Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02982-73

Combined Assessment Program Review of the Alexandria VA Medical Center Pineville, Louisiana

January 24, 2011

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 crime awareness briefings 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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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CBOC	community based outpatient clinic
CCC	Critical Care Committee
CHF	congestive heart failure
CLC	community living center
COC	coordination of care
ED	emergency department
EMR	electronic medical record
EMT	emergency medical technician
EOC	environment of care
facility	Alexandria VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
IC	infection control
JC	Joint Commission
MDRO	multidrug-resistant organisms
MH	mental health
MHEOCC	Mental Health Environment of Care Checklist
MSIT	Multidisciplinary Safety Inspection Team
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PI	performance improvement
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
PSB	Professional Standards Board
QM	quality management
RCA	root cause analysis
RRT	Rapid Response Team
SR	systems redesign
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Alexandria VA Medical Center, Pineville, LA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of October 18, 2010.

Review Results: The review covered seven activities. We made no recommendations in the following activities:

- Coordination of Care
- Medication Management

The facility's reported accomplishment was its cancer care collaborative, which reduced the number of days between initial suspicion of cancer to actual diagnosis.

Recommendations: We made recommendations in the following five activities:

Quality Management: The Critical Care Committee should review all resuscitation events occurring in the facility, and facility policy should be revised to include the roles and responsibilities of the emergency medical technicians on the Rapid Response Team.

Physician Credentialing and Privileging: Focused Professional Practice Evaluations should be initiated for all physicians who have been newly hired, and Professional Standards Board minutes need to reflect discussion of Focused Professional Practice Evaluations. Ongoing Professional Practice Evaluations should reflect the aggregate performance data used to validate competency.

Management of Test Results: Normal test results must be consistently communicated to patients within the specified timeframe.

Management of Multidrug-Resistant Organisms: Infection control strategies education should be provided to patients infected or colonized with multidrug-resistant organisms and their families and should be documented.

Environment of Care: Staff designated as high risk for exposure to airborne pathogens should receive annual respirator fit testing.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

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 crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- COC
- EOC
- Management of MDRO
- Management of Test Results
- Medication Management
- Physician C&P
- QM

The review covered facility operations for FY 2009 and FY 2010 through September 11, 2010, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Alexandria VA Medical Center, Pineville, Louisiana,* Report No. 08-00054-84,

February 27, 2008). During our follow-up review, we found sufficient evidence that program managers and staff had implemented appropriate actions to address the identified deficiencies in these areas. We consider these issues closed. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 155 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.

Reported Accomplishment

Cancer Care Collaborative

In 2009, the facility initiated a project to reduce the number of days from initial suspicion of lung cancer to diagnosis and treatment by improving timeliness of providers ordering and completing follow-up diagnostic testing on abnormal imaging results. The project was developed in response to VHA SR efforts, and in February 2010, the facility was 1 of 20 teams selected to participate in the national Cancer Care Collaborative to work on initiatives to improve the timeliness and reliability of cancer care across VHA. Through improved communication, effective utilization of data collection tools, team accountability, and feedback, the facility was able to reduce the number of days between initial suspicion of cancer to actual diagnosis. Timely diagnosis allows for more timely initiation of therapy.

Table A. Compliance with Performance Measure (in percent)

	Calendar Year 2009	Calendar Year 2010 through March
Abnormal chest x-ray(s) follow-up test ordered within 3 days	61	92
Follow-up diagnostic testing completed within 7 days	58	77

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following area that needed improvement.

Review of Resuscitation and Its Outcomes. Facility policy defined the roles, responsibilities, and documentation requirements for staff responding to resuscitation events, including the RRT. In addition, facility policy required CCC review of all resuscitation events. However, we found that RRT responses that occurred outside the inpatient building were not included as part of the CCC review. We also found that facility policy did not define the roles and responsibilities for EMTs who responded as the RRT outside of the inpatient building.

Recommendations

1. We recommended that the CCC review all resuscitation events occurring in the facility and that facility policy be revised to include the roles and responsibilities of the EMTs on the RRT.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following areas that needed improvement.

FPPE. VHA requires that an FPPE be initiated for all physicians who have been newly hired or have added new privileges.[1] VHA also requires that PSB minutes reflect discussion of completed FPPEs. One of the three newly hired physicians whose profiles we reviewed did not have an FPPE implemented. In addition, PSB minutes did not reflect discussion of one of the two completed FPPEs.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

OPPE. VHA requires that data consistent with service-specific competency criteria be collected, maintained in each physician's profile, and reviewed on an ongoing periodic basis.[2] We found evidence of OPPE performance data in the profiles. However, the OPPEs only reflected data related to predefined triggers, which would indicate a need for closer review. The OPPEs did not reflect the aggregated performance data to support competency.

