Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan

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VA Office of Inspector General
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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 October 23–27, 2006, the Office of Inspector General conducted a Combined Assessment Program (CAP) review of the John D. Dingell VA Medical Center (the 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 approximately 120 employees. The medical center is part of Veterans Integrated Service Network (VISN) 11.

Results of Review

The CAP review covered eight focused inspection areas and follow-up of several activities that were identified during our previous CAP review. The medical center complied with selected standards in the following area:

- Diabetes and Atypical Antipsychotic Medications.

We identified the following organizational strengths:

- The Seamless Transition Team ensures timely access to care.
- The Decontamination Team was selected as the Northern Tier experts in casualty decontamination.

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

- Improve documentation of patients' notification of abnormal mammography results and ensure timely mammography and biopsy evaluations.
- Correct identified environmental deficiencies.
- Ensure background investigations are completed and received timely.
- Improve background screenings of community based outpatient clinic employees who have access to sensitive information.
- Improve aspects of the Contract Community Nursing Home program to comply with Veterans Health Administration guidelines.
- Improve the cardiac catheterization informed consent process.
- Address low scores from the Survey of Healthcare Experiences of Patients.
- Improve QM review and follow-up processes.

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 agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 18–29, 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. Located in Detroit, MI, the John D. Dingell VA Medical Center (the medical center) provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics located in Yale and Pontiac, MI. The medical center is part of Veterans Integrated Service Network (VISN) 11 and serves a veteran population of about 330,994 in a primary service area that includes Wayne, Oakland, Macomb, and St. Clair counties.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services; a Homeless Veterans Program; and a Home-Based Primary Care Program (HBPC). The medical center has 217 hospital beds, which includes a 109-bed Nursing Home Care Unit (NHCU) and several regional referral programs, including the sleep study and orthopedic programs. The medical center also has a sharing agreement with Federal Strategic Health Alliance to conduct physical examinations for military reserve members.

Affiliations and Research. The medical center is affiliated with Wayne State University and supports approximately 75 medical resident positions in various training programs. Other affiliations include Audiology and Speech Pathology, Dietetics, Nursing, Psychology, Rehabilitation Medicine, Social Work, and Surgical Auxiliaries. In fiscal year (FY) 2006, the medical center research program had 22 funded VA projects and a budget of $3.5 million. Important areas of research include behavioral and neurosciences, cardiology, and oncology.

Resources. In FY 2006, medical care expenditures totaled $213.9 million. The FY 2007 budget projections were pending when we were onsite; for comparison, the FY 2005 budget was $189 million. FY 2005 staffing totaled 1,432 full-time equivalent (FTE) employees including 100 physician and 404 nursing FTE employees.

Workload. In FY 2006, the medical center treated 38,185 unique patients. The medical center provided 23,061 inpatient days in the hospital and 23,673 inpatient days in the NHCU. The inpatient care workload totaled 4,240 discharges, and the average daily census, including NHCU patients, was 128. The outpatient workload was 351,025 visits.

Objectives and Scope of the CAP Review

Objectives. Combined Assessment Program (CAP) reviews are one element of the Office of Inspector General's (OIG's) efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care, quality management (QM), 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.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered eight focused inspection areas and several follow-up activities from our previous CAP Review.[1] The QM Program and Environment of Care (EOC) reviews encompassed both current focused inspections and follow-up activities.

*Background Investigations
Breast Cancer Management
Cardiac Catheterization Laboratory Standards
*Colorectal Cancer Management
Community Based Outpatient Clinics (CBOCs)
*Credentialing and Privileging
Diabetes and Atypical Antipsychotic Medications
*EOC
*Pressure Ulcer Prevention and Management
QM Program
Survey of Healthcare Experiences of Patients (SHEP)
Contract Community Nursing Home (CNH) Program

*Follow-up Activities

The review covered medical center operations for FYs 2005, 2006, and 2007 through October 20, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews.

[1] *Combined Assessment Program Review of the John D. Dingell VA Medical Center*, Report No. 05-01226-211, September 29, 2005.

During this review, we also presented 3 fraud and integrity awareness briefings for approximately 120 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 5–14). Activities not otherwise mentioned had no reportable finding.

Results of Review

Organizational Strengths

The Seamless Transition Team Ensures Timely Access to Care

During the 2 years prior to the CAP review, the team conducted nearly 15 outreach efforts, which included partnering with local military units, the Transition Assistance Program, Family Readiness Detachments, veterans service officers, and the media, to inform returning veterans of available benefits. The team has case managed over 400 veterans and initiated outreach activities for over 3,000 veterans. The team works collaboratively with VISN 11 partners to improve access to care and to educate staff. They share best practices and challenges with staff throughout VISN 11 to ensure seamless transitions.

The team created a poster presentation and abstract entitled "A Collaborative Effort to Seamless Transition Services" that team members presented at the 2005 United Services Social Work Convention. The team also presented this abstract and poster at the November 2006 meeting of The Society of the Federal Health Agencies/Association of the Military Surgeons of the United States. The poster identifies the process for collaboration of all team members in providing access and care to returning combat veterans.

