



# **Department of Veterans Affairs Office of Inspector General**

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## **Combined Assessment Program Review of the Augusta VA Medical Center Augusta, Georgia**

## **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.
- 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 July 24–28, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Augusta 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 165 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 four areas. The remaining areas resulted in recommendations for improvement.

The medical center complied with selected standards in the following areas:

- Breast Cancer Management
- Environment of Care (EOC)
- Quality Management
- Survey of Healthcare Experiences of Patients (SHEP)

To improve operations, the following recommendations were made:

- Strengthen the Contract Community Nursing Home (CNH) Program by implementing a process for ongoing monitoring of quality indicators; developing and documenting collaboration with local Ombudsman offices; ensuring follow-up on the report of contact and report abuse as indicated, and clarifying and communicating the process of death notification.
- Strengthen management of diabetic patients taking atypical antipsychotic medications by providing appropriate interventions and education for weight management and ensuring the performance measures accurately demonstrate treatment actions.

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

## **VISN and Medical Center Director Comments**

The VISN 7 and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 10–15 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

### Medical Center Profile

**Organization.** The medical center is a two-division, tertiary care facility that provides a broad range of inpatient and outpatient health care services. The medical center is part of VISN 7 and serves a population of about 85,000 veterans in a primary service area that covers 24 counties in both Georgia and South Carolina.

**Programs.** The medical center provides medical, surgical, and spinal cord injury care at the Downtown Division; mental health, geriatric, medical rehabilitation, and blind rehabilitation care, along with the system's only Active Duty Rehabilitation Unit, are provided at the Uptown Division. The medical center has 278 hospital beds, 132 nursing home beds, 60 domiciliary beds, and operates several regional referral and treatment programs. The medical center also has an active joint venture agreement with Dwight David Eisenhower Army Medical Center.

**Affiliations and Research.** The medical center is affiliated with the Medical College of Georgia, supporting 74 medical resident positions in 28 training programs. Affiliations include numerous other academic programs in a wide variety of specialties.

In fiscal year (FY) 2005, the medical center research program had more than 125 projects open during the course of the year. The annual budget of \$2.7 million consists of \$1.4 million in VA-appropriated funds and the remainder in non-appropriated funds from Department of Defense, American Heart Association, and a number of industry-sponsored studies, which are administered through their non-profit research corporation. Areas of major interest include stroke, urology, oncology, and clinical neuroscience.

**Resources.** In FY 2005, medical care expenditures totaled approximately \$251 million. The FY 2006 medical care budget is \$257 million. FY 2005 staffing totaled 1,994 full-time equivalent employees (FTE), including 91 physician and 600 nursing FTE.

**Workload.** In FY 2005, the medical center treated 33,431 unique patients. The medical center provided 75,411 inpatient days of care in the hospital and 40,028 inpatient days of care in the Nursing Home Care Unit (NHCU). Additionally, there were 16,681 days of care for the domiciliary. The inpatient care workload totaled 6,917 hospital discharges, 74 NHCU discharges, and 210 domiciliary discharges. The average daily census, including nursing home patients and domiciliary, was 363. The outpatient workload was 304,415 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 six activities:

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

Activities needing improvement are discussed in the Opportunities for Improvement section (page 3). 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 165 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

We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Augusta, Georgia*, Report Number 03-00752-143, July 31, 2003).

## Results of Review

### Opportunities for Improvement

#### Contract Community Nursing Home – Program Oversight Needs To Be Improved

**Condition Needing Improvement.** The purpose of the CNH review was to assess Veterans Health Administration (VHA) facility compliance with requirements defined in VHA Handbook 1143.2,<sup>1</sup> regarding the selection, placement, and monitoring of patients in CNHs and the inclusion of patients and family members in this process. The purpose was also to determine if the VHA facility has improved the oversight of VA patients in CNHs to include the services contracted for and appropriate actions taken when problems are identified that adversely affect patient safety and quality of care.

