



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 09-00858-113

Combined Assessment Program Review of the VA Manila Outpatient Clinic Manila, Philippines



April 21, 2009

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 February 3–6, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Manila Outpatient Clinic (MOC), Manila, Philippines. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, 84 employees attended fraud and integrity awareness training. The MOC is part of Veterans Integrated Service Network (VISN) 21.

Results of the Review

The CAP review covered nine operational activities. We identified the following organizational strengths and reported accomplishments:

- System redesign improved efficiency and reduced costs.
- Joint Executive Board (JEB) restructured to improve communication and information flow.
- Compensation and pension (C&P) exam quality and timeliness exceeded national targets.
- New VA facility will provide a more modern clinic for veterans.

We made recommendations in six of the activities reviewed. For these activities, the MOC needed to:

- Implement and maintain an effective structure for the QM and performance improvement (PI) program.
- Improve the peer review process.
- Ensure that physician privileging processes comply with Veterans Health Administration (VHA) requirements.
- Revise the life support training policy.
- Ensure that information from MOC patients' hospitalizations is readily available to primary care providers (PCPs).
- Address identified infection control vulnerabilities.
- Ensure that the controlled substances (CS) inspection program complies with VHA requirements.
- Improve suicide prevention documentation, develop a process for re-evaluating Patient Record Flags (PRFs), and comply with the mandatory training requirement.

- Ensure that clinic managers comply with the annual employee performance evaluation requirement.

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

- Access to Care – No Show Rates.
- Patient Satisfaction Survey Scores.
- Post-Deployment Screening.

This report was prepared under the direction of Julie Watrous, former Director, Los Angeles Office of Healthcare Inspections.

Comments

The VISN and MOC Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 13–18, 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 MOC provides outpatient medical care and is the only VA facility located in a foreign country. Inpatient and specialty care are provided through fee basis arrangements with various community hospitals in the Philippines. The MOC is considered part of VISN 21 and offers health care services to eligible veterans throughout the Philippines.

Programs. The MOC provides primary care, mental health services, and limited specialty care, including cardiology, orthopedics, and neurology. Other specialty care, such as urology, is provided by non-VA providers on a fee basis.

Resources. The fiscal year (FY) 2008 medical care operating budget was \$8 million. The MOC currently has 81 full-time employee equivalents (FTE), including 11 physician and 4 nursing FTE.

Workload. In FY 2008, the MOC treated 4,085 unique patients. It has no inpatient or community living center (CLC) beds.¹ Outpatient workload totaled 20,051 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

¹ A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

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 nine activities:

- Continuity of Care.
- CS Inspection Program.
- Environment of Care (EOC).
- Post-Deployment Screening.
- Access to Care – No Show Rates.
- Patient Satisfaction Survey Scores.
- QM.
- Staff Competency Assessments.
- Suicide Prevention Program.

The review covered MOC operations for FY 2008 and FY 2009 through January 31, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. This was the first CAP inspection for the MOC.

During this review, 84 employees attended video training on fraud and integrity awareness. The training 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 Strengths

System Redesign

During the past year, the MOC made a number of significant changes in its operations under the VA’s system redesign initiative. It restructured its scheduling, patient flow, physician referral patterns, and return-to-clinic intervals. Managers thoroughly analyzed fee basis care and took steps to reduce unwarranted medical referrals and the use of

attendants and hired vehicles. These changes netted significant financial savings. MOC managers also implemented a centralized telephone center to better address patient needs and to improve efficiency. Additionally, the MOC initiated a review of patients hospitalized in the community at VA expense. This resulted in a cost savings by ensuring that patients were discharged timely.

Joint Executive Board

Within the past year, MOC senior managers restructured the JEB, incorporating all managers and program leads. They changed the meeting format to include presentations and discussions of a wide range of topics and performance results. The JEB is in the process of reviewing all policies and is revising them as appropriate. These changes have resulted in a more effective communication process.

Compensation and Pension Exam Quality and Timeliness

The MOC does a significant number of C&P exams for veterans seeking new or modified benefits. The MOC's C&P exam quality and timeliness exceeded national FY 2008 targets. The collaboration between the Manila Regional Office and the MOC demonstrates a best practice for reducing duplicate work and expediting veteran claims.

