Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00137-74

Combined Assessment Program Review of the El Paso VA Health Care System El Paso, Texas

February 12, 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 November 5–9, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the El Paso VA Health Care System (the system). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 247 system employees. The system is part of Veterans Integrated Service Network (VISN) 18.

Results of the Review

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

- Require that peer reviews be completed within the specified timeframe and that the Peer Review Committee (PRC) submit quarterly reports to the Clinical Executive Board (CEB).
- Require that root cause analyses (RCAs) be completed within the specified timeframe.
- Require that medication reconciliation complies with Joint Commission standards and that medication order changes be documented by the physician to prevent medication errors.
- Require that computerized patient record system business rules are in compliance with Veterans Health Administration (VHA) policy and Office of Information (OI) guidance.

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

- Environment of Care (EOC).
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Linda G. DeLong, Director, and Marilyn Walls, Health Systems Specialist, 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 8–12, 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 an outpatient facility located in El Paso, TX, that provides a broad range of health care services. Health care is also provided at one community based outpatient clinic in Las Cruces, NM. The system is part of VISN 18 and serves about 23,000 veterans throughout the counties of El Paso, Hudsbeth, Culberson, Presidio, and Otero in Texas and the county of Dona Ana in New Mexico.

Programs. The system provides primary and specialized ambulatory care services to veterans in El Paso and surrounding counties. Consultants and fee-basis specialists supplement the medical staff. Services include general medicine, women's health, psychiatry, post-traumatic stress disorder, substance abuse, prosthetics, dental, cardiology, ambulatory surgery, and visual impairment.

Inpatient services for acute medical, surgical, and psychiatric conditions are primarily provided through a VA/Department of Defense (DOD) sharing agreement with the William Beaumont Army Medical Center (WBAMC) and through referrals to community and other VA medical facilities.

Affiliations and Research. The system is affiliated with Texas Tech University's Schools of Medicine at El Paso and Lubbock and provides training for one psychiatric resident. The affiliation with WBAMC provides training for seven internal medicine residents. The system does not conduct research.

Resources. The fiscal year (FY) 2007 medical care budget was $85 million. FY 2007 staffing was 416 full-time employee equivalents (FTE), including 43 physician and 67 nursing FTE.

Workload. In FY 2007, the system treated 22,627 unique patients. Outpatient workload totaled 233,555 visits.

Objectives and Scope

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

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

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

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

- Business Rules for Veterans Health Information Systems.
- EOC.
- QM.
- SHEP.

The review covered system operations for FY 2006, FY 2007, and FY 2008 through November 9, 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 El Paso VA Health Care System, El Paso, Texas*, Report No. 06-01721-32, November 27, 2006). These recommendations are discussed in the QM section of this report.

During this review, we also presented fraud and integrity awareness briefings for 247 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

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.

The QM program was generally effective in providing oversight of the system's quality of care. Appropriate review structures were in place for 11 of 14 program activities. We identified three areas that needed improvement; two had repeat findings from the prior CAP review.

Peer Reviews. VHA guidelines specify national program requirements for the peer review process. Once the need for peer review is determined, VHA policy requires that initial reviews be completed within 45 days and that final reviews be completed within 120 days. The system did not consistently complete peer reviews within the specified timeframes. This was a repeat finding from our prior CAP review. Peer reviews should be completed in a timely manner in order to implement required quality improvement activities.

In addition, the PRC did not submit quarterly reports to the CEB for review, as required by VHA guidelines. Peer review is intended to promote confidential and systemic processes that contribute to improvement efforts in a non-punitive manner. Results can be used for education and training.

Root Cause Analysis. VHA specifies that RCAs for adverse events be completed within 45 days of the system becoming aware that an RCA is required. The system did not complete RCAs within the specified timeframe. This was a repeat finding from our prior CAP review. Without timely RCAs, managers could not be assured that quality improvement actions were promptly implemented to improve patient outcomes.

Medication Reconciliation. The Joint Commission[1] requires that medications be accurately and completely reconciled across the continuum of care. This process ensures that patients and clinicians are aware of medication changes when a patient is transferred from one setting, service, provider, or level of care to another within or outside the system. A complete list of a patient's medications is compared (reconciled) with their medications at the next level of care. The system did not consistently reconcile patient medications, as required.

In addition, when medication orders were changed by the nurse in the nurse clinic, the physician did not make the correction on the order sheet. Per established protocol, the nurse has the authority to change medication orders with the physician's concurrence. Medication order changes should be documented to prevent medication errors.

