



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Review of the Sheridan VA Medical Center Sheridan, Wyoming

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 is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits 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

The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center (the medical center), Sheridan, WY, during the week of June 12–15, 2006. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and integrity awareness training to 117 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 19.

Results of Review

The CAP review focused on six areas. The medical center complied with selected standards in the following three areas:

- Breast Cancer Management
- Diabetes and Atypical Antipsychotic Medications
- Survey of Healthcare Experiences of Patients (SHEP)

We identified three areas that needed additional management attention. To improve operations, we made the following recommendations:

- Evaluate Contract Community Nursing Homes (CNHs) prior to initial contracts, ensure that a registered nurse participates in monthly CNH visits, and comply with CNH oversight committee requirements.
- Conduct Environment of Care (EOC) rounds in outpatient clinical areas at least every 6 months.
- Improve Quality Management program coordination, data analyses, and follow-up actions.

This report was prepared under the direction of Ms. Virginia Solana, Director, and Ms. Dorothy Duncan, Associate Director, Kansas City Regional Office of Healthcare Inspections.

VISN 19 and Medical Center Director Comments

The Sheridan VA Medical Center Director and the VISN 19 Director agreed with the CAP review findings and provided acceptable improvement plans (see Appendixes A and

B, pages 11–15, for the full text of the Directors’ comments). We will follow up on the planned 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. The medical center serves as the tertiary mental health facility for VISN 19. It provides a continuum of care to veterans that includes inpatient acute and transitional care, residential care, outpatient care, and community treatment. A Domiciliary Residential Rehabilitation Treatment Program was opened in February 2006. Outpatient medical and mental health care is also provided at five community based outpatient clinics located in Casper, Riverton, Gillette, Powell, and Rock Springs, WY. The medical center serves a veteran population of about 34,000 in a primary service area that includes 15 counties in northern and western Wyoming.

Programs. The medical center provides medical, mental health, geriatric, and rehabilitation services; it has 149 hospital beds and 50 nursing home beds and operates several regional referral and treatment programs. These include the only domiciliary in VISN 19, a residential rehabilitation program, and acute and long-term psychiatry. The medical center has a sharing agreement with the local community hospital.

Affiliations and Research. The medical center is affiliated with the University of Washington College of Medicine and has affiliations with other colleges and universities to train nursing, dental assistant/hygienist, physical therapy, physician assistant, and social work students. In fiscal year (FY) 2005, the medical center had one research project looking at Quality of Care for Acute Coronary Syndromes Care in Veterans Health Administration (VHA), with a budget of \$16,000.

Resources. In FY 2005, medical care expenditures totaled about \$52 million. The FY 2006 medical care budget is \$58 million. In FY 2005, the medical center had 405.6 full-time equivalent employees (FTE), including 15.85 physician FTE and 68.8 nursing FTE.

Workload. In FY 2005, the medical center treated over 10,000 unique patients. The inpatient workload in FY 2005 totaled 1,640 discharges, and the average daily census, including nursing home patients, was 133. The outpatient workload totaled 91,609 visits in FY 2005.

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 and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations 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 and employees, and reviewed clinical and administrative records. The review covered the following six activities:

Breast Cancer Management	Environment of Care
Contract Community Nursing Homes	Quality Management
Diabetes and Atypical Antipsychotic Medications	Survey of Healthcare Experiences of Patients

The review covered facility operations from FY 2004 through May 31, 2006 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on the recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Sheridan VA Medical Center, Sheridan, Wyoming*, Report No. 03-02612-27, November 21, 2003).

During this review, we also presented fraud and integrity awareness briefings for 117 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 summarize selected focused inspections and state opportunities for improvement. We make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the section titled “Other Observations” have no reportable conditions.

Results of Review

Opportunities for Improvement

Contract Community Nursing Homes – Program Oversight Needed Strengthening

Condition Needing Improvement. The CNH Review Team needed to evaluate nursing homes prior to the award of initial contracts and subsequent placement of veterans in those homes. A registered nurse needed to alternate monthly follow-up visits with the CNH social worker who was conducting all the visits. The CNH oversight committee needed to meet at least quarterly and include QM representation.

According to VHA policy, the CNH Review Team must evaluate community nursing homes prior to awarding an initial contract. Site visits are important to determine the conditions of the homes. The CNH Review Team must obtain and analyze quality data, State survey findings, inspection reports, and the Center for Medicare and Medicaid Services quality indicators. This data provides comparative information on State nursing homes' compliance with quality standards and designates areas of deficiency, as well as actions taken to resolve problems. After the CNH Review Team analyzes the data, they make recommendations to the medical center Contracting Officer regarding the contract award. The medical center Contracting Officer awarded two of three contracts prior to an initial site evaluation. The medical center placed patients in those nursing homes before the CNH Review Team performed site visits.

