Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-02349-29

Combined Assessment Program Review of the New Mexico VA Health Care System Albuquerque, New Mexico

November 27, 2007

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.

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Executive Summary

Introduction

During the week of June 25–28, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the New Mexico VA Health Care System (the system), Albuquerque, NM. 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 419 system employees. The system is part of Veterans Integrated Service Network (VISN) 18.

Results of the Review

The CAP review covered seven operational activities. We made recommendations in six of the activities reviewed. For these activities, the system needed to:

- Require that computerized patient record system business rules are in compliance with Veterans Health Administration (VHA) policy and Office of Information (OI) guidance.
- Ensure that community based outpatient clinic (CBOC) staff are in compliance with VHA infection control policies and that provider-specific documentation is maintained on performance improvement data for provider reappraisal.
- Ensure that eyewash stations are maintained and that fire extinguishers are inspected in accordance with VHA policy.
- Require that clinicians inform patients of their right to file tort or benefit claims and document the discussions in the medical record; require that peer reviews be completed within the timeframes specified by VHA; and require that QM committees document activities, consistently gather and analyze data, implement effective action item tracking mechanisms, and submit reports to designated oversight committees.
- Require that Survey of Healthcare Experiences of Patients (SHEP) action plans be developed and implemented to improve patient satisfaction areas that fell below the target results.
- Ensure that the scopes of practice for all facility personnel engaged in research activities are reviewed and approved by the Associate Chief of Staff for Research and Development and otherwise meet current requirements for scopes of practice of unlicensed research personnel.

The system complied with selected standards in the following activity:

- Surgical Care Improvement Project (SCIP).

This report was prepared under the direction of Linda G. DeLong, Director, and Karen A. Moore, Associate Director, Dallas Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 15–20, 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 system is a tertiary facility located in Albuquerque, NM, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 10 CBOCs in New Mexico and 1 CBOC in Colorado. The system is part of VISN 18 and serves a veteran population of about 44,773 throughout a primary service area that includes 33 counties in New Mexico and 4 counties in Colorado.

Programs. The system provides medicine, surgery, long-term care, psychiatry, rehabilitation, and spinal cord injury services. It has 184 hospital beds, 36 nursing home beds, a 26-bed Psychosocial Residential Rehabilitation Treatment Program (RRTP), a 24-bed Substance Abuse RRTP, and a 40-bed Domiciliary RRTP.

Affiliations and Research. The system is affiliated with the University of New Mexico School of Medicine and provides training for 114 medical residents in 33 clinical training programs. In fiscal year (FY) 2006, the system research program had 133 projects and a budget of $15.9 million. Important areas of research include gastroenterology, infectious disease, cardiology, oncology, neurology, endocrinology, psychiatry, pulmonary disease, and the Cooperative Studies Program Clinical Research Pharmacy Coordinating Center.

Resources. In FY 2006, medical care expenditures totaled $262 million. The FY 2007 medical care budget was $276 million. In FY 2006, staffing was 1,636 full-time employee equivalents (FTE), including 116 physician and 455 nursing FTE.

Workload. In FY 2006, the system treated 54,559 unique patients and provided 54,685 inpatient days in the hospital and 7,840 inpatient days in the Nursing Home Care Unit. The inpatient care workload totaled 6,422 discharges, and the average daily census, including nursing home patients, was 171. Outpatient workload totaled 515,211 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, employees, and patients; and reviewed clinical and administrative records. The review covered the following seven activities:

- Business Rules for Veterans Health Information Systems.
- CBOC.
- Environment of Care (EOC).
- QM.
- SCIP.
- SHEP.
- Unlicensed Physicians.

The review covered system operations for FY 2006 and FY 2007 through June 28, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico*, Report No. 05-01141-186, August 15, 2005). Recommendations concerning the Patient Complaints Program and mortality reviews were closed. We found that the Mortality Review Program demonstrated significant achievement in provider-specific data trending.