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires that peer reviews be completed within the specified timeframe and that the PRC submit quarterly reports to the CEB.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that RCAs be completed within the timeframe specified by VHA.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that medication reconciliation complies with Joint Commission standards and that medication order changes be documented by the physician to prevent medication errors.

The VISN and System Directors concurred with the findings and recommendations and provided acceptable improvement plans. Actions already taken to strengthen the peer review process include temporarily transferring peer review activities to the Quality Manager and establishing a tracking mechanism to ensure timeliness. The system will establish a PRC and require that the committee submit quarterly reports to the CEB. Also, a Risk Manager position will be established by March 31, 2008, to assume permanent responsibility for peer review processes.

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

The system plans to develop and implement a standardized and comprehensive process for RCA completion, revise the RCA tracking tool to include timeliness, and provide bi-weekly reports to the Director. The system will provide mandatory training on the established medication reconciliation policy to all clinical staff and develop a performance monitor on compliance with the medication reconciliation process and policy. The Patient Safety Manager will report compliance to the CEB on a monthly basis. We will follow up on the planned actions until they are completed.

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 accurately reflecting the times and dates recorded.

A communication software (informational patch[2] 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.[3] 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.

[2] A patch is a piece of code added to computer software in order to fix a problem.

[3] 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. We found seven business rules that needed to be changed to limit retraction, amendment, or deletion of notes.

System staff took action to edit or remove these business rules while we were onsite. However, we made the following recommendation.

Recommendation 4

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 recommendations and provided acceptable improvement plans. System staff reviewed all business rules for compliance. The system will follow up on actions to ensure continued compliance. We consider this recommendation closed.

Review Activities Without Recommendations

Environment of Care

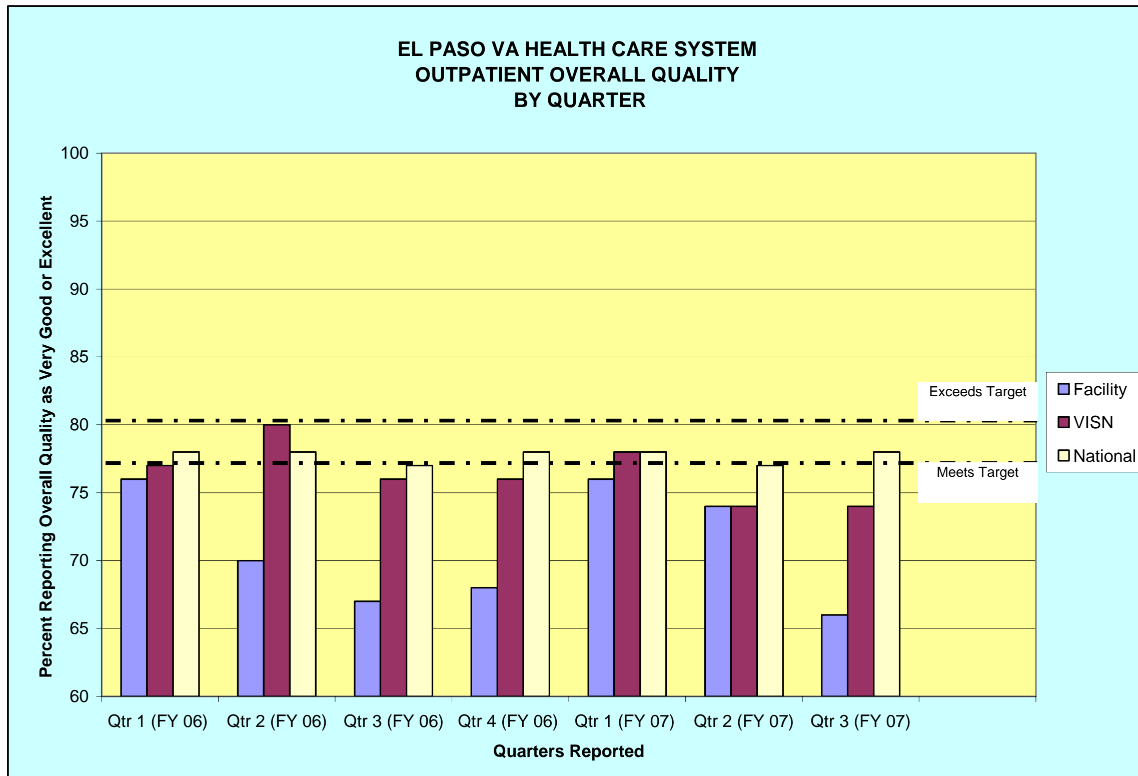
The purpose of this review was to determine if the system maintained a comprehensive EOC program that complied with National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards. We evaluated the infection control program to determine compliance with 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 the canteen, ophthalmology, women's health, radiology, 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. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical centers use the quarterly/semi-annual survey report results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percents for outpatients. Inpatient care is provided through an extensive VA/DOD sharing agreement with the WBAMC; therefore, only outpatient results are available.

