Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection
Review of Recommendations
El Paso VA Health Care System
El Paso, Texas

Report No. 07-01159-153 **June 25, 2007**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted a follow-up review for the purpose of evaluating the implementation of corrective action plans in response to findings in the *Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas*, 06-01721-32, November 27, 2006. The four healthcare programs receiving recommendations were:

- Breast Cancer Management.
- Diabetes and Atypical Antipsychotic Medication.
- Environment of Care.
- Quality Management.

An onsite review, January 22-24, 2007, concluded that managers implemented corrective actions in a timely manner to resolve or improve conditions in three of four healthcare programs.

However, managers failed to demonstrate the implementation of a corrective action plan to revise a policy per the response to a recommendation in the Diabetes and Atypical Antipsychotic Medication program. On February 26, 2007, the corrective action plan was implemented by managers, and a revised policy was published.

As a result of this follow-up review, we find the El Paso VA Health Care System has now implemented all corrective action plans, and systems are in place to monitor continuous performance improvement. We have no further recommendations.

This report was prepared under the direction of Ms. Linda G. DeLong, Director, Dallas Regional Office of Healthcare Inspections.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N18)

SUBJECT: Healthcare Inspection – Review of Recommendations, El Paso VA Health Care System, El Paso, Texas

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted a follow-up review of our 2006 combined assessment program (CAP) review to assess the implementation of corrective action plans at the El Paso VA Health Care System (the system), El Paso, TX. The assessment determined if OIG's recommendations were implemented and if the recommended actions were effective. The system is in Veterans Integrated Service Network (VISN) 18.

Background

We conducted a CAP review at the system during the week of June 12-16, 2006 (*Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas*, 06-01721-32, November 27, 2006) and made recommendations in four healthcare programs: Breast Cancer Management, Diabetes and Atypical Antipsychotic Medication, Environment of Care (EOC), and Quality Management (QM). Because we had a significant finding in the Breast Cancer Management Program, we conducted a follow-up review to ensure that the system director's planned actions were implemented for all our recommendations and that these actions were effective.

Scope and Methodology

The system was notified of OHI's follow-up site visit on January 5, 2007. The follow-up review was conducted January 22–24, 2007. We reviewed documentation related to actions taken to determine if: (a) planned corrective action plans were implemented, (b) there was evidence of improved performance, (c) continuous performance monitors were established, and (d) there was documentation that staff had been informed of expected standards of practice.

We interviewed managers and clinicians, reviewed clinical and administrative records, and reevaluated policies and procedures based on action plans developed by the system in response to the 2006 CAP report recommendations. We also assessed the effectiveness of newly implemented processes and compliance with Veterans Health Administration (VHA) standards.

This inspection was conducted in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results

Issue 1: Breast Cancer Management

2006 CAP Report Recommendations. We recommended the VISN Director ensure the System Director takes action to: (a) develop a policy for clinical oversight of fee-basis mammography services and consult referral program based on requirements outlined in VHA Handbook 1104.1, *Mammography Standards*, August 6, 2003; (b) provide medical staff training on consult order entry and tracking procedures; (c) ensure all mammography consults are reviewed for care determinations, coordinated, and prioritized by clinical staff dedicated to the managed care department; (d) ensure that mammogram appointments, patient notification, results reporting, and report scanning complies with local policies and VHA Handbook 1104.1; (e) establish patient privacy in women's health exam rooms; and (f) require the Leadership Quality Board (LQB) to provide oversight of patient complaints and incidents in the Women Veterans Health Program to trend and track improvements.

Follow-Up Findings. The purpose of this review was to determine the effectiveness of breast cancer screening and management at VHA facilities. During the 2006 CAP review, we obtained a consult tracking list of patients for the period September 2004—March 2006. The list showed 194 cancelled appointments for mammograms; 169 of which were documented as "no shows." Managers identified a system failure to document patient notification of an appointment. System managers provided documentation to support that all of the 194 patients who had cancelled appointment have since had mammography services completed with no adverse outcomes.

In March 2006, the system implemented the Mammogram Process Action Team (PAT), which examines the mammogram process from ordering to receiving the results and identifies needed changes within the current system. The Mammogram PAT has made significant improvements, which are documented in committee minutes, demonstrated throughout the mammography process, and measured in the patient satisfaction rates.

Training on consult order entry and tracking procedures has been provided to appropriate employees. Clinical staff manages all mammography consults and services. Women's Health examination rooms may now be secured for privacy. The LQB is providing

oversight of patient complaints and incidents in the Women Veterans Health Program to trend and track improvements. The Breast Cancer Management program is in compliance with VHA Handbook 1104.1, *Mammography Standards,* August 6, 2003.

Issue 2: Diabetes and Atypical Antipsychotic Medication

2006 CAP Report Recommendations. We recommended the VISN Director ensure the System Director require clinicians to: (a) monitor and provide intervention for elevated Hemaglobin A1c's (HbA1c) in all patients with diabetes who are receiving atypical antipsychotic medications, (b) document risk factors for diabetes in the medical record, and (c) make appropriate referrals to utilize the diabetic nurse educator.

