Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-02557-50

Combined Assessment Program Review of the Southern Arizona VA Health Care System Tucson, Arizona

January 3, 2008

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 July 30–August 3, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Southern Arizona VA Health Care System (the system), Tucson, AZ. 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 681 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 identified the following organizational strength:

- Medical Staff Verification System.

We made recommendations in four 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 crash carts, storage rooms, and ice machines are maintained in accordance with VHA and local policies and that abatement plans are submitted to the VISN in a timely manner.
- Require that peer reviews and root cause analyses (RCAs) be completed within the timeframes specified by VHA and that committees implement effective action item tracking mechanisms, submit reports to designated oversight committees, and document decisions.
- Ensure that the scopes of practice for all system personnel engaged in research activities comply with appropriate state licensure requirements and are duly executed.

The system complied with selected standards in the following three activities:

- Community Based Outpatient Clinics (CBOCs).
- Surgical Care Improvement Project (SCIP).
- Survey of Healthcare Experiences of Patients (SHEP).

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 16–21, for the full text of the Directors' comments.) The action plans are acceptable and have been implemented. We consider all recommendations closed.

(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 Tucson, AZ, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five CBOCs in Casa Grande, Green Valley, Safford, Sierra Vista, and Yuma, AZ. The system is part of VISN 18 and serves a veteran population of about 158,000 throughout southern Arizona and southeastern New Mexico.

Programs. The system provides medicine, surgery, critical care, and emergency services. It has 160 acute care beds, 90 geriatric rehabilitation beds, and 16 Psychosocial Residential Rehabilitation Treatment Program beds. The system includes the 34-bed Southwestern Blind Rehabilitation Center, which provides programs for visually impaired veterans from seven western states.

The system serves as a regional referral center, providing specialty services to facilities located in Arizona, New Mexico, and Texas. Referral services include cardiothoracic surgery, angiography, cardiac catheterization, blind rehabilitation, imaging, nuclear medicine, and telemedicine.

Affiliations and Research. The system is affiliated with the University of Arizona's Colleges of Medicine, Nursing, and Pharmacy and trains more than 700 students annually. In fiscal year (FY) 2006, the system's research program had an annual budget of $5.3 million and supported 65 principal investigators involved in 179 active projects, 6 merit reviews, 11 cooperative studies, and a human subjects research and development project.

Resources. In FY 2006, medical care expenditures totaled $235 million. The FY 2007 medical care budget was $257 million. FY 2006 staffing was 1,620 full-time employee equivalents (FTE), including 97 physician and 323 nursing FTE.

Workload. In FY 2006, the system treated 45,621 unique patients and provided 42,721 inpatient days in the hospital and 27,907 inpatient days in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 8,583 discharges, and the average daily census, including

nursing home patients, was 215. Outpatient workload totaled 516,792 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.
- CBOCs.
- Environment of Care (EOC).
- QM.
- SCIP.
- SHEP.
- Unlicensed Physicians.

The review covered system operations for FY 2006 and FY 2007 through July 30, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews.

During this review, we also presented fraud and integrity awareness briefings for 681 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.

Organizational Strength

Medical Staff Verification System

The Medical Staff Office (MSO) credentials all licensed independent practitioners. Other hospitals write to the MSO to request confirmation of a provider's specialty and appointment at the system. They also request confirmation that a provider is in good standing. The MSO responded to approximately 50 such requests each month, taking 15–20 minutes to process each request. Queries and responses required processing of over 100 pieces of mail per month. In addition, the query responses were manually tracked to generate an annual report to the system's Privacy Act Officer.

The system developed a website in close coordination with VHA. Formal approval was obtained, and the restricted website was implemented in May 2006. Only registered staff from local area hospitals may access the website to determine if the provider in question has an appointment at the system. Users may then print a verification letter. Access is managed by MSO personnel, who process requests and issue renewable 90-day access credentials. This web application also tracks users' online requests for physician staff affiliation information for web usage reporting purposes. This application is considered a first of its kind and will be offered to other VA facilities.

Implementation of this internet based public website saves the MSO approximately 150–200 hours annually in responding to and tracking queries and in manually generating the annual report for the Privacy Act Officer. Users obtain verification via the internet in minutes rather than days.

