Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-03100-63

Combined Assessment Program Review of the Manchester VA Medical Center Manchester, New Hampshire

January 23, 2008

Washington, DC 20420

Why We Did This Review

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

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

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

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Executive Summary

Introduction

During the week of November 5–8, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Manchester VA Medical Center (the medical center), Manchester, NH. 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 for 179 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 1.

Results of the Review

The CAP review covered four operational activities and assessed compliance with recommendations made during the December 2004 CAP review. We identified the following organizational strength and reported accomplishment**:**

- The medical center established a primary mental health care (PMHC) clinic in the primary care clinic area, which provided seamless and immediate integration of primary care and mental health services.

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

- Conduct thorough and credible root cause analyses (RCAs) and ensure that aggregate RCAs are completed.
- Ensure that the individuals responsible for implementation of improvement actions identified in RCAs report progress and efficacy of the actions to the medical center's Quality Executive Board (QEB).
- Ensure that the Peer Review Committee (PRC) reports quarterly to the Executive Committee of the Medical Staff (ECMS) and completes peer reviews within 120 days.
- Ensure that provider-specific performance improvement (PI) data are collected and reviewed during the reprivileging process.
- Ensure the development of plans for ongoing review of provider-specific PI data.
- Review computerized patient record system (CPRS) business rules regularly to assess compliance with Veterans Health Administration (VHA) regulations.

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 Katherine Owens, Director, Bedford 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. Located in Manchester, NH, the medical center offers primary, secondary, and extended care services and outpatient mental health services. It provides primary care services at community based outpatient clinics in Portsmouth, Tilton, Conway, and Somersworth, NH, and serves the Lakes Region and Seacoast areas. The medical center is part of VISN 1 and serves a veteran population of approximately 121,500 in the counties of Hillsborough, Rockingham, Merrimack, Strafford, Belknap, and Carroll, NH. The medical center's service referral area also includes portions of York County, ME, and Essex County, MA.

Programs. The medical center supports programs in medicine, surgery, extended care, and ambulatory care. The continuum of patient services is ensured through primary care, nursing home care, hospital-based home care, and respite and palliative care services. A contract to provide acute care in the community has been in place for several years.

Affiliations and Research. The medical center is affiliated with Dartmouth Medical School. It is also affiliated with Harvard University's School of Dental Medicine and the Massachusetts College of Pharmacy and Health Sciences. Nursing school affiliations include Northeastern University, the University of Massachusetts (the Lowell, MA, campus), Rivier College, and New Hampshire Community Technical College.

During fiscal year (FY) 2006, the medical center had 15 active research projects, 5 of which were post-traumatic stress disorder (PTSD) studies. Current PTSD research focuses on the examination of psychological and physiological predictors of risk for the development of chronic PTSD in recent victims of acute trauma, including returning Afghanistan and Iraqi veterans.

Resources. In FY 2006, the medical center's budget totaled over $79.5 million. For FY 2007, the budget was almost $91 million. FY 2007 staffing was 475 full-time employee equivalents (FTE), including 27 physician and 148 nursing FTE.

Workload. During FY 2006, the medical center treated more than 20,000 unique patients. It had no acute care

hospital beds in FYs 2006 and 2007. In FY 2006, the medical center had 112 operating Nursing Home Care Unit (NHCU) beds and an average daily census of 48. Operating NHCU beds for FY 2007 remained at 112, and the average daily census was 52. Outpatient workload for FY 2006 totaled more than 91,000 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:

- CPRS Business Rules.
- EOC.
- QM Program.
- SHEP.

The review covered medical center operations for FY 2006 and FY 2007 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from the previous CAP review (*Combined Assessment Program Review of the*

Manchester VA Medical Center, Manchester, New Hampshire, Report No. 05-00313-176, July, 21, 2005).

