Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-02837-83

Combined Assessment Program Review of the John J. Pershing VA Medical Center Poplar Bluff, Missouri

February 26, 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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Table of Contents

Page

Executive Summary i

Introduction 1
  Profile 1
  Objectives and Scope 1

Organizational Strengths 3

Results 4
  Review Activities With Recommendations 4
    Quality Management 4
    Business Rules 6
  Review Activities Without Recommendations 7
    Environment of Care 7
    Survey of Healthcare Experiences of Patients 8

Appendixes
  A. VISN Director Comments 11
  B. Medical Center Director Comments 12
  C. OIG Contact and Staff Acknowledgments 16
  D. Report Distribution 17

Executive Summary

Introduction

During the week of December 3, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the John J. Pershing VA Medical Center (the medical center), Poplar Bluff, MO. 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 43 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 15.

Results of the Review

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

- Complementary Chronic Pain Management Clinic.
- Pandemic Flu in the Rural Setting.

We made recommendations in two of the activities reviewed. For these activities, the medical center needed to:

- Complete peer reviews within 120 days and submit quarterly aggregate reports to the Clinical Executive Board (CEB).
- Complete root cause analyses (RCAs) within 45 days.
- Review and discuss all QM activities in the designated oversight committee and take action on identified opportunities for improvement.
- Continue to perform periodic reviews of all business rules, update rules to comply with Veterans Health Administration (VHA) policy, and delete rules no longer in use.

The medical center 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 Virginia L. Solana, Director, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–15, 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 medical center is a primary and secondary care facility located in Poplar Bluff, MO, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) in Cape Girardeau, Farmington, and West Plains, MO, and in Paragould, AR. The medical center is part of VISN 15 and serves a veteran population of about 19,000 throughout 23 counties in southeast Missouri and 5 counties in Arkansas.

Programs. The medical center provides primary care, ambulatory specialty care, long-term care, and community health/home care services. It has 18 hospital beds and 40 nursing home beds.

Affiliations. The medical center is non-affiliated but maintains agreements with the Southern College of Optometry, Three Rivers Community College, Southeast Missouri State University, the University of Missouri-Columbia, St. Louis College of Pharmacy, Saint Louis University, and Arkansas State University. The medical center provides clinical practice sites for programs in nursing, laboratory and radiographic technology, secretarial science, social work, and computer science.

Resources. In fiscal year (FY) 2007, medical care expenditures totaled $71.4 million. FY 2007 staffing was 456.7 full-time employee equivalents (FTE), including 35.5 physician and 113.5 nursing FTE.

Workload. In FY 2007, the medical center treated 18,356 unique patients and provided 3,541 inpatient days in the hospital and 12,488 inpatient days in the Nursing Home Care Unit. The inpatient care workload totaled 1,440 discharges, and the average daily census, including nursing home patients, was 43.9. Outpatient workload totaled 132,100 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.
- EOC.
- QM.
- SHEP.

The review covered medical center operations for FY 2007 and FY 2008 through November 30, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. There were no health care recommendations to follow up on from our prior CAP review of the medical center (*Combined Assessment Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, Missouri*, Report No. 05-01230-195, August 21, 2006).

During this review, we also presented fraud and integrity awareness briefings for 43 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 Strengths

Complementary Chronic Pain Management Clinic

The medical center developed a multidisciplinary pain management clinic that utilizes alternative methods to assist patients in managing chronic pain. The clinicians use no additional medication but instead teach techniques that enhance the patients' ability to assist in the management of their health care. Alternative modalities, such as use of meditation, hypnosis, massage therapy, and chiropractic care, are used to increase patient comfort and improve the sense of well being. The clinic has been well received by patients. Clinical outcomes include improved vital signs, decreased medication use, and high patient satisfaction scores.

Pandemic Flu in the Rural Setting

Because the medical center is located in an extremely rural environment, scarcities of health care resources coupled with communication barriers and transportation issues result in unique geographical challenges. In October 2006, a public health grant was funded for a project to improve veteran awareness and preparation for pandemic flu through training and veteran/community education.