A process needs to be implemented to ensure the Centers for Medicare and Medicaid Services quality indicator deficiencies are monitored, reviewed, and documented on an ongoing basis. The average number of deficiencies for nursing homes in South Carolina is nine. One of the five nursing homes reviewed had 38 deficiencies. The CNH staff was unaware of the high number of deficiencies identified in the state inspection. The CNH Coordinator explained that the medical center performed their annual inspection in January 2006 and the State conducted an inspection in February 2006. Healthcare inspectors expressed concerns for the number of deficiencies the medical center failed to identify in January. The CNH Team Coordinator could not verify that corrective action plans were implemented. The CNH Team Coordinator informed healthcare inspectors that quality measures were discussed during the Long Term Care Committee meetings. An onsite visit to the nursing home was conducted immediately by the VHA Inspection Review Team to confirm corrective action plans.

There was no documented evidence that the CNH staff 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 on a quarterly basis without documenting the discussion. Following the onsite visit, the CNH Coordinator initiated annual meetings with the local Ombudsman offices; the confirmation of these meetings will be indicated on the Certification Report.

During our medical record reviews, we found that a veteran was identified as having designated a power of attorney (POA) to an employee of the nursing home where the veteran resided. The veteran's brother contacted the medical center in February 2003 and voiced concerns with the holder of the POA abusing the veteran's funds. The following day the VA social worker received a copy of the POA document which was dated in June

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<sup>1</sup> VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.



2002. The copy was placed in the veteran's medical record with no further action. Healthcare inspectors identified a lack of oversight and follow-up for a period of 3 years. The CNH Coordinator immediately initiated a report of contact while healthcare inspectors were onsite. Monthly status reports will be submitted to OHI by the CNH Coordinator until this issue is resolved.

The medical center needs to review CNH contracts and clarify that processes are implemented to notify the medical center of patient deaths in a timely manner. During the medical record review, healthcare inspectors discovered a veteran had died in a nursing home on June 17, 2006. This information was not entered into the Computerized Patient Record System until July 26, 2006, after the issue was brought to the attention of the CNH Review team.

**Recommended Improvement Action 1.** We recommend the VISN Director ensure the Medical Center Director takes action to: (a) implement a process for ongoing monitoring of quality indicators, (b) develop and document collaboration with local Ombudsman offices, (c) ensure follow-up on the report of contact and report abuse as indicated in VHA Handbook 1143.2, and (d) clarify and communicate the process of death notification.

## **Diabetes and Atypical Antipsychotic Medications – Improve Interventions with Weight Control Management and Performance Measures Data Collection**

**Condition Needing Improvement.** The purpose of this review is 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). Clinicians needed to improve intervention and education for weight control to include diet and exercise and ensure the performance measures accurately reflect the treatment provided to patients.

**Criteria.** VHA clinical practice guidelines for the management of diabetes suggests that: diabetic patients' hemoglobin A1c (HbA1c), which reflects the average blood glucose level over a period of time, should be less than 9 percent to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dL).

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

- HbA1c greater than 9 percent (poor glycemic control) – 15 percent (lower percent is better)

- Blood Pressure less than or equal to 140/90mmHg – 72 percent (higher percent is better)
- Cholesterol (LDL-C) less than 120mg/dL – 75 percent (higher percent is better)

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggests that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1–3 years. A normal FBG is less than or equal to 110 mg/dL. Patients with FBG values greater than 110 mg/dL but less than 126 mg/dL should be counseled about prevention strategies (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.

**Findings.** We reviewed a sample of 13 patients who were on 1 or more atypical antipsychotic medications for at least 90 days. One of the 13 patients had diabetes. Our review showed that the medical center did not meet VHA clinical practice guidelines for management of diabetes through monitoring the interventions for weight control. Clinical managers could not provide documentation to support that the patient received intervention for weight control management including diet and exercise. Analysis of the medical center’s performance measures did not accurately reflect medical record reviews and onsite inspection by this team. The medical record documentation did support that HbA1c and LDL-C were monitored routinely on all patients reviewed. The performance measures demonstrated that HbA1c and LDL-C were below the national satisfactory level. Clinicians needed to improve collection of data for the medical center’s performance measures.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with B/P less than 140/90 mm/Hg	Diabetic patients with LDL-C less than 120mg/dL	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
None (0/1)	100 percent (1/1)	100 percent (1/1)	100 percent (12/12)	50 percent (6/12)