Although the CNH Review Team utilized the most recent State survey findings in their initial and annual review process, they did not use the Medicare and Medicaid quality indicators and did not compare data to other state nursing homes. Use of comparative data helps determine the severity of deficiencies.

The CNH coordinator needed to assure that a registered nurse visits CNH patients. VHA policy requires that a social worker and a registered nurse must alternate visits and see patients every 30 days unless otherwise indicated in an individual treatment plan. Although a social worker made monthly visits for the 12 months prior to our review, a registered nurse had not participated; the reason for this was not addressed in treatment plans.

VHA policy defines the CNH oversight committee responsibilities, membership, and frequency of meetings. A QM representative must be a member of the oversight committee and the committee must meet at least quarterly. QM was not represented on the medical center CNH oversight committee, and the committee had not met quarterly. The current medical center CNH policy does not include QM representation on the oversight committee and designates meeting frequency as annually.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) implement a process to evaluate all community nursing homes prior to initial contract and utilize quality comparative data in initial and annual reviews, (b) alternate monthly CNH visits between a social worker and a registered nurse, and (c) include QM representation on the CNH oversight committee and ensure that the committee meet quarterly.

The VISN and Medical Center Directors agreed with the findings and recommendations. Based on a newly developed medical center policy, the VISN Contracting Office will now have responsibility for all contracts. They will not award contracts until all requirements are met. A registered nurse will now alternate monthly CNH visits with the social worker. The CNH oversight committee reviews data at quarterly meetings that include QM representation. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Environment of Care Review – Routine Rounds Needed To Be Conducted in Outpatient Clinical Areas

Condition Needing Improvement. Managers did not conduct EOC rounds in outpatient clinics in accordance with VHA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements. VHA and JCAHO require EOC rounds in all patient care areas at least every 6 months. Although staff conducted rounds at the required intervals for the inpatient areas, they did not conduct routine rounds in the outpatient clinics.

The medical center generally had a clean and safe environment for patients and employees. Inpatient and outpatient units and waiting rooms were clean and free from clutter. A spot check of fire extinguishers found they were in compliance with policy. We selected a sample of eight pieces of medical equipment and determined they were in proper working order and had appropriate preventative maintenance checks.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to implement EOC rounds in the outpatient clinical areas at least every 6 months.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center Environment of Care Team members toured all clinic areas and will continue to do so every 6 months. The improvement action is acceptable, and we will follow up on the reported implementation action to ensure it has been completed.

Quality Management – Program Coordination, Data Analysis, and Follow-Up Actions Needed Improvement

Condition Needing Improvement. Program managers needed to trend and analyze pertinent data in all areas required by VHA policy and JCAHO. JCAHO requires hospitals to analyze data for trends and make recommendations to improve care. Although program managers collected data, it was not consistently analyzed. In addition, senior managers and program coordinators did not assign responsibility for follow-up of corrective actions or document how they would evaluate the effectiveness of actions taken.

The medical center's FY 2006 Performance Improvement (PI) Plan did not include corrective action plans for all performance measures that were below satisfactory for FY 2005. The PI plan was not comprehensive and did not include all of the JCAHO and VHA required elements. Medical center managers need a system for ensuring that implementation, evaluation, and follow-up of all recommendations are completed.

Although employees collected data in several services and program areas, trend analysis was lacking. Surgical Service had not analyzed data on surgical procedures since FY 2002. Patient complaint reports were limited to broad topic areas such as complaints involving access/timeliness and decisions/preferences. VHA policy requires that patient advocates aggregate complaints, analyze the data, and present trended reports to senior managers and patient care providers. The patient advocate needed to expand data analyses in the patient complaint program to identify meaningful trends and opportunities for improvement and compare the results with the medical center's SHEP scores. The medical center collected data to measure performance in responding to resuscitation events but had not trended the events by area, shift, day of the week, and outcome as required by VHA policy. Utilization review managers collected data for inpatient admissions and continued stay appropriateness but did not analyze the data for trends. Medical records reviews were not consistently analyzed for clinical appropriateness and completion of documentation. Individual patient deaths were reviewed, but program managers had not trended or analyzed the data. Trend analysis is vital to the QM process in order for managers to identify opportunities for improvement.

