Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 17-03399-150

Healthcare Inspection

Inadequate Intensivist Coverage and Surgery Service Concerns

VA Gulf Coast Healthcare System Biloxi, Mississippi

March 29, 2018

Washington, DC 20420

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report Suspected Wrongdoing in VA Programs and Operations:

1-800-488-8244

www.va.gov/oig

Table of Contents

Executive Summary

The VA Office of Inspector General (OIG) conducted a rapid response inspection to evaluate allegations of inadequate intensivist coverage in the intensive care unit (ICU) and other Surgery Service concerns at the VA Gulf Coast Healthcare System (System), Biloxi, MS. The alleged conditions potentially placed patients at ongoing risk and included:

- The System did not have full-time intensivist coverage in the ICU.
- Patients in the ICU died from complications as the result of inadequate [intensivist] staffing.
- A Veterans Integrated Service Network (VISN) 16 inspection [of intensivist staffing and other surgery-related issues] had not remedied the situation.

An allegation of poor quality of care by a thoracic surgeon will be addressed in a separate report.

We substantiated that the System did not have full-time intensivist coverage in the ICU during most of quarter (Q) 3 and all of Q4 fiscal year (FY) 2017. However, we found that the System had taken several actions to mitigate patient risk. Specifically, the System granted core critical care privileges for hospitalists to provide ICU care during the remaining intensivist's off-week and instructed Emergency Department staff to limit or divert patients who might require admission to the ICU during the week an intensivist was not available. While the System also reportedly implemented risk-based surgical screening processes and only scheduled intermediate-level surgeries on weeks when the intensivist was on duty, we found that clinicians were not fully compliant with this action. In 19 cases, surgeons performed intermediate procedures when they should have only performed standard procedures because the intensivist was not on duty. In 18 of those cases, we did not identify clinically significant adverse events as a result of this
non-compliance. However, one patient developed respiratory distress in the postanesthesia care unit, was intubated, and admitted to the ICU. After multiple complications, he was transferred to a community non-VA hospital due to the complexity of his care needs.[1] While it is unknown whether the presence of an intensivist would have changed the outcome, this case underscores the rationale for not performing surgery of this complexity level without an ICU staffed with an intensivist.

We did not substantiate that patients in the ICU died from complications as a result of inadequate [intensivist] staffing. Two deaths occurred in the ICU in Qs 3 and 4 FY 2017 when an intensivist was not available. In both cases, the patients had metastatic cancer and were subsequently placed on hospice or comfort measures only. We determined that the absence of an intensivist did not negatively impact the quality or course of care.

[1] The patient was subsequently diagnosed with cancer and was receiving treatment as of February 2018.

We substantiated that some of the intensivist staffing and Surgery Service-related conditions were not remedied after a VISN 16 inspection. However, we found that the VISN worked with the System to ensure that an appropriate action plan was developed, and we received evidence that actions were being taken to address the identified concerns. The System had implemented and/or completed improvement actions related to surgery chief assignment, VA Surgical Quality Improvement Program nurse hiring, Morbidity and Mortality Committee operations, pre-operative evaluation activities, and verbal order protocols. Intensivist hiring and "Surgical Home" program development were in process. Subsequent to our site visit, the System hired a vascular surgeon and activated tele-ICU.

The System reported that providers would not operate or perform other procedures on patients with pre-operative mortality risk calculations greater than 7.5 percent except in limited circumstances and only with the Chief of Surgery Service's approval. We were unable to find documentation of Service Chief approval to proceed with surgery in the 19 cases meeting our review criteria, 15 of which had a documented pre-operative mortality risk of greater than 7.5 percent. None of the patients died or experienced clinically significant complications within 30 days of surgery.

We also found several documented examples of poor communication and responsiveness, and an example of improper documentation.

We recommended that the System Director continue to follow through on incomplete actions as discussed in Issues 1 and 2 of this report and take action related to improper electronic health record documentation by two Surgery Service providers as appropriate.

We recommended that the VISN Director provide oversight of ICU and Surgery Service-related operations until corrective actions are completed and conditions have been resolved.

Comments

The VISN Director and the System Director concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes B and C, pages 12-15, for the full text of the comments.) We consider recommendation 3 closed. We will follow up on the planned actions for recommendations 1 and 2 until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) conducted a rapid response inspection to evaluate allegations of inadequate intensivist coverage in the intensive care unit (ICU) and other Surgery Service concerns at the VA Gulf Coast Healthcare System (System), Biloxi, MS. The alleged conditions potentially placed patients at ongoing risk.