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

A communication software (informational patch[1] USR*1*26) was sent from the VHA OI on October 20, 2004, to all medical centers, providing guidance on a number of issues related 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.

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. We found two business rules that needed to be

[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.

changed to limit retraction, amendment, or deletion of notes to the Privacy Officer.

System staff took action to edit 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 and the October 2004 OI guidance.

The VISN and System Directors concurred with the findings and recommendation. On July 30, 2007, the system updated Medical Center Memorandum 11-05-55, *Management of Health Information*. The two business rules that allowed editing of a signed note were changed during the CAP visit to be in compliance with VHA Handbook 1907.01. All business rules are now being monitored on a quarterly basis to insure compliance. 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 National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission[3] standards. We evaluated the infection control program to determine compliance with VHA directives based on the management of data collected and processes in which the data was used to improve performance.

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 inpatient units, ambulatory care, intensive care, hemodialysis units, the emergency room, NHCUs, and many public areas. Managers generally maintained a safe and clean health care environment.

The infection control program monitored, trended, analyzed, and reported data to clinicians for implementation of quality improvements. However, the following safety and infection control deficiencies needed to be corrected.

Safety Issues. Crash carts and defibrillators are lifesaving equipment that must be systematically checked and tested to

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

ensure readiness in case of an emergency. We reviewed crash cart check sheets for June and July 2007 throughout patient care areas. Crash carts had not been consistently checked and tested in accordance with the local policy on NHCU-B, Medical/Surgical Units 3 East and 2 South, and the Hemodialysis Unit.

During our inspection of inpatient care areas, we observed items and boxes on the floor in the soiled and clean linen rooms and in the dirty utility and housekeeping closets. The system corrected this deficiency during our site visit.

The VISN conducts an annual compliance inspection and program evaluation for VHA facilities to ensure a safe environment. The VISN Director must receive corrective actions and abatement plans from the facility within 30 calendar days following the evaluation report. The VISN conducted an inspection in January 2007; however, the system did not submit abatement plans to the VISN within the specified timeframe. System managers submitted the abatement plans to the VISN, including responses to 10 critical deficiencies, during our site visit.

Infection Control Issue. During our inspection of patient care areas, we observed two ice machines that needed cleaning and one that had rust and mineral buildup due to the hard water. The manager told us that ice machines are cleaned weekly but had not yet been cleaned at the time of our inspection.

That same day, both ice machines were cleaned, and we were informed of the pending delivery of a new ice machine to replace the one with the rust and mineral buildup.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that crash carts are checked and tested in accordance with local policy.

The VISN and System Directors concurred with the findings and recommendation. The system has a multifaceted approach to this issue. Code cart checks will be done, and the checklists will be sent monthly to the Nurse Executive (NE) for review and any necessary corrective actions. Checklist deficiencies will be reported by the NE at the Director's morning meeting. The NE will forward the monthly reports to the Code Blue Committee on a quarterly

basis for aggregate review. 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 storage room floors are maintained in accordance with VHA policy.

The VISN and System Directors concurred with the findings and recommendation. The system immediately addressed this deficiency during the site visit, and all items were removed from the floor. Housekeeping supervisors will perform monthly random audits. These audits will be reported to the EOC Committee and documented in the committee's minutes. We find the actions acceptable and consider this recommendation closed.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires that the system submits abatement plans to the VISN within the specified timeframe.

The VISN and System Directors concurred with the findings and recommendation. The system submitted the abatement plans during the site visit. The Chief of Facilities will monitor abatement plan status on a quarterly basis and will report to the EOC Committee for documentation in the committee's minutes. We find the actions acceptable and consider this recommendation closed.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires that ice machines are cleaned and well maintained.

The VISN and System Directors concurred with the findings and recommendation. The system has corrected the ice machine deficiencies. Two ice machines were cleaned at the time of the inspection. A third ice machine was replaced with a newly purchased ice machine that was in place on August 21, 2007. Housekeeping supervisors will perform monthly random audits to assure that the ice machines are cleaned and well maintained. These audits will be reported to the EOC Committee and documented in the committee's minutes. 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, Chief Nurse Executive, and QM personnel. We also evaluated plans, policies, and other relevant documents.

Senior managers were supportive of the QM program. However, the following areas needed improvement.