Medical center committees did not consistently follow up on corrective improvement actions or evaluate the effectiveness of actions taken. There was no system in place to track the status of actions. The QM Coordinator had only been in her position since May 2006 and was still learning her role.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the QM Coordinator develop and implement a comprehensive PI plan, (b) program managers trend and analyze data in all JCAHO- and VHA-required areas, and (c) the QM Coordinator develop and implement a system to track recommended actions and their effectiveness.

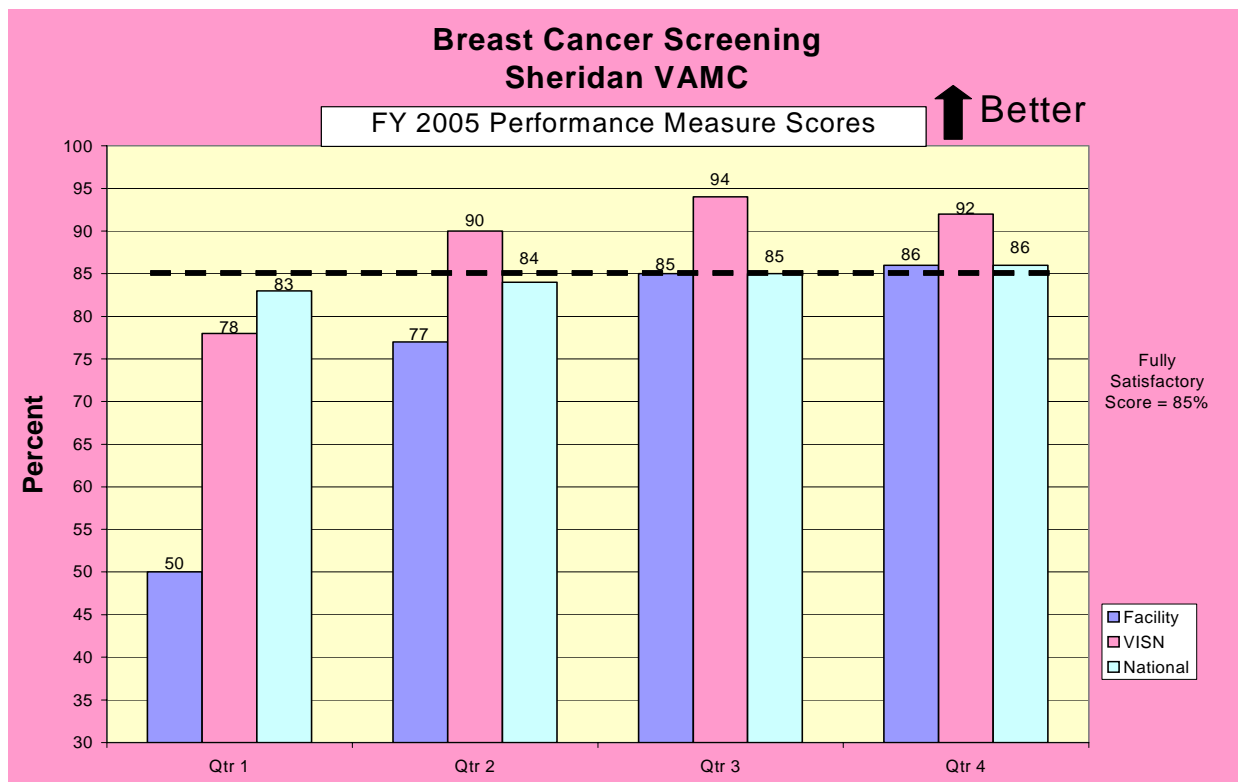
The VISN and Medical Center Directors agreed with the findings and recommendations. The medical center is developing a comprehensive improvement plan that will require program managers to trend and analyze data and report actions and recommendations. The program managers will report recommendations, actions, and follow-up effectiveness to upper management. Top management meets monthly with the Quality Manager to address actions and assess their effectiveness. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Other Observations

Breast Cancer Management

The medical center provided timely breast cancer screening and follow-up. Contract facilities perform mammography off site and the medical center receives timely reports from those facilities. Patients are promptly notified of results of diagnostic testing and biopsies.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center did not achieve the fully satisfactory level in the first 2 quarters of FY 2005, but exceeded the fully satisfactory level by the 4th quarter. They continue to improve and were at 95 percent compliance for the 2nd quarter of FY 2006.



Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection and appropriate management of breast cancer, leading to optimal patient outcomes. We reviewed these items in all patients (five) who had suspicious or highly suggestive mammogram results during FYs 2004 and 2005. Diagnostic procedures were timely, and none of the biopsies were positive for breast cancer.

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
5/5	5/5	NA	NA	5/5

Diabetes and Atypical Antipsychotic Medications

Clinicians appropriately screened and managed mental health patients receiving atypical antipsychotic medications. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of 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 randomly selected patients who were on one or more atypical antipsychotic medications for at least 90 days. Two of the 13 patients had diabetes and clinicians appropriately managed their care. Clinicians had appropriately screened the 11 non-diabetic patients for diabetes and counseled them about diabetes prevention.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with B/P less than 140/90mm/Hg	Diabetic patients with LDL-C less than 120mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
0/2	2/2	2/2	11/11	11/11

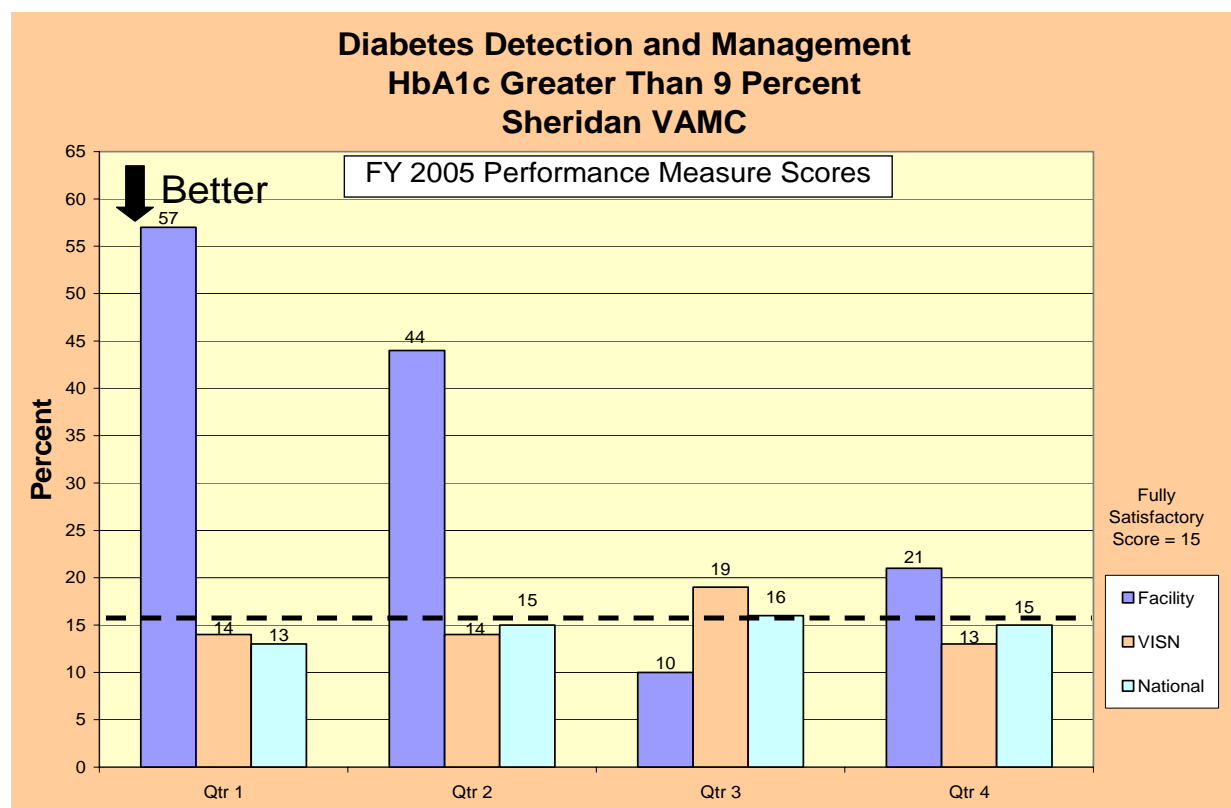
VHA clinical practice guidelines for the management of diabetes suggest that: a diabetic patient's hemoglobin A1c (HbA1c)¹ should be less than 9 percent; blood pressure should be 140/90 millimeters of mercury (mmHg) or less; and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl).