Figure 1 shows the system's SHEP performance measure results for outpatient services.



The system has been below the established target for the last 7 quarters of available data. Managers had identified opportunities for improvement based on the SHEP survey scores and had developed an action plan targeting specific services and departments. The action plan had been implemented, and there is evidence of ongoing activities and evaluation of the plan for effectiveness. Therefore, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 28, 2007

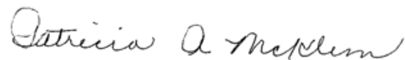
From: Network Director, VISN 18 (10N18)

Subject: **Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas**

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

Director, Management Review Service (10B5)

I concur with the attached facility draft responses to the recommendations for improvement contained in the Combined Assessment Program review at the El Paso VA Health Care System. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2699.



Patricia A. McKlem

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 28, 2007

From: Director, El Paso VA Health Care System (756/00)

Subject: **Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas**

To: Director, Veterans Integrated Service Network (10N18)

My staff and I have reviewed the draft Combined Assessment Program Review of the El Paso VA Health Care System and have attached our comments in the template provided by the OIG.

Should you have any questions concerning our response, please contact me at (915) 564-7901.

Maria L. Andrews for

Bruce E. Stewart

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 that peer reviews be completed within the specified timeframe and that the PRC submit quarterly reports to the CEB.

Concur

Corrective Actions:

1. Separate responsibility for the peer review process from the duties of the Patient Safety Manager – *Complete*.

2. Temporarily transfer responsibility for Peer Review to the Quality Manager – *Complete*.

3. Establish a tracking mechanism for timeliness of peer reviews – *Target date: January 11, 2008.*

4. Management (Chief of Staff) oversight to ensure timely peer reviews. Chief of Staff will review tracking data at least every 2 weeks – *Target date: January 11, 2008*.

5. Establish Peer Review Committee – *Target date*: *February 1, 2008*.

6. Peer Review Committee will report quarterly on progress of peer review timeliness to the Clinical Executive Board – *Target Date: Beginning February 26, 2008, meeting.*

7. Establish a Risk Manager position. The incumbent will assume permanent responsibility for the peer review process – *Target date: March 31, 2008.*

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that RCAs be completed within the timeframe specified by VHA.

Concur

Corrective Actions:

1. Develop a contingency plan for the absence of the Patient Safety Manager – Effective immediately, the OEF/OIF Program Manager is assigned to cover during the absence of the Patient Safety Manager to ensure the RCA process proceeds without delay – *Complete*.

2. Develop and implement a standardized and comprehensive process for RCA completion to include milestones – *Target date: February 1, 2008*.

3. Revise the RCA tracking tool to include timeliness standards – *Target date: February 1, 2008*.

4. Patient Safety Manager will provide a bi-weekly report to Director on the timeliness of RCAs – *Target date: February 15, 2008*.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that medication reconciliation complies with Joint Commission standards and that medication order changes be documented by the physician to prevent medication errors.

Concur

Corrective Actions:

1. Patient Safety Manager will provide mandatory training on the established Medication Reconciliation Policy to all clinical staff – *Target date: February 1, 2008*.

2. Develop a performance monitor on compliance with the medication reconciliation process and policy – *Target date: February 1, 2008*.

3. Patient Safety Manager will report compliance to the Clinical Executive Board on a monthly basis – *Target date: February 26, 2008*.

4. Add the topic of Medication Reconciliation knowledge to the tracer process – *Target Date: February 1, 2008*.

Recommendation 4. 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

Corrective Actions:

1. The Chief Information Officer will ensure that the identified business rules have been removed to assure compliance with VHA Handbook 1907.01 and the October 2004 OI guidance – *Complete*.

2. All business rules will be reviewed for compliance by the Privacy Officer in cooperation with the Clinical Informatics Coordinator – *Complete*.

OIG Contact and Staff Acknowledgments

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Contributors	Linda DeLong, Director Wilma Reyes, Heathcare Inspector Jeff Burke, Investigator

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