Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Iron Mountain VA Medical Center Iron Mountain, Michigan

Report No. 06-00510-192 **August 17, 2006**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care services are 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.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training 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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Executive Summary

Introduction

During the week of May 22–26, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Iron Mountain VA Medical Center. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and administrative controls. During the review, we also provided fraud and integrity awareness training to 143 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 12.

Results of Review

The CAP review covered six areas. The medical center complied with selected standards in the following two areas:

- All Employee Survey
- Breast Cancer Management

We identified the following organizational strengths:

- Volunteer support of medical center operations was noteworthy.
- Patients reported a high level of satisfaction with medical center services.

We made recommendations in four of the six activities reviewed. For these activities, the medical center needed to:

- Correct identified environmental deficiencies.
- Improve the VA Community Nursing Home Program's Oversight Committee membership and patient monitoring.
- Counsel patients with abnormal laboratory values.
- Analyze patient safety and restraint usage information and provide follow-up as needed.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, and Ms. Wachita Haywood, Associate Director, Chicago Office of Healthcare Inspections.

VISN and Medical Center Director Comments

The VISN and Medical Center Directors concurred with the CAP review findings and provided acceptable improvement plans. (See Appendix B, beginning on page 10 for the

full text of the Director's comments.) We will follow up on the implementation of planned improvement actions until they are completed.

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

Introduction

Medical Center Profile

Organization. Located in the upper peninsula of Michigan, the Iron Mountain VA Medical Center provides primary and secondary-level inpatient and outpatient health care services. Outpatient care is also provided at six community based outpatient clinics located in Marquette, Hancock, Menominee, Ironwood, and Sault Ste. Marie, Michigan; and in Rhinelander, Wisconsin. The medical center is part of VISN 12 and serves a population of about 17,400 unique veterans in a primary service area that includes all 15 counties in the upper peninsula of Michigan and 17 counties in northeastern Wisconsin.

Programs. The medical center provides acute inpatient care and limited emergency care and relies heavily on tertiary care facilities in VISN 12 to provide higher-level critical and emergency care and specialty services. The medical center employs state-of-the-art telemedicine technology and is a leader in rural health care delivery in the Veterans Health Administration (VHA). Ambulatory care and acute primary and secondary health care are provided in medicine, surgery, mental health, physical medicine and rehabilitation, oncology, dentistry, geriatrics, and extended care. The medical center has 17 operating beds, 5 observation beds, and a 40-bed Nursing Home Care Unit (NHCU). The medical center also has fee or contractual agreements with specialty providers in orthopedics, neurology, urology, podiatry, nephrology, and anesthesiology, and a contractual arrangement with Dickinson County Healthcare System for hemodialysis services.

Affiliations. The medical center has no medical school affiliations but is affiliated with Bay de Noc Community College for associate's degree registered nurse and licensed practical nurse programs, and a phlebotomy certification program. Other available affiliation agreements include Northern Michigan University for bachelor's and master's level nursing students and with Northeast Wisconsin Technical College for a phlebotomy certification program.

Resources. In fiscal year (FY) 2005, medical care expenditures totaled $53 million. The FY 2006 medical care budget is $55.5 million. FY 2005 staffing was 393 full-time equivalent (FTE) employees, including 22 physician and 150.8 nursing FTE.

Workload. In FY 2005, the medical center treated 17,398 unique patients, a 2.4 percent increase from FY 2004. The inpatient and NHCU care workload totaled 1,163 discharges, and the average daily census was 48, including NHCU patients. The outpatient care workload was 117,319 visits.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility focusing on patient care, quality management, and administrative controls.
- Provide fraud and integrity awareness training 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, QM, and management controls. 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. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical and administrative records. The review covered the following six activities:

All Employee Survey	Environment of Care
Breast Cancer Management	Quality Management Program
Diabetes and Atypical Antipsychotic Medications	VA Community Nursing Home Program

The review covered medical center operations for FY 2005 and FY 2006 through May 15 2006, and was done in accordance with OIG standard operating procedures for CAP reviews.

As part of the review, we used interviews to survey patient satisfaction with the quality of care. We interviewed 30 patients during the review and discussed the interview results with medical center managers.

During this review, we also presented 3 fraud and integrity awareness briefings for 143 employees. These briefings covered procedures for reporting suspected criminal activity

to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report we make recommendations for improvement that pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities needing improvement are discussed in the Opportunities for Improvement section (pages 4-7).