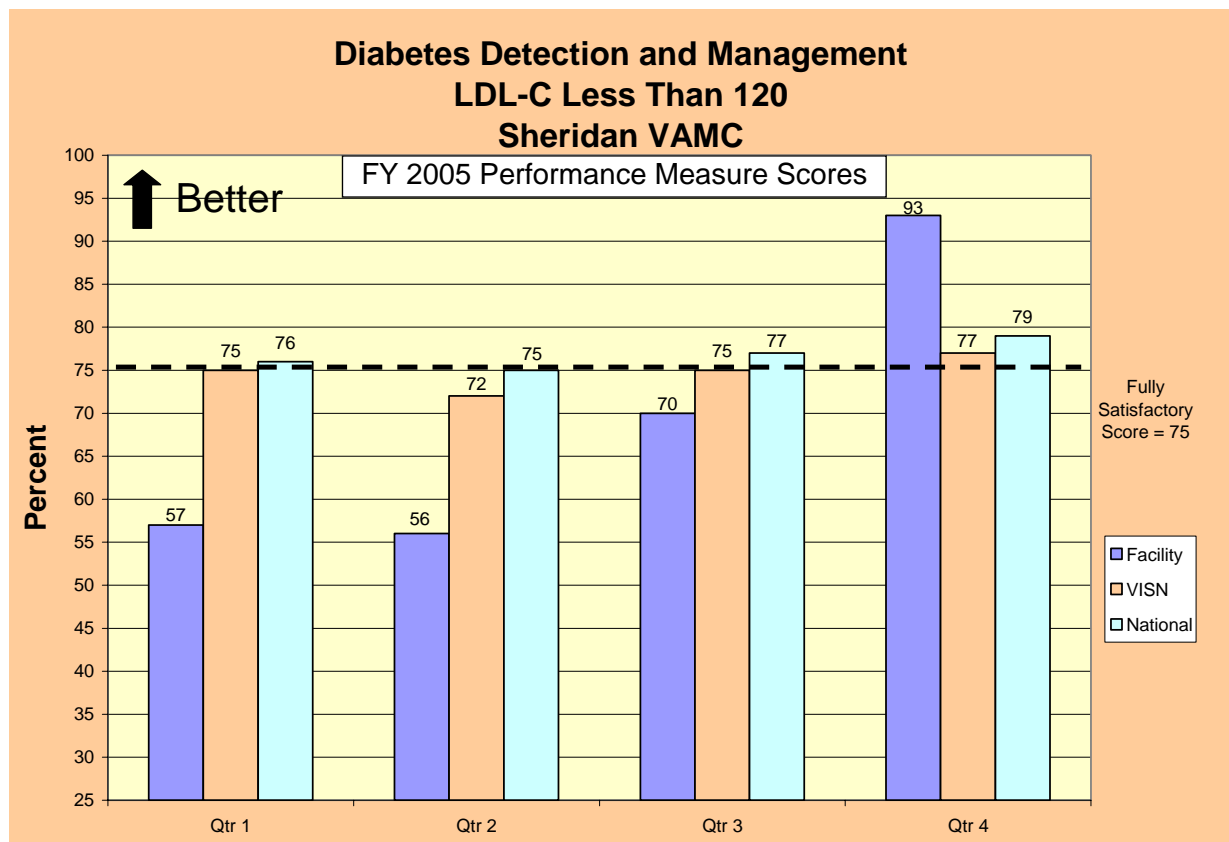
¹ HBA1C reflects the average blood glucose level over a period of time and should remain in control to prevent complications.

To receive fully satisfactory ratings for these diabetes performance measures, the medical center must achieve the following scores:

- HbA1c greater than 9 percent – 15 percent or lower
- Blood Pressure less than or equal to 140/90mmHg – 72 percent or higher
- Cholesterol (LDL-C) less than 120mg/dl – 75 percent or higher

The review showed that the medical center met or exceeded VHA performance measures for blood pressure monitoring and control for FY 2005. Although the medical center did not meet VHA performance measures for HbA1c and cholesterol control for diabetic patients for 3 out of 4 quarters in FY 2005, clinical staff had identified areas for improvement and implemented appropriate action plans. Because senior managers had analyzed performance measure results and supported the corrective actions for meeting these measures, we made no recommendations.