During this review, we also presented fraud and integrity awareness briefings for 419 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 reportable findings.

Results

Review Activities With Recommendations

Business Rules for Veterans Health Information Systems

The purpose of this review was to evaluate if the system was in compliance with VHA Handbook 1907.01, *Health Information Management and Health Records*, regarding the use of business rules that allow computerized patient medical record users different levels of access to the medical record.

The health record, as defined in VHA Handbook 1907.01, includes the electronic medical record and the paper record, combined, and is also known as the legal health record. It includes items, such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes, all reflecting the time and date recorded.

A communication (software informational patch[1] USR*1*26) was sent from the OI on October 20, 2004, to all medical centers, providing guidance on a number of issues relating to the editing of electronically signed documents in the electronic medical records system.[2] The Information Officer cautioned that, "The practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

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

Business rules define what functions certain groups or individuals are allowed to perform in the medical record. The OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the system's Privacy Officer. We reviewed VHA and system information and technology policies and interviewed Information Resource Management Service staff. The system had 12 rules that allowed editing of a signed note by users other than the author. System staff took action to edit or remove these business rules while we were onsite.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires compliance with VHA Handbook 1907.01, *Health Information Management and Health Records*, and the October 2004 OI guidance.

The VISN and System Directors concurred with the findings and recommendation. Business rules that allowed editing of a signed note were edited or removed during the CAP visit. Business rules are now being monitored on a quarterly basis to insure compliance. We find the actions acceptable and consider this recommendation closed.

Community Based Outpatient Clinics

The purpose of this review was to evaluate CBOC compliance with VHA regulations regarding selected standards of operations, such as EOC, patient safety, QM, credentialing and privileging, and emergency plans. CBOCs are designed to improve veterans' access to services by offering primary care and mental health services in local communities while delivering the same standard of care as the parent facility.

We conducted an onsite visit to the Santa Fe CBOC, which is located in Santa Fe, NM. We interviewed key individuals, reviewed local policies and self-assessment tools, and conducted EOC rounds. The CBOC generally provided quality care that improved patient access, convenience, and timeliness of health care services. Additionally, the CBOC maintained the same standards of care for providing mental health services and anticoagulation therapy as the parent facility. However, two areas needed improvement.

Infection Control. Infection control refers to strategies and procedures used to minimize the risk of spreading infections. During the tour of the CBOC, an infection control issue of cross-contamination was observed. A small bathroom at the

clinic had been converted into a clean supply room; it had three large cabinets containing patient supplies. The supply room was a small, confined area with open space limited to a small path in between the cabinets. A biohazardous waste container was sitting on top of a functional commode in close proximity to the patient supplies. The biohazardous waste container was currently being utilized for its intended purpose. The clinic had limited space due to a substantial growth in patient population. We were informed by staff that the parent facility was in the process of seeking a location with additional space.

Credentialing and Privileging. According to VHA Handbook 1100.19, *Credentialing and Privileging*, provider-specific performance improvement activities are used, in part, to evaluate professional performance, judgment, and clinical skills. For reappraisal, ongoing reviews are conducted by service chiefs and can include reviews, such as surgical cases, infection control, drug usage, medical records, monitoring and evaluation of quality, and appropriateness of care. We reviewed three provider credentialing and privileging folders. The system did not maintain documentation on QM data or performance improvement data for the three providers.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that CBOCs are in compliance with VHA infection control policies.

The VISN and System Directors concurred with the findings and recommendation. The CBOC is severely limited for space. Approval has been received to move to a larger space that will have a separate biohazardous waste area. The biohazardous waste container has been moved to another location in the clinic that is separate from patient supplies. We find the actions acceptable and consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that provider-specific documentation is maintained on performance improvement data for provider reappraisal.

The VISN and System Directors concurred with the findings and recommendation. Clinical service chiefs and the Clinical Executive Board (CEB) monitored the development of tools to assess provider-specific performance

information throughout the summer of 2007. Effective November 1, 2007, all services are required to include provider-specific data for credentialing and privileging. We find the actions acceptable and consider this recommendation closed.