The Decontamination Team Serves as Experts in Casualty Decontamination

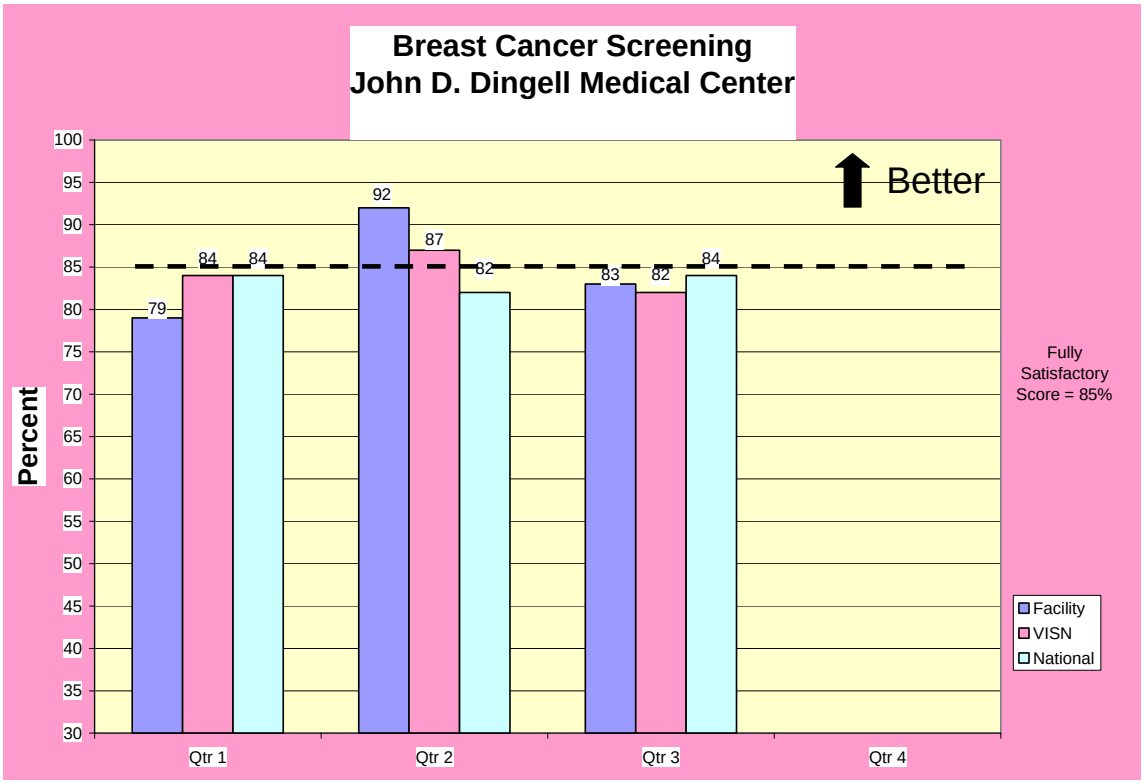
During the 2 years prior to the CAP review, over 50 medical center staff completed operational and awareness training in casualty decontamination. Their Decontamination Team also participated in over 25 drills, practicing with the City of Detroit and local hospitals. These full-scale drills included setting up and tearing down the decontamination tent. The drills also included the "suiting up" of staff, which was accomplished in an impressive 10-minute period. As a result of the medical center's commitment to readiness, the team was selected as the Northern Tier experts in casualty decontamination.

Opportunities for Improvement

Breast Cancer Management – Documentation of Patient Notification and Evaluation Timeframes Needed To Be Improved

Condition Needing Improvement. Clinicians needed to document patient notification of abnormal mammography results in the medical record and ensure timely mammography and biopsy evaluations.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center did not achieve fully satisfactory scores in 2 of 3 quarters for FY 2006. (See the graph below; note that 4th quarter data was not available.). Timely screening, diagnosis, communication, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. Clinicians informed us that they have implemented a telephone contact process with patients to determine if assistance can be offered to facilitate completing mammography exams.



We reviewed medical records of 10 patients with "highly suspicious" or "highly suggestive of malignancy" mammograms for FY 2005.

The medical center refers all patients to a contracted facility for mammography services. The medical center's contract with the imaging facility states that breast imaging must be

completed 30 days after receipt of referral. One patient had an appointment within the 30 day limit, but cancelled it herself and rescheduled for 32 days later than the original appointment. Since this was the patient's choice, we concluded that screening was appropriately offered. (See the table below.)

VHA mammography standards require the interpreting physician to document verbal communication with the patient in the medical record. Documentation of this communication must be available in the referring facility's computer software package. We did not find documentation of patient notification in 3 of 10 medical records. All 10 patients received biopsies after the abnormal mammograms were performed. However, in 3 of the 10 cases, biopsy evaluations exceeded the goal of 30 days after receiving an abnormal mammography.

Patients appropriately screened	Mammography results reported to facility within 30 days	Patients appropriately notified of their diagnoses	Patients received timely biopsy procedure
10/10	10/10	7/10	7/10

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that (a) clinicians document patient notification of abnormal mammogram results in the medical record and (b) mammography services are completed by the contract provider within 30 days.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that patient notification of abnormal results was corrected in the 3rd quarter of FY 2006, and a new policy will include documentation requirements. Clinicians in all relevant services will receive education on documentation requirements. Performance improvement monitors will be created to ensure that timely notification of patients is accomplished and documented and that mammography services are completed within 30 days. Clinicians will receive performance feedback on a monthly basis.

Environment of Care – Deficiencies Needed To Be Corrected

Condition Needing Improvement. The medical center was generally clean and effectively maintained; however, patient room cleaning and preventive maintenance (PM) practices needed improvement. Managers addressed concerns identified during the inspection. We inspected a sample of patient rooms and restrooms and followed up on recommendations from our previous CAP inspection. The following two areas required management attention.

General Cleaning Practices. We identified opportunities for improved cleaning practices, particularly in rooms that were prepared for new patient admissions. For example, some rooms required further cleaning of baseboards, tray tables, and air vents. Managers had developed an inspection tool for use by Environmental Management Service (EMS) supervisors to assess the cleaning provided by unit housekeepers. More frequent and comprehensive supervisory inspections were needed to ensure that these rooms are completely clean prior to a new patient's admission.

