Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00307-126

Combined Assessment Program Review of the Birmingham VA Medical Center Birmingham, Alabama

April 17, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CPR	Cardiopulmonary Resuscitation Committee
EHR	electronic health record
EOC	environment of care
facility	Birmingham VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
IAD	incontinence associated dermatitis
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
VA-TAMMCS	Vision-Analysis-Team-Aim-Map-Measure-Change-Sustain
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 27, 2014.

Review Results: The review covered six activities. We made no recommendations in the following two activities:

- Medication Management
- Coordination of Care

The facility's reported accomplishments were the use of the Vision-Analysis-Team-Aim-Map-Measure-Change-Sustain framework to reduce incontinence associated dermatitis and a successful multidisciplinary workgroup for specialty care access.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure the Medical Executive Committee documents discussion of Peer Review Committee quarterly summary reports. Consistently complete Focused Professional Practice Evaluations for newly hired licensed independent practitioners, and consistently report results to the Medical Executive Committee. Monitor compliance with the new observation bed policy, and continue to gather data about observation bed use. Perform continuing stay reviews on at least 75 percent of the patients in acute beds. Require that the Cardiopulmonary Resuscitation Committee reviews each code episode, that code reviews include screening for clinical issues prior to code that may have contributed to the occurrence of the code, and that code data is collected. Ensure the Surgical Work Group meets monthly and documents its review of required monthly and quarterly performance data elements. Review the quality of entries in the electronic health record at least quarterly. Ensure the quality control policy for scanning includes how a scanned image is annotated to identify that it has been scanned. Require that members from Medicine, Surgery, and Anesthesia Services attend Transfusion Process Committee meetings and that the blood/transfusions usage review process includes the results of proficiency testing.

Environment of Care: Ensure Infection Control Committee minutes reflect follow-up on actions that were implemented to address identified problems.

Nurse Staffing: Monitor the staffing methodology that was implemented in November 2012.

Pressure Ulcer Prevention and Management: Monitor compliance with the revised pressure ulcer policy as it pertains to prevention for outpatients. Ensure that the newly established Interprofessional Pressure Ulcer Committee meets as required and that the

committee provides oversight of the facility's pressure ulcer prevention program. Analyze pressure ulcer data, and report it to facility executive leadership. Accurately document pressure ulcer location, stage, and risk scale score for all patients with pressure ulcers. Consistently document pressure ulcer stage in initial skin assessments for patients at risk or with pressure ulcers. Develop interprofessional treatment plans for all hospitalized patients identified as being at risk for or with pressure ulcers. Ensure all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to discharge. Provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–27, for the full text of the Directors' comments.) We consider recommendation 9 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

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 quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012, FY 2013, and FY 2014 through February 27, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment*

Program Review of the Birmingham VA Medical Center, Birmingham, Alabama, Report No. 11-01295-232, July 21, 2011). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 379 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 171 responded. We shared summarized results with facility managers.

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.

Reported Accomplishments

Reducing IAD using the VA-TAMMCS Framework

The facility used the VA-TAMMCS framework to identify an effective process to eliminate IAD. An interprofessional team was chartered to evaluate the state of pressure ulcers at the facility. The team identified a pilot unit to observe the process for cleaning patients and used feedback from frontline clinical staff and patients to evaluate the current process for preventing IAD. The current process showed a wide variation in incontinence care and products used. As a result of using VA-TAMMCS framework, the team identified a superior and less costly process to prevent IAD and reduce pressure ulcer development. This process included the use of the three-in-one disposable wipe product, which was found to be cost effective and to provide the most effective means of eliminating IAD. During the test cycle, the use of the three-in-one product reduced the rate of patients with incontinence that developed IAD to nearly zero. These wipes are now available for use on incontinent patients throughout the facility.