Using evidence-based practice, the medical center developed an educational video entitled *Pandemic Flu: Preparing the Veteran in the Rural Setting*. The video prepares veterans in rural environments to cope with pandemic flu or other natural disaster events. Educational fliers and posters were developed and used within the medical center, at the CBOCs, and in the community. Also, medical center staff involved with the project published an article in a VHA journal. Since vast distances separate many VHA rural facilities, the medical center developed a "train the trainer" program that utilizes telecommunications so that other rural facilities can prepare veterans for pandemic flu.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers supported the program's activities. We interviewed the medical center's Director, Chief of Staff, Chief Nurse Executive, and Performance Improvement (PI) Manager. We also interviewed other PI staff. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care, and senior managers supported the program. Appropriate review structures were in place for 12 of the 15 program activities reviewed. However, we identified three areas that needed improvement.

Peer Review. The peer review process did not include all components required by VHA Directive 2004-054, *Peer Review for Quality Management.* Peer review is a protected, non-punitive, medical center process to evaluate the quality of care at the provider level. The peer review process includes an initial review by a peer of the same discipline to determine if most experienced, competent practitioners would have managed the case in a similar fashion or if most experienced, competent providers would have managed one or more aspects of the care differently.

The initial review must be completed within 45 days from the determination that a review is necessary. Once this is complete, the peer review is then forwarded to a multidisciplinary peer review committee (PRC) for validation of, or changes to, the initial findings. This is to be completed within 120 days from the determination that a review is necessary. The results are then shared with the involved provider in order to provide feedback about his or her practice. The PRC is required to submit quarterly aggregate reports to the Executive Committee of the Medical Staff in order to inform them of peer review results.

The medical center's FY 2007 peer review completion rate averaged 136 days, with 37 percent of reviews not completed within 120 days. Additionally, aggregate peer review findings were not submitted quarterly to the medical

center's CEB. When peer review feedback is delayed, opportunities to improve practice can be missed.

Patient Safety. Not all RCAs were completed in the required timeframe. The RCA process is used to identify contributing causes of variations in care associated with adverse events. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, requires that RCAs be completed within 45 days of the medical center becoming aware that an RCA is required.

Of the five RCAs we reviewed, the medical center did not complete two in the required 45-day timeframe. The Patient Safety Manager was aware of the delays and cited staffing issues as the reason. Key clinical staff assigned to the RCA teams were not available for completion of various steps of the RCA process. Patient safety reviews needed to be a higher priority for all managers.

Oversight of Quality Management Activities. Although the medical center had initiated quality improvement activities, PI Committee (PIC) minutes lacked documentation of committee discussion and analysis of QM data and of actions taken to improve processes.

According to local policy, PIC is the committee responsible for evaluating the effectiveness of departmental and monitoring committees' QM activities. The PIC is responsible for analyzing data from those groups and making recommendations for improvement. Although departments and other committees reported QM activities to the PIC, the PIC minutes did not reflect independent discussion or consideration of recommended corrective actions. For example, the discussion and action section of PIC minutes regarding blood usage review was an exact copy of the Blood Usage Review Committee minutes. This practice did not reflect oversight of data analysis or recommendations. QM staff agreed with our findings and stated that they had struggled with the purpose of the PIC.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC complete peer reviews within 120 days and submit quarterly aggregate reports of findings to the CEB.

The VISN and Medical Center Directors concurred with our findings and recommendation. QM staff will track peer review completion and, if necessary, alert the Chief of Staff to assure timeliness. The quarterly aggregate peer review report will be a standing agenda item for the CEB. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that RCAs are completed within 45 days.

The VISN and Medical Center Directors concurred with our finding and recommendation. A new process has been implemented to establish completion dates for RCAs and stress staff participation. The PIC will track quarterly RCA reports for timeliness. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that the PIC serve as an independent oversight group to review and discuss all QM activities and to take action on identified opportunities for improvement.

The VISN and Medical Center Directors concurred with our finding and recommendation. The PIC will now attach committee reports to their minutes, discuss those reports, and either concur or make recommendations to the Leadership Council. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Business Rules

The purpose of this review was to determine whether business rules governing the computerized patient record system (CPRS) comply with VHA policy. CPRS business rules define what functions certain groups or individuals are allowed to perform in the health record.

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, includes the combined electronic and paper medical 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.

On October 20, 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. In accordance with this guidance, OI has recommended that any editing of signed records be limited to a facility's Privacy Officer. 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.