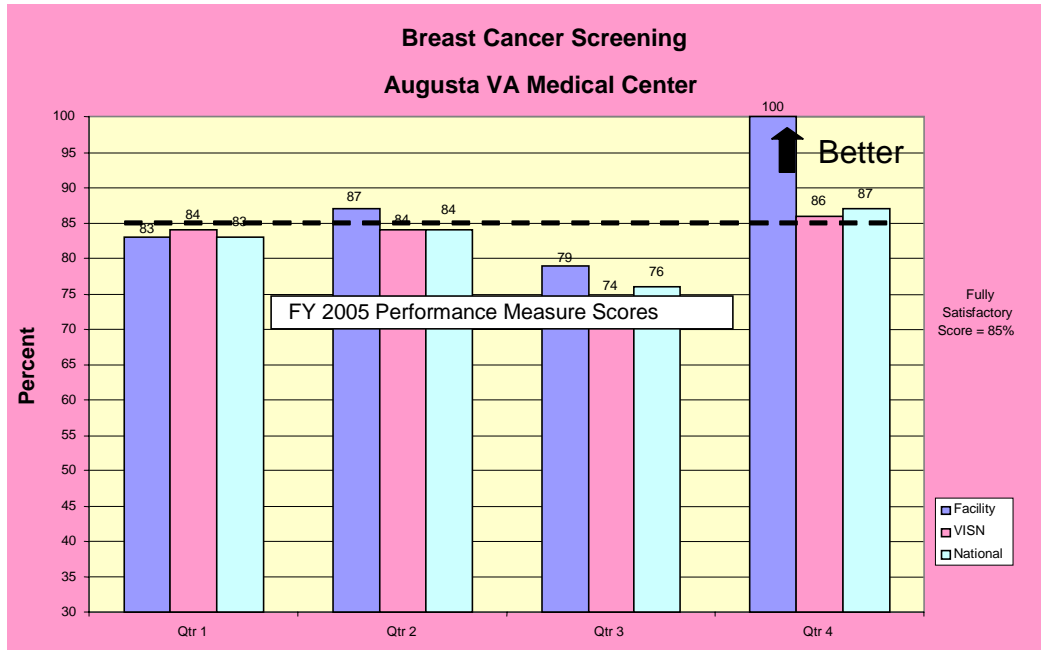
**Recommended Improvement Action 2.** We recommend the VISN Director ensure the Medical Center Director require clinicians to (a) provide appropriate interventions and education for weight management and (b) ensure the performance measures accurately demonstrate treatment actions.

## Other Observations

### 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. 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. When indicated, an interdisciplinary treatment plan was developed, and providers promptly informed the patient of diagnosis and treatment options.



### Environment of Care – No Areas Needed Improvement

The purpose of the evaluation is to determine if VHA maintains a safe and clean healthcare environment. The medical center must establish a comprehensive EOC program that fully meets all VHA, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. To evaluate EOC, we inspected clinical and non-clinical areas for cleanliness, safety, infection control, and general maintenance.

We reviewed the medical center with an emphasis on physical plant and sensitive information security. Vulnerability of the physical plant was addressed with the

immediate addition of a single exit door alarm system. Areas of review for sensitive information included business office printer/fax machine areas and nursing station printers that accumulate reports during the day and are collected at unspecified intervals. While no evidence of security breaches were identified, because of the increasing emphasis on privacy and security, all staff were reminded to remove documents as soon as possible from printer and fax machines.

Infection control observations included hand washing and maintenance of clean supply areas. No trends of non-compliance were noted in either area but singular events identified indicate the need to re-emphasize that infection control is a priority.

The medical center maintained a clean and safe environment with no reportable findings or recommendations.

### **Quality Management – No Areas Needed Improvement**

To evaluate QM activities, we interviewed the Medical Center Director, Chief of Staff, Chief Nurse Executive, and QM personnel; we evaluated plans, policies, and other relevant documents. For the purpose of this review, we defined a comprehensive QM program as including the following program areas:

- QM and Performance Improvement committees, activities, and teams.
- Patient safety functions (including healthcare failure mode and effects analyses, root cause analyses, aggregated reviews, and patient safety goals).
- Risk management (including disclosure of adverse events and administrative investigations related to patient care).
- Utilization management (including admission and continued stay appropriateness reviews).
- Patient complaints management.
- Medication management.
- Medical record documentation reviews.
- Blood and blood products usage reviews.
- Operative and other invasive procedure reviews.
- Reviews of patient outcomes of resuscitation efforts.