Specialty Care Access

In February 2013, the facility identified several specialty care areas that were unable to provide appointments within a 14-day timeframe. A multidisciplinary work group was created with the goal of improving overall access to specialty services. The group reviewed access data trends and established short- and long-term plans for the specialty areas identified as outliers. The short-term plans used non-VA care for immediate access. The long-term plans included reviewing space utilization, analyzing the cost benefit of staffing versus the use of fee services, realigning clerical support to high volume areas, and streamlining consults. As a result, facility FY 2013 specialty care access improved. For FY 2014, the multidisciplinary work group has refocused their efforts to improve access to care for additional specialties.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
X	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	Twelve months of MEC meeting minutes reviewed: • Quarterly summary reports were not documented as discussed.
X	FPPEs for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	Sixty-two profiles reviewed: • Ten FPPEs (16 percent) were not completed. This was a repeat finding from the previous CAP review. • Of the 52 FPPEs completed, results of 20 (38 percent) were not reported to the MEC.
NA	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
X	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	• The facility did not have an observation bed policy until January 21, 2014. • The facility did not begin gathering observation bed use data until January 2014.
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Four quarters of continuing stay data reviewed: • For all 4 quarters, less than 75 percent of acute inpatients were reviewed.
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Ten months of CPR Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each episode. • There was no evidence that code reviews included screening for clinical issues prior to code that may have contributed to the occurrence of the code. • There was no evidence that data was collected.
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group did not meet until October 2013. As a result, there was no evidence that required monthly and quarterly performance data elements, including local performance data and National Surgical Office reports, were reviewed.
	Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	Ten months of Medical Record Committee meeting minutes reviewed: • There was no evidence that the quality of entries in the EHR was reviewed.
X	The policy for scanning non-VA care documents met selected requirements.	• The scanning policy did not include how a scanned image is annotated to identify that it has been scanned.

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Nine months of Transfusion Process Committee meeting minutes reviewed: • Clinical representatives from Medicine, Surgery, and Anesthesia Services did not attend the meetings. • The review process did not include the results of proficiency testing.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that the MEC document discussion of PRC quarterly summary reports.

2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently completed and that results are consistently reported to the MEC.

3. We recommended that the facility monitor compliance with the new observation bed policy.

4. We recommended that processes be strengthened to ensure that data about observation bed use continues to be gathered.

5. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of the patients in acute beds.

6. We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode, that code reviews include screening for clinical issues prior to the code that may have contributed to the occurrence of the code, and that code data is collected.

7. We recommended that the Surgical Work Group meet monthly and document its review of required monthly and quarterly performance data elements, including local performance data and National Surgical Office reports.

8. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed at least quarterly.

9. We recommended that the quality control policy for scanning include how a scanned image is annotated to identify that it has been scanned.

10. We recommended that processes be strengthened to ensure that members from Medicine, Surgery, and Anesthesia Services attend Transfusion Process Committee meetings and that the blood/transfusions usage review process includes the results of proficiency testing.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in radiology and acute MH were met.[2]

We inspected five inpatient care areas (two medical/surgical care units, an intensive care unit, the blind rehabilitation unit, and the palliative care unit) and three outpatient areas (the emergency department, primary care, and the oncology clinic). Due to inclement weather, we were unable to inspect the radiology unit. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed nine radiology employee training records. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
X	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	Three quarters of Infection Control Committee meeting minutes reviewed: • Minutes did not reflect follow-up on actions that were implemented to address identified problems.
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had a policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
NA	Environmental safety requirements in x-ray and fluoroscopy were met.	
NA	Infection prevention requirements in x-ray and fluoroscopy were met.	
NA	Medication safety and security requirements in x-ray and fluoroscopy were met.	
NA	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
NA	MH EOC inspections were conducted every 6 months.	
NA	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
NA	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	
NA	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	

NM	Areas Reviewed for Acute MH (continued)	Findings
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Recommendation

11. We recommended that processes be strengthened to ensure that Infection Control Committee minutes reflect follow-up on actions that were implemented to address identified problems.

