Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03663-111

Combined Assessment Program Review of the Central Alabama Veterans Health Care System Montgomery, Alabama

March 14, 2012

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

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
ED	emergency department
EOC	environment of care
facility	Central Alabama Veterans Health Care System
FY	fiscal year
HF	heart failure
IC	infection control
MH	mental health
MM	medication management
MSDS	Material Safety Data Sheets
OIG	Office of Inspector General
PI	performance improvement
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
RRTP	residential rehabilitation treatment program
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, AL

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 November 28, 2011.

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

- Psychosocial Rehabilitation and Recovery Centers
- Quality Management

The facility's reported accomplishment was initiating the Clinical Pharmacist Specialist Disease-Specific Competency Evaluation tool, which can be used to broaden a clinical pharmacist specialist's scope of practice.

Recommendations: We made recommendations in the following five activities:

Colorectal Cancer Screening: Ensure that patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe.

Environment of Care: Ensure that the sleep laboratory is cleaned between patients. Require that Material Safety Data Sheets are available in areas where chemicals are used. Ensure that emergency power is provided for life support equipment. Require that multidose vials are dated when opened and that expired medications and supplies are removed and disposed of appropriately.

Coordination of Care: Ensure that providers include follow-up appointment recommendations in discharge instructions and that appointments are scheduled within the requested timeframes.

Medication Management: Ensure that clinicians screen patients for pneumococcal and tetanus vaccinations upon community living center admission and at clinic visits.

Polytrauma: Ensure that patients with positive traumatic brain injury screening results receive a comprehensive evaluation as outlined in Veterans Health Administration policy.

Comments

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

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
- CRC Screening
- EOC
- MM
- Polytrauma
- PRRCs
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2010, FY 2011, and FY 2012 through December 1, 2011, 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 Central Alabama Veterans Health Care System, Montgomery, Alabama,*

Report No. 08-03086-192, August 11, 2009). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 251 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 149 responded. Survey results were shared with facility managers.

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

Clinical Pharmacist Specialist Disease-Specific Competency Evaluation

In 2011, the facility initiated the Clinical Pharmacist Specialist Disease-Specific Competency Evaluation tool as a competency checklist that can be used to cross-train clinical pharmacist specialists to broaden their scopes of practice. The mentor uses the tool to assess and teach the skills necessary to evaluate and prescribe medications for a particular disease state, such as hypertension or diabetes mellitus.

Results

Review Activities With Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 21 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[1] Six of the 21 patients did not receive diagnostic testing within the required timeframe. Managers had designated a CRC coordinator to expedite all aspects of CRC detection and treatment, including communication with other clinical services, pre-procedure clinic visits, and follow-up scheduling for colonoscopies. However, the CRC coordinator was assigned other collateral duties from May–November 2011 and did not oversee the continuity of care for these patients. As a result, the six patients did not receive timely diagnostic testing.

Recommendation

1. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

[1] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).

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 and whether the facility's domiciliary and Psychosocial RRTP were in compliance with selected MH RRTP requirements.

At the Montgomery campus, we inspected the ED and the primary care, MH, geriatric and extended care, occupational health, dental, and specialty clinics. We also inspected the inpatient medical/surgical and intensive care units and the operating and recovery rooms.

At the Tuskegee campus, we inspected the primary care, dental, and specialty clinics. We also inspected the CLC, inpatient MH, and psychosocial and domiciliary residential treatment units. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
X	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
	Infection prevention requirements were met.
X	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Cleanliness. The Joint Commission requires that areas used by patients are clean. In the sleep laboratory, we found that patient rooms and the restroom were not being cleaned between patients.

Environmental Safety. The Occupational Safety and Health Administration requires MSDS to be available in the areas in which chemicals are used. In the ED at the Montgomery campus, the specialty clinics at the Tuskegee campus, and primary care clinics at both campuses, we found chemicals but no corresponding MSDS.

The Joint Commission requires that hospitals provide emergency power plugs for life support equipment. In the ED at the Montgomery campus and in the dental and specialty clinics at both campuses, we found crash cart defibrillators in areas without emergency power plugs.