Environment of Care

The purpose of this review was to determine if the system maintained a comprehensive EOC program that complied with VHA's National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and Joint Commission standards.[3] We evaluated the infection control program to determine compliance with VHA directives based on the management of data collected and the processes in which that data was used to improve performance. In addition, we reviewed the storage, use, and disposal of tritium, a radioactive material used in research protocols, to ensure that the system complied with VHA Directive 1105.1, *Management of Radioactive Materials*.

We inspected selected clinical and non-clinical areas throughout the system to evaluate cleanliness, safety, infection control, and biomedical equipment maintenance. The areas we inspected included ambulatory care areas, inpatient units, secure behavioral health units, the Sterile Processing Department, the laboratory, the nuclear waste disposal area, and common public areas. The system maintained a generally clean and sanitary environment. The infection control program monitored, trended, analyzed, and reported data to clinicians for implementation of quality improvements. The system maintained accurate inventories of tritium, consistent with VHA policies and procedures. Deficiencies in EOC identified in the prior CAP report had been corrected. However, two safety issues needed to have corrective actions implemented.

Eyewash Stations. We randomly selected four areas within the system and reviewed safety check documentation for eyewash stations. Nuclear Medicine and Cardiac Catheterization monitored eyewash stations once every 2 weeks, and the Laboratory Service conducted weekly checks. The Supply Processing and Distribution Department was unable to locate documentation for safety checks. The system's local policy states that eyewash stations are to be flushed and cleaned once every 2 weeks. However, local

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

policy contradicted the manufacturer's recommendations. Eyewash stations are to be maintained and tested in accordance with the manufacturer specifications, provided that OSHA has no formal requirements. The manufacturer recommends that units be activated weekly to flush lines and verify proper flow pattern and volume. Failure to monitor eyewash stations could lead to a hazardous outcome in an emergent situation.

Fire Extinguishers. At the Santa Fe CBOC, the annual inspection of the fire extinguishers expired in October 2006. A Fire Marshal noted the expired annual inspection of the fire extinguishers during a safety inspection in January 2007. In April 2007, the system documented in the EOC rounds that the annual inspection of the fire extinguishers was past due. Despite multiple reminders to the system by CBOC personnel, the fire extinguishers still had not been inspected at the time of our review.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires eyewash stations to be maintained in accordance with VHA policy.

The VISN and System Directors concurred with the findings and recommendation. The system agreed that eyewash stations need to be checked per manufacturer recommendations. Eyewash stations are now inspected weekly. The system's safety plan is being revised to include weekly eyewash station inspections. The expected publication date of the revised plan is December 1, 2007. We find the actions acceptable and consider this recommendation closed.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires fire extinguishers to be inspected in accordance with VHA policy.

The VISN and System Directors concurred with the findings and recommendation. Effective July 2, 2007, a process was initiated to assure that proper inspections occur. We find the actions acceptable and consider this recommendation closed.

Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the

system Director, Chief of Staff, two interim Chief Nurse Executives, and QM personnel. We also evaluated plans, policies, and other relevant documents.

Senior management support and clinician participation had been revitalized under new leadership. Senior managers had revised the system's strategic plan, committee structure, and reporting processes in May 2007. However, the following areas needed improvement:

Adverse Event Disclosure. If a serious adverse event occurs as a result of patient care, VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, requires that clinicians discuss the incident with the patient. With input from Regional Counsel, staff inform the patient of their right to file tort or benefit claims. We reviewed the medical records of three patients who experienced serious adverse events during FY 2006. We found documentation of the adverse events; however, one medical record did not contain documentation of a discussion with the patient's family members regarding their right to file tort or benefit claims. Without adequate disclosure practices, we could not be assured that patients were provided with timely and accurate information needed to make decisions.