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 33 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 34 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing an acute medical/surgical unit.[5]

We reviewed facility and unit-based expert panel documents and 21 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 1 randomly selected unit—acute medical/surgical unit 4 Main—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• Initial implementation was not completed until November 27, 2012.
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
	Members of the expert panels completed the required training.	
	The actual nursing hours per patient day met or exceeded the target nursing hours per patient day.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

12. We recommended that nursing managers continue to monitor the staffing methodology that was implemented in November 2012.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 25 EHRs of patients with pressure ulcers (8 patients with hospital-acquired pressure ulcers, 7 patients with community-acquired pressure ulcers, and 10 patients with pressure ulcers at the time of our onsite visit), and 10 employee training records. Due to inclement weather, we were unable to conduct the physical inspection portion of the review. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	Facility pressure ulcer prevention policy reviewed: • The policy did not address prevention for outpatients until December 2013.
X	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	• The facility did not establish an interprofessional pressure ulcer committee until January 2014.
X	Pressure ulcer data was analyzed and reported to facility executive leadership.	• Pressure ulcer data was not analyzed or reported to facility executive leadership.
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer	
X	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	• In 9 of the 25 EHRs, staff did not consistently document the location, stage, and/or risk scale score.
X	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	• In 4 of the 25 EHRs, the complete initial skin assessment did not include documentation of pressure ulcer stage.
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
X	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	• Three of the 25 EHRs contained no documentation that interprofessional treatment plans were developed.
X	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	• Two of the applicable five EHRs did not contain a wound care follow-up plan at discharge. • Three of the applicable four EHRs did not contain evidence that patients received dressing supplies prior to discharge.

NM	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	Facility pressure ulcer patient and caregiver education requirements reviewed: • For 6 of the applicable 15 patients at risk for or with a pressure ulcer, EHRs did not contain evidence that education was provided.
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
NA	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

13. We recommended that the facility monitor compliance with the revised pressure ulcer policy as it pertains to prevention for outpatients.

14. We recommended that the newly established Interprofessional Pressure Ulcer Committee meet as required and that the committee provide oversight of the facility's pressure ulcer prevention program.

15. We recommended that processes be strengthened to ensure that pressure ulcer data is analyzed and that program data is reported to facility executive leadership.

16. We recommended that processes be strengthened to ensure that acute care staff accurately document pressure ulcer location, stage, and risk scale score for all patients with pressure ulcers and that compliance be monitored.

17. We recommended that processes be strengthened to ensure that acute care staff consistently document pressure ulcer stage in initial skin assessments for patients at risk or with pressure ulcers and that compliance be monitored.

18. We recommended that processes be strengthened to ensure that acute care staff develop interprofessional treatment plans for all hospitalized patients identified as being at risk for or with pressure ulcers and that compliance be monitored.