Background

System Profile

The System, part of Veterans Integrated Service Network (VISN) 16, is a tertiary care hospital system consisting of a main hospital complex in Biloxi, Mississippi, and community based outpatient clinics (CBOCs) in Mobile, AL, and Pensacola, Eglin Air Force Base (Valparaiso), and Panama City, FL. The System, along with its associated CBOCs, served over 68,340 veterans in fiscal year (FY) 2016. The System operated 256 beds, including 83 inpatient beds, 72 domiciliary beds, and 101 community living center beds in FY 2016. The System is affiliated with Keesler Air Force Base, Louisiana State University, Tulane University, and the University of South Alabama.

Operative Complexity Designation and Intensivist Staffing Requirements

Veterans Health Administration (VHA) assigns each of its inpatient medical centers an "operative complexity" level of standard, intermediate, or complex based on infrastructure including facilities, equipment, workload, and staffing load.[2] The System has four operating rooms and is designated as an Intermediate VHA Surgical Program. The System's intermediate complexity designation requires a Level 2 or 3 ICU with an intensivist.[3] VHA policy states that "…scheduled (non-emergent) surgical procedures…are not to exceed the infrastructure capabilities of the facility."[4] This means that the System may perform intermediate surgeries only when appropriate intensivist staffing is available.

Morbidity and Mortality Rates

Morbidity rate refers to the number of persons in a population who become ill or are ill at any given time. Mortality rate is the measure of the frequency of deaths during a specified period of time.[5] VHA maintains and collects surgical morbidity and mortality

[2] VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate Or Complex* Surgical *Procedures*, May 6, 2010. This Directive expired on May 31, 2015, and has not yet been updated.
[3] An intensivist is a physician provider specializing in critical care of the surgical patient; this may include a surgeon, anesthesiologist, cardiologist, or pulmonologist.
[4] VHA Directive 2010-018. "VHA policy does not interfere with the judgment of the surgeon to perform a surgical procedure beyond the operative complexity designation of the facility, based upon new findings at the time of a planned procedure or in managing an emergency condition where the patient's best interest is served by care and treatment on-site rather than through transfer to a more complex facility."
[5] Centers for Disease Control and Prevention, https://www.cdc.gov/. Accessed November 6, 2017.

data through the VA Surgical Quality Improvement Program (VASQIP) as a way to measure the quality of surgical outcomes and improve the management of surgical care.[6]

Practitioner Privileging

Privileging refers to the process of approving the procedures and services a practitioner can provide. A practitioner's clinical privileges, based in part on the individual's clinical competence, are determined by peer references, professional experience, education, training, and licensure. Providers must be re-privileged every 2 years, which includes an evaluation of their professional performance, judgement, and clinical and/or technical competence.[7]

Prior Reports

See Appendix A for relevant OIG reports published in the past 3 years.

Allegations

On April 4, 2017, we received a complaint alleging:

- The System did not have full-time intensivist coverage in the ICU.
- Patients in the ICU died from complications as the result of inadequate staffing.
- A VISN 16 inspection [of intensivist staffing and other surgery-related issues] had not remedied the situation.

An allegation of poor quality of care by a thoracic surgeon is under review and will be addressed in a separate report.

We initiated action with the System soon after receiving the complaint, requesting specific information related to the allegations and the VISN 16 inspection corrective action plan to address areas of concern.[8] The System provided a response to our request for information on July 28, 2017; however, we determined that the response was not adequate. We initiated a formal rapid response inspection on August 17, 2017.

Scope and Methodology

We initiated our inspection on August 17, 2017, and conducted a site visit September 5–8. We interviewed the complainant by telephone prior to our site visit. We also interviewed the System's Acting Director and Acting Chief of Staff; the Chiefs of Surgery, Medicine, and Anesthesia; the VISN Surgical Consultant; VASQIP, operating

[6] VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
[7] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, expired on October 31, 2017 and has not been updated.
[8] The OIG also reviewed an ICU-related Issue Brief and asked additional questions of the System in late May 2017.

room (OR), and ICU staff; the current intensivist; credentialing and privileging staff; the Risk Manager; Logistics, Prosthetics, Contracting, and Sterile Processing Services staff; and other employees with knowledge of the issues.

We reviewed patient electronic health records (EHRs), System and VHA policies, patient safety documents, medical journal articles, and other documents relevant to these allegations.