Survey of Healthcare Experiences of Patients

The Survey of Healthcare Experiences of Patients (SHEP) scores either met national targets or the medical center had initiated improvement plans in areas where targets were not met. Veteran patient satisfaction surveying is designed to promote healthcare quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit healthcare surveying group. Measure 21 of the VHA performance plan for FY 2006 requires that the percent of patients reporting overall satisfaction of Very Good or Excellent in FY 2006 will meet or exceed targets. For FY 2006 the targets were:

- a. Ambulatory Care Meets Target: 77%
 Exceeds Target: 80%
- b. Inpatients Meets Target: 76%
 Exceeds Target: 79%

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 18, 2006
From: Director, Veterans Integrated Service Network (10N19)
Subject: **Sheridan VA Medical Center, Sheridan, Wyoming**
To: Director, Kansas City Regional Office of Healthcare Inspections (54KC)

1. Attached is the facility response to the OIG CAP Site Review of the Sheridan VAMC.
2. I have reviewed and concur with all the facility Director's comments.
3. If you have any questions, please contact the Quality Manager at the Sheridan VAMC, Ms. Lisa McClintock, at 307-672-3473, x3165.

(original signed by:)

LAWRENCE A. BIRO
Network Director
VISN 19 Rocky Mountain Network

cc: Director, Management Review Office (10B5)

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 12, 2006
From: Director, Sheridan VA Medical Center (666/00)
Subject: **Sheridan VA Medical Center, Sheridan, Wyoming**
To: Director, Veterans Integrated System Network 19 (10N19)

1. Attached is the action plan for the recommendations from the recent Sheridan VAMC OIG visit.
2. If you have any questions or need additional information, please contact Lisa McClintock at 307-672-3473, x3165.

(original signed by:)

G. V. MORTON
Acting Medical Center Director

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 Recommendation(s)

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) implement a process to evaluate all community nursing homes prior to initial contract, and utilize quality comparative data in initial and annual reviews; (b) alternate monthly CNH visits between a social worker and a registered nurse; and (c) include QM representation on the CNH oversight committee, and ensure that the committee meet quarterly.

Concur

Target Completion Date: Complete

- To avoid instances of placement of veterans in contract nursing homes prior to initial inspection, the VISN Contracting Office has taken responsibility for all Nursing Home Contracts. This process allows for consolidation of resources and one expert to have the responsibility for these types of contracts. The process also insures that no contract is awarded until all prerequisites have been accomplished. (complete)
- Quality comparative data, including Centers for Medicare & Medicaid Services (CMS) data and previous state survey results with plans for improvement, is reviewed at quarterly meetings by the team, which now includes the Quality Manager. The initial review of the facility must now be done prior to the VISN Contracting Office taking action on a contract, and an annual review of current contracts with community nursing homes occurs at the quarterly CNH meetings. (complete)

- As for monthly visits of the contract nursing homes, a registered nurse has been identified to interchange months with the social worker and will begin to vary the visits this month. (complete)

- To support and reflect the changes, the corresponding Medical Center Memorandum has been revised and was approved and published September 22, 2006. (complete)

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to implement EOC rounds in the outpatient clinical areas at least every 6 months.

Concur **Target Completion Date:** January 31, 2007

- The Sheridan Environment of Care Team members toured the five CBOC clinics on July 19, 20, and 27, 2006. A follow-up visit is scheduled for November, 8, 9, and 15, 2006, to fulfill the recommendation and requirements for environment of care rounds every 6 months. (complete)

- Staff will visit each CBOC at 6-month intervals thereafter.

- To support and reflect the change, the corresponding Medical Center Memorandum is undergoing revision.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the QM Coordinator develop and implement a comprehensive PI plan, (b) program managers trend and analyze data in all JCAHO- and VHA-required areas, and (c) the QM Coordinator develop and implement a system to track recommended actions and their effectiveness.

Concur **Target Completion Date:** January 15, 2007

- A Quality Management Medical Center Memorandum is being developed to define and implement a comprehensive performance improvement plan at the Sheridan VAMC.

- To develop and implement a comprehensive performance improvement plan using data gathered, trended and analyzed by program managers, a call for performance improvement activities in each area of the Medical Center for FY07 was made.
- Quarterly, program managers are tasked with providing the results of the measures and any trends noted, analysis, actions and recommendations.
- This information is to be funneled through the Quality Manager who will take recommendations, actions and follow-up effectiveness monitoring to upper management.
- To address follow-up for recommended actions and to track their effectiveness, the Medical Center Director, Associate Director, Chief of Staff, Nurse Executive and Quality Manager meet monthly and as needed. (complete)
 - These meetings are used to assess the successful completion of recommendations and to determine where additional action is required.
 - Follow-up with responsible parties occurs at these meetings to ensure recommendations are not only complete, but effective.

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections 816/426-2023
Acknowledgments	Dorothy Duncan Jennifer Kubiak Randy Rupp James Seitz Marilyn Stones

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