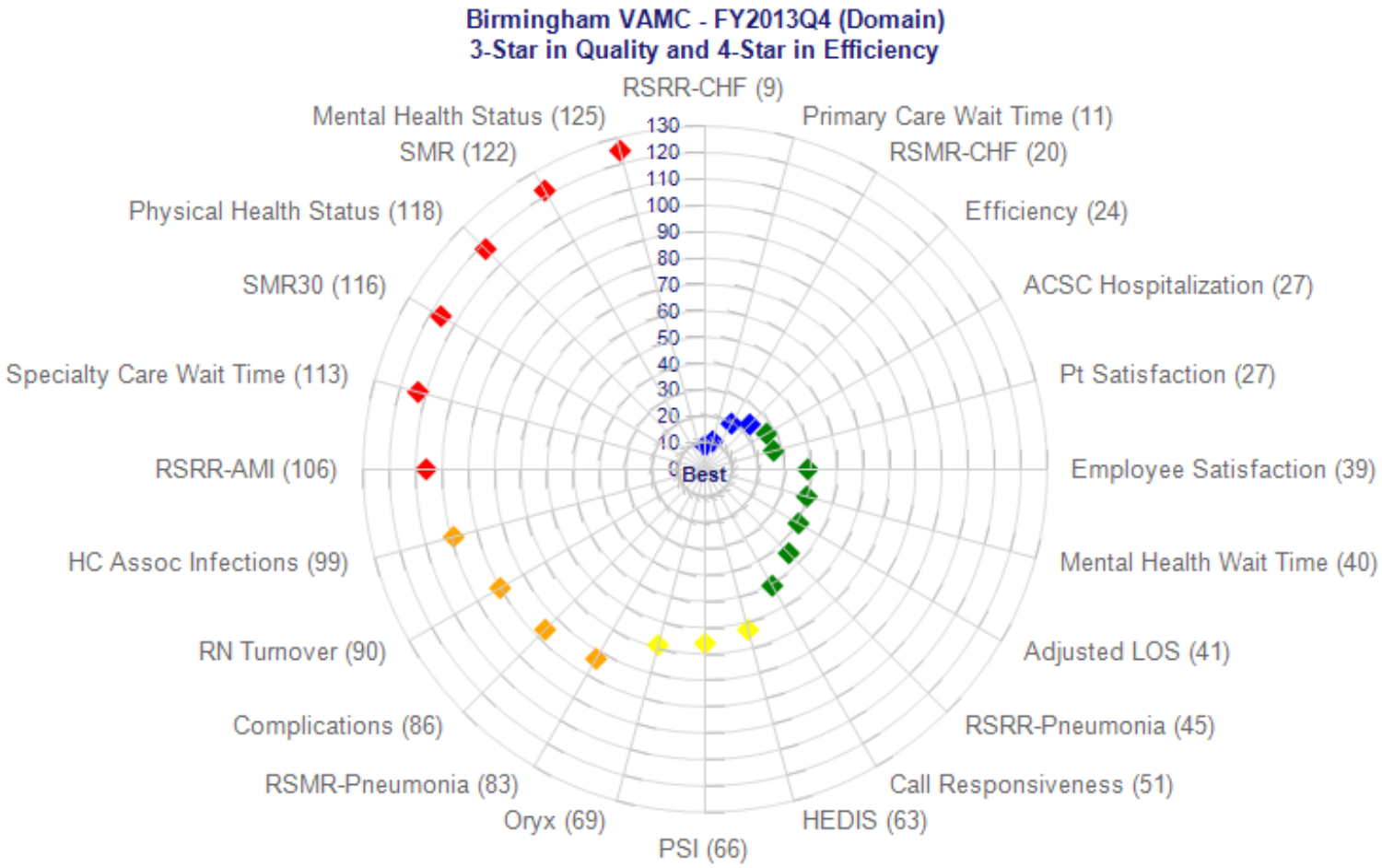
19. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

20. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Facility Profile (Birmingham/521) FY 2014 through March 2014[a]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$378.7
Number of:	
• **Unique Patients**	46,877
• **Outpatient Visits**	281,554
• **Unique Employees**[b]	1,950
Type and Number of Operating Beds (January 2014):	
• **Hospital**	139
• **Community Living Center**	NA
• **MH**	NA
Average Daily Census (February 2014):	
• **Hospital**	97
• **Community Living Center**	NA
• **MH**	NA
Number of Community Based Outpatient Clinics	9
Location(s)/Station Number(s)	Huntsville/521GA Decatur (Madison)/521GB Florence/521GC Rainbow City/521GD Anniston (Oxford)/521GE Jasper/521GF Bessemer/521GG Childersburg/521GH Guntersville/521GI
VISN Number	7

[a] All data is for FY 2014 through March 2014 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