We reviewed VHA and medical center information and technology policies and interviewed medical center Information Technology staff. The medical center shared business rules with three other VISN facilities. Although a group had reviewed business rules following issuance of the guidance, we found two rules that were not in compliance with VHA policy. One rule was shared and one was unique to the medical center. Program staff deleted both rules while we were onsite.

Recommendation 4

We recommended that the VISN Director ensure that the Medical Center Director requires program staff to continue to perform periodic reviews of all business rules, update rules to comply with VHA policy, and delete rules no longer in use.

The VISN and Medical Center Directors concurred with our finding and recommendation. Specific business rules were deleted while we were onsite. The corrective action is acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine whether the medical center complied with selected infection control (IC) standards and maintained a clean and safe health care environment. Medical centers are required to establish a comprehensive EOC program that fully meets National

Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.[1]

We evaluated the IC program to determine compliance with VHA directives that require management to collect and analyze data to improve performance. IC staff appropriately monitored, trended, analyzed, and reported infection data to clinicians for implementation of quality improvements to reduce infection risks for patients and staff.

We conducted onsite inspections of ambulatory care areas, inpatient units, long-term care units, and the intensive care unit. We also inspected the laboratory and radiology departments. We found that the medical center maintained a generally clean and safe environment. Nurse managers on the inpatient units expressed high satisfaction with the responsiveness of the housekeeping staff. Safety guidelines were met, and risk assessments complied with VHA standards. 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 (PM) goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

We reviewed the inpatient and outpatient survey results for the 4th quarter of FY 2006 and the 1st, 2nd, and 3rd quarters of FY 2007. Figures 1 and 2 on the next page show the medical center's SHEP PM results for inpatients and outpatients, respectively.

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

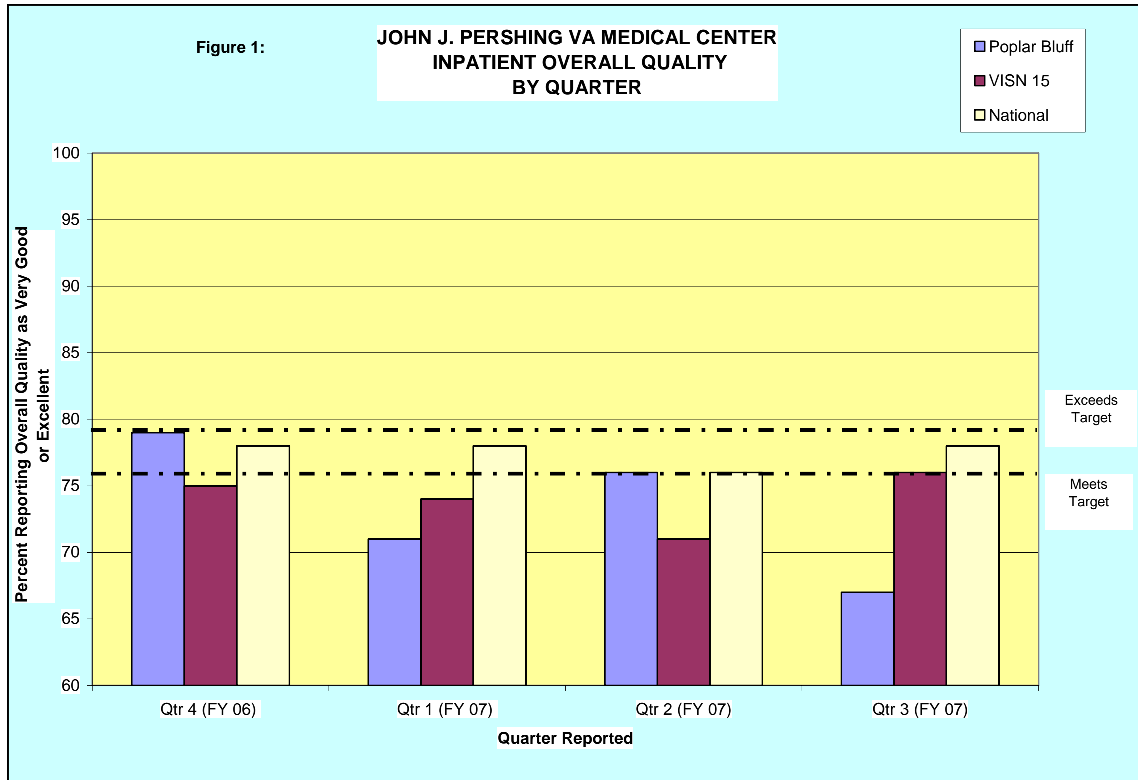
Figure 1:
JOHN J. PERSHING VA MEDICAL CENTER
INPATIENT OVERALL QUALITY
BY QUARTER
Poplar Bluff
VISN 15
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Quarter Reported

