Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Atlanta VA Medical Center Atlanta, Georgia

Report No. 06-01571-231 **September 29, 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 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.
- 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 1–5, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Atlanta VA Medical Center (referred to as the medical center). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 295 employees. The Medical Center is under the jurisdiction of Veterans Integrated Service Network (VISN) 7.

Results of Review

The CAP review covered six operational activities. As identified below, the medical center complied with selected standards in five areas. The remaining area resulted in recommendations for improvement.

The system complied with selected standards in the following areas:

- All Employee Survey
- Breast Cancer
- Diabetes and Atypical Antipsychotic Medication
- Environment of Care
- Quality Management

To improve operations, we recommended that the medical center improve program oversight of Contract Community Nursing Homes.

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

VISN and Medical Center Director Comments

The VISN 16 and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 6–9 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Facility Profile

Organization. The medical center is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. There are four community based outpatient clinics located in Lawrenceville, Oakwood, Smyrna, and Eastpoint, Georgia. The medical center is part of VISN 7 and serves a veteran population of about 387,000 in a primary service area that includes portions of Alabama, South Carolina, and 45 counties in Georgia.

Programs. The medical center provides primary and specialized outpatient health care, extended care, acute and intermediate medical, surgical, and psychiatric care services with most major specialties and subspecialties. Currently the facility has 121 operating hospital beds and 100 nursing home beds. The medical center functions as the Primary Receiving Center in the VA/Department of Defense Contingency Planning Process and as a Federal Coordinating Hospital in the National Disaster Medical System.

Affiliations and Research. The medical center is affiliated with Emory University School of Medicine, and supports 125 medical resident positions in 33 training programs. In total, there are 35 schools with active affiliation agreements with the medical center. In fiscal year (FY) 2005, the medical center research program had over 660 projects and a budget of approximately $29 million. Important areas of research include infectious disease, bone research, and a Center of Excellence in Rehabilitation Research and Development dealing with veterans with visual impairment.

Resources. In FY 2005, medical care expenditures totaled $240.6 million. The FY 2006 medical care budget is $267.6 million. FY 2005 staffing totaled 1,755 full-time equivalent (FTE) employees, including 163 physician and 418 nursing FTE.

Workload. In FY 2005, the medical center treated 57,350 unique outpatients. The medical center provided 36,750 inpatient days, 3,266 inpatient days in the Psychosocial Residential Rehabilitation Treatment Program (PRRTP), and 28,003 inpatient days in the Nursing Home Care Unit. The inpatient care workload totaled 5,528 discharges with a average daily census of 100 hospital, 76 Nursing Home Care Unit, and 8 PRRTP Veterans. The outpatient workload included 606,064 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 care. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care and quality management.

- 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 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 work areas; interviewed managers, employees, and patients; and reviewed clinical records. The review covered the following 6 activities:

All Employee Surveys	Diabetes and Atypical Antipsychotic Medication
Breast Cancer Management	Environment of Care
Community Nursing Home Contracts	Quality Management

As a part of the review, we interviewed 30 patients to survey satisfaction with timeliness of service and the quality of care. The survey results were shared with medical center managers.

Activities needing improvement are discussed in the Opportunities for Improvement section (page 4). Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

During this review, we also presented fraud and integrity awareness briefings for 295 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Follow-Up on Prior CAP Review Recommendations

As part of this review, we followed up on recommendations from the prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center Atlanta, Georgia*, Report No. 2002-02757-HI-0333, February 25, 2003). In 2002, it was identified that the Medical Center Director needed to improve cleanliness and safety deficiencies in the medical center and require that peer reviews be conducted and documented in accordance with local policy.