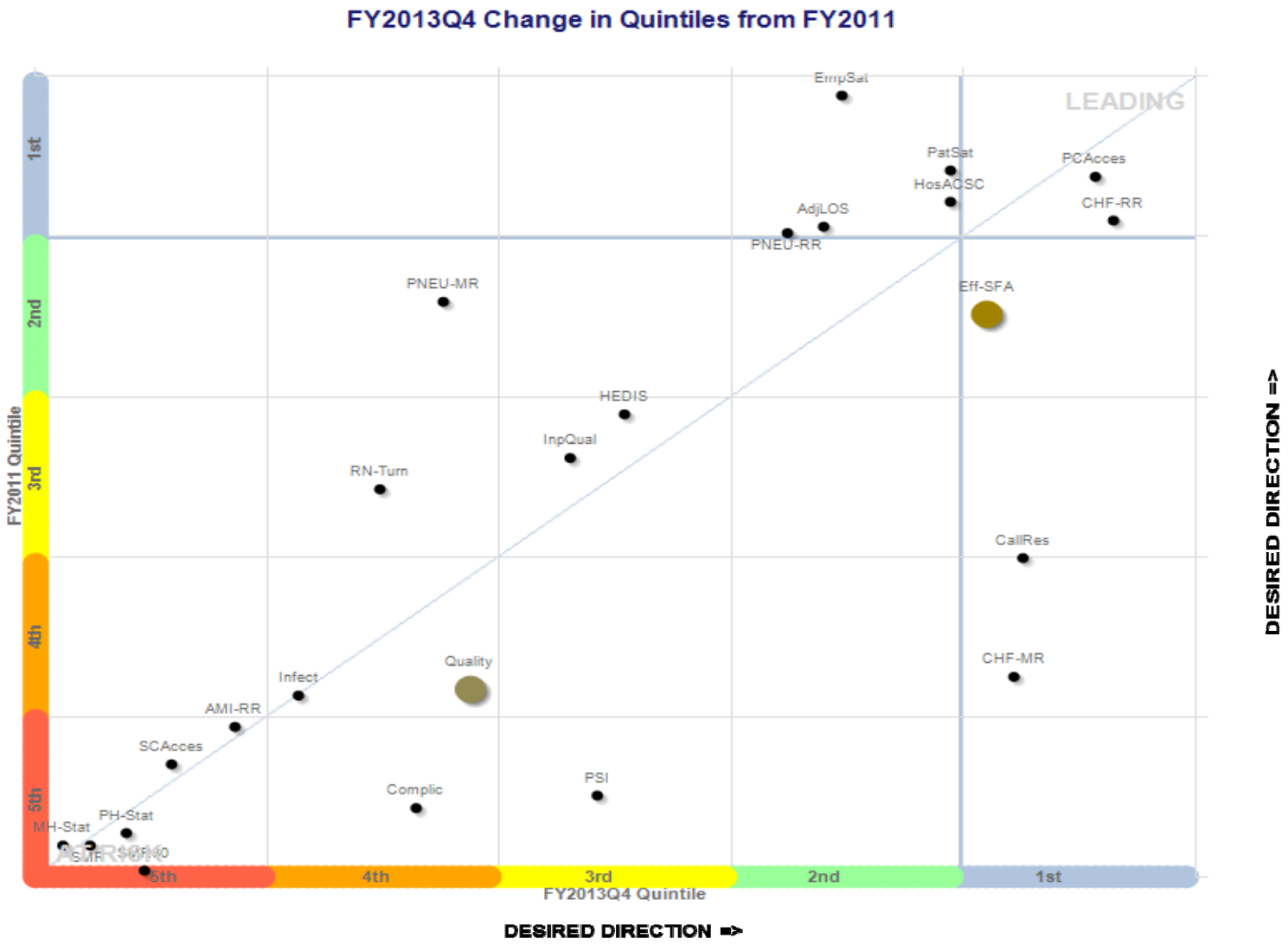
Strategic Analytics for Improvement and Learning (SAIL)[c]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[c] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 1, 2014

From: Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Birmingham VA Medical Center, Birmingham, AL**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have reviewed the OIG CAP Report and Birmingham's submitted actions plans. VISN 7 leadership will provide required support as needed.

2. If you have questions or need additional information, please contact Robin Hindsman, VISN Quality Management Officer at (678) 924-5723.

(original signed by:)
Charles E. Sepich, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 31, 2014

From: Director, Birmingham VA Medical Center (521/00)

Subject: **CAP Review of the Birmingham VA Medical Center, Birmingham, AL**

To: Director, VA Southeast Network (10N7)

1. The Birmingham VA Medical Center has reviewed the CAP Report and concurs with the recommendations. Corrective actions are underway with identified target completion dates.