Medication Security and Safety. The Joint Commission requires that multidose vials be dated when opened and that expired medications and supplies be removed and disposed of appropriately. In the ED, operating room, and recovery room at the Montgomery campus and in primary care and specialty clinics at the Tuskegee campus, we found opened and undated multidose vials and expired medications and supplies.

Recommendations

2. We recommended that processes be strengthened to ensure that the sleep laboratory is cleaned between patients.

3. We recommended that processes be strengthened to ensure that MSDS are available in areas where chemicals are used.

4. We recommended that processes be strengthened to ensure that emergency power is provided for life support equipment.

5. We recommended that processes be strengthened to ensure that multidose vials are dated when opened and that expired medications and supplies are removed and disposed of appropriately.

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 28 HF patients' medical records and relevant facility policies, and we interviewed employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
X	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[2] Four records did not include follow-up appointment recommendations in discharge instructions. Additionally, of the 24 records that specified follow-up timeframes, 12 appointments were not scheduled within the timeframes requested.

Recommendation

6. We recommended that processes be strengthened to ensure that providers include follow-up appointment recommendations in discharge instructions and that appointments are scheduled within the requested timeframes.

[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

MM

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 20 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
X	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

Vaccination Screening. Through its clinical reminders, VHA requires that clinicians screen patients for pneumococcal and tetanus vaccinations at key points, such as upon admission to a CLC and at clinic visits. Eighteen of 20 records lacked documentation of tetanus vaccination screening, and 3 of 7 records lacked documentation of pneumococcal vaccination screening.

Recommendation

7. We recommended that processes be strengthened to ensure that clinicians screen patients for pneumococcal and tetanus vaccinations upon CLC admission and at clinic visits.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive TBI results, and training records, and we interviewed key staff. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
X	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Comprehensive Evaluation. VHA requires that patients with positive TBI screening results at a Level IV site be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[3] A higher level Polytrauma System of Care site must complete the comprehensive evaluation or a Level IV site can develop and submit an alternate plan for review by the VISN and the national Director of Physical Medicine and Rehabilitation for approval of alternate arrangements outside of the directive.

The polytrauma point of contact, a nurse practitioner with appropriate experience and training, was completing the comprehensive TBI evaluations onsite. We reviewed the medical records of 10 veterans who screened positive for TBI and found that the polytrauma point of contact completed the comprehensive TBI evaluations according to clinical guidance. Facility and VISN clinical managers approved of and supported this

[3] VHA Directive2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010.

approach to improve the timeliness of evaluations and for the convenience of patients. However, we were not provided with evidence that the national Director of Physical Medicine and Rehabilitation had approved this alternate plan.

Recommendation

8. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Review Activities Without Recommendations

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/PI, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Comments

The Acting VISN and Interim Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 19–23, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[4]		
Type of Organization	Two-division secondary health care system	
Complexity Level	2	
VISN	7	
Community Based Outpatient Clinics	Columbus, GA Dothan, AL Ft. Rucker, AL	
Veteran Population in Catchment Area	148,466 (FY 2011)	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	Hospital = 71 Psychosocial RRTP = 12	
• **CLC/Nursing Home Care Unit**	160	
• **Other**	Domiciliary = 73	
Medical School Affiliation(s)	Morehouse School of Medicine University of Alabama at Birmingham – School of Medicine	
• **Number of Residents**	24	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$240.2	$213.9
• **Medical Care Expenditures**	$240.2	$213.8
Total Medical Care Full-Time Employee Equivalents	1,514.7	1,482.0
Workload:		
• **Number of Station Level Unique Patients**	43,811	41,808
• **Inpatient Days of Care:**		
o **Acute Care**	9,027	9,094
o **CLC/Nursing Home Care Unit**	26,787	25,680
Hospital Discharges	2,475	2,505
Total Average Daily Census (including all bed types)	191	197
Cumulative Occupancy Rate (in percent)	60.3	62.4
Outpatient Visits	410,098	403,185