New VA Facility

A new VA facility that will combine VA benefits and medical operations in one location is under construction on the U.S. Embassy grounds. Presently, the MOC is approximately 2 miles away from the Manila Regional Office. The new facility is scheduled for completion by 2011. It will provide more efficient operations and a larger, more modern medical clinic for veterans. The project is part of the U.S. Embassy's commitment to provide one stop, user-friendly services to veterans.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the MOC's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the MOC's Director, Chief Medical Officer, and Quality Assurance Manager. We also interviewed the Clinic Manager and several other staff members. We evaluated

plans, policies, and other relevant documents. We identified four areas that needed improvement.

Quality Management and Performance Improvement Structure. For the period February 2008–January 2009, the MOC did not have an effective structure in place to provide oversight of quality of care and PI activities.² The local policy required that the Quality Care Team (QCT) meet monthly and report regularly to both the Medical Executive Committee (MEC) and the JEB. The QCT met only twice during the 12-month period and did not report to either the MEC or the JEB. Managers needed to ensure that QM and PI review results are consistently presented, discussed, and acted upon, as appropriate.

Recommendation 1

We recommended that the VISN Director ensure that the MOC Director requires that the structure for an effective QM and PI program be fully implemented and maintained, in accordance with VHA requirements.

The VISN and MOC Directors agreed with the findings and recommendation. The QCT plans to meet at least quarterly, and discussion of quality of care issues is now a recurring agenda item for the JEB. The MOC revised the local policy to reflect these changes. Target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Peer Reviews. Although the MOC had a policy defining peer review, peer reviews were not initiated in accordance with the policy. Also, the peer review process was not consistent over the past 12 months and was not in compliance with VHA requirements,³ as follows: (1) the Peer Review Committee did not meet quarterly, (2) reports were not submitted to the MEC quarterly, and (3) final peer reviews were not completed within the designated timeframe. For FY 2008, 14 peer reviews were initiated. While initial peer reviews were completed within the required 45 days, only 2 final reviews (14 percent) were completed within the 120-day timeframe.

The VHA directive lists several types of patient events that require peer review, such as unexpected death. Although

² VHA Directive 2008-061, *Quality Management Program*, October 7, 2008.

³ VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

the MOC experienced none of these events, we expected the MOC to comply with the directive in a way that would be appropriate to the scope of care it provides. The Chief Medical Officer agreed with our findings.

Recommendation 2

We recommended that the VISN Director ensure that the MOC Director requires that the peer review process comply with VHA requirements and local policy.

The VISN and MOC Directors agreed with the findings and recommendation. The MOC revised the local policy, and managers developed case finding reports to help identify events for peer review. The Peer Review Committee plans to meet quarterly. Target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Continuous Performance Monitoring. The MOC did not have the required written plan for continuous performance monitoring of its privileged physicians.⁴ We reviewed the profiles for all 23 physicians and found adequate performance data in only 5 (22 percent) profiles. In addition, the MEC met only twice in the past 12 months rather than quarterly, and meeting minutes did not reflect detailed discussion of physicians' performance data prior to reprivileging. Also, when physicians are given appointments of less than 2 years, privileges are to be granted for the same period of time. However, privileges had been routinely granted for 2 years, regardless of the length of appointment.

Recommendation 3

We recommended that the VISN Director ensure that the MOC Director requires that physician privileging processes are in compliance with VHA requirements.

The VISN and MOC Directors agreed with the findings and recommendation. The MOC revised its Medical Staff Bylaws to ensure that contract physicians' privileges are granted according to the length of the contract. A written plan for profession practice evaluation will be developed. Target date for completion is September 30, 2009. The

⁴ VHA Handbook 1100.19, *Credentialing and Privileging*, October 2, 2007. Revision issued November 14, 2008.

improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Life Support Training. Local policy defines the different levels of life support training required for physicians and nurses. In January 2008, the MOC provided appropriate levels of training onsite for staff nurses and physicians. However, we noted that two physicians were hired after the training session. The Clinic Manager assured us that training would be provided to these two physicians within 90 days of hire; however, the local policy does not address how to obtain training for new employees. Also, the policy does not describe actions to be taken when staff training certifications expire. The Clinic Manager agreed that the local policy needed to be revised.

Recommendation 4

We recommended that the VISN Director ensure that the MOC Director requires that the local policy be revised to include processes to be followed when training certificates expire and when nurses or physicians are hired between training sessions.

The VISN and MOC Directors agreed with the findings and recommendation. The local policy was revised to clarify training requirements, and training for the two new employees has been scheduled. Target date for completion is May 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Continuity of Care

The purpose of this review was to evaluate whether communication between MOC PCPs and community hospitals was adequate. Such communication is essential to continuity of care and optimal patient outcomes. We identified one area that needed improvement.