2. If you have questions or need additional information, please contact my office at (205) 933-4515.

(original signed by:)
Thomas C. Smith, III, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the MEC document discussion of PRC quarterly summary reports.

Concur

Target date for completion: September 30, 2014

Facility response: The Risk Manager will report quarterly Peer Review Reports to Health System Council. Reports will be documented in Health System Council (Medical Executive Committee).

Recommendation 2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently completed and that results are consistently reported to the MEC.

Concur

Target date for completion: September 30, 2014

Facility response: The Chief of Staff and Professional Standards Board will ensure the Service Chiefs submit FPPEs for newly hired independent practitioners which are then consistently reported to Health System Council. FPPEs not reported to Medical Executive Board will be referred to Chief of Staff for further action.

Recommendation 3. We recommended that the facility monitor compliance with the new observation bed policy.

Concur

Target date for completion: September 30, 2014

Facility response: The Chief of Business Management Service will monitor compliance with Observation Policy. The information will be tracked by the Patient Flow Committee and reported monthly to Health System Council. The Health Systems Council will monitor compliance of observation admissions.

Recommendation 4. We recommended that processes be strengthened to ensure that data about observation bed use continues to be gathered.

Concur

Target date for completion: September 30, 2014

Facility response: The Chief of Business Management Service will ensure data collection for observation beds. The Patient Flow Committee will analyze, trend and report information to Health System Council monthly.

Recommendation 5. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of the patients in acute beds.

Concur

Target date for completion: September 30, 2014

Facility response: Business Management Service has been authorized for 3 additional UM FTE. Expected target date for all staff to be on duty is June 30, 2014. The Chief of the Business Management Service will ensure that 75 percent of patient admitted are reviewed according to Inter Qual Criteria. The percentage of reviews completed will be monitored by Patient Flow Committee. The Patient Flow Committee will report information monthly to Health System Council for review and recommendations.

Recommendation 6. We recommended that processes be strengthened to ensure that the CPR Committee reviews each code episode, that code reviews include screening for clinical issues prior to code that may have contributed to the occurrence of the code, and that code data is collected.

Concur

Target date for completion: September 30, 2014

Facility response: The Cardio Pulmonary Resuscitation Committee will review each code episode for clinical issues that may have contributed to the code. The CPR Committee will track and trend events and report clinical issues to the Quality Value Council and Peer Review as indicated.

Recommendation 7. We recommended that the Surgical Work Group meet monthly and document its review of required monthly and quarterly performance data elements, including local performance data and National Surgical Office reports.

Concur

Target date for completion: September 30, 2014

Facility response: The Surgical Work Group will continue to meet monthly and document review of required monthly and quarterly performance data elements, including local performance data and National Surgical Office Reports. The information will be reported to Quality Value Council for review and approval of performance improvement actions.

Recommendation 8. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed at least quarterly.

Concur

Target date for completion: September 30, 2014

Facility response: The Medical Record Committee will work with Clinical Services to ensure quality reviews are completed on clinic entries into the electronic health record. The data collected will be reviewed by Medical Record Committee and referred to Health System Council for approval.

Recommendation 9. We recommended that the quality control policy for scanning include how a scanned image is annotated to identify that it has been scanned.

Concur

Target date for completion: Complete

Facility response: The Medical Center Memorandum 136-04 has been updated to describe how scanned images are annotated to identify that it has been scanned.

Recommendation 10. We recommended that processes be strengthened to ensure that members from Medicine, Surgery, and Anesthesia Services attend Transfusion Process Committee meetings and that the blood/transfusions usage review process includes the results of proficiency testing.

Concur

Target date for completion: September 30, 2014

Facility response: Members from Medicine, Surgery, and Anesthesia Service will be required to attend the Transfusion Process Committee meetings. Attendance will be tracked and reviewed by Health System Council for compliance. The Transfusion Committee will ensure that the blood/transfusions usage review process include the results of proficiency testing and report the findings to Health System Council to be tracked for compliance.