Patient Safety. VHA guidelines and the National Center for Patient Safety outline specific requirements for a comprehensive program. A critical part of any patient safety program is completing RCAs within defined 45-day timelines to mitigate risk of repeat events. In FYs 2006 and 2007, the system reported 13 RCAs (10 individual and 3 aggregate) but failed to complete the RCAs, as required. We found that the completion times ranged from 69–157 days. Without timely identification of adverse events and completion of RCAs, managers could not be assured of comprehensive and efficient patient safety processes.

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 October 2006 through June 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 to be completed within 120 days. Our document review determined that 9 of 53 (17 percent) initial reviews were not completed within the required 45 days, and 3 of 53 (6 percent) final reviews were not completed by the PRC within the required 120 days. Without timely peer review, the system cannot implement required quality and performance improvement activities.

[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.

Committee Oversight. Monitoring and improvement efforts were evaluated in each of the program areas through a series of data management process steps that were consistent with Joint Commission standards. Data was analyzed to identify trends, and corrective actions were documented for problem resolution and improvement efforts. However, we found inconsistent committee oversight documentation and inadequate evidence of implementation and evaluation of corrective actions in the areas of code blue, patient safety, peer review, and other committee minutes. We could not determine if effective communication existed among committees due to inconsistent follow-up of action plans, incomplete evaluation of performance improvement activities, and limited documentation of oversight committee decisions. Due to insufficient documentation, we could not be assured that patient care and patient safety processes were functioning effectively.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that RCAs are completed in accordance with VHA requirements.

The VISN and System Directors concurred with the findings and recommendation. The system has implemented a new tracking system for RCAs that monitors the progress of each action item. The Patient Safety Officer is now providing monthly updates to executive leadership and service/care line chiefs regarding the timeliness of RCAs and action items. Additionally, for all action items, the Patient Safety Officer is reminding care line chiefs and executive leadership 1 week prior to due dates. We find the actions acceptable and consider this recommendation closed.

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

The VISN and System Directors concurred with the findings and recommendation. The system's Clinical Director of Performance Management developed a VistA/Excel tracking process to ensure that initial peer reviews are completed within 45 days and that final peer reviews are completed within 120 days. Performance Management will monitor all peer reviews to ensure that they are completed in a timely manner and will report to the Executive Quality Board. We

find the actions acceptable and consider this recommendation closed.

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

The VISN and System Directors concurred with the findings and recommendation. The system is restructuring committees and has trained personnel on documentation. The Clinical Director of Performance Management will monitor tracking of recommendations made by key committees. 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. Staff in research positions must have verification of educational background and degrees.

The system identified three unlicensed physicians assigned to 11 human subjects research studies. The system reported that one of the unlicensed physicians (referred to hereafter as Researcher 1) was not assigned to any research protocols. However, during our inspection, we determined that Researcher 1 was assigned to six active protocols.

Our review of 114 medical records disclosed that one of the unlicensed physicians (referred to hereafter as Researcher 2) was performing physical examinations. Prior to our arrival onsite, the system took action to stop Researcher 2 from performing this activity. Initially, the system defined Researcher 2's scope of practice to include performing physical examinations. We reviewed the scopes of practice of the two other unlicensed physicians and found that they began their research activities prior to having a scope of practice duly executed. Additionally, prior to June 2007, none of the unlicensed physicians had their scopes of practice reviewed and approved by the Associate Chief of Staff for Research. These are violations of the 2003 guidance on verifying the privileging of all individuals involved in human subjects research, which is posted on the Office of Research and Development's website. The system revised the scopes of practice of all three unlicensed physicians in June 2007 to comply with the guidance.

While reviewing patient medical records from six research protocols assigned to Researcher 1, we found progress notes by an unlicensed physician (referred to hereafter as Researcher 3) no longer employed by the system. The medical records show evidence that Researcher 3 interpreted laboratory results, made medical assessments, and recommended medication changes and diagnostic procedures. These activities can be perceived as the practice of medicine. Arizona State law defines the practice of medicine as follows:

> Practice of medicine means the diagnosis, the treatment or the correction of or the attempt or the holding of oneself out as being able to diagnose, treat or correct any and all human diseases, injuries, ailments, infirmities, deformities, physical or mental, real or imaginary, by any means, methods, devices or instrumentalities…

The system cannot supersede state or Federal laws or regulations prohibiting the practice of medicine without a license.