Community Hospitalization Documentation. We reviewed the medical records of 10 MOC patients who had been hospitalized in the local community at VA expense during October 2008. Although hospital discharge summaries are required for billing purposes, this information is not scanned into the computerized medical records. We assessed whether this information was consistently available to PCPs for the first MOC visit subsequent to the hospitalization. Although all 10 patients had been seen at the MOC subsequent to hospitalization, we only found documentation

of the hospitalization for 2 (20 percent) of the patients. We concluded that communication of discharge summary information needed to be improved. The Clinic Manager agreed with our findings.

Recommendation 5

We recommended that the VISN Director require that the MOC Director ensures that information from MOC patients' community hospitalizations is readily available to PCPs.

The VISN and MOC Directors agreed with the findings and recommendation. The MOC developed documentation and notification procedures. Clerks will record fee basis information in the medical records, and PCPs will document care plans using the appropriate note template. File room staff were trained on the procedures. Additionally, the MOC requested installation of an automated system to scan hard copy reports from community hospitals. Target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine if the MOC maintained a safe and clean patient care environment. VHA facilities are required to establish a comprehensive EOC program that meets applicable VA and local standards.

We inspected all clinical areas and found them to be clean and well maintained. The MOC is behind a guarded and gated fence and appeared to be adequately secured. EOC rounds are conducted on a quarterly basis, as required. We suggested that the Safety Officer or designee document the names and titles of individuals participating on all EOC rounds to ensure compliance with the Deputy Under Secretary for Health's memorandum related to environmental rounds participants.

We identified the following area that that needed improvement:

Infection Control. The clinic has three ultraviolet germicidal irradiation (UVGI) fixtures. UVGI is an air cleaning technology used to irradiate the air to minimize the risk for Mycobacterium tuberculosis. To function properly and minimize potential hazards to staff and others, the fixtures should be properly installed and maintained. The MOC does not have a preventive maintenance policy for these fixtures, and although they have been in place for more than

2 years, we found no evidence that they have been maintained. We also noted that although the local policy requires Engineering to perform weekly testing of the air quality in the laboratory isolation room, air exchange testing has only been conducted monthly.

Recommendation 6

We recommended that the VISN Director require that the MOC Director addresses identified infection control vulnerabilities.

The VISN and MOC Directors agreed with the findings and recommendation. UVGI fixtures will be maintained according to the manufacturer's recommendations, and a logbook will be used to record maintenance. The infection control policy is being revised to reflect new procedures for testing air quality in isolation rooms. Target date for completion is April 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

**Controlled
Substances
Inspection Program**

The purpose of this review was to evaluate whether VA health care facilities had adequate controls to ensure the security and proper management of CS. The MOC's CS inspection program has a CS coordinator (CSC), an alternate CSC, and an inspector. We identified two areas that needed improvement.

Monthly Inspections. We found that the required monthly inspections were not always conducted. The inspections for October 2008 did not take place because the CSC was on leave. We also found several instances of the CSC conducting inspections of the same areas for 2 consecutive months, in violation of VHA policy.⁵ The CSC was not aware of this restriction. In addition, prior to January 2009, the CSC did not complete CS inventories during the 1st month of each quarter, as required. Instead, the CSC completed inventories during the 3rd month. Also, the CSC had not developed a comprehensive inspection checklist to ensure that all requirements were addressed. Therefore, we noted that certain inspection elements, such as communication with the patient advocate about CS issues and drug disposal and destruction, were not documented as being completed. We suggested that the CSC contact other

⁵ VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003.

program coordinators in VISN 21 to obtain a copy of a comprehensive inspection checklist.

Training. We did not find current training certificates for the CSC and the alternate CSC. The last documented training for the CSC occurred in 2004. While we were onsite, all program participants completed the required training.

Recommendation 7

We recommended that the VISN Director require that the MOC Director ensures that the CS inspection program complies with VHA requirements related to inspections and training.

The VISN and MOC Directors agreed with the findings and recommendation. The MOC revised the CS inspection report and will use this new version for future inspections. The CSC and alternate CSC received training. A local policy delineating responsibilities and inspection procedures is being developed. This policy will meet VHA requirements. Target date for completion is April 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Suicide Prevention Program

The purpose of this review was to determine whether VHA health care facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We verified whether medical records of patients determined to be at high risk for suicide contained Category II PRFs⁶ and documented safety plans that addressed suicidality. We also verified compliance with training requirements.

