Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-01731-28

Combined Assessment Program Review of the Central Texas Veterans Health Care System Temple, Texas

November 27, 2007

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of May 21–25, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Central Texas Veterans Health Care System (the system), Temple, TX. 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 694 system employees. The system is part of Veterans Integrated Service Network (VISN) 17.

Results of the Review

The CAP review covered six operational activities. We identified the following organizational strength:

- Center of Excellence (COE) for Mental Health – Waco VA Medical Center.

We made recommendations in one of the activities reviewed. For the QM activity, the system needed to:

- Require committees to implement effective action item tracking mechanisms and submit reports to designated oversight committees.
- Require peer reviews to be completed within the timeframes specified by the Veterans Health Administration (VHA).
- Require clinicians to inform patients of their right to file tort or benefit claims and document the discussions in the medical record.

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

- Business Rules for Veterans Health Information Systems.
- Community Based Outpatient Clinics (CBOCs).
- Environment of Care (EOC).
- Surgical Care Improvement Project (SCIP).
- Survey of Healthcare Experiences of Patients (SHEP).

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

Comments

The Acting VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–18, for the full text of the Directors' comments.) The action plans have been implemented, and 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 consists of divisions located in Temple and Waco, TX, and provides a broad range of inpatient and outpatient health care services. The system has a large stand-alone outpatient clinic in Austin, TX. Outpatient care is also provided at four CBOCs in Brownwood, College Station, Palestine, and Cedar Park, TX. The system is part of VISN 17 and serves a population of about 238,000 veterans residing within 39 counties in Texas.

Programs. The system provides medicine, surgery, long-term care, psychiatry, and rehabilitation services. It has 268 hospital beds, 230 nursing home beds, 408 domiciliary beds, and 93 Psychosocial Residential Rehabilitation Treatment Program beds.

Affiliations and Research. The system is affiliated with Texas A&M University and provides training for 35 medical residents, as well as other disciplines, including nursing, pharmacy, physical and occupational therapy, dietetics, respiratory therapy, recreational therapy, and allied health. In fiscal year (FY) 2006, the system research program had 77 projects and a budget of $1.9 million. Important areas of research include breast, lung, and gastric cancer; coronary artery disease; hypertension; post-traumatic stress disorder; schizophrenia; and psychosis.

Resources. In FY 2006, medical care expenditures totaled $370 million. The FY 2007 medical care budget was $368 million. In FY 2006, staffing was 2,680 full-time employee equivalents (FTE), including 195 physician and 739 nursing FTE.

Workload. In FY 2006, the system treated 70,184 unique patients and provided 92,090 inpatient days in the hospital and 66,199 inpatient days in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 7,053 discharges, and the average daily census, including nursing home patients, was 434. Outpatient workload totaled 806,886 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 six activities:

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

The review covered system operations for FY 2006 and FY 2007 through May 21, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on select recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, Texas,* Report No. 04-03403-133, May 5, 2005). These recommendations are discussed in the QM section of this report.

We also followed up on recommendations from a report by VHA's Office of the Medical Inspector (OMI) (*Final Report: Special Site Visit Report, Nursing Home Care Unit, Olin E. Teague Veterans' Center, Temple, Texas*, January 23, 2004). In that report, the OMI made recommendations to improve the quality of care in the

NHCU. We reviewed documentation of the system's follow-up that was provided to us and found improvement actions to be acceptable. We consider the OMI recommendations closed.

During this review, we presented fraud and integrity awareness briefings to 694 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

Center of Excellence for Mental Health – Waco VA Medical Center

The system has emerged as a national leader in providing a comprehensive array of mental health services to veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In 2005, the Waco VA Medical Center was designated a COE for mental health needs, with particular focus on veterans returning from OIF and OEF. The primary emphasis of the program is rehabilitation and recovery from post-traumatic stress disorder and other related disorders.

