

STATEMENT OF
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BEFORE
THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
THE UNITED STATES HOUSE OF REPRESENTATIVES
ON
QUALITY OF CARE ISSUES AT W.G. (BILL) HEFNER VA MEDICAL CENTER IN
SALISBURY, NORTH CAROLINA
APRIL 19, 2007

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify today on patient quality of care issues at Department of Veterans Affairs (VA) medical facilities. Today I will present the results of the Office of Inspector General (OIG) *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2006*; the *OIG Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2004 and 2005*; and the *OIG Combined Assessment Program (CAP) Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina*, published on September 25, 2006. I will also present the facts surrounding the OIG hotline call that resulted in the Office of the Medical Inspector (OMI) report of June 9, 2005, *Review of the Delivery of Surgical Services Veterans Integrated Service Network 6 W.G. (Bill) Hefner VA Medical Center Salisbury, N.C.*, and the results of our follow-up inspection at the Hefner VA Medical Center (VAMC) conducted during the week of April 9–13, 2007. I am accompanied by Ms. Victoria Coates, Director of the Atlanta Office of Healthcare Inspections.

Since the early 1970's VA has required its health care facilities to operate comprehensive quality management (QM) programs to monitor the quality of care provided to patients and to ensure compliance with VA directives and accreditation standards. Public Laws 99-166 and 100-322 require the VA OIG to oversee VA QM programs at every level. QM review has been a constant focus during the OIG

Combined Assessment Program (CAP) reviews since 1999. The CAP review is an OIG initiative that involves an inspection and publication of the inspection's findings for approximately one third of VA's medical centers each year.

A comprehensive VA QM program should include the following program areas: quality management and performance improvement committees, peer review activities, patient safety activities (health care failure mode and effects analysis, aggregated root cause analyses, and national patient safety goals), disclosure of adverse events protocols, utilization management programs, patient complaint management programs, medication management programs, medical record documentation reviews, blood and blood products usage reviews, operative and other invasive procedures reviews, patient outcomes of resuscitation efforts reviews, restraint and seclusion usage reviews, and staffing effectiveness reviews.

OIG SUMMARY REPORTS

The OIG published a summary of the CAP findings regarding VA medical center QM findings for fiscal year 2006 in March of 2007 and for fiscal years 2004 and 2005 in December of 2006. The report of FY 2006 QM findings identified three QM activities that required system-wide improvements: peer review activities, adverse event disclosure procedures, and utilization management programs. For FY 2006, OIG reported peer review activities were established in 46 of 47 inspected medical centers. Only 40 of 46 peer review committees complied with Veterans Health Administration (VHA) policy to meet quarterly and only 49 percent of the committees completed their reviews within the required 120 days. VHA facilities have an obligation to disclose adverse events to patients who have been harmed in the course of their care. In FY 2006, 39 of the 47 inspected facilities documented that patients had experienced serious adverse outcomes. Of these, 29 documented that the clinical discussions occurred with the veteran or family member, and 22 documented that the discussion informed the patient of the right to file tort claims or claims for increased benefits. Utilization management is the process of evaluating and determining the appropriateness of medical care services across the patient health care continuum to ensure the proper use of resources. In FY 2006, our review found that when resource utilization exceeded standards, referral was not made to physician advisors 16 percent of the time, thus bypassing appropriate review of resource utilization. Recommendations regarding peer review, adverse event reporting, and utilization review were made and accepted by the Acting Under Secretary of Health.

In the OIG report on FYs 2004 and 2005, VA medical center QM programs indicated that 2 of 93 facilities did not have comprehensive programs in place. These programs were identified to VA in CAP reports. Recent CAP reports indicate that one of the two facilities made significant improvements in their QM program, while the other has been less successful at improving the components of its QM program. There are ongoing personnel changes at this facility and OIG will closely monitor this facility's QM program. The FYs 2004 and 2005 QM review made recommendations to improve the analysis of patient resuscitation episodes, better consider the alternatives and document the use of

restraints, and adjust current directives regarding re-privileging activities to ensure effective implementation of the continuous professional practice evaluation process.

W.G. (BILL) HEFNER MEDICAL CENTER IN SALISBURY, NORTH CAROLINA

The OIG maintains a hotline call center to permit stakeholders to notify the OIG of problems. On August 30, 2004, OIG received an anonymous hotline alleging that there had been more than 12 surgical deaths in over 2 years on the surgical service at the Hefner VAMC. On September 21, 2004, due to limited OIG resources, this hotline was referred to the OMI. The OMI was onsite at Salisbury from March 28–31, 2005. The VHA Director of Surgery conducted a review from April 5–6, 2005. OMI issued its report of the hotline allegations and surgical services, after an OIG review, on June 9, 2005. It contained 18 recommendations that were accepted by the Under Secretary of Health. A regularly scheduled CAP inspection was conducted June 19–23, 2006. An OMI follow-up inspection of the Hefner VAMC occurred between March 26–27, 2007, and an OIG follow-up inspection occurred April 9–13, 2007.