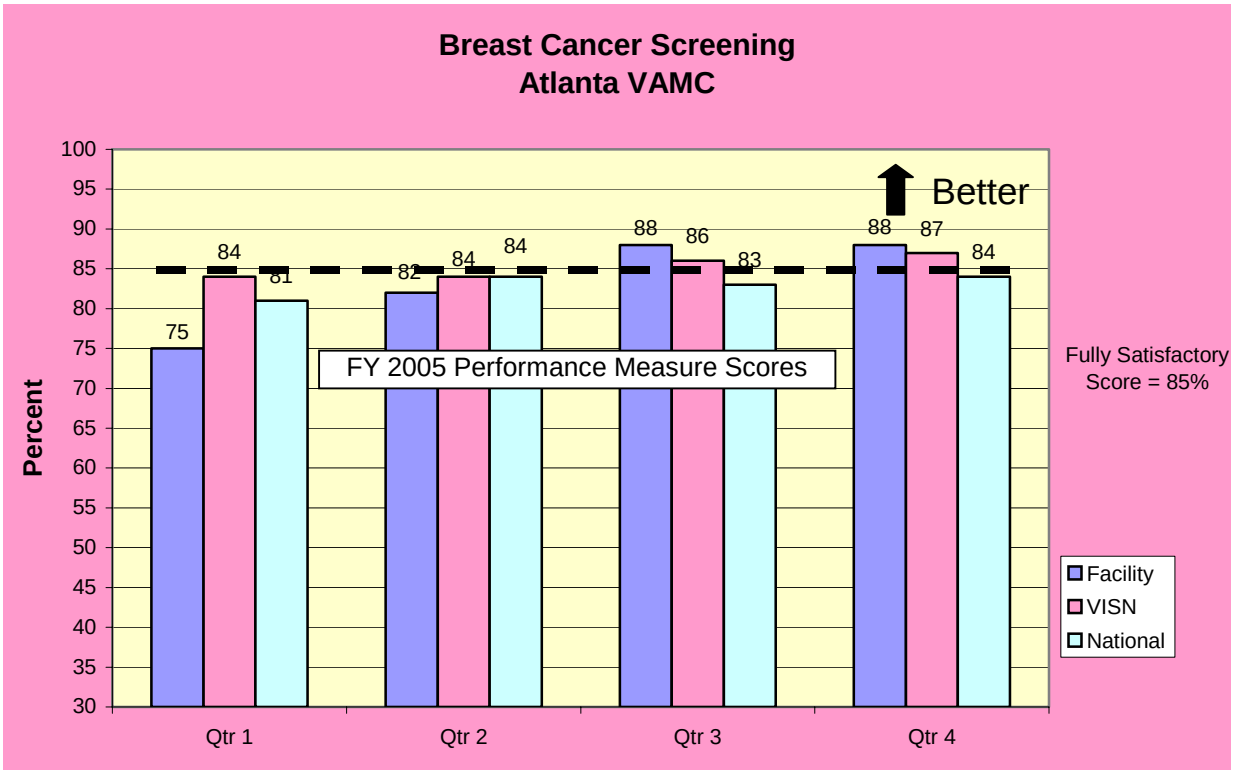
Our May 2006 CAP review found that medical center management had implemented adequate corrective actions for the conditions identified**.**

Results of Review

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 target level for the last 2 quarters in FY 2005. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes.

Mammogram services were offered to the patients by fee-basis providers. Timely radiology, consultative, and treatment services were provided to the patients by the medical center. When indicated, an interdisciplinary treatment plan was developed, and providers promptly informed the patient of diagnosis and treatment options.



Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
10/10	**10/10**	**10/10**	**2/2**	**9/9**

Opportunities for Improvement

Contract Community Nursing Home – Program Oversight Needs To Be Improved

Condition Needing Improvement. The medical center needed to establish a Contract Community Nursing Home (CNH) Oversight Committee for supervision at an upper management-level. Medical centers are required to incorporate two separate entities, a CNH Review Team and a CNH Oversight Committee, with each being responsible for specific tasks. The CNH Review Team is responsible for the evaluations and inspections of the nursing homes as well as ongoing monitoring and follow-up visits with veterans who reside in the nursing homes. The CNH Oversight Committee consists of multidisciplinary management-level representatives who supervise the structure and methodology of the CNH Review Team and assure a plan for quality monitoring is implemented. The medical center had established a CNH Review Team, but had not organized a CNH Oversight Committee, which should include a medical staff representative as outlined by the VHA Handbook. The Medical Center Director has since created a CNH Oversight Committee to comply with VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*.

The medical center demonstrated a lack of oversight with ongoing monitoring and follow-up visits in the nursing homes. Veterans, family members, and staff at the CNHs stated a social worker or nurse from the medical center did not visit on a regular basis, as required in the VHA Handbook. However, documentation in the electronic medical record indicated monthly visits with the veteran and nursing home staff were conducted on a routine schedule. This concern was discussed with the Medical Center Director, and a Board of Investigation was immediately initiated.

There was no documented evidence that the facility met with the local Ombudsman offices. The purpose for interaction with the regional offices is to discuss issues of mutual interest and concern. The CNH coordinator communicated with the Ombudsman offices on an as needed basis without documenting the discussion. Following the onsite visit, the CNH Coordinator initiated annual meetings with the local Ombudsman offices; confirmation of these meetings will be indicated on the Certification Report.