Results of Review

Organizational Strengths

Volunteer support of medical center operations was noteworthy. During FY 2005, medical center volunteers contributed their time in hours that are equivalent to 30 FTE. Cash and "in kind" donations received from volunteers to support veterans' activities totaled over $1 million. Medical center managers regularly meet with volunteer organizations to provide updates on operations, share concerns, and resolve issues.

Patients reported a high level of satisfaction with medical center services. VHA conducts a Survey of Healthcare Experiences of Patients (SHEP) for inpatient and outpatient care settings to determine patients' satisfaction with defined dimensions of care. During the 3rd and 4th quarters of FY 2005, medical center inpatients who responded to the SHEP rated 9 of 10 dimensions higher than VHA national averages. In the summary score, Overall Quality, inpatients rated the medical center (on a scale of 100 being the best rating) as 92.80, compared to the VHA national average of 76.90. Outpatients also rated their care at the medical center and at the six community based outpatient clinics. Eighty-nine percent of all dimension scores at these care sites were equal to or above VHA national averages.

Opportunities for Improvement

Environment of Care – Environmental Deficiencies Needed To Be Corrected

Condition Needing Improvement. VA policy requires that the medical center be clean, sanitary, and maintained to optimize infection control and patient safety. We inspected a sample of occupied and made-ready patient rooms and their restrooms (private and communal). We found that the medical center was generally clean and effectively maintained. We identified the following concerns that required management attention.

Infection Control Concern. Emergency call system cords made of a rope-like material were used in patient restrooms near sink and commode areas. Many of these cords appeared soiled, and the surfaces could not be easily cleaned due to the fabric consistency of the cords. Managers reported that they plan to replace the cords with fluorescent plastic cords.

Patient Safety Concerns. Two cleaning products were stored in unsecured cabinets under sinks; a tube of lubricant and small bottle of mouthwash were found in an unsecured cabinet in a hallway; and sharp items including disposable razors, suturing kits, and sterile scissors, were stored in an unsecured cabinet in a patient care area. We noted that patient food trays were stored in unsecured holding carts that remained in patient care

areas several hours after meal time. Patients could access the leftover food. Soap dispensers in the NHCU were noted to be leaking.

Cleaning Practices. We noted an accumulation of debris and dust on the floor along baseboards and corners in patient rooms in the NHCU. Patient lockers adjacent to beds that were in made-ready rooms needed additional cleaning in the NHCU, Intensive Care Unit, and 4 East. Additionally, we found dead insects between dual-paned windows in the NHCU.

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires that the environmental deficiencies detailed above are corrected.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they have replaced call system cords; secured cleaning products, patient care products, and sharp items; replaced soap dispensers; established a procedure for timely pick-up and security of patient food trays; and improved cleaning practices. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

VA Community Nursing Home Program – Oversight Committee Membership and Patient Monitoring Required Improvement

Condition Needing Improvement. VHA Handbook 1143.2 provides guidelines for the VA Community Nursing Home (CNH) Program, to include oversight and monitoring of patients who have been placed in CNHs by VA facilities. The medical center's Home and Community Care Oversight Committee provides oversight of the CNH Review Team efforts. VHA policy requires that the membership of this oversight committee includes a registered nurse, physician, social worker, and representatives from Quality Management and Acquisitions. The Home and Community Care Oversight Committee membership did not include a representative from Acquisitions.

We reviewed the medical records of nine VA patients who were placed in CNH facilities. Six of the nine patients did not receive VA staff visits and/or monthly monitoring as required by VHA policy.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that (a) an Acquisitions representative be appointed to the Home and Community Care Oversight Committee and (b) staff complete visits and/or monthly monitoring of VA patients in CNH facilities as required.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they have appointed an Acquisitions representative to the Home and Community Care Oversight Committee and developed plans to ensure staff visits and/or

monthly monitoring of CNH patients is completed. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Diabetes and Atypical Antipsychotic Medications – Patients with Abnormal Laboratory Values Needed To Be Counseled

Condition Needing Improvement. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment for 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). We reviewed a sample of 13 patients who were prescribed one or more atypical antipsychotic medication for at least 90 days. VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1 to 3 years. The medical center defined that a normal FBG was less than or equal to 100 milligrams per deciliter (mg/dL). Patients with FBG values greater than 100 mg/dL but less than 126 mg/dL should be counseled about prevention strategies such as calorie-restricted diets and exercise. A FBG value that is greater than or equal to 126 mg/dL on at least two occasions is diagnostic for diabetes mellitus.