Peer Review. The peer review process did not include all components required by VHA Directive 2004-054, *Peer Review for Quality Management*. Peer review is a confidential, non-punitive, and systematic process to evaluate quality of care at the individual provider level. The peer review process includes an initial review by a peer of the same discipline to determine the level of care,[4] with subsequent Peer Review Committee (PRC) evaluation and concurrence with findings. We examined peer reviews completed in FY 2006 through March of FY 2007 and identified issues related to timeliness of reviews.

Once the need for peer review is determined, VHA requires initial reviews to be completed within 45 days and final reviews be completed within 120 days. Our document review determined that 20 of 52 (38 percent) initial reviews were not completed within the required 45 days, and 28 of 52 (54 percent) final reviews were not completed by the PRC

[4] Peer review levels: Level 1 – Most experienced, competent practitioners would have managed the case similarly; Level 2 – Most experienced, competent practitioners might have managed the case differently; Level 3 – Most experienced, competent practitioners would have managed the case differently.

within the required 120 days. Without timely peer review, the system cannot implement required quality and performance improvement activities.

Performance Improvement. Documentation of Leadership Board (LB) meetings during an interim management period of June 2006 through June 2007 was inconsistent. According to local policy, Memorandum 00-1, *NMVAHCS Governance*, the LB will meet weekly and document proceedings in minutes distributed to all members and service chiefs. However, when problems were identified, they were addressed by the executive team in weekly meetings without minutes.

Quality Council oversight was the sole responsibility of the system Director. Due to the lack of documentation, implementation and follow-up of action plans and performance improvement activities were difficult to evaluate.

We found that the QM program provided minimal oversight of performance improvement activities. We evaluated monitoring and improvement efforts in each of the program areas through a series of data management process steps consistent with Joint Commission standards. We determined that for aggregate patient safety reviews, national patient safety goals, medical record reviews, patient flow processes, and utilization management the system failed to consistently gather and critically analyze data, identify specific corrective actions when results did not meet goals, and implement and evaluate actions until the problems were resolved or the improvements were achieved.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that clinicians inform patients of their right to file tort or benefit claims and document the discussions in the medical record.

The VISN and System Directors concurred with the findings and recommendation. Clinical service chiefs will remind their physicians that if a serious adverse event occurs in the course of patient care, the attending physician must inform the patient of his or her right to file a tort or benefit claim and document the discussion in the medical record. Results of monitoring this process will be reported to the CEB on a

monthly basis beginning October 2007. We find the actions acceptable and consider this recommendation closed.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires that peer reviews be completed within the timeframes specified by VHA.

The VISN and System Directors concurred with the findings and recommendation. The PRC and the Risk Manager will monitor the peer review process and report to the CEB on a monthly basis. We find the actions acceptable and consider this recommendation closed.

Recommendation 8 We recommended that the VISN Director ensure that the System Director requires that committees document activities, consistently gather and analyze data, implement effective action item tracking mechanisms, and submit reports to designated oversight committees.

The VISN and System Directors concurred with the findings and recommendation. Transition to a new governance structure is in process and will be completed by December 1, 2007. We find the actions acceptable and consider this recommendation closed.

Survey of Healthcare Experiences of Patients

The purpose of the review was to assess the extent to which the system used the results of VHA's patient satisfaction survey to improve care, treatment, and services.

Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group.

VHA set FY 2006 SHEP target results of patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. The tables on the next page show the national, VISN 18, and the system's inpatient and outpatient results.