VHA Directive 2010-018, *System Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010, expired on May 31, 2015, and VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, expired on October 31, 2017. These directives have not been updated. We considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(3),[9] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[10] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[11]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[9] VHA Directive 6330(3), *Controlled National Policy/Directives Management System*, June 24, 2016.
[10] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.
[11] Ibid.

Inspection Results

Issue 1: Intensivist Coverage

A. Full-Time Intensivists

We substantiated that the System did not have full-time intensivist coverage in the ICU during most of quarter (Q) 3 and all of Q4 FY 2017. While we found that the System had taken several actions to mitigate patient risk, other System-proposed actions had not been fully implemented.

The ICU has 10 beds, nurse staffing to support 6 patients, and reportedly has an average daily census of 2.8 patients. In May 2017, one of the two ICU intensivists reportedly left the System unexpectedly. Since that time, the remaining intensivist has provided alternating weekly coverage (12-hour in-house and 12-hour off-tour on-call) with 7 days on and 7 days off. System managers are presently working to increase the number of contracted intensivists and implement tele-ICU care.[12] In the interim, System clinical leaders reported taking the following actions:

a) Granting multiple hospitalists[13] core critical care privileges for ICU care. Patients requiring ventilator support and patients with complex medical needs who require ICU care during the intensivist's off week are transferred to other medical facilities.[14] The current intensivist manages the transfer of ICU patients to non-VA care, and continues to provide ICU coverage until the transfer is complete.

b) Instructing Emergency Department staff to limit or divert patients (to community non-VA hospitals) who might require admission to the ICU during the week an intensivist was not available.

c) Implementing risk-based (more complex) surgical screening processes to identify cases which may require admission to the ICU. Those cases are scheduled on weeks when the intensivist is on duty.

While actions (a) and (b) appeared to have been largely implemented, we found that some System clinical leaders had not fully complied with risk-mitigation action (c). Specifically, on weeks with no intensivist, the surgeons should only have performed standard operative procedures.[15] We reviewed all 81 operative procedures, as

[12] Tele-ICU care was activated subsequent to our site visit.
[13] A hospitalist is usually an internal medicine physician who specializes in providing care to patients in the hospital (not in outpatient clinic settings). An intensivist is a board-certified physician who has advanced training and specializes in caring for critically ill patients.
[14] We reviewed the two cases where patients were transferred from a System location to a non-VA facility between April 1 and September 30, 2017 during a week when there was no intensivist coverage and died subsequent to the transfer. In both cases, the transfers appeared appropriate as the needed services were not available at the System.
[15] The System informed us that the surgical schedule was adjusted so that intermediate cases were performed during the week the contract intensivist was on duty.

captured in the VISTA Surgical Package of "all surgical cases," which were completed during intensivist off-weeks from April 1 to September 30. According to VHA's surgical complexity designation, 19 cases were classified as intermediate procedures. For 18 of the cases, we did not identify clinically significant adverse events[16] as a result of patients undergoing intermediate-level surgeries without an intensivist on duty. However, the remaining (19th) patient developed respiratory distress in the postanesthesia care unit, was intubated, and admitted to the ICU. During the course of his stay, he was intubated a total of three times for respiratory distress and developed cardiac arrhythmias with elevations of his cardiac enzymes. He also developed signs and symptoms of alcohol withdrawal and bled into the surgical site, requiring transfusion. The surgical team ultimately determined that the patient's care needs were too complex for the System and transferred him to a community non-VA hospital.[17] While it is unknown whether the presence of an intensivist would have changed the outcome, this case underscores the rationale for not performing intermediate-level surgery without an ICU staffed with an intensivist.

B. Alleged Complications Related to Intensivist Staffing

We did not substantiate that patients who remained in the System's ICU died from complications as a result of inadequate [intensivist] staffing. Two deaths occurred in the ICU in Qs 3 and 4 FY 2017 when an intensivist was not available. In both cases, the patients had metastatic cancer (the cancer had spread to distant sites), were admitted to the ICU from a medical floor for respiratory distress, and were subsequently placed on hospice or comfort measures only. We determined that the absence of an intensivist did not negatively impact the quality or course of care.

Issue 2: Surgery Service Concerns and Follow-up

We substantiated that some of the intensivist staffing and Surgery Service-related conditions were not remedied after a VISN 16 inspection. However, we found that the VISN worked with the System to ensure that an appropriate action plan was developed, and we received evidence that actions were being taken to address the identified concerns.