- Restraint and seclusion usage reviews.
- Staffing effectiveness analyses.

We evaluated monitoring and improvement efforts in each of the program areas through a series of data management process steps consistent with JCAHO standards and including:

- Identifying problems or potential improvements.
- Gathering and critically analyzing the data.
- Comparing the data analysis results with established goals or benchmarks.
- Identifying specific corrective actions when results do not meet goals.
- Implementing and evaluating actions until the problems are resolved or the improvements are achieved.

We evaluated whether clinical managers appropriately used the results of quality monitoring in the medical staff privileging process. We also reviewed mortality analyses to determine the level of medical center compliance with VHA guidance.

We found that the QM program provided comprehensive oversight of the quality of care. Generally, when problems were identified, actions were taken and adequately evaluated. We found good senior management support and clinician participation. We have no reportable findings or recommendations.

## **Survey of Healthcare Experiences of Patients**

Presidential Executive Order 12862 requires agencies to publish customer service standards, survey their respective customers, and use customer feedback information to manage the agency. The Executive Career Field Performance Plan for FY 2006 established that 77 percent of ambulatory care patients and 76 percent of discharged inpatients must report overall satisfaction of “very good or excellent” in order to meet or exceed target goals for satisfaction.

The following charts show the medical center’s SHEP results for inpatients and outpatients.

Augusta VA Medical Center									
INPATIENT SHEP RESULTS									
Q1 and Q2 FY 2006	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	81.31	78.63	89.95	68.02	65.08	75.85	83.41	74.49	70.03
VISN	80.60	77.90	88.3-	70.1+	66.60	76.10	81.8-	73.80	70.90
Medical Center	78.8-	77.1-	87-	69.50	67.50	76.50	79.8-	73.00	71.00

OUTPATIENT SHEP RESULTS											
Q2 FY 2006	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.7	78.1	94.8	72.6	83.3	75.8	81.5	65.5	81.7	80.8	84.7
VISN	78.1	81.6	93.7	73.4	84.7	75.8	82.3	63.7	81	78.3	83.7
Outpatient Clinics-Overall	80.7	81.3	95.2	73.3	85.3	76.1	81	59.1	82.5	78.1	84.5

+ Significantly better than national average.

- Significantly worse than national average.

The Medical Center Director was aware of the SHEP report results for the first 2 quarters of FY 2006, and results had been communicated to the employees. Medical center analysis of the survey results identified various areas targeted for improvement. The medical center developed action plans based on these results to improve patient care, treatment, and services. As a result, outpatient appointment wait times and timeliness for pharmacy prescription pick-up survey results improved in the 3rd quarter of FY 2006.

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** October 12, 2006


**From:** Acting Director, VA Southeast Network (10N7)

**Subject:** **CAP Project Number: 2006-02107-HI-0349—VA Medical Center Augusta**

**To:** Director, Dallas Audit Operations Division (52DA)

1. Attached is Augusta's response to the Office of Inspector General (QIG) Combined Assessment Program Review Site Visit July 24-28, 2006 I have reviewed the CAP recommendations, which have been individually addressed.

2. I concur with the comments and actions taken by the Medical Center Director to improve processes at the Augusta VA Medical Center



Thomas A. Cappello, MPH, FACHE

Attachments

## Medical Center Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** October 5, 2006  
**From:** Medical Center Director  
**Subject:** **Augusta VA Medical Center Augusta, Georgia**  
**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, please contact Ellen W. Harbeson, CPHQ, Quality Management Coordinator, at 706-823-2286.

*(original signed by:)*

James F. Trusley III



### **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 recommend the VISN Director ensure the Medical Center Director takes action to: (a) implement a process for ongoing monitoring of quality indicators; (b) develop and document collaboration with local Ombudsman offices; (c) ensure follow-up on the report of contact and report abuse as indicated in VHA Handbook 1143.2; and (d) clarify and communicate the process of death notification.