New Mexico VA Health Care System

INPATIENT SHEP RESULTS

FY 2006 Quarters 3 and 4	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	81.4	78.9	89.9	67.9	66.0	76.0	83.4	74.7	70.1
VISN	81.8	78.8	90.8+	68.1	65.9	76.0	84.7+	75.3	70.6
System	**78.7-**	**74.6-**	**89.7**	**67.3**	**65.1**	**75.4**	**83.7**	**76.0**	**71.1**

OUTPATIENT SHEP RESULTS

FY 2007 Quarter 1	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-Up	Preferences	Specialist Care	Visit Coordination
National	81.0	77.8	94.9	72.7	83.5	75.7	82.0	65.3	82.0	81.1	84.8
VISN	79.8	82.4	94.6	72.2	83.6	74.3	81.8	67.3	81.5	78.1	81.2
System Clinics	**79.5**	**83.2**	**97.1**	**70.1**	**84.3**	**69.9**	**88.6**	**59.9**	**82.4**	**74.7**	**77.9**

"+" Indicates results that are significantly **Better** than the national average
"-" Indicates results that are significantly **Lower** than the national average

The system scored at or above the 76 percent threshold in four of nine areas for inpatient SHEP. The system scored below the threshold of 76 percent in Coordination of Care, Education and Information, Emotional Support, Family Involvement, and Transition. Managers had not developed action plans to address Coordination of Care, Family Involvement, and Transition.

The system scored above the 77 percent threshold in 7 of 11 areas for outpatient SHEP. The system scored below the 77 percent threshold in Education and Information, Overall Coordination, Pharmacy Pick-Up, and Specialist Care. Managers had not developed action plans to address Overall Coordination and Specialist Care.

Recommendation 9 We recommended that the VISN Director ensure that the System Director requires that action plans be developed and implemented to improve patient satisfaction areas that fell below the target results.

The VISN and System Directors concurred with the findings and recommendation. Action plan development and

implementation is being incorporated into appropriate service chiefs'/managers' performance expectations for the performance period beginning October 1, 2007. Specific action plans are due by December 1, 2007. We find the actions acceptable and consider this recommendation closed.

Unlicensed Physicians

The purpose of this review was to determine whether research activities performed by unlicensed physicians constitute the practice of medicine.

In order to practice medicine in the United States, a graduate of medical school, with few exceptions, must complete a United States residency. This requirement exists regardless of the skills, training, or experience of the graduates. Medical school graduates who cannot or do not complete an internship or residency in the United States and do not otherwise have an exemption, are not eligible for licensure. If engaged in research activities, these individuals may function in roles such as study coordinators or research assistants, but they cannot practice medicine. Activities traditionally considered to constitute the practice of medicine include performing invasive procedures, conducting physical examinations, and altering medications.

VHA Handbook 1200.5, *Requirements for the Protection of Human Subjects in Research*, requires the system Director to ensure that Institutional Review Board members and investigators are appropriately knowledgeable to conduct research in accordance with ethical standards and all applicable regulations. As a result, unlicensed physicians operate under a scope of practice. "Scope of practice" is a term used to describe activities that may be performed by health care workers, regardless of whether they are licensed independent health care providers.

The system identified one unlicensed physician assigned to six human subjects research studies (five with active patient enrollment). In our review of 51 patient medical records, we found no progress notes by the unlicensed physician or documentation of activities he performed. Therefore, we were not able to determine if activities he performed were within his scope of practice.

Upon review of the unlicensed physician's scope of practice, we found that it had not been reviewed and approved by the Associate Chief of Staff for Research and Development.

This is a violation of the 2003 guidance on verifying the credentialing of all individuals involved in human subjects research, which is posted on the Office of Research and Development's website.

Recommendation 10 We recommended that the VISN Director ensure that the System Director reviews the scopes of practice for all facility personnel engaged in research activities to ensure that they are reviewed and approved by the Associate Chief of Staff for Research and Development and otherwise meet current requirements for scopes of practice of unlicensed research personnel.

The VISN and System Directors concurred with the findings and recommendation. Effective September 4, 2007, the Associate Chief of Staff for Research and Development for the system began reviewing and initialing the position descriptions for personnel engaged in research activities to ensure that they meet current requirements for scopes of practice of unlicensed research personnel. In the case of an unlicensed physician, a scope of practice will be written, reviewed, and approved by the Associate Chief of Staff for Research and Development, the Chief of Staff, and the Director. We find the actions acceptable and will follow up on planned actions until they are completed.