PM Practices. Closer monitoring of PM and documentation completed by student interns training at the medical center was warranted. The medical center uses the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS) to electronically document PM and equipment repairs. We selected a random sample of eight patient care equipment items to determine if PM was completed at required intervals. Six of the items received PM as required. One item, an infusion pump, did not receive the first semi-annual PM during 2005. A second item, a tube feeding pump that required annual PM, was noted in AEMS/MERS to be "beyond economical repair" and taken out of service in March 2003. Subsequently, records reflected that PM was conducted on this item in 2004 and 2005, and it was repaired in April 2006. A notation in May 2006 again listed the pump as "beyond economical repair" and scheduled for turn-in. However, the item was being used on the day of our inspection and had a current inspection sticker. Managers told us that interns made several incorrect entries in AEMS/MERS.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) patient rooms are thoroughly cleaned and monitored by EMS supervisors for compliance and (b) PM is conducted at required intervals, and managers closely monitor student interns to ensure that documentation of PM and necessary repairs is accurate.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that EMS managers will monitor cleaning activities, conduct more frequent patient room inspections, and provide training on proper patient room cleaning. Managers created a new PM schedule for all equipment and will review all work completed by student interns.

Background Investigations – Results of Clinicians' Background Investigations Needed To Be Monitored for Timeliness

Condition Needing Improvement. We reported findings in this area in the two previous CAP inspections (2001 and 2004) and performed a follow-up review, which again identified opportunities for improvement. Background screenings are required to ensure that individuals are suitable to serve as VA employees, students, trainees, or volunteers. Newly appointed clinicians are subject to background investigations conducted by the Office of Personnel Management (OPM). Human Resources Management Service

(HRMS) staff are required to request an investigation within 14 workdays of each employee's appointment and to follow up if results are not received within 2 months. In response to a suggested improvement action made in our CAP review of December 20, 2001, HRMS staff developed a procedure to follow up with OPM when new clinicians' background investigation results were not returned within 2 months of submission.

In our 2004 CAP review, one of eight Official Personnel Folders (OPFs) reviewed did not contain evidence that an initial background investigation was performed. In that report, we recommended that HRMS staff review all clinicians' OPFs and follow up on background investigation and security clearance discrepancies. The VISN and Medical Center Directors agreed with the finding and recommendation and reported that, by August 1, 2005, HRMS staff would complete a review to confirm evidence of initial background investigations and appropriate security clearances for all clinicians and would establish a tracking system to ensure follow-up on past due investigations. The improvement plans were acceptable, and we followed up on the completion of planned actions in our review during this site visit.

On August 14, 2006, the Deputy Under Secretary for Health for Operations and Management established new Employment Screening Requirements for all VHA facilities, which clarifies screening requirements and establishes processes for documentation of screening backgrounds of VHA appointees, contractors, and volunteers. HRMS managers followed processes and took actions to comply with the new requirements. However, we reviewed 19 positions and identified the following areas as needing improvement.

- There was no evidence of completed background investigations for three physician medical consultants, and all three had been employed for at least 5 years.
- There was no evidence of completed background investigations for two contract employees (a physician and physician assistant). The physician had worked for the medical center less than 1 year, and the Physician Assistant is currently working at a clinic where he has been for over 1 year.
- There was no evidence of completed background investigations for a dentist who has been employed for 8 years. As a result of VHA's new screening requirements, this employee's record was recently reviewed and found deficient by the HRMS manager. As of September 2006, a background investigation was pending.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to comply with policies governing VHA's Employment Screening Requirements and to correct the above discrepancies.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that by December 15, 2006, HRMS staff will have reviewed the OPFs or

appointment documents for all appointed positions to ensure that they are in compliance with VHA Employment Screening Requirements.

Community Based Outpatient Clinics – Background Screenings of Individuals Needed To Be Improved

Condition Needing Improvement. The medical center's main facility needed to improve the process for completing background screenings and to verify information on the criminal background of appointees. The purpose of this review was to assess the effectiveness of CBOC operations and VHA oversight and to determine whether CBOCs are in compliance with selected standards of operations (for example, patient safety, QM, credentialing and privileging, and emergency plans).

Federal agencies are required to conduct appropriate background screenings of individuals who have access to sensitive information, including patient records. In addition, the Joint Commission on Accreditation of Healthcare Organization's standards require facilities to verify information on the criminal background of appointees.

We reviewed three folders for CBOC providers. Two of the primary care providers did not have background screening documentation. Both contracted employees have been employed at the CBOC for over 5 years; and both employees have access to the medical center's computer systems and patient information.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires the Contracting Officer to ensure that appropriate position risk and sensitivity designations are made and that the appropriate level of background screening is completed.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the Contracting Service staff will review all current providers' contracts and take corrective actions where warranted. Background investigations will be followed up until completion. Contracting managers will establish new procedures and tracking tools and train staff to ensure that background investigations are appropriate for employees' positions.

Contract Community Nursing Home Program – Selected Program Aspects Required Improvement

Condition Needing Improvement. The medical center needed to improve CNH oversight, patient monitoring, and documentation. We visited patients in two CNH facilities and found they were receiving adequate care. Additionally, we interviewed the Administrator and Director of Nursing (or designee) at both facilities, and they reported that their relationships with the medical center staff were positive and that there were no unresolved issues. VHA guidelines for the CNH Program include oversight and

monitoring of patients who are placed in CNHs by VA facilities. We identified four CNH program areas that required management attention.

Oversight Committee Membership. The medical center's Geriatric/Extended Care Oversight Committee provides oversight of the CNH review team's efforts. VHA policy requires that this oversight committee include multidisciplinary management-level representatives from social work, nursing, QM, acquisitions, and the medical staff. We noted that the oversight committee does not include a representative from the acquisitions section.

Patient Monitoring. We reviewed the medical records of 10 patients who were placed in CNH facilities. Eight of the patients did not receive monitoring through medical center staff visits, as required by VHA policy. We were also provided hard-copy records of some medical center nurse visits, including dates in 2005 and 2006. These visits were not entered into the computerized patient record system (CPRS). It is important that visits be documented in CPRS so that other CNH team members are aware of the patients' status. Laptop computers have been ordered for use by the visiting staff, which will be able to interface with CPRS when the employee returns to the medical center.