Follow-Up Findings. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes). Management took corrective action during the 2006 CAP to resolve one issue. Clinical reminder alerts were implemented to improve documentation of diabetes risk factors and are removed only after the provider completes required information.

The system's official response to the 2006 CAP report indicated that all corrective action plans for the program were completed. Corrective action plans for two issues indicated that the system would identify patients with an elevated HbA1c by a weekly pull list and refer appropriate patients to the diabetic nurse educator. However, during the follow-up review, the system could only provide a pull list from the weeks of January 8 and January 15, 2007. A policy was implemented on February 26, 2007 to ensure the process continued, which defines the actions necessary to monitor and provide intervention for patients with elevated HbA1c's and to utilize the diabetic nurse educator for improved patient outcomes. The policy meets the intent of VHA clinical practice guidelines for the management of diabetes.

Issue 3: Environment of Care

2006 CAP Report Recommendations. We recommended the VISN Director ensure the System Director requires: (a) outstanding work orders and tracking are completed and (b) prioritization of work orders accurately reflect the needs of the system.

Follow-Up Findings. The purpose of this review was to determine if managers have established a comprehensive EOC program that results in a safe and clean environment, to assess whether staffing resources are a barrier to maintaining the EOC, and to determine if biomedical equipment is clean and maintained. Outstanding work orders were completed and reconciled during the onsite 2006 CAP inspection. Audits for tracking work orders are now completed on a weekly basis and reviewed by EOC managers. The system has redesigned the work order process to limit the number of staff

authorized to enter work orders into the database. Training for authorized staff members has been provided. The EOC program fully meets VHA standards for work order tracking and prioritization of work orders.

Issue 4: Quality Management

2006 CAP Report Recommendations. We recommended the VISN Director ensure the System Director requires: (a) the LQB implement, monitor, and track performance improvement recommendations from PATs and Root Cause Analysis (RCA); (b) tracking and reporting processes include anticipated completion dates which are followed and documented; (c) credentialing and privileging files contain documentation attempts to obtain primary source verification from insurance companies, courts, or attorneys of circumstances surrounding malpractice claims disclosed on initial or reappointment applications for privileges; (d) initial peer reviews and RCAs are completed in 45 days; and (e) mortality assessments are conducted in accordance with VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005.

Follow-Up Findings. The purpose of this review was to determine whether: (1) VHA facilities have comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and (2) VHA facility senior managers actively support and appropriately respond to QM efforts. The LQB minutes reflect that PATs provide a monthly written progress report. Implementation and monitoring of performance improvement recommendations from the PAT and RCA team are tracked by the LQB. The credentialing and privileging process includes prime source verification of malpractice claims reported on initial and reappointment applications for privileges.

The system is in compliance with provisions of VHA Handbook 1100.19, *Credentialing and Privileging*, March 6, 2001. Initial peer review and RCAs are completed in the required 45 days per VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, January 30, 2002. A mortality review program was developed in conjunction with the clinical service chiefs and Chief of Staff in accordance with the guidelines in VHA Directive 2005-056, *Mortality Assessment*, December 1, 2005. Patient satisfaction rates are monitored to trend and track improvements and are reported to the LQB for performance improvement oversight. The LQB was providing effective oversight for all quality activities.

Conclusion

Corrective action plans were implemented in three of the healthcare programs with recommendations at the time of the follow-up review. The system complied with selected standards in Breast Cancer Management, EOC, and QM. Analysis for the action plans and recommendations collectively demonstrated sufficient information and documentation of performance improvement. Furthermore, there were continuous performance monitors established, and staff members were educated on expected standards of practice.

The Diabetes and Atypical Antipsychotic Medication program implemented a corrective action plan after the follow-up review was completed. The corrective action plan required a change in policy mandating clinicians to monitor and provide intervention for patients with elevated HbA1c and to utilize the diabetic nurse educator. The corrective action plan was not implemented until February 26, 2007, one month after the OHI follow-up review. The system is currently in compliance with VHA clinical practice guidelines for the management of diabetes.

As a result of the follow-up review, we find the system has implemented all corrective action plans from the previous CAP inspections and have no further recommendations.

Comments

The VISN and system Directors agreed with the review of recommendations. All corrective action plans were implemented. We consider all recommendations closed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 14, 2007

From: Network Director, VISN 18 (10N18)

Subject: **Review of Recommendations, El Paso VA Health Care System, El Paso, Texas**

To: Director, Dallas Regional Office (54DA)

Thru: Director, Management Review Service (Ms. Peggy Seleski) (10B5)

I concur with the facility draft response. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2692.

Patricia A McKlem

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 13, 2007

From: System Director

Subject: **Review of Recommendations, El Paso VA Health Care System, El Paso, Texas**

To: Director, Veterans Integrated Service Network (10N18)

I have reviewed the El Paso VA Health Care System Draft Health Care Inspection – Review of Recommendations and concur. If you have any questions or concerns, please contact Everett Perdue, Executive Assistant to the Director, at 915-564-7902.

(original signed by:)

Bruce E. Stewart

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Linda G. DeLong, Director Dallas Regional Office of Healthcare Inspections (214) 253-3331
Acknowledgments	Karen Moore, Associate Director Shirley Carlile Roxanna Osegueda

Appendix D

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