We noted that 5 of the 13 patients in our sample had FBG results that were over 100mg/dL. Of those five, there was no medical record documentation to show that three of the patients were counseled by clinicians.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires clinicians to provide and document counseling to patients who have abnormal FBG results.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they educated providers on the need to provide and document counseling for patients with abnormal FBG results. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Quality Management Program – Review of Patient Safety and Restraints Needed In-Depth Analysis and Follow-Up

Condition Needing Improvement. Senior managers actively participated in and supported QM activities and initiatives. The QM program was generally effective and provided appropriate oversight in 12 of the 14 clinical areas reviewed. The following two areas required management attention.

Patient Safety Aggregate Reviews. Program managers conducted aggregate root cause analyses for adverse drug events, falls, missing patients, and parasuicidal behaviors. However, program managers were not consistent in identifying specific recommended

corrective actions with measurable goals and documenting follow-up. Determination of the effectiveness of any interventions taken was difficult without clearly defined recommendations and actions.

Patient Restraint Reviews. Program managers had collected and reported patient restraint usage data for years. There was no critical analysis of these data, and recommendations for process improvements and actions taken were reported anecdotally to the OIG team. Program managers had not followed up on actions taken to determine their effectiveness.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires that (a) patient safety aggregate reviews result in specific recommendations with defined measurable goals, and the effectiveness of actions taken is evaluated and (b) patient restraint data are critically analyzed, and recommendations are documented and followed up to determine their effectiveness.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that training has been accomplished and is continuing on development of measurable goals, recommended actions, and follow-up. Quarterly reports of actions will be presented to and followed up by the Quality Council. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Other Activities Reviewed

Breast Cancer Management – Processes Were Timely and Appropriate

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center exceeded the fully satisfactory level for 3 of the 4 quarters in FY 2005. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. The medical center provides mammography to its patients by utilizing fee-basis providers. We assessed the timeliness and communication for three patients with abnormal mammogram results in FY 2005 and two patients with abnormal mammogram results in FY 2004.

Patients received timely mammography services through a fee-basis provider, and they received timely results of their mammograms. The medical center appropriately referred patients requiring further care and treatment to providers at other VA or community facilities.

All Employee Survey – Data Was Utilized To Improve Employee Satisfaction

The Executive Career Field (ECF) Performance Plan for FY 2005 required that the VISN ensured that results from the FY 2004 All Employee Survey (AES) were widely disseminated throughout the network by, at a minimum, conducting a town hall meeting open to all employees at each facility during the rating period. VISNs were to have analyses of the FY 2004 AES results, with formulation of action plans to address items identified for improvements, completed by September 30, 2004. Plans were required to incorporate milestones that included timelines and measures that assessed achievement. The medical center met all requirements of the ECF Performance Plan for 2005. The AES results and action plan were disseminated to employees through scheduled town hall meetings with the Director and through electronic messages. Medical center managers also appointed an interdisciplinary AES committee to formulate and track plans to address areas with low scores.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 28, 2006

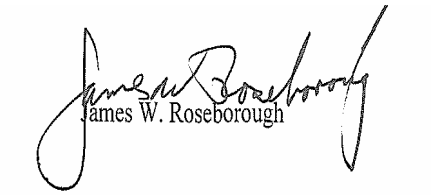
From: Network Director (10N12)

Subject: **Combined Assessment Program Review of the Iron Mountain VA Medical Center, Iron Mountain, MI**

To: Office of Inspector General

Attached please find our response to the Combined Assessment Program review of Iron Mountain VA Medical Center conducted May 22 - 26, 2006.

If you have any questions, you may contact the Associate Director at Iron Mountain VA Medical Center at (906) 774-3300 extension 32013.



Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 28, 2006

From: Director, Iron Mountain VA Medical Center (585/00)

Subject: **Combined Assessment Program Review of the Iron Mountain VA Medical Center, Iron Mountain, MI**

To: Office of Inspector General

Attached please find our response to the Combined Assessment Program review of Iron Mountain VA Medical Center conducted May 22 - 26, 2006.