We interviewed the MOC's Suicide Prevention Coordinator, and we reviewed pertinent policies and the medical records of four patients determined to be at risk for suicide. We identified two areas that needed improvement.

Medical Record Documentation. VHA regulations⁷ require that all medical records of patients at high risk for suicide have a Category II PRF and a safety plan and show evidence of collaboration. We found deficiencies in two of the four records. In one record, the clinician documented a safety plan in July 2008 that included specific interventions, but the record was not flagged until January 2009. The

⁶ A Category II PRF is an alert mechanism that is displayed prominently in medical records.

⁷ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

other record had a PRF but not a safety plan. Also, we did not find evidence that the MOC has established a process for re-evaluating PRFs in patients' records to ensure that they are removed when the high-risk status is resolved. MOC managers acknowledged that documentation could be improved.

Training. We reviewed clinicians' training records and found that only 88 percent (28 of 32) had received the mandatory suicide risk and intervention training for health care providers. Four contract physicians have yet to complete this training.

Recommendation 8

We recommended that the VISN Director require that the MOC Director ensures that clinicians comply with VHA documentation requirements for patients deemed at high risk for suicides, that a process for re-evaluating PRFs is developed, and that all health care providers receive training in suicide prevention techniques.

The VISN and MOC Directors agreed with the findings and recommendation. Program responsibilities and procedures, including safety plan monitoring, are now delineated in the local policy. PRFs in two of the four medical records were removed, and all clinicians have completed the required training. The corrective actions are acceptable, and we consider this recommendation closed.

Staff Competency Assessments

The purpose of this review was to ensure that employees who provide care to veterans possess the appropriate knowledge, skills, and behaviors necessary to fulfill their responsibilities. Competence is monitored by a variety of assessment methods, and the continued competence of staff should be documented annually through the performance evaluation system and more frequently, if needed. We identified one area that needed improvement.

Performance Evaluations. We reviewed performance evaluation records of 10 ancillary and support staff (pharmacists and lab and radiology technologists). We found that 3 (30 percent) of the 10 records did not contain current performance evaluations. The last performance evaluations recorded for these individuals were for the rating year 2004/2005. MOC managers told us that they had been informed that because these employees had reached the last step (maximum) at their grade levels, annual

evaluations were no longer necessary. The Human Resources manager disagreed with this information and confirmed that all employees are to undergo an annual performance evaluation.

Recommendation 9

We recommended that the VISN Director require that the MOC Director ensures that MOC managers comply with the annual employee performance evaluation requirement.

The VISN and MOC Directors agreed with the findings and recommendation. The circular on performance management is being revised to ensure that all employees receive annual performance evaluations. Target date for completion is April 2009. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

**Access to Care –
Patient No Shows**

The purpose of this review was to assess whether the MOC has provided adequate access to care by addressing patient no shows. The MOC has struggled with high percentages of veterans failing to show up for scheduled appointments. MOC's goal is to have fewer no shows. VHA target rates range from 7 to 17 percent, and the MOC's rates range from 19 to 24 percent. Managers have assessed the reasons for the higher than average rates and have implemented actions to address them, including changing scheduling processes and making follow-up telephone calls. Therefore, we made no recommendations.

**Patient Satisfaction
Survey Scores**

The purpose of this review was to assess the extent that VHA medical facilities use the quarterly survey results of patients' health care experiences with VHA to improve patient care, treatment, and services. VHA set performance measure results for patients reporting overall satisfaction of "very good" or "excellent" at 77 percents for outpatients.

The MOC's performance measure results for outpatients included only 72 patients for all of FY 2008. The MOC's cumulative outpatient score of 71.8⁸ did not meet the target. However, the numbers are too small to be meaningful. Managers had implemented internal patient satisfaction

⁸ This is the only score available on the Office of Quality and Performance's website for the MOC for FY 2008.

surveys to provide larger numbers. Therefore, we made no recommendations.