Recommendation 9 We recommended that the VISN Director ensure that the System Director reviews the scopes of practice for all system personnel engaged in research activities to ensure that they comply with appropriate state licensure requirements and that they are duly executed.

The VISN and System Directors concurred with the findings and recommendation. The improvement actions taken by system staff prior to our visit and while we were onsite, including revision of the scopes of practice of unlicensed physicians, are acceptable. We consider this recommendation closed.

Review Activities Without Recommendations

Community Based Outpatient Clinics

The purpose of this review was to evaluate CBOC compliance with VHA regulations regarding selected standards of operation, 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 visited the Casa Grande CBOC located in Casa Grande, AZ. The CBOC complied with VHA standards of operations and generally provided high quality care that improved patient access, convenience, and timeliness of health care services. The five CBOC patients we interviewed were satisfied with all aspects of care they received at the clinic. Additionally, the CBOC maintained the same standards of care as the parent facility for providing mental health services and anticoagulation therapy.

The local policy outlined appropriate emergency protocols, and CBOC employees were knowledgeable of the procedures. Clinical managers provided adequate privacy and confidentiality during all stages of a patient's appointment. Physician and nurse licenses, background checks, and provider privileging documentation were verified and current. All clinicians had current cardiopulmonary resuscitation certifications. We made no recommendations.

Surgical Care Improvement Project

The purpose of this 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 each of the following surgical categories: (a) cardiac, (b) colorectal, (c) vascular, (d) orthopedic (knee or hip replacement), and (e) hysterectomy. 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 established target scores, which are summarized in the table on the next page.

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. Results are displayed in the table below.

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)**	**90 percent (9/10)**

We found that none of the PM indicators reviewed fell below VHA established target scores. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this 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 2007 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.

Southern Arizona VA Health Care System

INPATIENT SHEP RESULTS

FY 2007 Quarters 1 and 2	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	80.2	77.8	89.5	67.1	65.0	75.4	82.8	74.1	69.2
VISN	81.2	77.9	90.2	67.1	65.3	75.7	82.8	75.9+	69.2
System	79.9	78.5	89.7	68.5	66.5	76.3	83.5	78.3+	69.7

OUTPATIENT SHEP RESULTS

FY 2007 Quarter 2	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-Up	Preferences	Specialist Care	Visit Coordination
National	80.2	77.8	94.3	72.1	82.3	75.0	81.2	65.1	81.1	80.9	84.1
VISN	75.0-	80.6	93.3	68.4	79.8	72.0	84.4	59.3	78.2	77.7	78.6 -
System Clinics	75.3	85.2	95.5	63.6	79.4	65.9	85.3	56.8	79.3	73.4	75.2

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

The system scored above the 76 percent threshold in six of nine areas for inpatient SHEP. Although the system scored below the threshold of 76 percent in Education and Information, Emotional Support, and Transition, it scored significantly above the national average for Preferences.

The system scored above the 77 percent threshold in 5 of the 11 areas for outpatient SHEP. The system was below the threshold of 77 percent for Access, Education and Information, Overall Coordination, Pharmacy Pick-Up, Specialist Care, and Visit Coordination.

The system had shared SHEP results with employees, as directed, and had analyzed the results and developed action plans for improvements in areas that fell below inpatient and outpatient target results. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 10, 2007

From: Network Director, VISN 18 (10N18)

Subject: **Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona**

To: Director, Dallas Healthcare Inspections Division (54DA)

Director, Management Review Office (10B5)

I concur with the findings from the OIG CAP visit conducted July 30–August 3, 2007, and with the actions plans developed by the Tucson 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: October 9, 2007

From: Southern Arizona VA Health Care System Director, Tucson, Arizona

Subject: **Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona**

To: Office of Inspector General

Thru: VISN 18 Director

Attached, please find our response to the Combined Assessment Program (CAP) review of the Southern Arizona VA Health Care System conducted July 30–August 3, 2007.

If you have any questions or comments, you can reach Ms. Joan Ricard, Associate Director at (520) 629-1821.

Sincerely,

(original signed by:)

Jonathan H. Gardner, FACHE

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 1907.01 and the October 2004 OI guidance.