Concur                      **Target Completion Date:** 10/31/06

Recommendation 1a. Implement a process for ongoing monitoring of quality indicators:

Concur. Effective immediately, CMS reports are reviewed by the coordinator of CNH Program and provided to each reviewer/team member prior to the inspection. The team will review and discuss the Nursing Home, CMS reports, and the State Inspection Report in their review meeting. This review will be documented and discussed prior to, during and following the inspections. All findings will be documented in the final Inspection Report, forwarded to Contracting and reviewed in by the Allied Health Community NH Advisory Committee which is held quarterly.

Recommendation 1b. Develop and document collaboration with local Ombudsman offices.

Concur. Communications were held with Ombudsman Office prior to the I.G. visit; however, documentation of such was missing. To ensure compliance, the following plan has been implemented:

- On each CNH monthly visit, the RN/SW will communicate with the local Ombudsman Office. This communication will be documented in veteran's chart and findings reported to Allied Health Community NH Advisory Committee.
- Scheduled annual Ombudsman Meeting will be held with documentation of meeting and reported to Allied Health Advisory Committee and Allied Performance Improvement Committee. A meeting was held on September 7, 2006.

Recommendation 1c. Ensure follow-up on the report of contact and report abuse as indicated in VHA Handbook 1143.2.

Concur. Regarding the specific veteran referenced in the report as having designated a power of attorney (POA) to an employee of the nursing home where the veteran resided, staff have communicated and submitted necessary documentation to VARO to establish a fiduciary for this patient. However we recognize there have been gaps in communication between inpatient staff and staff following the patient on contract. In order to ensure ongoing communication, the following actions have been implemented:

- Each month the social worker and the community health nurse visit veterans in the CNH's. They are contacting the local ombudsman office and providing and receiving reports for any outstanding issue/s on the nursing homes and veterans. These contacts are documented in the medical record.
- An annual Social Work staff & VARO staff meeting is held each year (August 2006) to discuss the importance of following through with contacting, sending and receiving timely information regarding incapable/incompetent veterans.

- The issue of incompetent/incapable veterans has been discussed and reviewed with the medical center social work staff and the CNH Social Worker and RN who visits CNH monthly. The visiting SW and RN will use a record check list for all veterans placed in CNH's prior to their visiting veterans in the CNH. All unresolved issues discovered by the SW & RN will be referred to the Allied Health Advisory Committee for follow-up and action.
- The issue of incapable/incompetent veterans and the referrals process to the inpatient social worker prior to discharge will be discussed at two clinical staff meeting, one chaired by the Chief of Staff and the other for nursing staff chaired by the Associate Director for Patient/Nursing Services. The discussion was held at the COS Meeting on October 10, 2006 and a coordinated time with Nursing Staff.

Recommendation 1d. Clarify and communicate the process of death notification.

Concur. The following plan has been implemented:

- All contract NHs have been contacted verbally by CNH coordinator to discuss the importance of timely death notification (within 72 hours) and the importance of keeping staff informed. Additionally this information is provided in writing with each individual contract.
- At semi-annual CNH meeting, this topic will be re-discussed. At our September 21, 2006 semi-annual conference with Contract NH, the details clerk gave an overview of death notification.
- Staff will continue to educate CNH at inspections, semi-annual conferences and at monthly visits, as appropriate.

**Recommended Improvement Action 2.** We recommend the VISN Director ensure the Medical Center Director requires clinicians to: (a) provide appropriate interventions and education for weight management, and (b) ensure the performance measures accurately demonstrate treatment actions.

Concur                    **Target Completion Date:** 10/31/06

Recommendation 2a. Provide appropriate interventions and education for weight management.

Concur. Clinicians are actively referring patients to the MOVE Program. This program is specifically designed to work with obese patients and address their nutritional, exercise and psychosocial needs. As a balanced program, it will have a much higher success rate than simple dietary instruction. It is also an ongoing support program to the enrollees further assuring compliance with the regimen. Weight loss achieved via this program can be expected to directly decrease the incidence of type II Diabetes in our patient population.

Recommendation 2b. Ensure the performance measures accurately demonstrate treatment actions.

Concur. We are utilizing the VISN 7 Corporate Database to identify diabetic patients and appropriate follow up is conducted to ensure maximal glycemic control and hypertension is being well managed in this cohort. The outcome of this focus is apparent with the results for 4th quarter on the DM performance measures. For glycemic control and hypertension management in both populations (general and SCI), VAMC Augusta met the exceptional level.

## OIG Contact and Staff Acknowledgments

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