During this review, we presented fraud and integrity awareness briefings for 179 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 OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Primary Mental Health Care Clinic

Medical center clinical managers established a PMHC clinic in the primary care clinic area in 2006. The purpose of the PMHC clinic is to provide seamless and immediate integration of primary care and mental health services. When patients are seen by their primary care providers and either request or are assessed to need mental health services, they are referred to the PMHC clinic and seen by a mental health provider the same day. Two mental health providers are available in the PMHC clinic during regular primary care hours, and at least one provider can prescribe medications. This initiative combines advanced clinical access and integrated care and was featured as a workshop presentation at the Institute for Healthcare Improvement's Office Practice Summit in 2006.

Results

Review Activities With Recommendations

Quality Management Program

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the medical center Director, Chief of Staff, and the QM Manager. We reviewed and evaluated current QM policies, PI data, and other relevant documents. We also assessed compliance with QM recommendations from the previous CAP review.

The QM program was generally effective, and senior managers supported the program through participation in QM and PI activities. Data collection and analysis had generally improved from the previous CAP review. However, we identified the following areas that needed improvement.

Root Cause Analyses. We reviewed four individual RCAs conducted during the past 12 months. We found that three lacked the critical analysis required to identify all potential root causes that would make them thorough and credible, as defined in VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, January 30, 2002.

Additionally, we could not verify that action items identified in two RCAs were implemented because the individuals responsible for implementing the improvement actions were not required to report their progress to the medical center's QEB. We also found that aggregate RCAs had not been completed since 2005. While the requirements for the frequency of aggregate RCAs have changed, these reviews are still required.

Peer Review Process. The PRC met at least quarterly, as required by VHA Directive 2004-054, *Peer Review for Quality Management,* September 29, 2004. However, both this directive and Medical Center Policy 11-35, *Peer Review Policy*, September 30, 2005, require that the PRC submit quarterly reports of peer review results to the ECMS. These reports should contain trended data on the number of peer reviews completed, the outcome levels assigned by the peer reviewers, the number of changes the PRC made to the outcome levels, and follow-up on actions items and recommendations that resulted from completed reviews. We did not find documentation to support that the PRC submitted quarterly reports to the ECMS. Because the medical center did not have acute care beds, it was possible that no peer reviews would have been required for a given quarter. For those quarters, negative reports should have been submitted to the ECMS.

Additionally, VHA regulations and the medical center's policy require that the PRC complete final reviews of cases within 120 days from the date it was determined that a peer review was needed. If the review cannot be completed in that timeframe, the PRC should request an extension, which

must be approved by the Chief of Staff. We did not find data to support that reviews were completed within 120 days.

Provider Profiles. VHA Handbook 1100.19, *Credentialing and Privileging,* October 2, 2007, and The Joint Commission[1] require that provider-specific PI data are reviewed as part of the reprivileging process. As of January 1, 2007, Joint Commission accreditation standards require that clinical managers review PI data on an ongoing basis. We reviewed five credentialing and privileging folders and asked for corresponding PI data. We were provided some data on three of the five providers and received no data on the remaining two providers. Professional Standards Board (PSB) minutes did not reflect that PI data were reviewed at the time of reprivileging for any of the five providers. Additionally, clinical managers had not developed plans that defined what provider-specific PI data would be reviewed or the frequency of the reviews.

Pressure Ulcer Follow-Up. As part of the QM review, we followed up on the recommendations regarding pressure ulcer prevention and management documentation from the previous CAP review. A review of five medical records of patients being monitored for pressure ulcers showed that skin assessments were documented in accordance with the medical center's policy, and documentation showed that patients were turned and positioned according to individual treatment plans. These actions addressed the recommendations from the previous CAP report.

Recommendation 1

We recommended that the VISN Director ensure that the Medical Center Director requires that all RCAs are thorough and credible and that aggregate RCAs are completed in accordance with VHA regulations.