[4] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
EOC		
1. Require that IC staff develop a comprehensive hand hygiene program which includes data collection and analysis for PI and that results are consistently documented in IC Committee minutes.	The IC Coordinator monitors outcomes of the hygiene program. Information is provided to PI quarterly. The IC Committee meets quarterly to assess outcomes related to IC and collaborate concerning improvement strategies. Data analyses are included in committee minutes.	N
2. Require that the action plan and standard operating procedures for use of personal panic alarms on the locked MH unit are implemented and that staff compliance is monitored.	The nurse managers of MH and PI continue to monitor the compliance rate for the use of panic alarms in MH. Results are submitted to PI monthly. The compliance rate from October 2010 to date has been 100 percent.	N
3. Implement strategies for the prevention of Legionnaire's disease.	PI and Industrial Hygiene/Safety monitor strategies for the prevention of Legionnaire's disease. The water system is tested annually by an external contracting source. Industrial Hygiene completes a report concerning outcomes and planned actions annually following submission of the contractor's analysis of the water. This report is submitted to PI, which tracks the completion of related actions and water testing. The water was tested in May 2010 and May 2011.	N
QM		
4. Require that all designated staff complete life support training and that compliance with certification requirements is monitored.	All relevant services, including respiratory, imaging, and nursing, monitor staff member education and training regarding life support. Results are submitted to PI monthly. Current compliance is 100 percent. In FY 2011, the facility was above 96 percent for both Advanced Cardiac Life Support and Basic Life Support training.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
5. Ensure compliance with medication reconciliation requirements.	Documentation demonstrates continued improvements and achievements.	N
6. Require root cause analysis actions to be implemented and corresponding outcome measures to be evaluated by the designated due date.	In August 2009, timely completion of actions and outcomes was 49 percent. In August 2010, timely completion of actions and outcomes was 71 percent (target 75 percent). As of September 2011, timely completion of actions and outcomes was 78 percent, which exceeded the target.	N
MM		
7. Require that nurses document the effectiveness of PRN (as needed) pain medications within the timeframe established by local policy.	PRN effectiveness timeframes continue to be in compliance this FY. The established goal is 90 percent, and achievement has been consistently above this. This is monitored weekly by nurse managers. Results are analyzed by the Bar Code Medication Administration Coordinator. These results are submitted to PI monthly.	N
8. Require that nurses document a patient's understanding of his/her medication regimen education prior to beginning a self-medication program.	The compliance rate of 90 percent was monitored for the MH RRTP by PI and the unit's nurse manager. The compliance rate was 100 percent for 18 months. PI discontinued monitoring in October 2010 because of the stability of the success.	N
Emergency/Urgent Care Operations		
9. Require that inter-facility transfer documentation is completed, as required by VHA policy.	Inter-facility transfer documentation is consistently completed. The compliance rate was 100 percent for FY 2011. This is tracked monthly by the Business Office and PI. Business Office results are submitted to PI.	N