Recommendations

2. We recommended that FPPEs be initiated for all physicians who have been newly hired and that PSB minutes reflect discussion of FPPEs.

3. We recommended that OPPEs reflect the aggregated performance data used to validate competency.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[3]

We reviewed the facility's policies and procedures, and we reviewed medical records. We identified the following area that needed improvement.

Communication of Normal Results. VHA requires facilities to communicate normal results to patients no later than 14 calendar days from the date that the results were available to the ordering provider.[4] We reviewed the medical records of 20 patients who had normal results and found that only 10 (50 percent) of the 20 records contained documented evidence that the facility had communicated the results to the patients.

Recommendation

4. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Management of MDRO

The purpose of this review was to evaluate whether the facility had developed a safe and effective program to reduce the incidence of MDRO in its patient population in accordance with applicable requirements.

[2] VHA Handbook 1100.19.
[3] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results,* Report No. 01-01965-24, November 25, 2002.
[4] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

We reviewed the facility's IC risk assessment, employee training records, and medical records. We inspected the CLC (45-C2) and the acute inpatient medicine/surgery (7BN) units, and we interviewed six employees. We did not identify any deficits in either the inspections or staff interviews. However, we identified the following area that needed improvement.

Patient/Family Education. The JC requires that patients infected or colonized[5] with MDRO receive education on IC strategies, such as hand washing and the proper use of personal protective equipment. We reviewed 16 medical records and found that 3 (19 percent) of the records did not have documented evidence of MDRO education.

Recommendation

5. We recommended that IC strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the locked MH (9A&B), acute inpatient medicine/surgery (7A), intensive care (7B), Alzheimer's (45-A), long-term care and hospice (45-B), and post-anesthesia care units. We also inspected the ED; the dental, eye, and podiatry clinics; and four primary care outpatient (B, C, E, and F) clinics. The facility maintained a generally clean and safe environment. However, we identified the following area that needed improvement.

Respirator Fit Testing. The Occupational Safety and Health Administration requires that staff at risk for exposure to airborne pathogens, such as swine flu or tuberculosis, have annual respirator fit testing. We found that 6 (40 percent) of 15 employees who were designated as high risk did not have the required annual respirator fit testing. Five of the six employees were assigned to the ED.

Recommendation

6. We recommended that staff designated as high risk for exposure to airborne pathogens receive annual respirator fit testing.

[5] Colonization is the presence of bacteria in the body without causing clinical infection.

Review Activities Without Recommendations

COC

The purpose of this review was to evaluate whether the facility managed advance care planning, advance directives, and discharges in accordance with applicable requirements.

We reviewed 16 patients' medical records and determined that the facility generally met requirements in these areas. We made no recommendations.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 13–17, for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

Facility Profile[6]		
Type of Organization	Primary and secondary care medical center	
Complexity Level	3	
VISN	16	
CBOCs	Lafayette, LA Jennings, LA Natchitoches, LA (opened 10/4/10)	
Veteran Population in Catchment Area	89,198	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	114	
• **CLC/Nursing Home Care Unit**	112	
• **Other**	0	
Medical School Affiliation	Tulane University School of Medicine, Sections of Preventative Medicine and Ophthalmology	
• **Number of Residents**	13	
	Current FY (through August 2010)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$186.1	$185.6
• **Medical Care Expenditures**	$168	$185.4
Total Medical Care FTE	1,184	1,182
Workload:		
• **Number of Station Level Unique Patients**	27,726	28,191
• **Inpatient Days of Care:**		
o **Acute Care**	8,367	10,130
o **CLC/Nursing Home Care Unit**	29,504	36,159
Hospital Discharges	1,321	1,488
Total Average Daily Census (including all bed types)	148.6	157.1
Cumulative Occupancy Rate	69.6%	69.5%
Outpatient Visits	191,339	222,166