During the CNH review, healthcare inspectors discovered that a social worker failed to follow up on possible neglect of a veteran upon discharge from the medical center in 2001 as reported by a family member. From 2001–2005, the veteran continued in the same environment and was seen rarely at the medical center. In 2005, a hospital in the private sector admitted the veteran to a nursing home and notified the medical center. At that time, an elder abuse assessment was completed, which determined there were serious concerns for the veteran's safety and well-being. There was no documented evidence to

support that medical center staff followed up regarding these concerns. This case was forwarded to the Medical Center Director for further action.

Recommended Improvement Actions 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) establish a Contract Community Nursing Home Oversight Committee, (b) implement recommendations given by the Board of Investigation, (c) develop and document collaboration between the CNH Coordinator and the local Ombudsman office, and (d) ensure clinicians report elder abuse as indicated in VHA Handbook 1143.2.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 28, 2006

From: VISN Director

Subject: **Response to Project # 2006-01571-HI-0315**

To: **Assistant Inspector General for Healthcare Inspections**
Thru: **Director, Management Review Services (10B5)**

The following VISN Director's comments are submitted in response to the recommendations in the Office of Inspector General report.

If you have any questions, please contact Wayne Saxton, Program Manager, VA Southeast Network, at phone number 678-924-5700.

Thomas A. Cappello, FACHE

VISN Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) establish a Contract Community Nursing Home Oversight Committee; (b) implement recommendations given by the Board of Investigation; (c) develop and document collaboration between the CNH Coordinator and the local Ombudsman office; and (d) ensure clinicians report elder abuse as indicated in VHA Handbook 1143.2.

Concur

I concur with the above recommendations. Per the attached memorandum from the Acting Medical Center Director, all recommendations have been implemented.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 28, 2006

From: Acting Director, Atlanta VAMC (508/00

Subject: **Response to Project # 2006-01571-HI-0315**

To: **Assistant Inspector General for Healthcare Inspections**
Thru: **Director, Management Review Services (10B5)**

The following Medical Center Director's comments are submitted in response to the recommendations in the Office of Inspector General report.

If you have any questions regarding this response, please contact Ted Johnson, MD, MPH, Manager for the Geriatrics, Extended Care & Rehabilitation Service Line, at phone number 404-728-7775.

James A. Clark, MPA

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

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

OIG Recommendations

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) establish a Contract Community Nursing Home Oversight Committee; (b) implement recommendations given by the Board of Investigation; (c) develop and document collaboration between the CNH Coordinator and the local Ombudsman office; and (d) ensure clinicians report elder abuse as indicated in VHA Handbook 1143.2.

Concur

Recommendation 1a: Establish a Contract Community Nursing Home Oversight Committee.

Concur. The Community Nursing Home (CNH) program had included a Community Compliance Review Committee, but its composition did not include a member of the medical staff (as is required in VHA Handbook 1143.2 dated June 4, 2004). The Manager of the Geriatrics, Extended Care, & Rehabilitation Service Line was added as a member of this committee in May 2006, and the committee's name was changed to the Community Nursing Home Oversight Committee.

Recommendation 1b: Implement recommendations given by the Board of Investigation.

Concur. All recommendations given by the Board of Investigation have been implemented.

Recommendation 1c: Develop and document collaboration between the CNH Coordinator and the local ombudsman office.

Concur. The CNH Coordinator contacted all of the ombudsman offices in April to schedule quarterly meetings to discuss veteran issues (evidence attached). At the request of the ombudsman, these meetings have been scheduled on a semi-annual basis and are supplemented by conference calls as needed, for individual issues. Documentation of these meetings will be reflected on the Certification Report.

Recommendation 1d: Ensure clinicians report elder abuse as indicated in VHA Handbook 1143.2.

Concur. All geriatric patients in Community Nursing Homes, Residential Care, our Nursing Home Care Unit and our Bronze Geriatrics clinic are screened by the Social Worker utilizing an elder abuse assessment template. Additionally, abuse screens are included in assessment templates with a link to our Medical Center Policy titled "Identification and Reporting of Adult and Child Victims of Alleged or Suspected Abuse or Neglect or Assault". Health Care Providers have been educated and reminded of the policy by their team's respective Social Worker.

Appendix C

OIG Contact and Staff Acknowledgments

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

Appendix D

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