Documentation of Visits. A CPRS template note was developed for documentation of nurse visits to CNH patients. We identified an opportunity to improve documentation by ensuring that the notes are individualized and include observations and findings. During our review, managers revised the note and received approval for immediate use.

Documentation of Placement Decisions. We reviewed documentation in CPRS to determine if notes reflected that the patient (if capable), family, and/or legal guardian were offered CNH placement options and agreed with the placement decisions. Seven of 10 records did not definitively include this documentation but, rather, reflected that the decision was made by the medical center staff. We recommended that managers encourage employees involved in CNH placement to document patient, family, and/or legal guardian involvement.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) a management-level representative from the acquisitions section be added to the Geriatric/Extended Care Oversight Committee; (b) patients in CNHs receive medical center staff visits per policy; (c) staff document visits in CPRS timely; and (d) CPRS documentation reflects involvement of the patient, family, and/or legal guardian in placement decisions.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that an acquisitions manager is now a member of the Geriatric/Extended Care Oversight Committee. The social worker and HBPC nurse will alternately visit each patient monthly. Performance will be monitored to ensure compliance with VHA policy. Managers will monitor staff documentation for timely entry into CPRS.

Managers revised the CNH visit template note to include documentation of patient and family involvement in placement decisions. Managers also developed a quality improvement monitor to track follow-up visits and documentation of visits.

Cardiac Catheterization Laboratory Standards – Informed Consent Process Needed To Be Improved

Condition Needing Improvement. The medical center needed to improve documentation of informed consents for cardiac catheterization procedures. The purpose of this review was to determine if the medical center's cardiac catheterization laboratory practices were consistent with relevant standards and VHA policy. These standards define requirements for provider procedure volumes, laboratory procedure volumes, cardiac surgery resources, QM, the informed consent process, and cardiopulmonary resuscitation (CPR) training. VHA policy requires that informed consents include the names and professions of all participants in the procedure and any risks, benefits, and alternative treatments or procedures.

We reviewed the medical records of 10 patients who had undergone a cardiac catheterization procedure in FY 2005. In two cases, the informed consents did not show the name of an attending physician, and in another case, the informed consent showed a different attending physician than listed on another document. One informed consent lacked a cardiology fellow's name, and two included a cardiology fellow that did not participate in the procedure. Eight informed consents did not include procedure alternatives.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director requires that staff complete informed consents for cardiac catheterization procedures that are consistent with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the medical center is implementing a new electronic package, iMed consents, to manage informed consents. Paper copy consents will be written to comply with VHA policy. Training was provided to staff, and a performance improvement monitor was initiated to track compliance.

Survey of Healthcare Experiences of Patients – Plans Were Needed To Address Low Scores

Condition Needing Improvement. The medical center needed to develop improvement plans to address low scores from patient satisfaction surveys. Patient satisfaction surveys are designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying patients using a standardized instrument modeled from Picker Institute, a non-profit health care surveying group. A national performance measure states that in

FY 2006, the percent of patients reporting overall satisfaction as Very Good or Excellent will meet or exceed targets for the performance period October 2005–June 2006. (See the table below).

	Meets Target	Exceeds Target
Ambulatory Care	77 percent	80 percent
Inpatients (Discharged 10/2004–6/2005)	76 percent	79 percent

The following tables show the medical center's SHEP results for inpatients and outpatients:

Inpatient SHEP Results
Q1 and Q2 FY 2006

	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03	*
VISN	83.8+	79.6+	90.10	68.10	66.40	76.20	83.60	74.40	68.90	*
Medical Center	79.3-	75.5-	86.4-	63.2-	59.7-	72.6-	78.2-	67.3-	63.3-	*

Outpatient SHEP Results
Q3 FY 2006

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.90	77.00	94.6	72	83	75.1	81.1	64.4	81.3	80.5	84.1
VISN	82.10	74.80	95.8	69.4	81.8	74.8	83.1	65.9	80.2	80.9	83.5
Overall	75.40	69.40	94.7	67.3	82.1	77.7	79.7	59.3	76.4	82.7	81.2

* Less than 30 respondents
+ Significantly better than national average
- Significantly worse than national average

The medical center did not meet the performance measure. Scores were below targets in 6 of the 9 inpatient aspects of care and 5 of the 11 outpatient aspects of care. Senior managers were aware of the SHEP results, and the Customer Service Council reports the results to its membership. However, there was inconsistent communication of these results and their significance to medical center employees. The medical center did not

develop improvement plans to address deficiencies for FY 2006, but they stated that they will develop plans for FY 2007 results.

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) SHEP results are shared with employees at all levels of the organization and (b) improvement plans to address the low scores are developed and implemented.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that medical center managers have formulated a plan to ensure that SHEP results are regularly shared with employees throughout the organization. Patient advocates will provide in-service training at service-level meetings to facilitate employees' understanding of the significance of SHEP scores and to involve them in process improvement initiatives. Service chiefs and relevant committees will develop and implement plans to improve the organization's performance and SHEP scores.

Quality Management Program – Review and Follow-Up Processes Needed To Be Improved

Condition Needing Improvement. The QM program was generally effective; however, improvement was needed in peer review (PR), root cause analysis (RCA) aggregated reviews, credentialing and privileging (C&P), and patient complaints. Senior managers were supportive of performance improvement activities. Processes were in place to ensure that performance improvement and patient safety were maintained. The recommendation from the previous CAP that all licensed independent clinicians have current CPR certifications and that the certifications are documented in the C&P files had been met. A policy and process are in place to ensure continued compliance. However, the following areas required management attention.

PR Process. This process needed to be improved to ensure effective communication, follow-up on issues raised during PR Committee meetings, and identification of trends that would lead to process improvements.