Recommendation 11. We recommended that processes be strengthened to ensure that Infection Control Committee minutes reflect follow-up on actions that were implemented to address identified problems.

Concur

Target date for completion: September 30, 2014

Facility response: The Infection Control Nurse will ensure that the Infection Control Committee minutes reflect follow-up on actions that were implemented to address identified problems. The Infection Control Minutes will be reviewed by the Quality Value Council for completion of identified problems.

Recommendation 12. We recommended that nursing managers continue to monitor the staffing methodology that was implemented in November 2012.

Concur

Target date for completion: September 30, 2014

Facility response: The Associate Director of Patient Care Services will ensure that the staffing methodology is continued. The staffing report will be provided to Quality Value Council to monitor compliance.

Recommendation 13. We recommended that the facility monitor compliance with the revised pressure ulcer policy as it pertains to prevention for outpatients.

Concur

Target date for completion: September 30, 2014

Facility response: The Associate Director of Patient Care Services will ensure monitored compliance with the revised pressure ulcer policy as it pertains to prevention for outpatients. Monthly pressure ulcer reports will be provided to Quality Value Council to monitor compliance.

Recommendation 14. We recommended that the newly established Interprofessional Pressure Ulcer Committee meet as required and that the committee provide oversight of the facility's pressure ulcer prevention program.

Concur

Target date for completion: September 30, 2014

Facility response: The Associate Director of Nursing will ensure the newly established Interprofessional Pressure Ulcer Committee meet as required and that the committee provide oversight of the facility's pressure ulcer prevention program. Monthly pressure ulcer reports will be provided to Quality Value Council to monitor compliance.

Recommendation 15. We recommended that processes be strengthened to ensure that pressure ulcer data is analyzed and that program data is reported to facility executive leadership.

Concur

Target date for completion: September 30, 2014

Facility response: The Associate Director of Patient Care Services will ensure that pressure ulcer data is analyzed and that the program data is reported to Quality Value Council. Monthly pressure ulcer reports will be provided to Quality Value Council to review and then reported to Facility Leadership Board.

Recommendation 16. We recommended that processes be strengthened to ensure that acute care staff accurately document pressure ulcer location, stage, and risk scale score for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The Associate Director of Patient Care Services will ensure that acute care staff accurately document pressure ulcer location, stage, and risk scale score for all patients with pressure ulcers and that compliance be monitored. The action plan for staff to document pressure ulcer information will be reported and monitored monthly by Quality Value Council for compliance.

Recommendation 17. We recommended that processes be strengthened to ensure that acute care staff consistently document pressure ulcer stage in initial skin assessments for patients at risk or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The Associate Director of Patient Care Services will ensure that acute care staff accurately document pressure ulcer stage in initial skin assessments for patients at risk or with pressure ulcers and that compliance be monitored. The action plan for staff to document pressure ulcer information will be reported and monitored monthly by Quality Value Council.

Recommendation 18. We recommended that processes be strengthened to ensure that acute care staff develop interprofessional treatment plans for all hospitalized patients identified as being at risk for or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The Associate Director of Patient Care Services will ensure that acute care staff develops Interprofessional treatment plans for all hospitalized patients identified as being at risk for or with pressure ulcers and that compliance be monitored. The action plan will be reported and monitored monthly by Quality Value Council for compliance.

Recommendation 19. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The Associate Director of Nursing will ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored. The action plan will be reported and monitored monthly by Quality Value Council for compliance.

Recommendation 20. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: September 30, 2014

Facility response: The Associate Director of Nursing will ensure that acute care staff provide and document pressure ulcer education for patients at risk for and with pressure ulcers and/or their caregivers and that compliance be monitored. The action plan will be reported and monitored monthly by Quality Value Council for compliance.

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Endnotes

[1] References used for this topic included:
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- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
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[3] References used for this topic included:
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- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
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- VHA Handbook 1120.04, *Veterans Health Education and Information Core Program Requirements*, July 29, 2009.
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- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.