Post-Deployment Screening

The purpose of this review was to assess whether the MOC was performing required screening assessments of Operation Enduring Freedom and Operation Iraqi Freedom veterans. We reviewed 10 medical records and found evidence of post-deployment screening in all 10 records. We noted that the MOC does not currently have a process to refer veterans who screen positive for alcohol abuse to treatment programs and suggested that they consider developing such a process. We made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 27, 2009

From: VISN Director (10N/21)

Subject: Combined Assessment Program Review of the VA Manila Outpatient Clinic, Manila, Philippines

To: Director, Los Angeles Healthcare Inspections Division (54LA)
Director, Management Review Service (10B5)

1. Thank you for the opportunity to review the draft report on the Combined Assessment Program Review of the VA Manila Outpatient Clinic, February 3–6, 2009. We concur with the recommendations in the report and will ensure completion by the target dates listed in the attached implementation plan.
2. If you have any questions regarding our responses to the recommendations in the draft report, please contact Ms. Judy Daley, VISN 21 Quality Management Officer, at 775- 328-1461.

(original signed by:)
Sheila M. Cullen

Attachment

Outpatient Clinic Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 3, 2009

From: Director, VA Regional Office & Outpatient Clinic, Manila, Philippines (358/00)

Subject: Combined Assessment Program Review of the VA Manila Outpatient Clinic, Manila, Philippines

To: Director, Los Angeles Healthcare Operations Division (54LA)
Director, Management Review Office (10B5)

1. On behalf of VA Regional Office & Outpatient Clinic, Manila, Philippines, I would like to thank you for the informative and constructive OIG CAP audit performed the week of February 3–5, 2009. Attached you will find comments, corrective action plans, and completion dates for each recommendation.

2. If you have any questions, or need additional information, please feel free to contact Cecilia P. Salbilla, Acting Clinic Manager, at telephone number (632) 833-4566 local 8302.

(original signed by:)
Jon Skelly

Attachment

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 MOC Director requires that the structure for an effective QM and PI program be fully implemented and maintained, in accordance with VHA requirements.

Concur.

Planned Action: For this FY, the Quality Care Team (QCT) met on Dec. 10, 2008, Jan 28, 2009, and March 18, 2009, and will continue to meet at least quarterly. Qualities of Care Issues are now part of the Joint Executive Board (JEB) meeting as a recurring agenda item. OPC Policy Memo No. 00-02 Plan for Organizational Quality and Performance was revised as well as the structure of the Quality Care Team (QCT).

Target date of implementation/completion: September 30, 2009

Recommendation 2. We recommended that the VISN Director ensure that the MOC Director requires that the peer review process comply with VHA requirements and local policy.

Concur.

Planned Action: The Peer Review Policy was revised to include case findings as a tool to assist in identifying circumstances that will be considered for peer review. Quality Management is working with V21 staff to develop further case finding reports such as: abnormal chest x-rays, positive fecal occult blood, and INR results for anti-coagulation therapy. The Peer Review Committee met on Jan. 23, 2009, for the 2nd quarter and will meet quarterly as required.

Target date of implementation/completion: September 30, 2009

Recommendation 3. We recommended that the VISN Director ensure that the MOC Director requires that physician privileging processes are in compliance with VHA requirements.

Concur.

Planned Action: Bylaws' of the Medical Staff were revised to include renewal of privileges of contract physicians to every year or to coincide with their length of the contract and the use of on-going and focus professional practice evaluations as basis for renewal of privileges. A written plan for on-going and focus professional practice evaluation will be developed for submission to the Medical Executive Board for approval. This plan will specify provider profiles for all physicians.

Target date of implementation/completion: September 30, 2009

Recommendation 4. We recommended that the VISN Director ensure that the MOC Director requires that the local policy be revised to include processes to be followed when training certificates expire and when nurses or physicians are hired between training sessions.

Concur.

Planned Action: OPC Policy Memo No. 11-05 Emergency Code Blue and CPR was revised to address ACLS and BLS training for physicians and nurses within 90 days of initial hire as well as ongoing requirements for certification. BLS training for the new nurse is scheduled for April 17, 2009, and ACLS training for the new primary care physician is scheduled for May 26 to 28, 2009. Training will be conducted by the Philippine Heart Center, whose program is recognized by the American Heart Association and Philippine Heart Association.

Target date of implementation/completion: May 30, 2009

Recommendation 5. We recommended that the VISN Director require that the MOC Director ensures that information from MOC patients' community hospitalizations is readily available to PCPs.

Concur.

Planned Action: A process that informs the Primary care Physician that a fee-basis medical report was received has been developed. There are two kinds of note titles on CPRS which the clerk can use to enter fee-basis information: Non-VA Inpatient Medical Report and Non-VA Outpatient Medical Report. Once the fee-basis report is received, the Clerk makes a note on CPRS using any of the above note titles. The Primary Care Physician enters his plan of care in response to the fee-basis event in a text box on the note template. This is a field required to complete the note. To monitor compliance to this process, an incomplete non-VA inpatient and outpatient medical note report will be submitted to QA on a regular basis.