Review Activities Without Recommendations

Surgical Care Improvement Project

The purpose of the review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of surgical infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We reviewed the medical records of 30 patients who had surgery performed during the 2nd quarter of FY 2007. The review included medical records for vascular, orthopedic (knee or hip replacement), cardiac, and colorectal surgeries. OIG inspectors evaluated the following VHA performance measure (PM) indicators:

- Timely administration of prophylactic antibiotics to achieve therapeutic serum and tissue antimicrobial drug levels throughout the operation. Clinicians should administer antibiotics within 1–2 hours prior to the first surgical

incision. The time of administration depends on the antibiotics given.

- Timely discontinuation of prophylactic antibiotics to reduce risk of the development of antimicrobial resistant organisms. Clinicians should discontinue antibiotics within 24–48 hours after surgery. The time depends on the surgical procedure performed.
- Controlled blood glucose levels for cardiac surgery, which should be maintained below 200 milligrams/deciliter for the first 2 days post-operative. Elevated levels are associated with impaired bactericidal activity of the immune system.
- Controlled core body temperature for colorectal surgery, which should be maintained at greater than or equal to 36 degrees Centigrade or 96.8 degrees Fahrenheit immediately post-operative. Decreased core body temperature is associated with impaired wound healing.

VHA set target PM scores for each of the above indicators. To receive fully satisfactory ratings, a facility must achieve the scores shown in the table below.

Performance Measure	Score
Timely antibiotic administration	**90 percent**
Timely antibiotic discontinuation	**87 percent**
Controlled blood glucose 2 days post-operative – cardiac surgery	**90 percent**
Controlled body temperature – colorectal surgery	**70 percent**

Our review showed that the system appropriately administered and discontinued antibiotics or documented clinical reasons why this did not occur. Clinicians monitored blood glucose for the first 2 days post-operative for patients who had cardiac surgery performed and controlled immediate post-operative body temperature for patients who had colorectal surgery performed. The system's results are displayed in the following table.

Antibiotic Given Timely	Antibiotic Stopped Timely	Blood Glucose Control (cardiac surgery)	Body Temperature Control (colorectal surgery)
100 percent (30/30)	**100 percent (30/30)**	**100 percent (10/10)**	**100 percent (9/9)**

We found that no PM indicators reviewed fell below VHA's established targets. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 25, 2007

From: VISN Director

Subject: **Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico**

To: Director Dallas Healthcare Inspections Division (54DA)

Thru: Director, Management Review Office (10B5)

I concur with the findings from the OIG CAP visit conducted June 25–28, 2007, and with the actions plans developed by the New Mexico VAHCS. If you have any questions, please contact my Executive Assistant, Joan Funckes, at 602-222-2692.

Patricia A. McKlem

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 25, 2007

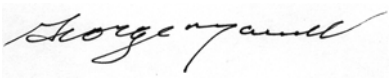
From: System Director

Subject: **Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, Management Review Service (10B5)

I concur with the findings from the OIG CAP visit conducted June 25–28, 2007. Attached are responses with action plans, as appropriate, for each recommendation.



George Marnell

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 System Director requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

Concur **Target Completion Date**: Completed

As stated in the report, the business rules regarding editing of a signed note were edited and removed to be in compliance with VHA Handbook 1907.01 during the CAP visit. The business rules are now being monitored on a quarterly basis to insure compliance with VHA Handbook 1907.01 and the October 2004 OI guidance.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that CBOCs are in compliance with VHA infection control policies.

Concur **Target Completion Date**: Completed

The facility is severely limited for space. Approval has been received to locate and move to a larger space, which will allow a separate bio-hazardous waste room. Until the new space is occupied, the bio-hazardous waste has been moved to another location in the clinic separate from patient supplies.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that provider-specific documentation is maintained on performance improvement data for provider reappraisal.