The VISN and Medical Center Directors agreed with the findings and recommendation. They stated that the National Center for Patient Safety will provide RCA training for the Patient Safety Manager (PSM) and 20 interested employees during January and February 2008. RCAs will be submitted to the VISN Patient Safety Officer for comments and guidance.

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

The VISN and Medical Center Directors also reported that the falls aggregate RCA was completed and that the three other aggregate RCAs—missing patients (due March 1, 2008), drug events (due June 1, 2008), and parasuicidal behavior and outpatient suicides (due September 2, 2008)—will be completed on time. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that the individuals responsible for implementing improvement actions identified in RCAs report progress and efficacy of the actions to the QEB.

The VISN and Medical Center Directors agreed with the finding and recommendation. They stated that service line managers began reporting to the QEB on December 6, 2007. The PSM will keep a schedule of RCA report requirements and notify managers about report dates. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC report quarterly to the ECMS and complete peer reviews within 120 days.

The VISN and Medical Center Directors agreed with the findings and recommendation. They stated that the PRC will report trended peer review data quarterly to the ECMS beginning February 2008. Additionally, they reported that peer reviews will be completed within 120 days. If more time is needed to complete a review, the Chief of Staff will approve the extension. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that provider-specific PI data are collected and reviewed at the time of reprivileging and that PSB minutes reflect that data were considered during the reprivileging process.

The VISN and Medical Center Directors agreed with the findings and recommendation. They stated that the ECMS will determine data sets for each clinical service line at its

January meeting. These provider-specific criteria will become effective February 1, 2008, and will be considered during the reprivileging process. PSB minutes will reflect that PI data were reviewed. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5

We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers develop plans for ongoing collection and review of provider-specific PI data and that the plans indicate the frequency of those reviews.

The VISN and Medical Center Directors agreed with the finding and recommendation. They stated that clinical managers will develop processes for ongoing collection and review of provider-specific PI data by January 2008. Clinical managers will trend the data no less than quarterly and provide this trended information to the PSB. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Computerized Patient Record System Business Rules

Business rules define which groups or individuals are allowed to edit, amend, or delete documentation in electronic medical records. The health record as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006, includes both the electronic and paper medical record. It includes items, such as physician orders, progress notes, and examination and test results. In general, once progress notes are signed, they should not be altered.

On October 20, 2004, the VHA Office of Information sent a software informational patch (USR*1*26) to all VA health care facilities with instructions to assure that business rules complied with VHA regulations. The guidance 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." In January 2006, the OIG identified a facility where progress notes could be improperly altered and recommended that VHA address the issue on a national basis. On June 7, 2006, VHA issued a memorandum to VISN Directors instructing all VA health care facilities to comply with the informational patch sent in October 2004.

We reviewed VHA and medical center information and technology policies and interviewed Information Resource

Management Service staff. We found one rule that managers needed to modify or delete, and they deleted it while we were onsite.

Recommendation 6

We recommended that the VISN Director ensure that the Medical Center Director requires that managers review CPRS business rules regularly to assess compliance with VHA regulations.

The VISN and Medical Center Directors agreed with the finding and recommendation. They stated that the Chief of Health Information Management Service and/or the Computer Applications Coordinator will review CPRS business rules quarterly. This information will be reported to the Medical Records Committee and the QEB. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Environment of Care

VHA regulations require that health care facilities provide clean and safe environments in all patient care areas and establish comprehensive EOC programs that fully meet National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

We inspected urgent care, same day surgery, NHCU, and dental clinic areas and the Nutrition and Food Service kitchen for cleanliness, safety, infection control (IC) processes, and general maintenance. Nurse managers expressed satisfaction with the housekeeping staff assigned to their units, and the areas inspected were clean and well maintained. We found that managers had resolved the identified EOC issues from the previous CAP review.

We evaluated the IC program to determine compliance with VHA directives and to determine how managers used data to improve performance. We interviewed IC personnel and reviewed IC policies and the IC annual report. We also reviewed the management of patients with multi-drug resistant organisms. We found that the medical center's IC program was comprehensive and that IC clinicians appropriately screened for and managed patients with multi-drug resistant organisms.