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. 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. Data analysis and trending had improved since the prior CAP visit. However, the following areas needed improvement:

Committee Oversight. Data was analyzed to identify trends, and corrective actions were documented for problem resolution and improvement efforts. However, we found

inadequate implementation and evaluation of corrective actions in the program areas of patient complaints, patient safety, medication reconciliation, restraint review, and advanced clinic access. Due to only partial implementation of improvement actions, we could not be assured that patient care and patient safety processes were functioning effectively.

The Executive Council of the Governing Body (ECGB) is ultimately responsible for all committee oversight. The Quality Executive Council (QEC) and Medical Staff Executive Council (MSEC) receive quarterly reports from subcommittees and subsequently report quarterly to the ECGB. The Invasive Procedure Operative Committee analyzed data, identified trends, and monitored corrective actions; however, the committee did not submit any reports to the QEC. In addition, our document review determined that the Peer Review Committee submitted only two quarterly reports to the MSEC in FY 2006.

Peer Review. When the need for peer review is determined, VHA Directive 2004-054, *Peer Review for Quality Management*, requires initial reviews to be completed within 45 days and final reviews to occur within 120 days. Nineteen of 76 (25 percent) cases that the system determined necessary for initial peer review were not completed within 45 days. Twenty-three of 34 (68 percent) final reviews exceeded 120 days. Without timely peer review, the system cannot implement required quality and performance improvement activities.

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

Recommendation 1 We recommended that the VISN Director ensure that the System Director requires committees to implement effective

action item tracking mechanisms and submit reports to designated oversight committees.

The VISN and System Directors concurred with the findings and recommendation. The system implemented a tracking tool to effectively monitor and track compliance of open actions. This process was presented and approved by the ECGB on September 27, 2007. This approach will be standardized for system-wide use by all committees. We find the actions acceptable and consider this recommendation closed.

Recommendation 2 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. As of August 21, 2007, the timeliness process for peer review was strengthened. Peer Review Committee reports are now submitted to the MSEC on a quarterly basis. As of July 2007, a peer review dashboard timeline was designed and executed to augment the tracking tool and database. This dashboard timeline will provide members with the current status of peer review cases. We find the actions acceptable and consider this recommendation closed.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires clinicians to inform patients of their right to file tort or benefit claims and document the discussions in the medical record.

The VISN and System Directors concurred with the findings and recommendation. VHA Directive 2005-049, *Disclosure of Adverse Events to Patients,* was reviewed and compared to local system Memorandum 006-007-07, *Disclosure of Adverse Events to Patients*. All of the requirements from the VHA directive were incorporated into the system's memorandum, which was approved and republished. The system is currently providing education to their providers regarding VHA Directive 2005-049. We find the actions acceptable and consider this recommendation closed.

Review Activities Without 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 the time and date recorded.

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

Business rules define what functions certain groups or individuals are allowed to perform in the medical record. OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to a facility's Privacy Officer. We reviewed VHA and system information and technology policies and interviewed Information Resource Management Service staff. We found that the business rules provided to the OIG inspector were in compliance with VHA Handbook 1907.01. We made no recommendations.

[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.

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 conducted an onsite visit at the Cedar Park CBOC located in Cedar Park, TX. The CBOC complied with VHA standards of operations. The CBOC generally provided high quality care that improved patient access, convenience, and timeliness of health care services. The 10 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. We verified that physician and nurse licenses and provider privileging documentation were current and that background checks were complete. All clinicians had current cardiopulmonary resuscitation certifications. We made no 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.[3] 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. In addition, we reviewed the storage, use, and disposal of tritium, a radioactive material used in research protocols, to ensure that the system complied with VHA Directive 1105.1, *Management of Radioactive Materials*.

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

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; NHCUs; secure behavioral health units; ambulatory care areas; a research and development unit, which contained a nuclear waste disposal area; and many public areas. The system 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. Consistent with VHA policies and procedures, the system maintained accurate inventories of tritium. We made no recommendations.

Surgical Care Improvement Project

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

We reviewed the medical records of 30 patients who had surgery performed during the 1st quarter of FY 2007. The review included medical records for each of the following surgical categories: (1) vascular, (2) colorectal, and (3) orthopedic (knee or hip replacement). 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 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.