On March 20–21, 2017, a VISN 16 team consulted with the System to assess the Surgery Service in response to an increase in mortality rates.[18] The VISN team interviewed all surgeons, anesthesia staff, OR nursing staff, and other knowledgeable providers. The VISN team also reviewed all relevant morbidity and mortality cases identified in the previous 12 months.[19] The VISN visit was required by VHA policy.

[16] We defined "clinically significant adverse event" as a delay in diagnosis or treatment, a change in the course of treatment, or a change in the patient's level of care (such as a hospital admission).
[17] The patient was subsequently diagnosed with cancer and was receiving treatment as of February 2018.
[18] Reportedly, several cases were erroneously included in the calculation that increased the mortality.
[19] Relevant cases are those identified via VASQIP data.

We learned through interviews and document review that the System has implemented and/or completed improvement actions related to surgery chief assignment, VASQIP nurse hiring, Morbidity and Mortality Committee operations, pre-operative evaluation activities, and verbal order protocols.[20] In addition to the intensivist hiring and tele-ICU efforts outlined in Issue 1 above, we further learned the following actions, among others, are in process:

- The System is actively interviewing to fill a vascular surgeon position.
- Surgery and Extended Care leaders are developing "surgical home"[21] options to optimize patient care outcomes.
- The System's Chief of Surgery and VISN 16 Surgical Consultant discuss the status of the System's surgical program regularly.[22]
- The VISN 16 team intends to conduct a follow-up site visit.

Based on available documentation, we determined that surgeons did not appear to be complying with an additional action item that would curtail surgeries for some high-risk patients.[23] The American College of Surgeons National Surgical Quality Improvement Program Surgical Risk Calculator is a web-based tool that allows surgical teams to enter pre-operative information about the patient (for example, type of surgery, age, sex, significant medical conditions) to statistically predict outcomes for that specific patient. System managers told the VISN that surgeons would not operate on patients with expected 30-day mortalities greater than 7.5 percent with the exception of some emergencies and palliative procedures as approved by the Chief of Surgery. We reviewed 19 surgeries and procedures[24] that occurred between June 1 and September 30, 2017. Fifteen patients had a documented pre-operative risk calculation between 7.5–18 percent and four patients had no risk calculation. We were unable to find documentation that any of the 19 cases were discussed with or approved by the Chief

[20] We considered the action related to verbal orders to be complete because the discussion occurred even though no actions have been implemented. According to the Acting System Director, the System meets Joint Commission requirements and VHA guidelines for managing verbal orders.
[21] Perioperative "surgical home" refers to a model of care in which an anesthesiologist manages a patient's surgical experience in collaboration with the patient, the patient's family members, and other healthcare providers. The goal is to reduce the length of hospital stays and increase the rates of discharge home.
[22] The VISN 16 Surgical Consultant reported that he speaks with the System's Chief of Surgery about every 2 weeks.
[23] This action item was presumably included to minimize patient risk while ICU and Surgery Service-related issues could be resolved.
[24] These 19 procedures were performed on patients with mortality risk scores exceeding 7.5 percent. Procedures included cardioversions (which restores normal heart rhythm in patients with abnormal heartbeats) and endobronchial ultrasounds (which allow physicians to obtain tissue samples from the lungs to diagnose lung cancer, infection, or other conditions).

of Surgery to proceed.[25] None of the patients died or experienced clinically significant adverse events within 30 days of their surgery.

We concluded that System staff were making efforts to address the ICU and Surgery Service-related conditions, but additional time is needed to resolve the deficiencies.

Issue 3: Other Findings

During the course of our EHR reviews, we found several documented examples of poor communication and responsiveness. Specifically:

- Patient 1 was experiencing mental status changes. A charge nurse documented that when notified, the physician refused to talk to the patient's primary nurse. The following day, a nurse noted Patient 1's respiratory decline and tachycardia (a rapid heart rate greater than 100). The nurse wrote that she attempted to notify the physician of the patient's change in status on two occasions without success.
- Patient 2 was experiencing oxygen desaturation, tachycardia, and chest pain and was transferred to the ICU. The nurse documented repeated attempts to reach the hospitalist without success. Per EHR documentation, the hospitalist was unaware that he was carrying the wrong pager.

ICU nursing staff confirmed to us that they notify the Chief of Medicine when a hospitalist does not respond promptly. Reportedly, this is an infrequent occurrence, happening only "once or twice in the past several months."