Concur

SAVAHCS changed the two business rules during the VAOIG review. MCM 11-05-55, Management of Health Information, was updated on July 30, 2007. Effective August 2007, the Chief of HIMS or his/her designee, in conjunction with the Privacy Officer and the Computerized Patient Record System Team, will be monitoring compliance with all Business Rules on a quarterly basis. We recommend this issue be closed.

Target Completion Date: Implemented August 2007

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that crash carts are checked and tested in accordance with local policy.

Concur

SAVAHCS has a multifaceted approach to this issue. First, a responsible RN in each care line with a code cart has been identified. Second, the code cart checklists will be sent monthly to the office of the Nurse Executive for review and corrective action as necessary. Third, any checklist deficiencies will be reported by the Nurse Executive at the Director's morning meeting. Fourth, the office of the Nurse Executive will forward the monthly reports to the Code Blue Committee quarterly for aggregate review.

Target Completion Date: January 2008

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that storage room floors are maintained in accordance with VHA policy.

Concur

SAVAHCS immediately addressed this deficiency during the VAOIG visit, and all items were removed from the floor. Housekeeping supervisors will perform monthly random audits. These audits will be reported to the Environment of Care (EOC) Committee and documented in the Committee's minutes.

Target Completion Date: January 2008

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that the system submits abatement plans to the VISN within the specified timeframe.

Concur

SAVAHCS submitted the abatement plans during the VAOIG visit. The Chief of Facilities will monitor this on a quarterly basis, and this will be reviewed at the EOC Committee and documented in the Committee's minutes.

Target Completion Date: January 2008

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires that ice machines are cleaned and well maintained.

Concur

SAVAHCS corrected the ice machine deficiency during the VAOIG visit. The ice machine was cleaned, and a new ice machine was purchased and replaced on August 21, 2007. Housekeeping supervisors will perform monthly random audits to assure the ice machines are cleaned and well maintained. These audits will be reported to the Environment of Care (EOC) Committee and documented in the committee's minutes.

Target Completion Date: January 2008

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that RCAs are completed in accordance with VHA requirements.

Concur

SAVAHCS has implemented a new tracking system for RCAs, which monitors progress of each action item. The Patient Safety Officer is now providing monthly updates to Executive Leadership and Service/Care Line Chiefs regarding the timeliness of RCAs and action items. Additionally, the Patient Safety Officer is reminding Care Line Chief and Executive

Leadership, in morning reporting, one week prior to due dates on all action items.

Target Completion Date: January 2008

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

Concur

The Clinical Director, Performance Management, at SAVAHCS developed a VISTA/Excel tracking process to ensure initial peer reviews are completed within 45 days and final peer reviews are completed within 120 days. Performance Management will monitor all peer reviews to ensure they are completed in a timely manner and report to the Executive Quality Board.

Target Completion Date: January 2008

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

Concur

Improvements are underway. SAVAHCS has implemented a new format for committee minutes to enhance the flow of communication and follow up on recommendations between committees. SAVAHCS is also in the process of restructuring committees to improve the flow of communication. Secretaries have been trained on the documentation requirements for committee minutes. The Clinical Director of Performance Management will monitor tracking of recommendations of key committees to ensure improved communication between committees and follow up to recommendations.

Target Completion Date: January 2008

Recommendation 9. We recommended that the VISN Director ensure that the System Director reviews the scopes of practice for all system personnel engaged in research activities to ensure that they comply with appropriate state licensure requirements and that they are duly executed.

Concur

SAVAHCS is pleased to note that the VAOIG Team found improvements taken by the system staff prior to the visit and that the improvements made by SAVAHCS while the Team was on site were acceptable. We recommend this issue be closed.

Target Completion Date: Implemented August 30, 2007

OIG Contact and Staff Acknowledgments

Contact	Karen Moore, Associate Director Dallas Office of Healthcare Inspections (OHI) (214) 253-3332
Contributors	Linda DeLong, Director Wilma Reyes, Healthcare Inspector Marilyn Walls, Healthcare Inspector Annette Nowak, Special Agent in Charge Andrea Buck, M.D., J.D., Medical Consultant Marisa Casado, Director, OHI Follow-Up

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