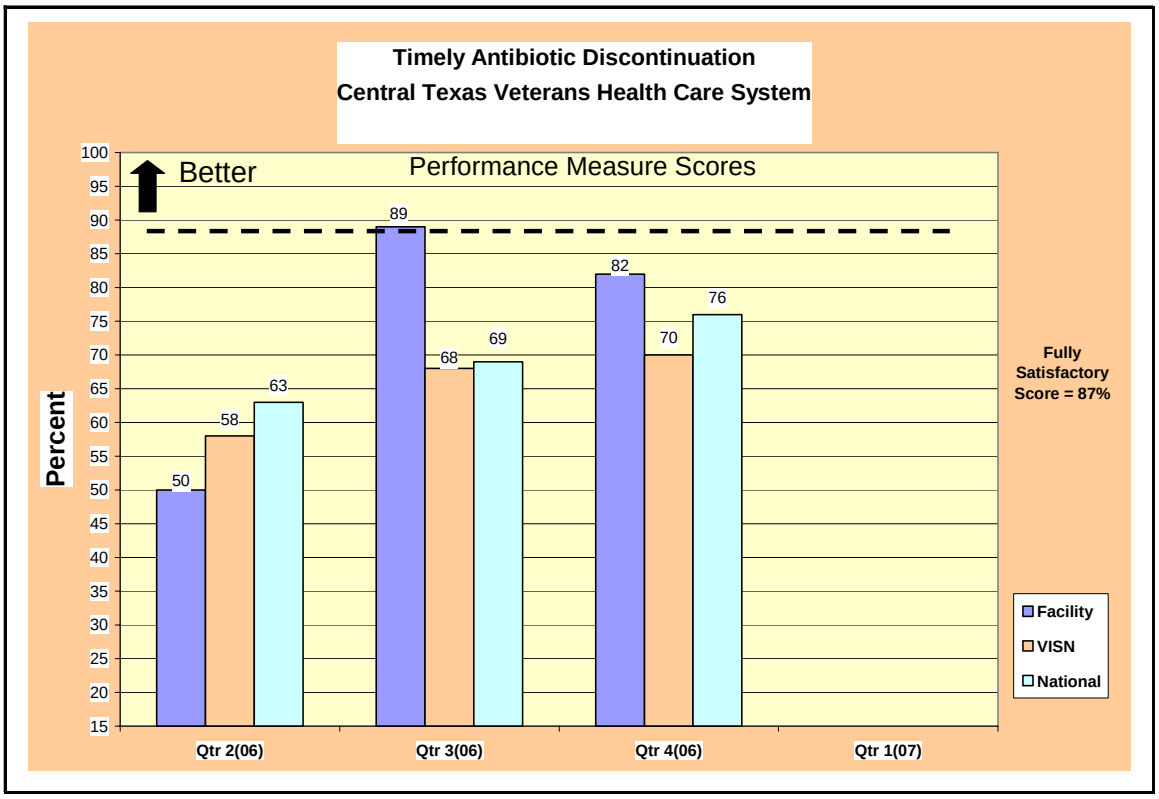
VHA set target PM scores for each of the previous indicators. To receive fully satisfactory ratings, a facility must achieve the scores summarized in the table below.

Performance Measure	Score
Timely antibiotic administration	**90 percent**
Timely antibiotic discontinuation	**87 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 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	Body Temperature Control (colorectal surgery)
100 percent (30/30)	**100 percent (30/30)**	**100 percent (9/9)**

Clinical managers developed and implemented action plans for the antibiotic stopped timely PM, which fell below the VHA established target in 2 out of the 3 quarters we reviewed in FY 2006. The chart on the next page represents data for quarter 2 through quarter 4 of FY 2006. Data for quarter 1 of FY 2007 was not available at the time of this review.



Improvement strategies were monitored, and results were communicated to the staff. We made no recommendations.

Survey of Healthcare Experiences of Patients

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

Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. VHA set FY 2006 SHEP target results of patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

The tables on the next page show national, VISN 17, and the system's inpatient and outpatient results.