[6] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Complete the RCA process in accordance with VHA policy.	Facility has a policy that contains an RCA checklist. The patient safety manager developed an RCA action item tracking log and record system.	Y	N
2. Timely review all deaths to identify issues that may require follow-up.	Facility established a computerized menu option that tracks death reviews to completion, automatically generating and printing a daily report in PI. Daily, an administrative person assigns newly identified death reviews to PI staff.	Y	N
EOC			
3. Track and report all findings, actions, and outcomes from safety rounds on the locked MH unit, as required by the Deputy Under Secretary for Health for Operations and Management.	The MHEOCC is presented quarterly as a separate agenda item at EOC Committee meetings. Once environmental concerns are identified, the level of risk is rated, a corrective action plan is developed, and progress is monitored until closed.	Y	N
4. Complete an interim corrective action plan to address environmental safety concerns on the locked MH unit that pose a risk but cannot be immediately corrected.	The MHEOCC is presented quarterly as a separate agenda item at EOC Committee meetings. Once environmental concerns are identified, the level of risk is rated, a corrective action plan is developed, and progress is monitored until closed.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
5. Ensure all staff assigned to the locked MH unit and all members of the MSIT receive training on identifying and correcting environmental hazards.	One-hundred percent in compliance. All locked MH unit staff and all members of the MSIT completed training on identifying and correcting environmental hazards.	Y	N
EMR Business Rules			
6. Continue compliance with VHA Handbook 1907.01 and the October 2004 Office of Information guidance related to EMRs.	This recommendation was closed during the December 2007 onsite visit. The facility continues to comply.	Y	N
Patient Satisfaction			
7. Develop a comprehensive Survey of Healthcare Experiences of Patients program that includes specific service-level action planning and follow-up.	In FY 2009, three SR teams were chartered to improve inpatient and outpatient satisfaction. Through effective communication, health care information, and education, there was a 5 percent improvement in inpatient MH, Lafayette CBOC, and facility outpatient satisfaction scores. Based on FY 2009 scores, a facility-wide customer service redesign team was chartered. Its aims were to improve inpatient and outpatient overall quality in FY 2010 and to decrease the number of patient complaints in inpatient, outpatient, and CLC areas.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
8. Ensure Customer Service Council minutes include all appropriate elements and show continuity of process from month to month.	Monthly Customer Service Council minutes include all appropriate elements and show continuity of process from month to month. Identification and correction of customer complaint(s) and customer service issues are reviewed at Director's Staff Leadership Council.	Y	N

VHA Satisfaction Surveys

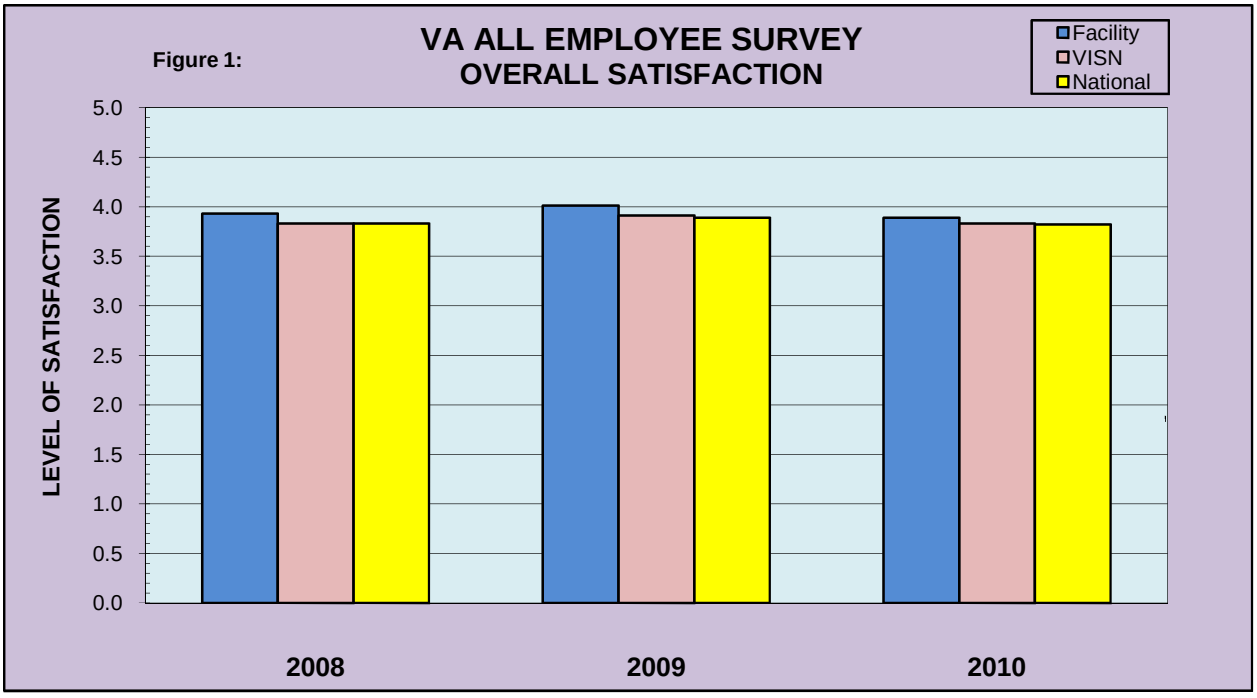
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 1–3 of FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)					
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	74.2	60.9	68.2	58.1	61.1	56.0
VISN	66.1	64.6	63.1	53.1	54.3	54.6
VHA	63.3	63.9	64.5	54.7	55.2	54.8

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[7] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	CHF	Pneumonia	Heart Attack	CHF	Pneumonia
Facility	11.77	9.68	16.37	20.03	21.09	15.01
VHA	13.31	9.73	15.08	20.57	21.71	15.85

[7] CHF is a weakening of the heart's pumping power. With heart failure, your body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the sedition of the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills your lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 23, 2010

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Alexandria VA Medical Center, Pineville, LA**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA CO 10B5 Staff)

I have reviewed the recommendations and concur with the response and action plans. If you have any questions, please contact Mary Jones, HSS at 601-206-6974.