We also identified an example of improper documentation:

- Patient 3's surgery was postponed because he had not stopped taking his blood thinner medication prior to the scheduled procedure. Physician A documented in the patient's EHR that Physician B should have communicated to the patient the need to stop this medication. Physician B responded, also in the EHR, that he had advised the patient to stop the medication and to "…stop it with placing blame on me."

VHA Handbook 1907.01, *Health Information Management and Health Records*, states "The health record needs to reflect accurate and clinically-relevant statements; derogatory or critical comments are prohibited."

[25] The Chief of Surgery told us on November 27, 2017, that some of the 19 cases were scored using the Acute Physiology and Chronic Health Evaluation (APACHE) II tool rather than the National Surgical Quality Improvement Program tool to predict mortality.

Conclusions

We substantiated that the System did not have full-time intensivist coverage in the ICU during most of Q3 and all of Q4 FY 2017. However, we found that the System had taken several actions to mitigate patient risk. Specifically, the System granted core critical care privileges for hospitalists to provide ICU care during the intensivist's off-week and instructed Emergency Department staff to limit or divert patients who might require admission to the ICU during the week an intensivist was not available. While the System also reportedly implemented risk-based surgical screening processes we found that in 19 cases, surgeons performed intermediate procedures when they were only authorized to perform standard procedures because the intensivist was not on duty. For 18 of the 19 cases reviewed, we did not identify clinically significant adverse events as a result of this non-compliance. However, one of the 19 patients developed respiratory distress in the postanesthesia care unit, was intubated, and admitted to the ICU. After multiple complications, he was transferred to a community non-VA hospital due to the complexity of his care needs. While it is unknown whether the presence of an intensivist would have changed the outcome, this case underscores the rationale for not performing intermediate-level surgeries without an ICU staffed with an intensivist.

We did not substantiate that patients in the ICU died from complications as a result of inadequate [intensivist] staffing. Two deaths occurred in the ICU in Qs 3 and 4 FY 2017 when an intensivist was not available. In both cases, the patients had metastatic cancer and were subsequently placed on hospice or comfort measures only. We determined that the absence of an intensivist did not negatively impact the quality or course of care.

We substantiated that some of the intensivist staffing and Surgery Service-related conditions were not remedied after a VISN 16 inspection but found that, in general, System leaders were taking actions to address the identified concerns. The System had implemented and/or completed improvement actions related to surgery chief assignment, VASQIP nurse hiring, Morbidity and Mortality Committee operations, pre-operative evaluation activities, and verbal order protocols. Intensivist hiring and "Surgical Home" program development were in process. Subsequent to our site visit, the System hired a vascular surgeon and activated tele-ICU.

The System reported that providers would not operate or perform other procedures on patients with pre-operative mortality risk calculations greater than 7.5 except in limited circumstances and only with the Chief of Surgery Service's approval. We were unable to find documentation of Service Chief approval to proceed with surgery in the 19 cases meeting our review criteria. None of the patients died or experienced clinically significant complications within 30 days of surgery.

We also found several documented examples of poor communication and responsiveness, and an example of improper documentation.

Recommendations

1. We recommended that the System Director continue to follow through on incomplete actions as discussed in Issues 1 and 2 of this report.

2. We recommended that the Veterans Integrated Service Network Director provide oversight of intensive care unit and Surgery Service-related operations until corrective actions are completed and conditions have been resolved.

3. We recommended that the System Director take action as appropriate related to Physicians A and B and their improper electronic health record documentation as discussed in this report.

Prior OIG Reports

System Reports

Evaluation of Human Immunodeficiency Virus Screening in Veterans Health Administration Outpatient Clinics
2/28/2017 | 15-04925-469

Community Based Outpatient Clinics Summary Report – Evaluation of Alcohol Use Disorder Care at Community Based Outpatient Clinics and Other Outpatient Clinics
6/23/2016 | 15-01296-203

VA's Federal Information Security Modernization Act Audit for Fiscal Year 2015
3/15/2016 | 15-01957-100

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | 15-01579-457

Combined Assessment Program Review of the Gulf Coast Veterans Health Care System, Biloxi, Mississippi
1/20/2015 | 14-04214-70

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Gulf Coast Veterans Health Care System, Biloxi, Mississippi
1/12/2015 | 14-04380-79

Healthcare Inspection – Community Living Center Patient Care, Gulf Coast Veterans Health Care System, Biloxi, Mississippi
5/28/2014 | 14-01119-168

Topic Reports

Healthcare Inspection – Quality of Care Concerns of a Surgical Patient, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas
5/17/2017 | 15-04516-229