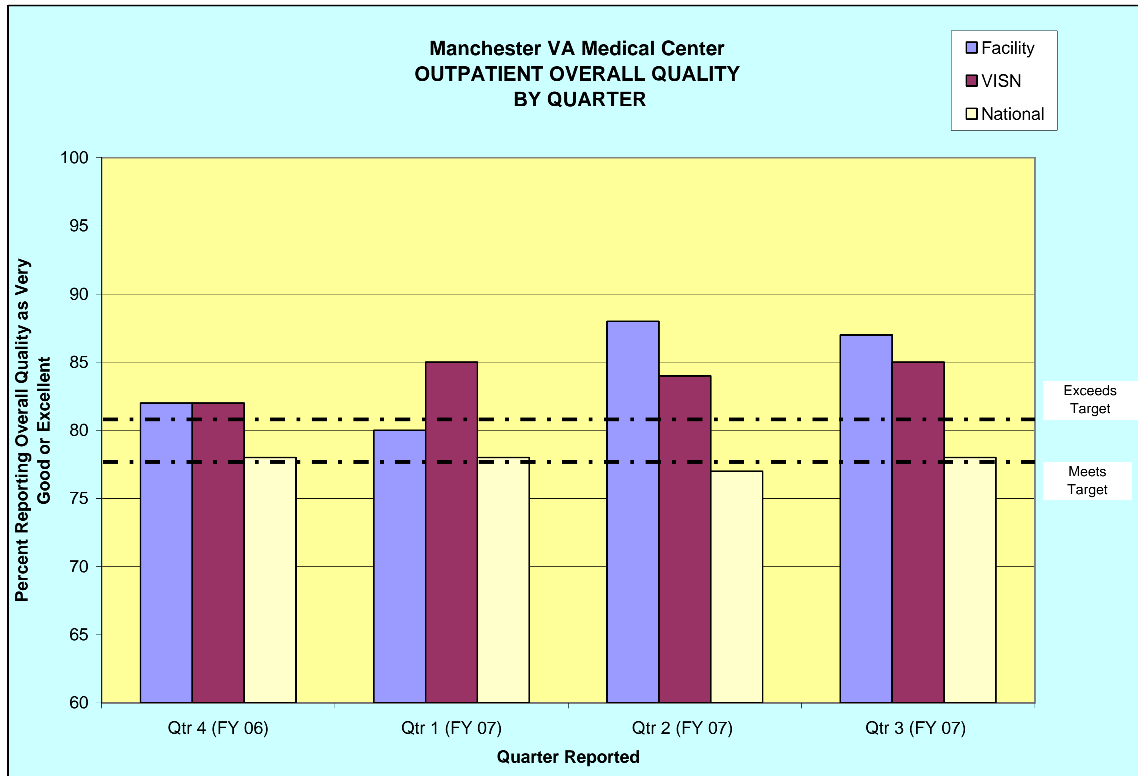
Additionally, as part of the EOC review, we assessed compliance with Emergency Preparedness Program

recommendations from the previous CAP review. We found that managers had developed and implemented a policy to ensure that non-VA employees are identified when they enter the medical center. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical facilities used SHEP results to improve patient care 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 goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. The medical center had no acute care beds, so inpatient scores were not applicable.

We reviewed the outpatient survey results for quarter 4 of FY 2006 and quarters 1–3 of FY 2007. The medical center met or exceeded the outpatient target score during all quarters reviewed. A summary of the findings is displayed in the graph below.



Medical center managers analyzed their survey results, developed strategies for continued improvement, and communicated the results throughout the organization. We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 13, 2007

From: Director, VA New England Healthcare System (10N1)

Subject: Combined Assessment Program Review of the Manchester VA Medical Center, Manchester, New Hampshire

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

We concur with the recommendations and have actions listed below. Please contact Allan Shirks, MD, (781-687-4850), VISN 1 Quality Management Officer, if anything further is needed.