(original signed by:)
George H. Gray, Jr.
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 21, 2010

From: Director, Alexandria VA Medical Center (502/00)

Subject: **CAP Review of the Alexandria VA Medical Center, Pineville, LA**

To: Director, South Central VA Health Care Network (10N16)

1. Our comments and actions plans have been entered directly in this report as requested.

2. Should you need additional information, please contact Portia McDaniel, RN, BSN, Chief, Performance Improvement, at (318) 4566-2370.

(original signed by:)
Gracie Specks, MS, MBA

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 the CCC review all resuscitation events occurring in the facility and that facility policy be revised to include the roles and responsibilities of the EMTs on the RRT.

Concur

Target date for completion: January 13, 2011

The current function of the CCC includes a review of all resuscitation events that occur at the facility. Medical Center policy, MCM-11-29, Critical Care Committee, documents the function. The facility is in the process of changing the policies and procedures related to emergency response. EMT's will no longer respond to RRT in Bldg 7. The Medical Center policy, MCM 138S-33, Medical Emergency Responses: Outside Building 7, has been developed to delineate the roles and responsibilities of the EMT's. The policy is currently under review by the CCC and EOC. It will be sent for final concurrence no later than December 23, 2010. The existing policy, MCM 111-36, Rapid Response Team, will remain in effect for Bldg. 7 only.

Recommendation 2. We recommended that FPPEs be initiated for all physicians who have been newly hired and that PSB minutes reflect discussion of FPPEs.

Concur

Target date for completion: Completed November 16, 2010

The medical center has initiated FPPE's for all physicians who have been hired and will continue this process on each new hire. The PSB minutes reflect discussion of the FPPE for all new hires. The content of the PSB minutes has been updated to strengthen the evidence of the discussion. November 2010 minutes document the FPPE discussion for the most recent hire that was boarded on November 16, 2010.

Recommendation 3. We recommended that OPPEs reflect the aggregated performance data used to validate competency.

Concur

Target date for completion: January 13, 2011

The medical center continues to utilize performance data to validate the competency for all physicians. The OPPE data has been updated to reflect aggregated outcomes for each physician.

Recommendation 4. We recommended that normal test results be consistently communicated to patients within the specified timeframe.

Concur

Target date for completion: Completed December 9, 2010

The medical center has distributed instructions to providers regarding the communication of normal test results to patients within the specified timeframe. A template field has been added to the provider ambulatory care progress note. A random sample of patients who have had an outpatient encounter has been reviewed. The medical center reviewed 6 records for patients receiving care through December 2010. The documentation revealed that all patient records contained documentation that normal test results were communicated to the patient within 14 days. The data from this review is available upon request.

Recommendation 5. We recommended that infection control strategies education be provided to patients infected or colonized with MDRO and their families and be documented.

Concur

Target date for completion: Completed November 26, 2010

The Infection Control program has developed a patient education package for each patient admitted to the facility. The package contains education material to include MDRO prevention strategies. Nursing staff provides the package to the patient and family members during the admission process. A review of the content occurs throughout the patient's encounter at the facility. For the Community Living Center, residents lacking capacity to manage their own affairs, education materials are being sent to surrogates/next of kin via mail to ensure infection prevention education has been provided. Documentation of the education provided is written in the medical record. A sample record review of patients who were infected or colonized with MDRO was completed. The results of this review revealed that all patient records contained documentation of infection control strategies.

Recommendation 6. We recommended that staff designated as high risk for exposure to airborne pathogens receive annual respirator fit testing.

Concur

Target date for completion: January 13, 2011

The medical center has identified staff that is designated as high risk for exposure to airborne pathogens. The Safety Office has identified a labor pool of six staff that is trained in fit testing procedures. The medical center determines whether an employee is cleared for fit testing during the pre-employment exam. Once the staff reports to duty, the fit testing is completed during the service level orientation. This process has been implemented in Nursing Service and will be rolled out to the remaining high risk for exposure work units. The labor pool is currently working to ensure that all high risk for exposure to airborne pathogens staff is current with their annual requirements. The staff that is due to complete annual respirator fit testing will complete the requirement no later than January 13, 2011.

OIG Contact and Staff Acknowledgments

Contact	Audrey Collins-Mack, Team Leader Atlanta Office of Healthcare Inspections
Contributors	Tishanna McCutchen Judy Montano Karen Sutton Toni Woodard Susan Zarter Thomas Bennett, Office of Investigations Ryan Gholson, Office of Investigations

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