Minutes from the PR Committee were not regularly submitted to a medical executive committee, as required by VA policy. Staff reported that the PR Committee chair informally discussed the committee's business with the Chief of Staff. Twice since the PR Committee was formed in April 2005, the minutes revealed issues of concern regarding cases under review that needed follow-up. A physician was designated as the responsible party, yet minutes from the following months' meetings did not indicate that any follow-up information was shared with the committee.

Individual PRs were tracked, but outcomes were not trended by levels or by changes from one level to another. Follow-up actions were not identified, and processes were not improved. For example, according to staff, a template note used by physicians in Urgent

Care to document patient evaluations was identified as problematic in several PRs, yet the template remained unchanged.

RCA Aggregated Reviews. Staff conducted quarterly RCA aggregated reviews, but reports did not indicate any analysis to identify trends. Data were reported in a narrative format that made it difficult to track trends over time and to identify any resulting recommendations, implementation plans, and follow-up.

C&P. Although the medical center had fulfilled the previous CAP review recommendation, another aspect of the credentialing process needed improvement. VA policy requires that service chiefs conduct ongoing reviews to evaluate professional performance, judgment, and clinical and/or technical competence and skills based, in part, on results of clinician-specific performance activities. In 4 of 10 C&P records reviewed, documentation of this performance review was not available. Some staff mistakenly believed that clinicians who worked without compensation, on a fee basis, as a consultant, or in the CBOCs were exempt from this requirement.

Patient Complaints. Patient complaints were collected and aggregated in reports that were presented to the Healthcare Leadership Council. However, there was no trending of the data that could have revealed possible opportunities for improvement. This data was also not compared to the results of the SHEP surveys. Without the trending and comparison with other sources of similar data, opportunities to improve customer service and patient satisfaction may have been lost.

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) PR processes are established to ensure effective communication, to follow-up on issues raised during PR Committee meetings, and to identify trends through data analysis; (b) aggregated reviews are trended and reported in a visual statistical format; (c) service chiefs conduct on-going reviews of clinicians' performance-related activities; and (d) patient complaints are trended and compared with SHEP survey results.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that medical center managers will establish processes to improve communication, follow up of issues, and trending of data. Reports from the PR Committee will be forwarded to the Healthcare Leadership Committee on Clinical Care and the Chief of Staff for review. Data summarized in the Patient Safety Annual Report will be graphed and trended beginning with the first quarter FY 2007 report. Service chiefs will include performance reviews for all clinicians as part of the re-privileging process. Patient complaints data from the Patient Advocate's office will compared with SHEP data on a quarterly basis.

Other Activities Reviewed

Diabetes and 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. While these medications cause fewer neurological side effects than other classes of medications, they increase the risk of developing diabetes.

VHA clinical practice guidelines for the management of diabetes suggest that: (a) 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; (b) blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and (c) 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:

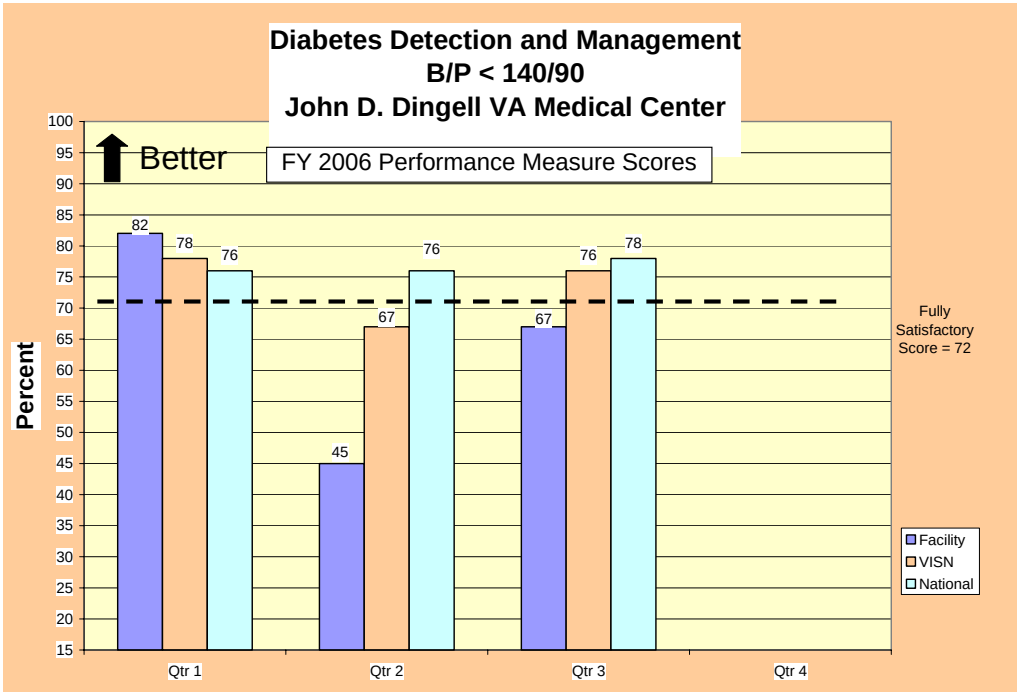
- HbA1c greater than 9 percent—15 percent (lower is better).
- Blood Pressure less than or equal to 140/90mmHg—72 percent (higher is better).
- Cholesterol (LDL-C) less than 120mg/dl—75 percent (higher percent is better).