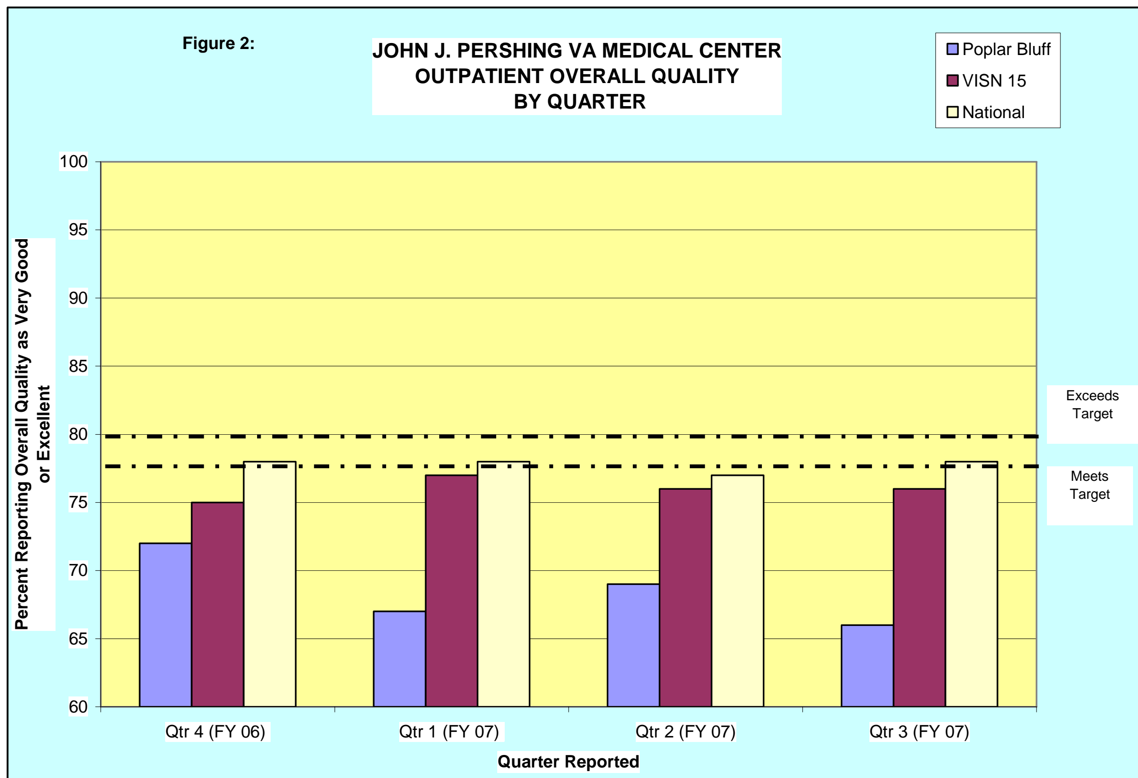
Figure 2:
JOHN J. PERSHING VA MEDICAL CENTER
OUTPATIENT OVERALL QUALITY
BY QUARTER
Poplar Bluff
VISN 15
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Quarter Reported

The medical center met the target in 2 of the past 4 quarters for inpatients. The medical center did not meet the outpatient target for any of the past 4 quarters. However, managers had identified opportunities for improvement based on the SHEP results and had developed an action plan targeting specific services and departments. They reestablished the Customer Service Committee and initiated "quick cards" for immediate patient feedback. Because the medical center had implemented an action plan, demonstrated evidence of ongoing activities, and evaluated the plan for effectiveness, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 6, 2008

From: Director, Veterans Integrated Service Network (10N15)

Subject: **Combined Assessment Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO**

To: Director, Kansas City Regional Office of Healthcare Inspections (54KC)

Director, Management Review Service (10B5)

I have reviewed and concur with the responses to the recommendations outlined in this report.