Central Texas Veterans Health Care System

INPATIENT SHEP RESULTS

FY 2006 Quarters 3 and 4	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	81.4	78.9	89.9	67.9	66.0	76.0	83.4	74.7	70.1
VISN	78.2-	77.0-	88.0-	67.8	66.7	76.0	82.5	75.3	71.3
System	83.3	82.0+	91.6	72.6+	70.6+	73.9	86.6+	78.6+	73.7+

OUTPATIENT SHEP RESULTS

FY 2007 Quarter 1	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-Up	Preferences	Specialist Care	Visit Coordination
National	81.0	77.8	94.9	72.7	83.5	75.7	82.0	65.3	82	81.1	84.8
VISN	71.2 -	73.6	91.6	69.4	79.1 -	71.3	74.2	59.6	78.0 -	76.6	80.3 -
System Clinics	76.5	79.6	92.0	70.6	73.3 -	73.6	76.2	73.9	77.2	80.8	82.5

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

The system scored above the 76 percent threshold in five of nine areas for inpatient SHEP. Although the system scored below the threshold of 76 percent in Education and Information, Emotional Support, Family Involvement, and Transition, it scored significantly above the national average for Coordination of Care, Education and Information, Emotional Support, Physical Comfort, Preferences, and Transition.

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, Emotional Support, Overall Coordination, Pharmacy Mailed, and Pharmacy Pick-Up.

The system had shared SHEP results with employees, as directed, and had analyzed the results and developed action plans to improve areas that fell below inpatient and outpatient target results. We made no recommendations.

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 1, 2007

From: Acting Director, Veterans Integrated Service Network (10N17**)**

Subject: **Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, TX**

To: Director Dallas Healthcare Inspections Division (54DA)

Director, Management Review Office (10B5)

1. Attached please find Central Texas Veterans Health Care System, Temple, Texas' response to the Office of Inspector General Combined Assessment Program (OIG-CAP Review conducted May 21–25, 2007).

2. I have reviewed and concurred with the findings and recommendations outlined in the Combined Assessment Program report. The Central Texas Veterans Health Care System has completed the improvement actions for all recommendations, which will be tracked and trended to ensure continuous implementation. I recommend the closure of these action items.

3. Should you have questions, or require additional information, please do not hesitate to contact Deborah Antai-Otong, VISN 17 Continuous Readiness Officer, at 817-385-3794.

Timothy P. Shea, FACHE
Acting, Network Director

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 26, 2007

From: System Director

Subject: **Combined Assessment Program Review of the Central Texas Veterans Health Care System, Temple, TX**

To: **Network Director, VA Heart of Texas Health Care Network, VISN 17**

1. The recommendations made during the Office of Inspector General Combined Assessment Program review conducted May 21–25, 2007, were reviewed, and I concur with the findings. Our comments and implementation plan are delineated below. All actions have been implemented for continuous monitoring.

2. I would like to take this opportunity to commend the OIG CAP review team for their professionalism, the excellent feedback provided to our staff, as well as their consultative approach that was evident throughout the review process.

3. Should you have questions or require additional information, please do not hesitate to contact Sylvia Tennent, MBA, RN, Chief, Quality Management and Improvement Service, at 254-743-0719.

(original signed by:)

Bruce A. Gordon

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 committees to implement effective action item tracking mechanisms and submit reports to designated oversight committees.

Concur Target Completion Date: Completed September 27, 2007

Central Texas Veterans Health Care System's Compliance Officer designed and implemented a tracking tool to effectively monitor and track compliance of open actions. This process was presented and approved by the Executive Council of the Governing Body on September 27, 2007. This approach will be standardized system-wide to all committees which will complement the CTVHCS Station Memorandum 00-029-05. This mechanism will be utilized for tracking open actions and reports for all committees and oversight councils, including the Quality Executive Council's (QEC), the Medical Staff Executive Council (MSEC), and the Executive Council of the Governing Body (ECGB). Education and training will be conducted for the committee/council chairs, and the individuals responsible for tracking open actions. The ECGB will utilize this approach to strengthen the current process and set the agenda for quality to effectively monitor, take appropriate actions, and provide effective leadership span of control. Continuous monitoring will occur through resolution.