Healthcare Inspection – Administrative and Clinical Concerns, Central California VA Health Care System, Fresno, California
11/2/2017 | 16-00352-12

Appendix A

Healthcare Inspection – Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma
7/10/2017 | 16-02676-297

Healthcare Inspection – Quality of Care Concerns of a Surgical Patient, Central Arkansas Veterans Healthcare System, Little Rock, Arkansas
5/17/2017 | 15-04516-229

Healthcare Inspection – Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina
9/30/2016 | 15-00084-370

OIG reports are available at **www.va.gov/oig.**

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 8, 2018

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

Subj: Healthcare Inspection—Inadequate Intensivist Coverage and Surgical Service Concerns, Gulf Coast Veterans Health Care System, Biloxi, Mississippi

To: Director, Rapid Response, Office of Healthcare Inspections (54RR)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, "Healthcare Inspection—Inadequate Intensivist Coverage and Surgical Service Concerns, Gulf Coast Veterans Health Care System, Biloxi, Mississippi".

2. VISN 16 will actively support the facility in the completion of all recommendations.

Skye McDougall, PhD
Director, South Central VA Health Care Network (10N16)

Appendix B

VISN Director Comments

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

OIG Recommendation

Recommendation 2. We recommended that the Veterans Integrated Service Network Director provide oversight of intensive care unit and Surgery Service-related operations until corrective actions are completed and conditions have been resolved.

Concur

Target date for completion: August 31, 2018

System response: The Veterans Integrated Service Network Director will provide oversight of ICU and Surgery Service-related operations until the corrective actions are completed. The Gulf Coast Veterans Health Care System has taken actions since the inspection for this report was completed. Under guidance from the VISN, they have activated Tele-ICU. The VISN 16 Surgical Consultant is engaged and planning a follow up visit.

System Director Comments

Department of Veterans Affairs

Memorandum

Date: Date MAR 02 2018

From: Director, Gulf Coast Veterans Health Care System (520/00)

Subj: Healthcare Inspection—Inadequate Intensivist Coverage and Surgical Service Concerns, Gulf Coast Veterans Health Care System, Biloxi, Mississippi

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

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, "Healthcare Inspection—Inadequate Intensivist Coverage and Surgical Service Concerns, Gulf Coast Veterans Health Care System, Biloxi, Mississippi".

2. As a health care team, Gulf Coast is committed to providing safe, quality care. Through our combined efforts, we will ensure all recommendations are successfully addressed.

Bryan C. Matthews, MBA

System Director's Comments

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

OIG Recommendations

Recommendation 1. We recommended that the System Director continue to follow through on incomplete actions as discussed in Issues 1 and 2 of this report.

Concur

Target date for completion: August 31, 2018

System response: The Director will ensure incomplete actions identified in Issues 1 and 2 of this report are completed. Since the completion of this Health Care Inspection, Gulf Coast Veterans Health Care System has activated our Tele-ICU and hired a new vascular surgeon. Additional actions to include the development and implementation of the surgical home model, the appropriate and consistent use of the risk calculator with respect to operative case selection and the completion of a follow-up visit by the VISN 16 Surgical Consultant are being addressed and are expected to be completed by the above target date.

Recommendation 3. We recommended that the System Director take action as appropriate related to Physicians A and B and their improper electronic health record documentation.

Concur

Target date for completion: February 28, 2018

System response: The Chief of Staff and the Chief of Surgery at Gulf Coast Veterans Health Care System reviewed the documentation of physicians A and B. Physician A's documentation was determined to be appropriate. However, the documentation of Physician B was not. As Physician B is no longer with the health care system there is no action to be taken concerning this matter.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Victoria Coates, LICSW, MBA, Project Leader Toni Woodard, BS, Team Leader Gail Bozzelli, RN Eileen Keenan, RN, MSN Robin Moyer, MD Larry Selzler, MSPT Monika Spinks, RN, BSN
Other Contributors	Tracy Brumfield Nicholas DiTondo Kathy Gudgell, RN, JD Andy Waghorn, JD

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, South Central VA Health Care Network (10N16)
Director, Gulf Coast Veterans Health Care System (520/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
Alabama: Richard C. Shelby, Doug Jones;
Florida: Bill Nelson, Marco Rubio
Mississippi: Thad Cochran, Roger F. Wicker
U.S. House of Representatives:
Alabama: Bradley Byrne,
Florida: Neal Dunn, Matt Gaetz
Mississippi: Steven M. Palazzo

OIG reports are available at **www.va.gov/oig**.