(original signed by:)

JEANNETTE CHIRICO-POST, M.D.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 13, 2007

From: Director, Manchester VA Medical Center (608/00)

Subject: Combined Assessment Program Review of the Manchester VA Medical Center, Manchester, New Hampshire

To: Director Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (10B5)

We concur with the recommendations and have actions listed below. Please contact Valerie Zaleski (603-624-4366 x 6006), Manchester VAMC Quality Manager, if anything further is needed.

(original signed by:)

MARC F. LEVENSON, M.D.

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 all RCAs are thorough and credible and that aggregate RCAs are completed in accordance with VHA regulations.

Concur

RCA training will be provided to the new Patient Safety Manager (PSM) and 20 interested staff through January–February 2008. This training is provided by National Center for Patient Safety and will provide RCA team members with standards and expectations of process and thoroughness of RCAs. RCAs will be submitted to VISN PSO for comments and guidance.

The Falls aggregate has been completed and submitted in SPOT. The Falls Team will be implementing recommendations for FY 2008 at the December 10, 2007, meeting. The three other aggregate RCAs, which include missing patients (due 3/1/08), drug events (due 6/1/08), and para and outpatient suicides (due 9/1/08), will be completed on time.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the individuals responsible for implementing improvement actions identified in RCAs report progress and efficacy of the actions to the QEB.

Concur

Service Line Managers began reporting to the QEB on December 6, 2007, on their progress with implementing RCA recommendations. Reporting schedule will be based on RCA recommended reporting schedule as approved by Facilities Director. The PSM will keep a schedule of RCA reporting requirements and will be responsible for notifying managers of reporting date and assisting in preparation of reports.

List of responsibilities:

FY 07	RCA Number	Title	Responsible Party	QEB Date
#1	RC0143	Combative Patient	Chairperson, Disruptive Behavior Committee	1/3/2008
#2	RM0003	Fall with Patient Death	Geriatric and Extended Care (GEC) Service Line Manager	1/10/2008
#3	RC0144	Outpatient Attempted Suicide	Mental Health (MH) Service Line Manager	12/20/07
#4	CB0072	Outpatient Suicide	MH Service Line Manager	12/20/07
FY 08	**RCA Number**	**Title**	**Responsible Party**	**QEB Date**
#1	CB0003	Patient Elopement	Patient Safety Manager and GEC Service Line Manager	12/6/2007

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the PRC report quarterly to the ECMS and complete peer reviews within 120 days.

Concur

The PRC will report trended peer review data quarterly to ECOMS beginning February 2008. Peer reviews will be completed within 120 days. If a longer amount of time is needed to complete the review, the Chief of Staff will approve the extension.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that provider-specific PI data are collected and reviewed at the time of reprivileging and that PSB minutes reflect that data were considered during the reprivileging process.

Concur

At the January 2, 2008, ECOMS meeting will determine data sets for each clinical service line and become effective February 1, 2008. Thereafter, provider-specific data will be used in all reprivileging and will be documented in the PSB.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that clinical managers develop plans for ongoing collection and review of provider-specific PI data and that the plans indicate the frequency of those reviews.

Concur

Clinical Managers will develop processes for ongoing collection and review of Core Performance Improvement Indicators and other VISN or locally determined Indicators on all providers January 2008. These PI data will be centrally located in Performance Management Department, and Clinical Managers will submit and trend this data no less than on a quarterly basis. This data on individual providers will be made available to the PSB members effective February 1, 2008.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that managers review CPRS business rules regularly to assess compliance with VHA regulations.

Concur

The computerized patient record system business rules will be reviewed quarterly by the Chief of HIMS and/or the Computer Applications Coordinator. This will be reported to the Medical Records Committee and the Quality Executive Board.

OIG Contact and Staff Acknowledgments

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