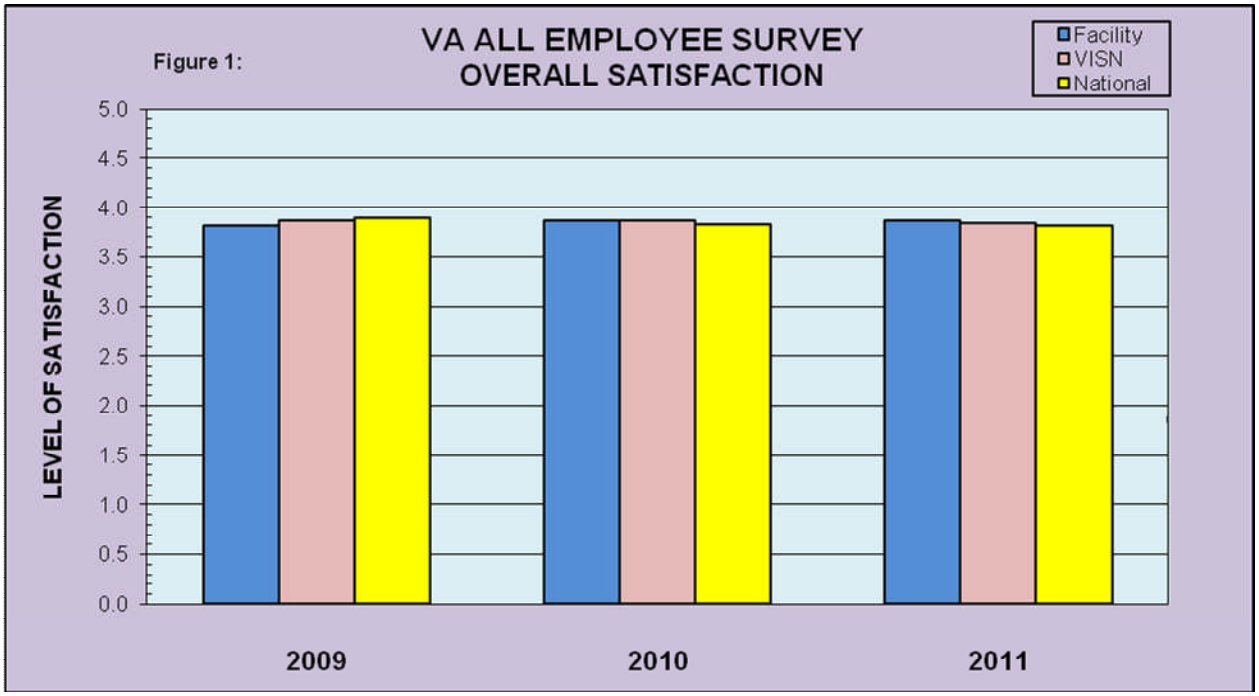
VHA Satisfaction Surveys

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 satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	49.1	42.9	51.2	44.8	41.0	39.6
VISN	66.3	52.1	63.3	52.1	51.1	50.9
VHA	64.1	54.4	63.9	55.9	55.3	54.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[5] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[6]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	**	12.1	11.7	**	24.2	17.1
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[5] A heart attack occurs 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 timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[6] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 16, 2012

From: Acting Director, VA Southeast Network (10N7)

Subject: **CAP Review of the Central Alabama Veterans Health Care System, Montgomery, AL**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

VISN 7 supports the Central Alabama Veterans Health Care System's Action Plan and performance improvement initiatives detailed in the attached document. If there are any questions, please contact Robin Hindsman, Quality Management Officer at 678-924-5723.

(original signed by:)
James A. Clark, MPA

Interim Facility Director Comments

Department of Veterans Affairs **Memorandum**

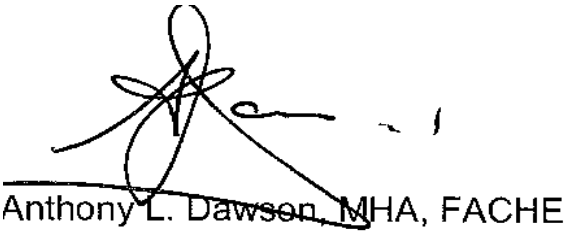
Date: February 10, 2012

From: Interim Director, Central Alabama Veterans Health Care System (619/00)

Subject: **CAP Review of the Central Alabama Veterans Health Care System, Montgomery, AL**

To: Acting Director, VA Southeast Network (10N7)

Management concurs with the identified recommendations in the report.



Anthony L. Dawson, MHA, FACHE

Comments to OIG's Report

The following Interim Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

CAVHCS concurs with this recommendation.

Target date for completion: 2/9/12

CAVHCS has developed a Standard Operating Procedure (SOP) identifying the steps to be taken to ensure patients with positive CRC screening test results receive diagnostic testing within the required 60 day time frame.

Recommendation 2. We recommended that processes be strengthened to ensure that the sleep laboratory is cleaned between patients.

CAVHCS concurs with this recommendation.

Target date for completion: 2/9/12

On December 4, 2011, the sleep lab was thoroughly cleaned by Environmental Management Service (EMS). CAVHCS has developed a Standard Operating Procedure (SOP) identifying the steps to be taken to ensure that the sleep lab is cleaned between patients. The SOP includes the monitoring process to ensure compliance.

Recommendation 3. We recommended that processes be strengthened to ensure that MSDS are available in areas where chemicals are used.

CAVHCS concurs with the recommendation.