Committee Oversight: Data was analyzed to identify trends, and corrective actions were documented for problem resolution and improvement efforts. However, we found inadequate implementation and evaluation of corrective actions in the program areas of patient complaints, patient safety, medication reconciliation, restraint review, and advanced clinic access. Due to only partial implementation of improvement actions, we could not be assured that patient care and patient safety processes were functioning.

Patient Complaints are reviewed, conducted, and documented according to VHA Handbook 1003.4:

1) The medical center identified the vulnerability that SHEP scores were not consistently compared with patient complaint data at the Customer

Service Executive Council (CSEC). On May 1, 2007, a process was initiated where discussions relevant to SHEP scores and customer complaints were compared and discussed.

- This strategy has now become a standing agenda item at the CSEC. Corrective action plans are developed by the responsible service, and opportunities identified are monitored through completion.

- CTVHCS has also funded a full-time Customer Service Specialist and doubled the number of full-time Patient Advocates at the Temple site. Recruitment is in progress.

- The increased staff will be more visible and will conduct "Patient Advocate Walk Rounds" to units and services to facilitate rapid and timely response to patient concerns. Efforts are underway to identify office space for the staff and a new receptionist position to enhance this process.

Patient Safety follow-up action plans and implementation of improvement actions are accomplished as specified in VHA Handbook 1050.1.

The Patient Safety Managers utilize a spreadsheet and a dashboard for tracking and monitoring outcomes. The current dashboard has been enhanced to include the following:

- RCA recommendations are input into the SPOT Database to facilitate tracking and monitoring.

- Timeliness in completion of RCAs within 45 days was strengthened and will be tracked on a dashboard to be reported to the Patient Safety Council (PSC), the Quality Executive Council (QEC), and the Executive Council of the Governing Body (ECGB).

- Timeliness for implementation of corrective actions are specified, tracked, and reviewed by leadership at CTVHCS routine operations reviews.

- Upon the request for an RCA team to be convened, the Patient Safety Manager submits a request to the appropriate leadership for a staff member to participate in the RCA. Unless there are mitigating circumstances, the appropriate leadership will submit the name of the staff to participate within 3 business days.

- Outstanding actions by service and number of days overdue will be reviewed by leadership at CTVHCS routine operations reviews.

- Leadership will monitor the effectiveness of the implemented changes to ensure that the change has the desired effect by observing a reduction of similar incidents on an annual basis.

- Quality Management Data Analyst will also support the Patient Safety Program for tracking the timeliness of implementation of actions.

- Completion and execution of RCA recommendations are tracked by the dashboard and reported to the PSC, QEC, the ECGB, and the VISN.

The Patient Safety Office has been placed under the Office of the Director.

Medication Reconciliation – National Patient Safety Goal 8A&B.

The medical center identified opportunities for improvement, and the Quality Executive Council recommended the convening of a team to conduct a HFMEA for Medication Reconciliation. This was completed and debriefed to the executive leadership on June 6, 2007.

A HFMEA Project Plan was initiated and monthly reports submitted to the QEC for review, analysis, and monitoring for performance improvements actions through completion (start date July 24, 2007).

IT class 3 software has been identified that will facilitate the printing of a medication list for patients to share with their providers. An education plan was designed and implemented. Education to "Train the Trainer" was completed on August 24, 2007. Evidence of training will be obtained from TEMPO documentation.

Medication Reconciliation outcomes will be monitored by the Patient Safety Council, Pharmacy and Therapeutics Committee and the MSEC though resolution. The established goal is for 95 percent of patients to receive a list of current medications at admission/entry, and a complete list is also provided at discharge from the facility. Continuous monitoring will continue.

Medication Reconciliation Policy, Memorandum 011-033-07, was resubmitted to the Medical Staff Executive Council (MSEC) after complete revision to provide a consistent process for accurately reconciling patient medication across the continuum of care at CTVHCS. This policy was unanimously approved by the MSEC on August 21, 2007.

Restraint and Seclusion Review are conducted and documented in accordance with CTVHCS Station Memorandum 116A-007-04.