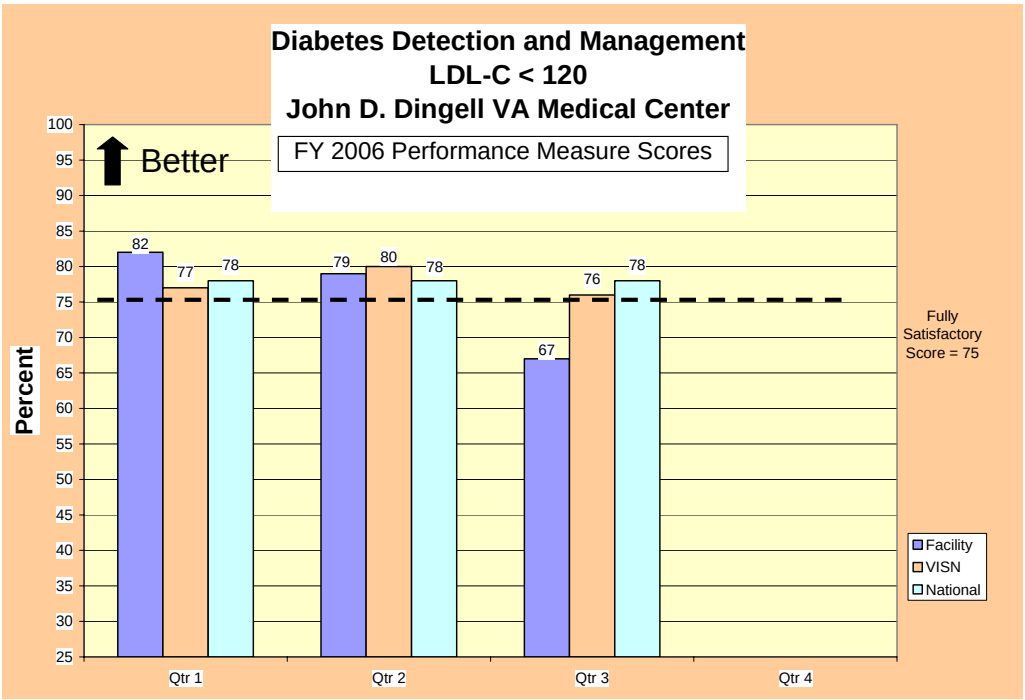
We reviewed a sample of 13 patients who were on 1 or more atypical antipsychotic medications for at least 90 days in FY 2005. Three patients in the sample were diagnosed with diabetes. Two of the diabetic patients had HbA1c values greater than (>) 7 percent, but not greater than 9 percent. (See the table below.) Interventions were implemented for optimal blood sugar control. One diabetic patient had a blood pressure of 148/94 mm/Hg. The patient's medication was changed, and the blood pressure was assessed on three subsequent occasions. Of the 10 non-diabetic patients, 1 patient did not have laboratory values present in CPRS. A clinician informed us that this patient is followed in the Mental Health Clinic and that the provider would be notified.

Diabetic patients with HbA1c < 9 percent	Diabetic patients with B/P < 140/90 mm/Hg	Diabetic patients with LDL-C < 120mg/dl	Non-diabetic patients appropriately screened
100 percent (3/3)	67 percent (2/3)	100 percent (3/3)	90 percent (9/10)

The medical center did not consistently meet the VHA performance measures for blood pressure monitoring or cholesterol control. (See the charts on the next page; note that 4th

quarter scores were not available.) Clinicians informed us that they plan to implement a Diabetes Clinic consisting of a nurse practitioner, a physician, a nutritionist, and a physical therapist. Also, the medical center has developed a clinical reminder to alert providers of patients' blood pressures that are outside of the normal range. Patients are educated on the importance of returning to the clinic for follow-up blood pressure assessments. We found these actions to be acceptable; thus we are not making any recommendations.





Pressure Ulcer Prevention and Management

During the previous CAP review, we identified deficiencies in documentation of skin integrity assessments; inconsistencies in documentation, such as improper description of the ulcer location and condition in eight patient records; and incomplete documentation of pressure ulcer treatments. In response to these deficiencies, the medical center planned to update nursing policy to (a) include standardized medical record templates to outline skin assessment and treatment expectations, (b) conduct training to address the new policy, and (c) establish a performance indicator to monitor compliance and outcomes and report these findings to nursing leadership monthly.

An updated nursing policy was finalized, and 87 percent of the inpatient nursing staff has been trained. Plans are to complete training with the remaining staff within the next 2 months. QM information regarding the pressure ulcer program is collected and reported monthly. We found these actions to be acceptable and are making no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 13, 2006

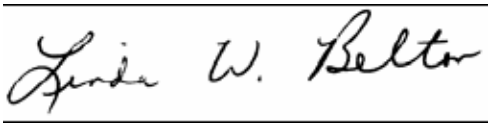
From: Network Director, VISN 11 (10N11)

Subject: **Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan**

To: Director, Chicago Office of Healthcare Inspections, Office of Inspector General (54CH)

Per your request, attached is the response from the Detroit VAMC.

If you have any questions, please contact Jim Rice, VISN 11 QMO, at (734) 222-4314.



Linda W. Belton

Attachments

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 30, 2006

From: Medical Center Director (553/00)

Subject: **Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan**

To: Director, Chicago Office of Healthcare Inspections, Office of Inspector General (54CH)

1. The recommendations noted in this draft report have presented opportunities for improvement in the care that we provide to veterans. I welcome the review of services provided as it is always helpful to learn how others may view our internal processes.

2. The OIG team was helpful, non-threatening, and cited areas that we are performing well in, as well as areas that need improvement. The staff at the John D. Dingell VA Medical Center are always poised to provide the best possible care to our nation's veterans, and we appreciate the support and knowledge presented by the OIG team. I further appreciate the support of the Network 11 staff as we seek to continuously improve the care and services that we provide our veterans.

(original signed by:)

Michael K. Wheeler

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's Report:

OIG Recommendation(s)

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that (a) clinicians document patient notification of abnormal mammogram results in the medical record and (b) mammography servicess are completed by the contract provider within 30 days.

