report is submitted and presented to the Quality of Care Committee.

Additionally, a qualitative monitor has been developed for submission and presentation at the quarterly Quality and Performance Meeting that will encompass identification of exceptions with corrective actions noted for cases that were non-compliant for meeting InterQual Criteria for admission, delays in Mental Health transfers, and veteran complaints post discharge from the VIP Unit.

Display and Analysis of invasive procedure data for procedures performed in our Health Care system is presented to ECMS on a quarterly basis. The first set of review data was presented to ECMS on 4/5/2010.

Recommendation 4. We recommended that the VISN Director ensure that the Facility Director requires that clinicians develop comprehensive suicide prevention safety plans for patients identified as at high risk for suicide, as required by VHA guidelines.

Concur

SLVHCS has a safety plan template that includes all necessary components of an effective safety plan. The template allows the provider and patient to collaboratively identify alternative coping behaviors appropriate for the patient. The information can be printed out and provided directly to the patient. Training regarding safety plan implementation has been provided by the Suicide Prevention Coordinator and Lisa Brenner, Ph.D., national suicidologist, to all mental health providers. To ensure use of the safety plan, the Suicide Prevention Coordinator now is reviewing records for all newly flagged veterans to ensure timely completion of a safety plan. A psychiatrist performance measure includes 100% completion of safety plans for appropriate patients.

Recommendation 5. We recommended that the VISN Director ensure that the Facility Director assigns an SPC for the Baton Rouge CBOC.

Concur

SLVHCS is committed to having a SPC for the Baton Rouge Outpatient clinic but this position has not yet been filled.

Recommendation 6. We recommended that the VISN Director ensure that the Facility Director requires that privileges are granted in accordance with VHA requirements.

Concur

The Medical Staff Manager and the Performance Improvement Coordinator are working together to develop a database to be utilized to track and trend OPPE data over time. They are also collaborating with other services as needed to ensure accurate feedback and ideas are explored. A recommendation will be submitted to the Chief of Staff by June 18, 2010. The OPPE/FPPE data will be maintained in the Medical Staff Office in the provider's specific file; however, it's the responsibility of the service to ensure this data is collected and submitted to Medical Staff Office on a routine basis.

The Medical Staff Manager attended a training program on how to implement OPPE and FPPE data for current medical staff members. This training provided guidance on how to work with our medical staff to assist them in determining and collecting data, how to use benchmark data to interpret performance and how to create an effective physician performance profile for competency evaluation.

Chief of Staff, Deputy Chief of Staff, and the Medical Staff Manager met and discussed the availability of reports and documentation to support the ongoing, competency process of medical staff members. They were able to look at opportunities that can used at this facility as measurable output for our providers.

Recommendation 7. We recommended that the VISN Director ensure that the Facility Director requires that clinical service chiefs define the criteria for delineation of privileges, as required by VHA policy.

Concur

The Chief of Staff has already discussed with his service chiefs the need to define criteria for privileging and re-privileging. At next month's (June) Professional Standards Board (PSB) meeting, service chiefs will present proposed criteria for discussion. After input from PSB members, service chiefs will revise the criteria and represent the final criteria for approval at the July meeting of the PSB. By July 31st each service chief will have in place defined criteria for delineation of privileges by PSB.

Recommendation 8. We recommended that the VISN Director ensure that the Facility Director requires PM to be completed on all sterilizers according to the prescribed schedule.

Concur

All printed PM lists will be double checked for completeness. Each page will be checked to make sure that all pages print out completely. The PM lists will be compared to the list from the previous year to make sure no equipment has been excluded. If equipment is found to be excluded, the equipment status will be checked to determine whether it has been turned in. If the equipment has been turned in it will remain off of the PM schedule. If the equipment is in use a work order will be created denoting "Off Schedule PM" to document that a PM is to be completed. After the PM work lists are closed, a check will be done to ensure that all completed PMs are properly documented in the work history for each piece of equipment. Additionally, the hardcopy print outs that the technicians mark as they complete the PMs will be kept on file.

SPD implemented the weekly PMS schedule log book to document sterilizers semi-annual PMS schedule dates. The Chief of SPD or Assistant Chief SPD will notify Bio Med (30) days prior to the semi-annual PMS expiration date for each sterilizer.

Once the Semi-annual PMS is complete, SPD will request a copy of the PMS repair history data for the inspection and attach the semi-annual PMS to the weekly log book. A copy of each semi-annual PMS for each sterilizer will also be filed in the SPD Office.

Recommendation 9. We recommended that the VISN Director ensure that the Facility Director requires annual MRI safety education to be provided to appropriate staff.

Concur

Annual MRI Safety training has been provided to MRI technologists as well as all other Imaging Center staff. Training for Facilities Management, BioMed, Housekeeping, and Police Service is ongoing and will be completed by May 27th, 2010. For future annual training, Workforce Development plans to load the MRI Safety Training video into LMS and assign it to the appropriate personnel.

Recommendation 10. We recommended that the VISN Director ensure that the Facility Director requires Zone 3 access to be physically restricted and uniquely keyed, in accordance with JC guidance.

A punch key pad was placed on the door to the MRI suite (Zone III). It is now necessary for the staff to enter a code for access to the MRI/CT

control room (room IC113). Police Service was notified of the changes to the security of the physical building.

Concur

Recommendation 11. We recommended that the VISN Director ensure that the Facility Director requires that medical records include information about patients who have been hospitalized at VA expense and discharged from community hospitals.

Concur

The Business Office is responsible for obtaining and scanning discharge summary documents into the medical record. Members of the Outsourced Document Team will utilize the daily report (generated from a locally created real time database) for all consults outsourced for the previous month to ensure that all inpatient and outpatient reports are obtained and scanned into CPRS. In the event a report has not been received and scanned into Vista Imaging, the ODT will contact the vendor to obtain the reports.

The RN reviews all outsourced results/documents (i.e., diagnostic reports, laboratory results, medical/clinical assessments) received by SLVHCS; notifies the ordering provider of results with critical values and/or abnormal results via the CPRS provider alert, with an added signature, and also by telephone.

The PSA Scanning Clerk ensures documents that comprise a complete report have the same date and scans or electronically attaches documents separately into CPRS. The PSA Scanning Clerk then reviews the reason for the appointment(s), which is located on the consult, for documents presented with different appointment dates and attaches the report with the appropriate consult.

PSA Scanning Clerks check the document(s) to ensure they are scanned properly and notifies HIMS Chief if any errors are made so the document can be removed. They will then re-scan the document to the appropriate patient/consult.

Ambulatory Care has developed an educational plan to ensure that primary care providers sign the discharge summary and ensure that recent hospitalizations are noted in the record and discussed with the patient.

OIG Contact and Staff Acknowledgments

Contact	Victoria Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5962
Contributors	Toni Woodard, CAP Coordinator Tishanna McCutchen, Team Leader Audrey Collins-Mack Melanie Cool Deborah Howard John Ramsey, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, South Central VA Health Care Network (10N16)
Director, Southeast Louisiana Veterans Health Care System (629/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Mary L. Landrieu, David Vitter
U.S. House of Representatives: Rodney Alexander, Charles W. Boustany, Jr., Joseph Cao, William "Bill" Cassidy, John Fleming, Charlie Melancon, Steve Scalise

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