Staff in the file room were trained and staff was increased to two full-time clerks to ensure that hard copy fee-basis medical reports are routed to PCPs and filed into the Consolidated Health Record in a timely manner.

A request was sent to OI&T thru the Manila Facility CIO last March 25, 2008, to install VISTA imaging or a system that will scan medical reports received from community hospitals and providers and make it available to Manila OPC providers on-line via CPRS. This need was brought to the Facility CIO in the middle of FY08 and therefore was not in that IT budget. The imaging system was budgeted for in the FY09 IT budget. The new system should be implemented by the end of FY09.

Target date of implementation/completion: September 30, 2009

Recommendation 6. We recommended that the VISN Director require that the MOC Director addresses identified infection control vulnerabilities.

Concur.

Planned Action: Maintenance of UVLs is now done following manufacturer's recommendation which is: to use UVLs within the manufacturer's rated average effective life of 10,000 hours or replacement of lamp after every one year of continuous operation. A log to reflect dates when lamps are cleaned and changed will be kept by the Biomedical Engineer for record purposes.

Isolation rooms are tested according to CDC Guidelines which states: Periodic checks are required to maintain the desired negative pressure and the optimal operation of monitoring devices: Checks will be conducted for the following:

- Isolation rooms with pressure-sensing devices will be checked daily with Smoke tubes or other visual checks for negative pressure. A vaneometer was installed in the Sputum Collection Room for visual monitoring.
- Laboratory isolation room will be checked daily for negative pressure.

All these changes will be incorporated in the TB Infection Control Policy, which is being revised by the TB Control Officer.

Target date of implementation/completion: April 30, 2009

Recommendation 7. We recommended that the VISN Director require that the MOC Director ensures that the CS inspection program complies with VHA requirements related to inspections and training.

Concur.

Planned Action: Control Substance Inspection report was revised and will be used for subsequent inspection. A local policy that specifies responsibilities and procedures for the Controlled Substances Inspection Program including training for all inspectors is being developed to address all requirements for inspections. Both the CSC and alternate took the controlled Substance/Drug Diversion Inspection certification training on Feb 5, 2009. A 3rd CSC will be selected and will take the training also.

Target date of implementation/completion: April 30, 2009

Recommendation 8. We recommended that the VISN Director require that the MOC Director ensures that clinicians comply with VHA documentation requirements for patients deemed at high risk for suicides, that a process for re-evaluating PRFs is developed, and that all health care providers receive training in suicide prevention techniques.

Concur.

Planned Action: OPC Policy Memo No. 111-15 Suicide Prevention Program specifies responsibilities and procedures of the program. Monitoring of the safety plan is addressed under Procedures, number 5, safety plan. All four remaining staff completed the training last Feb. 4, 2009. Out of four patients with category II suicide PRF reviewed, two were deactivated and two were continued.

Target date of implementation/completion: March 30, 2009

Recommendation 9. We recommended that the VISN Director require that the MOC Director ensures that MOC managers comply with the annual employee performance evaluation requirement.

Concur.

Planned Action: The station circular on Performance Management for Local Employees is being revised to provide instructions so that those employees who have reached the top step will move to a 10/01 to 09/30 rating cycle. Other employees will have a rating cycle determined by EOD, Promotion, or Reassignment. Under Part 3.h. of the circular, Human Resources is responsible for reporting past due performance evaluations to the Station Director. Admin. Assistants will maintain a manual log of performance appraisals of staff from their service. Information on the log will include the rating cycle and date when the appraisal was submitted to HR. The Clinic Manager is informed of staff who have delayed appraisals.

Target date of implementation/completion: April 15, 2009

OIG Contact and Staff Acknowledgments

Contact	Julie Watrous, former Director Los Angeles Office of Healthcare Inspections (213) 253-5134 ⁹
Contributor	Daisy Arugay, Associate Director

⁹ Julie Watrous is currently the CAP Director.

Report Distribution

VA Distribution

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Director, Veterans Integrated Service Network (10N21)
Director, Veterans Benefits Administration Western Area Office through Phoenix
Regional Office (345/00)
Director, VA Manila Regional Office and Outpatient Clinic (358/00)

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