If you have any questions, you may contact the Associate Director at Iron Mountain VA Medical Center at (906) 774-3300 extension 32013.

(original signed by:)
/es/Terry E. Taylor
for/Janice M. Boss, M.S., CHE

Medical Center Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires that the environmental deficiencies detailed are corrected.

Emergency call system cords appeared soiled and could not be easily cleaned.

Concur **Completed : 6/15/2006**

Soiled emergency call system cords have been replaced with washable plastic cords throughout the Medical Center.

Cleaning products, lubricants, mouthwash, and sharp items were stored in unsecured cabinets in patient care areas.

Concur **Completed: 5/26/2006**

Items noted during review were promptly removed while OIG visit was underway. EOC Rounds now includes surveillance for these types of inappropriate storage.

Soap dispensers in the NHCU were noted to be leaking.

Concur **Completed: 6/1/2006**

We have replaced all leaking soap dispensers and Housekeeping & Food Service staff continues to check for leaking dispensers during daily routines.

Patient food trays were stored in unsecured holding carts that remained in patient care areas several hours after meal time. Patients could access the leftover food.

Concur **Completed: 6/26/2006**

Trays noted during review were promptly removed just after the finding. Nursing and Housekeeping & Food Service implemented a procedure to ensure more timely pick-up and/or storage of trays and tray carts away from easy access by patients. Trays and tray carts are now stored in a secured area. EOC Rounds now includes surveillance for the presence of trays and tray carts, effective 6/1/06.

Dust/debris accumulation was noted on floors along baseboards, in corners, and in patient lockers, and dead insects were found between dual-paned windows in the Nursing Home Care Unit.

Concur **Completed: 6/9/2006**

Identified areas were promptly cleaned during survey. Nursing and Housekeeping & Food Service daily routines now include monitoring for areas which require further cleaning. Special EOC Rounds on the Nursing Home Care Unit are conducted daily, effective 6/2/06 until "Steady State" compliance is achieved and maintained.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) an Acquisitions representative be appointed to the Home and Community Care Oversight Committee;

Concur **Completed: 5/26/2006**

An Acquisitions representative was appointed to the Home and Community Care Oversight Committee on May 23, 2006.

and (b) staff complete visits and/or monthly monitoring of VA patients in CNH facilities as required.

Concur **Completed: 5/26/2006**

VA staff is conducting visits and/or monthly monitoring per policy effective 5/26/06 in accordance with VHA Handbook 1143.2, VHA Community Nursing Home Oversight Procedures.

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director requires clinicians to provide and document counseling to patients who have abnormal FBG results.

Concur **Target Completion Date: 9/1/2006**

A mechanism has been put into place which identifies patients who are on atypical antipsychotic medications and who have abnormal fasting blood glucose results. Providers were educated at Provider staff meeting regarding documenting counseling/education of patients who have abnormal FBG results and are on atypical antipsychotic medications. Documentation of patient counseling will be monitored by ongoing chart review by Primary Care Service and Mental Health Service, and reported to Pharmacy & Therapeutics Committee and Clinical Executive Board.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires that:

(a) patient safety aggregate reviews result in specific recommendations with defined measurable goals, and the effectiveness of actions taken is evaluated;

Concur **Target Completion Date: 9/1/2006**

The Patient Safety Manager will provide a quarterly RCA report to Quality Council, who will have a standing agenda item addressing RCA action items, follow-up and effectiveness of actions taken. The Patient Safety Manager will provide training on how to develop measurable goals as a result of specific RCA recommended action items at the next Quality Council. Additionally, the Patient Safety Manager will enhance RCA team training to include how to develop measurable goals.

and (b) patient restraint data are critically analyzed and recommendations are documented and followed up to determine their effectiveness.

Concur Target Completion Date: 8/1/2006

Nursing Leadership and Staff involved with the reporting, tracking and analysis of restraint data have received additional training on effective data analysis and data presentation. Restraint data will continue to be submitted to the Associate Director for Nursing and Patient Care Service and Quality Management Section. Restraint data and analysis, recommendations and their implementation actions, including follow-up, will be reported quarterly to the Quality Council. The report will also be presented to the Clinical Executive Board as part of the Performance Improvement Report.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson Director, Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	John Brooks Paula Chapman Wachita Haywood Jennifer Reed Leslie Rogers

Appendix D

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