OIG CAP Review – June 2006

During the week of June 19–23, 2006, the OIG CAP team evaluated clinical care and patient outcomes at the Hefner VAMC. The CAP team reported as an organizational strength, the fact that medical center staff had significantly improved their ability to provide timely laboratory support for the evaluation of patients who present with a possible myocardial infarction.

The OIG CAP inspection found that the clinicians properly addressed specific treatment issues related to diabetes that arise in the use of atypical antipsychotic medications. The review of breast cancer management found that clinicians at the facility met the VHA performance measure for breast cancer screening, provided timely surgical and oncology consultative and treatment services, promptly informed patients of diagnoses and treatment options, and developed coordinated interdisciplinary treatment plans. A review of the inpatient and outpatient Survey of Healthcare Experiences of Patients found that the Hefner VAMC measures were within acceptable ranges when compared to national and Veterans Integrated Service Network data. The OIG report noted the efforts taken by the VAMC leadership to respond to this patient-derived data.

The OIG inspection team found several conditions needing improvement in the Contract Nursing Home Program, the Quality Management Program, and the medical center environment of care. The Contract Nursing Home Program policy requires regular, periodic visits to veterans in nursing homes by VA nursing staff. These did not occur between October 2003 and June 2006 in the selected patient sample. In addition, OIG inspectors found that 4 of the 11 contract nursing homes were on the State nursing home “watch list,” meaning that they had been found to be deficient during their last State inspection. Despite these deficiencies, program managers continued to place veterans in these homes without taking prudent steps to ensure veterans would receive quality care at these homes. The medical center did not establish the required Contract

Nursing Home Oversight Committee. The OIG inspectors made recommendations in the CAP report that were accepted by facility managers to remedy these conditions.

OIG inspectors identified deficiencies in the medical center's QM program in that peer reviews were not completed as required between July 2005 and June of 2006. Further, the Peer Review Committee had not met since November of 2005 because of actions taken by the VA's Office of Resolution Management to review information that was protected by 38 USC § 5705, Confidentiality of medical quality-assurance records. The chief of staff acknowledged the importance of peer review activities and reported that the peer review meetings would resume, but stated that he would not disclose protected information to the Office of Resolution Management. OIG did not make recommendations as the medical center leadership indicated that the peer review process would be resumed. A review of the Root Cause Analysis processes at this medical center found several defects, as did a review of the Administrative Board of Investigation process. OIG recommended and VA leadership agreed to make the changes required to bring these programs into compliance with appropriate policy.

A review of the facility environment of care identified several issues that were addressed prior to the inspection team leaving the facility. The OIG team also found that managers at the facility had not addressed environment of care issues that were previously identified to facility managers in 2005. Facility managers agreed with OIG recommendations to address this issue.

OIG CAP Review – April 2007

OIG inspectors visited the Hefner VAMC between April 9–13, 2007, in preparation for this hearing with two goals: to evaluate the surgical service programs and processes to determine if clinical care meets with community standards, and to determine if the facility had taken appropriate follow-up actions in response to the CAP report of 2006 and the OMI report of 2005. Our review of the facility Surgical Service Performance Improvement Program, National Surgical Quality Improvement Program data, morbidity and mortality minutes, surgical staffing, peer review, and surgery infection control data combined with discussions with hospital staff and leadership leads us to conclude that the Hefner VAMC surgery services meet or exceed community standards. Our review of the actions taken by the leadership of this facility in response to our CAP recommendations permits us to conclude that these recommendations have been appropriately addressed.

The OIG inspectors identified two new issues to facility leadership during the April 9–13, 2007, visit. On the locked mental health unit, there are exposed pipes that should be covered, going from the wall to toilet fixtures. In addition, telephones in tunnels connecting buildings on the campus were accessible by staff who had a key, but not by patients. OIG will follow-up to ensure these issues are addressed.

SUMMARY

The OIG will continue to review QM in VA medical centers as part of the CAP process. With respect to the W.G. (Bill) Hefner Medical Center in Salisbury, North Carolina, we believe that VA leadership has responded appropriately to recommendations made by OMI and OIG in reports.

Mr. Chairman, thank you again for this opportunity and I would be pleased to answer any questions that you or other members of the Subcommittee may have.