Concur **Target Completion Date:** 2/28/07

a. Patient notification of abnormal results was corrected in the 3rd quarter of FY 06 when the Women's Health Program began generating results notification letters from the Women's Health software. Documentation requirements will be included in the upcoming revision of MCNM 11-17, Care of Women Veterans. Clinicians in all relevant services will be provided with education on documentation requirements and the mechanisms in place for doing so. A performance improvement monitor shall be created and implemented to ensure clinicians are documenting notification of results to patients, and performance feedback is transmitted to providers on a monthly basis.

b. Ensure mammography services are completed by the contract provider within 30 days. Remind contractor about the requirement to schedule requested exams. A performance improvement monitor shall be created and implemented to ensure exams are appropriately scheduled. Performance feedback will be provided to the contractor on a monthly basis. Target dates for each action item for both actions a and b are outlined in Appendix A (on file in OIG).

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) patient rooms are thoroughly cleaned and monitored by EMS supervisors for compliance and (b) PM is conducted at required intervals, and managers closely monitor student interns to ensure that documentation of PM and necessary repairs is accurate.

Concur **Target Completion Date:** 11/18/06

a. Environmental Management Section will include an inspection sheet to be completed by EMS management staff that will monitor the cleaning activities done while preparing an unclean bed/room for a new admission. This will allow for more frequent room inspections by EMS management. EMS management staff will also provide in-service training to all employees on patient room cleaning to ensure rooms are thoroughly cleaned. The template for this inspection sheet is attached as Appendix B (on file in OIG). This will be completed by November 18, 2006.

b. The preventative maintenance program has been reviewed. It was identified that the infusion pump inspection was not an oversight but a process issue. Typically, we schedule all new items in the current month that similar items are already scheduled. The infuser was scheduled for December 2005, which was several months past the 6 month interval following the incoming inspection. This was a past practice utilized by Biomedical Engineering Section to have similar items inspected at the same time. This practice will be discontinued; all equipment will receive a scheduled inspection within the timeframe established by our risk assessment criteria. The tube feeding pump had work orders entered by a Biomedical Engineering Section intern who incorrectly detailed the work performed on this pump. As of November 1, 2006, all work completed by section interns will be reviewed by fully trained Biomedical Engineering Section technicians or Biomedical Engineering Section management.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director takes action to comply with policies governing VHA's Employment Screening Requirements and correct the above discrepancies.

Concur **Target Completion Date:** 12/15/06

In August 2006, HR reviewed the OPF or appointment documents of all appointed positions, including fee basis, consultant/attending, without compensation, residents, and students and identified those found to be deficient. Within 30 days of receipt of the CAP review report, HR will again review the OPF or appointment documents of all appointed positions, focusing primarily on fee basis, consultant/attending, without compensation, residents, and students to ensure that they are in compliance with the policies governing VHA's Employment Screening Requirements. All discrepancies will be corrected by December 15, 2006.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical center Director requires the Contracting Officer to ensure that appropriate position risk and sensitivity designations are made and that the appropriate level of background screening is completed.

Concur **Target Completion Date:** 2/9/07

By November 14, 2006, the Contracting Service will review the current contracts of the Community Based Outpatient Clinic (CBOC) providers to ensure the inclusion of the appropriate Federal Acquisition Regulation (FAR) clauses, appropriate sensitivity level, and will ensure that each contract contains the requirement to conduct the background investigation. If current contracts do not have the appropriate FAR clauses, the contracting officer will modify the contracts to include the FAR clauses. This will be completed by November 15, 2006. The Contracting Officer's Technical Representative (COTR) will work with the CBOC program official to determine the level of sensitivity for each provider. The Contracting Officer will also obtain the contracted employee's information, which is required to initiate the background investigation, and submit all data as required by the VHA Handbook and VHA Directive 0710. By January 26, 2007, the Contracting Officer will also track all requested background investigations and follow through until completed. Upon completion and review of all necessary actions, these background investigations will be considered completed and closed by February 9, 2007. Standard Operating Procedures and a tracking tool will be developed, which will outline the process to be followed for background investigations, and shared with the staff, no later that November 29, 2006. In addition, contracting will implement a tracking tool to ensure that background investigations are completed.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) a management-level representative from the acquisitions section be added to the Geriatric/Extended Care Oversight Committee; (b) patients in CNHs receive medical center staff visits per policy; (c) staff document visits in CPRS timely; and (d) CPRS documentation reflects involvement of the patient, family, and/or legal guardian in placement decisions.

Concur **Target Completion Date:** 12/31/06

a. The Acquisition member (management level) has been added to the Geriatrics and Extended Care Oversight Committee Team as of October 30, 2006. See Appendix C (on file in OIG).

b. By December 31, 2006, the social worker and the HBPC nurse will visit each patient on VA contract, according to VHA Handbook 1143.2. The social worker and HBPC nurse will alternate visits monthly. Monitors were implemented October 25, 2006, and we will aggregate the data beginning December 1, 2006; a quarterly report will occur thereafter. This aggregated data will be trended and reported to the COTR, Quality Management, Home and Community Based Care Advisory Board, and HLC for Organization Performance for compliance review and follow-up as needed. All patient concerns/issues that arise will be addressed immediately. See Appendixes D, E, and F (on file in OIG).

c. Staff documentation will be completed in a timely manner. Quality Monitors developed to assure visit documentation is completed on each patient and entered into CPRS timely. Data will be collected and tabulated monthly; reports will be forwarded quarterly to the COTR, HLC for Organizational Performance, Home and Community Based Care Advisory Board, and Quality Management for compliance review and follow-up as needed. See Appendixes D and F (on file in OIG).

d. Social Work will implement the following. (1) A section on the CNH visit template has been added to reflect patient/family involvement with placement to community long-term care facility. See Appendix J (on file in OIG). (2) The Quality Monitor has been developed and will be implemented to assure this plan is being followed. Data will be collected and tabulated monthly; quarterly reports will be forwarded to the COTR, HLC for Organizational Performance, Home and Community Based Care Advisory Board, and Quality Management for compliance review and follow-up as needed. Nursing has revised the Community Nursing Home (CNH) Follow-up Visit template to reflect individuality of care and services provided. See Appendix E (on file in OIG). Nursing has also developed a follow-up visitation log to track such elements as visits, documentation, and any concerns identified during each visit. See Appendix F (on file in OIG).