Target date for completion: 3/30/12 and ongoing monitoring

Staff have been trained continuously on the Hazardous Communication Standards. However, additional training will be made available for new employees or those who have not been trained. Leadership will determine which employees in their services need training by 2/24/12. Training will be complete on or before 3/20/12. All MSDS relevant to a service area will be acquired and/or posted on or before 3/20/12. CAVHCS will hold the manager and/supervisor responsible for following health care policy OO1S-11-01 SOP 28.

The SOP states that the service manager/supervisor is responsible for ensuring the inventory is completed semi-annually with an annotation of whether the MSDS is available or not available. Service manager/supervisor can always get assistance from the Safety Office to ensure that an MSDS is available. This is monitored during environmental rounds that are conducted weekly on both campuses; annually during the workplace evaluation; and when requested by the service. The Safety Office is available for help in compiling the data and matching the inventory with the MSDS in a book that is easily accessible and identified by all staff.

Recommendation 4. We recommended that processes be strengthened to ensure that emergency power is provided for life support equipment.

CAVHCS concurs with this recommendation.

Target date for completion: 11/29/2011

The life support equipment was moved to a location with an emergency outlet. The crash cart checklist has been updated to include daily checks of the emergency equipment being plugged into the emergency outlet. The equipment will be monitored monthly on environmental rounds.

Recommendation 5. We recommended that processes be strengthened to ensure that multidose vials are dated when opened and that expired medications and supplies are removed and disposed of appropriately.

CAVHCS concurs with this recommendation.

Target date for completion: 11/29/2011

In all of the acute care areas, expired medications and supplies and multi-dose vials that were not dated, were immediately removed. Multi-dose vials are currently dated when opened as required by policy. Medications and/or supplies that needed to be discarded are done so by the prescribed timeframe. Leadership of respective areas are monitoring compliance on a weekly basis. Findings are documented on weekly logs that are maintained in respective service areas.

Recommendation 6. We recommended that processes be strengthened to ensure that providers include follow-up appointment recommendations in discharge instructions and that appointments are scheduled within the requested timeframes.

CAVHCS concurs with this recommendation.

Target date for completion: 2/15/12

The following actions were implemented to ensure that providers include follow-up appointment recommendations in discharge instructions and that appointments are scheduled within the requested timeframes:

- The Associate Chief of Staff of Acute Care and Specialties discussed scheduling and appointment issue with the hospitalist prior to departure of OIG team (completed 12/1/11).

- The Cardiology nurse provided her telephone number to ward clerk staff so that they could contact her directly to obtain an appointment for CHF patients prior to patient discharge (completed 12/1/2011).

- The administrative staff of Acute Care and Specialties will conduct random chart audits on the 1st and 15th monthly to monitor compliance with the recommendation (implementation date is 2/15/12).

Recommendation 7. We recommended that processes be strengthened to ensure that clinicians screen patients for pneumococcal and tetanus vaccinations upon CLC admission and at clinic visits.

CAVHCS concurs with this recommendation.

Target date for completion: 2/28/12

Both clinical reminders are available for Primary care and the Community Living Center. However, the clinical reminder for the tetanus vaccination was implemented on November 16, 2012. The Clinical Informatics Department is currently running a report from October 1, 2011 through January 30, 2012 to provide a listing of patients with clinical reminders for pneumococcal and tetanus vaccinations that are pending. During the month of February 2012, the list will be run weekly and monthly thereafter. The list will be provided to management for actions and follow-up.

Recommendation 8. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

CAVHCS concurs with this recommendation.

Target date for completion: 4/10/12

The facility applied for an approval of “an alternate plan” from the VISN 7 Chief Medical Officer to continue plans for evaluations of Veterans who were screened positive in the TBI Reminder. The approval documentation has been submitted to the Interim Director of CAVHCS for signature and will be forwarded to the Interim Network Director on or before 2/13/12. Additionally, the facility will apply for Level III designation once required staff is hired.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720
Contributors	Victoria Coates, LICSW, MBA, Project Leader Audrey Collins-Mack, RN, Team Leader Karen Sutton, BS Toni Woodard Susan Zarter, RN, BSN Carl Scott, Resident Agent in Charge, Office of Investigations

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