Concur **Target Completion Date**: November 1, 2007

This Joint Commission requirement has been an agenda item at meetings of clinical service chiefs and the Clinical Executive Board throughout summer 2007. Many clinical services have developed tools to assess provider-specific performance information, but other services are still under development. Effective November 1, 2007, all services are required to include provider-specific data for credentialing and privileging.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that eyewash stations to be maintained in accordance with VHA policy.

Concur **Target Completion Date**: December 1, 2007

The facility agrees the eyewash stations need to be checked per manufacturer recommendations. Effective September 25, 2007, eyewash stations are inspected weekly. Facility safety plan is being revised to reflect weekly eyewash station inspections, with expected publication date of December 1, 2007.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires fire extinguishers to be inspected in accordance with VHA policy.

Concur **Target Completion Date**: Completed

Effective July 2, 2007, the CBOC Manager inspects the fire extinguishers monthly to assure that proper inspections have occurred. One month prior to annual certification, the manager will notify the contracting officer and copy the Ambulatory Care Service CBOC Supervisory Program Specialist. When the inspection is complete, both the contracting officer and the Supervisory Program Specialist will be notified.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that clinicians inform patients of their right to file tort or benefit claims and document the discussions in the medical record.

Concur **Target Completion Date**: November 1, 2007

Clinical service chiefs will remind their physicians that if a serious adverse event occurs in the course of patient care, the attending physician must inform the patient of his or her right to file a tort or benefit claim and document the discussion in the medical record using the National VA Disclosure in the Hospital Wide Documents, Disclosure of Adverse Event template. This discussion will be monitored by the Risk Manager, who will review the progress notes of patients who have serious adverse events that are discovered or reported through any of several mechanisms. When this discussion has not taken place, the Risk Manager will notify the clinical service chief, who will ensure this discussion takes place and is documented in the record. Results of this monitoring will be reported to the Clinical Executive Board on a monthly basis beginning October 2007.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires that peer reviews be completed within the timeframes specified by VHA.

Concur **Target Completion Date**: December 1, 2007

Clinical service chiefs will address the timely completion of protected peer reviews with their physicians and take appropriate action if reviews are not completed by the suspense date. The Peer Review Committee will also address the timeliness of peer reviews and has instituted meetings twice monthly to complete the backlog of peer reviews that are ready for committee discussion. This process will be monitored by the Risk Manager, who will report progress at the Clinical Executive Board on a monthly basis, and this will be documented in the minutes.

Recommendation 8. We recommended that the VISN Director ensure that the System Director requires that committees document activities, consistently gather and analyze data, implement effective action item tracking mechanisms, and submit reports to designated oversight committees.

Concur **Target Completion Date**: December 1, 2007

Transition to a new governance structure is in process and will be completed by December 1, 2007.

Recommendation 9. We recommended that the VISN Director ensure that the System Director requires that action plans be developed and implemented to improve patient satisfaction areas that fell below the target results.

Concur **Target Completion Date**: December 1, 2007

This is being incorporated into appropriate service chiefs'/managers' performance expectations for the performance period beginning October 1, 2007. Specific action plans are due by December 1, 2007.

Recommendation 10. We recommended that the VISN Director ensure that the System Director reviews the scopes of practice for all facility personnel engaged in research activities to ensure that they are reviewed and approved by the Associate Chief of Staff for Research and Development and otherwise meet current requirements for scopes of practice of unlicensed research personnel.

Concur **Target Completion Date**: Completed

Effective September 4, 2007, the Associate Chief of Staff (ACOS), Research Service, for the New Mexico VA Health Care System began reviewing and initialing the position descriptions for all facility personnel engaged in research activities to ensure that they meet current requirements for scopes of practice of unlicensed research personnel. In the case of an unlicensed physician, a scope of practice will be written, reviewed, and approved by the facility ACOS for Research Service, the Chief of Staff, and the Director.

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