PETER L. ALMENOFF, MD., FCCP

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 5, 2008

From: Director, John J. Pershing VA Medical Center (657A4/00)

Subject: **Combined Assessment Program Review of the John J. Pershing VA Medical Center, Poplar Bluff, MO**

To: Director, Veterans Integrated Service Network (10N15)

1. Attached, please find Poplar Bluff VA Medical Center's response to the Office of Inspector General Combined Assessment Program (OIG-CAP) review conducted during the week of December 3, 2007.

2. If you have any questions regarding the information provided, please contact Dawna Bader, Director of Performance Improvement. Ms. Bader can be reached at (573) 778-4280.

(original signed by:)

NANCY ARNOLD, BSN, MA, ACHE
Medical Center Director

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 Medical Center Director requires that the PRC complete peer reviews within 120 days and submit quarterly aggregate reports of findings to the CEB.

Facility Response: Concur with recommendation.

Corrective Action: In order to improve tracking of peer reviews and ensure that they are completed within 120 days, we implemented a new Excel spreadsheet that automatically calculates the number of days from the initiation of the review until the final peer review level is issued by the Peer Review Committee. The "days lapsed to completion" not only calculates the number of days but also changes colors 30 days before the 120-day limit has passed. The Peer Review Log is monitored daily by Quality Management staff who alert the Quality Manager when a review has been flagged. This allows the Quality Manager time to alert the Chief of Staff and convene a special Peer Review Committee meeting, if necessary, to avoid delinquency. In addition, the quarterly aggregate Peer Review Report was added as a standing agenda item on the Medical Staff (CEB) agenda to ensure timely reporting.

Target Completion Date: Completed 1/28/2008.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that RCAs are completed within 45 days.

Facility Response: Concur with recommendation.

Corrective Action: All future RCAs will include a brief pre-meeting with the Medical Center Director (MCD) or designee, the Patient Safety Manager, and applicable area supervisors to discuss team membership, establish completion dates, and share expectations for staff participation. Problems with attendance will be taken first to the responsible supervisor followed by the MCD, as necessary.

In addition, quarterly reports on RCA timeliness will be submitted to Leadership through the Performance Improvement Committee.

Target Completion Date: Implement new process 2/1/2008.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the PIC serve as an independent oversight group to review and discuss all QM activities and to take action on identified opportunities for improvement.

Facility Response: Concur with recommendation.

Corrective Action: The facility was already in transition at the time of the CAP survey to initiate independent oversight functions by the Performance Improvement Committee (PIC). Approximately 2 months prior to the CAP survey, the facility had reorganized the Committee into an oversight body. As part of its functions, the PIC reviews all services' performance improvement activities/results, including the aggregation and analysis of data. They also review the appropriateness and effectiveness of service improvement actions and either concur or make recommendations, as appropriate.

As a result of the CAP survey, the PIC minutes were revised so that they more clearly document the committee's discussions and subsequent recommendations. Revisions were also made so that PI reports are attached to the PIC minutes as opposed to cutting and pasting them into the minutes. This revised practice provides clear information to the Leadership Council, enabling them to make the final decision on the proposed recommendations.

Target Completion Date: Completed December 2007.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires program staff to continue to perform periodic reviews of all business rules, update rules to comply with VHA policy, and delete rules no longer in use.

Facility Response: Concur with recommendation with comment. In clarification of the 2 individuals who had CPRS business rules that made the facility non-compliant, note that one of the persons was not a Poplar Bluff staff; rather, this rule had been added from another site within the VISN and had already been corrected by the other site at the time of the survey. Since this event fell between audit schedules, it had not yet been detected and corrected by the Poplar Bluff VAMC. The other person contributing to the non-compliant rating served as the backup for the Privacy Officer and had the assigned rules as part of their duties. However, a recent change in staffing resulted in the duty of Alternate Privacy Officer being removed, and the rules had not yet been changed to reflect this recent change in duty.

Corrective Action: The Chief, Health Information Management Service, will review CPRS Business Rules quarterly. This information will be reported to the Medical Records Committee and to Leadership.

Target Completion Date: March 31, 2008.

OIG Contact and Staff Acknowledgments

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