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the Medical Center Director requires that staff complete informed consents for cardiac catheterization procedures that are consistent with VHA policy.

Concur **Target Completion Date:** 11/1/06

The implementation of I-Med consents is in progress within certain areas of the medical center. It is expected this consent package will meet the requirements consistent with VHA policy for informed consents. Informed Consents (paper) that are not completed through I-Med are written to comply with VHA policy. However, to ensure appropriate completion, a new monitor has been established to coincide with the findings of this OIG/CAP review. Beginning November 1, 2006, this monitor will be completed monthly. Also, these OIG/CAP findings were discussed with each Cardiac Catheterization Laboratory Physician. The importance of procedure participants and signatures was emphasized. The new monitor will identify any deficiencies in these areas and appropriate action will be taken. See Appendix G (on file in OIG).

Recommended Improvement Action 7. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) SHEP results are shared with employees at all levels of the organization and (b) improvement plans to address the low scores are developed and implemented.

Concur **Target Completion Date:** 11/1/06

a. Data will be collated as described in 7b. Once the data is collected, it will be collated, put into graph format, and forwarded to the Quadrad, HLC on Organizational Performance, Strategic Planning Committee, Customer Service Council, and service chiefs. The Customer Service Council will post SHEP results in a public area. Patient Advocates (PA) will provide SHEP in-services at service meetings.

PAs will provide quarterly copies of graphs to be displayed in work areas, clinics, Firms, etc. Services will take ownership of scores, recommend and implement processes to improve scores, and will report back to the Customer Service Council. Service chiefs will share with staff and involve them in the change process. Please see Appendix K (on file in OIG).

b. PA Data/Reports—will not contain patient specific information. PA data will be all encompassing (outpatient, inpatient, internet, letters, etc.) and will be collated on a monthly basis. Comparison of data on a monthly interval will help to identify items requiring prompt action. The PA data will be forwarded to the appropriate personnel/service to implement process improvements. This information will be shared with the Strategic Planning Committee and the Quadrad.

Since SHEP (performance measures, inpatient and outpatient) data at times is cumulative, reports will be completed quarterly. PA data will be compared to SHEP data on a quarterly basis. Customer service standards (SHEP and PA data) will be put in graph format. See Appendix I (on file in OIG). Non-customer service scores (i.e., requests for information and eligibility) will be provided in a separate format, provided to the Customer Service Council, and forwarded to the appropriate service(s). Inpatient scores will be depicted by service as well as in an overall format.

Quarterly SHEP and PA reports will be presented to the HLC for Organizational Performance, Strategic Planning Committee, and provided to all service chiefs for action and involvement with staff at all levels of the organization as described in 7a.

PA Data collection and reporting will begin November 1, 2006. PA data and SHEP data will be compared quarterly effective 1st quarter FY 07. Please see Appendix I (on file in OIG).

Recommended Improvement Action 8. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) PR processes are established to ensure effective communication, to follow-up on issues raised during PR Committee meetings, and to identify trends through data analysis; (b) aggregated reviews are trended and reported in a visual statistical format; (c) service chiefs conduct on-going reviews of clinicians' performance-related activities; and (d) patient complaints are trended and compared with SHEP survey results.

Concur **Target Completion Date:** 3/31/07

a. The utilization of an agenda for each meeting to include old business follow-up of previously discussed issues. Early distribution of the previous meeting minutes for review by the membership to be voted upon at the next meeting. The format of the minutes will be enhanced to also address the resolution of issues of concern. Monthly tracking will continue and trending to be completed on a quarterly basis with a prepared report to be shared with the Healthcare Leadership Committee on Clinical Care, which is chaired by the Chief of Staff.

b. Data that is summarized in the Patient Safety Annual Report, such as the number of RCAs/Aggregated Reviews completed per year, will be analyzed using quality management tools, such as graphs and charts, beginning with the first quarter FY 07 reports which will be due during the 2nd week of January 2007.

c. Beginning 2nd quarter of FY 07, the Chief of Staff will ensure that each service chief will use the same process with consultants, fee basis physicians, WOCs, CBOC providers, and others that is currently in place for full-time and part-time providers. This includes periodic review of performance and skills and documentation of this review using the form already in existence. This form will be used during re-privileging, as is the case with full-time and part-time providers. To obtain a full cycle of data, we will review this process at the end of 2nd quarter of FY 07. See Appendix H (on file in OIG).

d. PA Data/Reports will not contain patient specific information. PA data will be all encompassing (outpatient, inpatient, internet, letters, etc.) and will be collated on a monthly basis. Comparison of data on a monthly interval will help to identify items requiring prompt action. The PA data will be forwarded to the appropriate personnel/service to implement process improvements. This information will be shared with the Strategic Planning Committee and the Quadrad.

Since SHEP (performance measures, inpatient and outpatient) data at times is cumulative, reports will be completed quarterly. PA data will be compared to SHEP data on a quarterly basis. Customer service standards (SHEP and PA data) will be put in graph format (sample below). Non-customer service scores (i.e., requests for information and eligibility) will be provided in a separate format, provided to the Customer Service Council, and forwarded to the appropriate service(s). Inpatient scores will be depicted by service as well as in an overall format.

SHEP and PA reported will be presented to the HLC for Organizational Performance and Strategic Planning Committee. Data collection and reporting will begin November 1, 2006. PA data and SHEP data will be compared quarterly effective 1st quarter FY 07. See Appendix I (on file in OIG).

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, MN, RN 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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