The system's QEC has oversight for restraints, and the process has been strengthened with a restraint subcommittee being activated in May 2007. Opportunities to enhance the current restraint process were identified for improvement. Improvement strategies and corrective action plans were reported to the QEC July 31, 2007, where performance improvement initiatives will be monitored through resolution.

Advanced Clinic Access corrective actions are executed and corrective actions are evaluated in accordance with VHA Directive 2006-028.

The system's MSEC has oversight for Advanced Clinic Access. The process of oversight has been strengthened for monitoring reports for specific services through our routine operations reviews. Leadership review reports and corrective action plans with service chiefs and specific improvement teams. The reports and corrective action plans are presented and reviewed by the Advanced Clinic Access Committee and MSEC where opportunities identified are monitored. The improvement initiatives will be monitored through resolution.

The Executive Council of the Governing Body – IPOC Reports.

The Executive Council of the Governing Body (ECGB) is ultimately responsible for all committee oversight. The Quality Executive Council (QEC) and Medical Staff Executive Council (MSEC) receive quarterly reports from subcommittees and subsequently report quarterly to the ECGB. The Invasive Procedure Oversight Committee (IPOC) analyzed data, identified trends, and monitored corrective actions; however, the committee did not submit any reports to the QEC.

The ECGB delegated oversight for all clinical committees to the Medical Staff Executive Council (MSEC), and a reporting schedule was executed which began July 2007. The IPOC initiated reporting to the MSEC on July 3, 2007. Continuous monitoring will continue.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires peer reviews to be completed within the timeframes specified by VHA.

Concur Targeted Completion Date: Completed August 21, 2007

Peer Review timeliness, monitoring, and evaluation meet the intent of VHA Directive 2004-054.

This process has been strengthened, and Peer Review Committee reports are now submitted to the MSEC on a quarterly basis. Immediately following the CAP review, the backlog was reduced by providing an additional Program Support Clerk, hired on April 16, 2007. Quarterly peer

review reports were consistently submitted to the Peer Review Committee since April, 18, 2007, and the MSEC since May 2, 2007. A dashboard was designed and executed to augment the tracking tool and database to facilitate communication of the timeline to completion of each case and provide members with the current status, as of July 2007. The dashboard includes the following indicators for review and reporting to the Peer Review Committee and the MSEC: days to completion within 45-day requirement for initial review, days to completion within 120 days for Peer Review Committee evaluations. Continuous monitoring will occur through completion.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires clinicians to inform patients of their right to file tort or benefit claims and document the discussions in the medical record.

Concur Target Completion Date: Completed July 31, 2007

Adverse Event Disclosure is conducted and documented in accordance to VHA Directive 2005-049.

VHA Directive 2005-049, Disclosure of Adverse Events to Patients, was reviewed and compared to local CTVHCS Memorandum 006-007-07 "Disclosure of Adverse Events to Patients." All the requirements were incorporated in the Memorandum, which was approved and re-published. Immediately following the OIG CAP visit, the Quality Management and Improvement Service conducted additional education at the June 4, 2007, monthly accreditation readiness training, augmenting previous education conducted by the Medical Staff. The presentation was placed in Health Streams for future viewing. The education focused on the VHA Adverse Event Reporting Directive, including patient advisement of the right to file tort or benefit claims for adverse event.

Quality Management identified targeted medical records for auditing to identify compliance with disclosure. Beginning July 2007, monthly audits of targeted medical records was conducted by the Risk Manager. A dashboard developed to facilitate monitoring of and trending of disclosure was submitted to the QEC on July 31, 2007. This report is to be submitted to the QEC on a monthly basis.

Evaluation of the current process revealed that additional education is warranted to facilitate documenting and conducting appropriate disclosure with outcomes reported to the QEC and the ECGB. Continuous monitoring will occur through completion.

OIG Contact and Staff Acknowledgments

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U.S. House of Representatives: John Carter, Michael K. Conaway, Lloyd Doggett, Chet Edwards, Jeb Hensarling, Michael T. McCaul, Lamar Smith

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