Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Chillicothe VA Medical Center Chillicothe, Ohio

Report No. 06-03710-76

February 5, 2007

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care 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 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

The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Chillicothe VA Medical Center, Chillicothe, OH, during the week of October 16–20, 2006. 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 3 fraud and integrity awareness briefings to 57 employees. The medical center is part of Veterans Integrated Service Network (VISN) 10.

Results of Review

This review focused on eight areas. The system complied with selected standards in the following areas:

- Breast Cancer Management.
- Diabetes and Atypical Antipsychotic Medications.
- Survey of Healthcare Experiences of Patients.

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

- Ensure that business rules for Veterans Health Information Systems comply with requirements.
- Update community based outpatient clinic mental health emergency plans and complete and document background checks.
- Strengthen Contract Community Nursing Home Program administrative controls.
- Correct environment of care deficiencies and comply with National Fire Protection Association standards.
- Standardize QM minutes, monitor action items until completed, and strengthen peer review practices.

This report was prepared under the direction of Mr. Randall Snow, JD, Associate Director, and Mrs. Gail Bozzelli, RN, Health Systems Specialist, Washington, DC, Office of Healthcare Inspections.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B 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

Facility Profile

Organization. Located in Chillicothe, OH, the Chillicothe VA Medical Center (the medical center) provides acute and chronic mental health services, primary and secondary medical services, and a wide range of nursing home care services to the veterans residing primarily in southeastern and south central Ohio. Outpatient care is also provided at four community based outpatient clinics (CBOCs) located in Athens, Lancaster, Marietta, and Portsmouth, OH. The medical center is part of Veterans Integrated Service Network (VISN) 10 and treated nearly 19,000 enrolled veterans in fiscal year (FY) 2005 in a primary service area that includes 18 counties in southeastern Ohio.

Programs. The medical center provides medical, ambulatory surgery, mental health, and long term care services. The medical center has 60 hospital beds, 25 residential rehabilitation treatment beds, 50 domiciliary beds, and 162 nursing home beds.

Affiliations. The medical center has affiliations with Ohio State University College of Medicine, Ohio University College of Medicine, and the University of Cincinnati College of Medicine and supports over 250 residents, interns, and students.

Resources. In FY 2005, medical care expenditures totaled $102.4 million. The FY 2006 budget was $103.4 million. FY 2005 staffing totaled 1,041.5 full-time equivalent employees (FTE), including 390 nursing and 40 physician FTE.

Workload. In FY 2005, the medical center treated 18,747 unique patients. The medical center provided 13,167 inpatient days in the hospital and 51,564 inpatient days in the nursing home care units. The inpatient care workload totaled 4,187 discharges, and the average daily census, including nursing home patients, was 180.4. The outpatient workload was 210,695 visits.

Objectives and Scope of the Combined Assessment Program 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 (QM).
- 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 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 and employees; and reviewed clinical and administrative records. The review covered the following eight activities:

- Breast Cancer Management
- Business Rules for Veterans Health Information Systems
- Community Based Outpatient Clinic (CBOC)
- Contract Community Nursing Home (CNH) Program
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care (EOC)
- QM
- Survey of Healthcare Experiences of Patients (SHEP)

The review covered facility operations for FYs 2005 and 2006 and was done in accordance with OIG standard operating procedures for CAP reviews. 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 Chillicothe, Ohio,* Report No. 04-00928-164, July 15, 2004).

In this report we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Results of Review

Opportunities for Improvement

Business Rules for Veterans Health Information Systems

We reviewed Veterans Health Administration (VHA) and medical center information and technology policies and interviewed Information Resource Management Service staff. On October 20, 2004, VHA's Office of Information (OI) issued guidance and a software "patch"[1] addressing a number of issues relating to the editing of electronically signed documents in VHA's computer system. The guidance cautioned that "the practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." On June 7, 2006, VHA issued instructions to comply with the patch sent in October 2004. The OI recommended institution of a VHA-wide software change that would only permit each facility's Privacy Officer to edit a signed medical record document.

Business rules define what functions certain groups or individuals are allowed to perform in the computerized medical record. The following medical center business rules were in violation of VHA policy. Medical Center staff took action to remove these business rules while we were onsite.

- Individuals designated as expected cosigners were able to edit the summary.
- A clinical document with a status of "Deleted" could be removed (deleted) from the record by an individual enrolled as a Clinical Coordinator.
- If a document has been deleted, but its audit trail has not been deleted, the Chief, Medical Information Service (MIS) could delete the audit trail.
- If a document has been purged, but its audit trail still exists, the Chief, MIS could delete its audit trail.
- If a history and physical or medical certificate is un-cosigned, it could be edited by a designated physician cosigner.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires compliance with all applicable guidance.

[1] A patch is a piece of code added to computer software in order to fix a problem.

Community Based Outpatient Clinics

A CBOC is a VA operated, funded, or reimbursed health care facility or site geographically distinct or separate from the main medical facility. Under legislation passed in 1996, VHA created CBOCs throughout the United States. The legislation requires that VA maintain its capacity to provide for the specialized treatment and rehabilitation needs of disabled veterans in a manner that affords those veterans reasonable access to care and services. We visited the CBOC in Athens, OH, and interviewed eight veterans, who all rated the care provided them as "excellent." The following areas needed management attention:

Background Investigations. VA directives require medical centers to conduct appropriate background screenings of individuals, both employees and non-employees, who have access to sensitive information (including patient records). Of the four personnel files reviewed, one lacked the required background investigation.

Mental Health Emergency Response. The CBOC mental health emergency plan needs to be updated. The current plan directs CBOC providers to call the main medical center in the event of a mental health emergency. This is in conflict with medical center policy, which directs CBOC providers to call 911 in any emergency.

Recommended Improvement Action 2: We recommended that the VISN Director ensure that the Medical Center Director requires that (a) human resources staff collect and maintain background investigations for CBOC providers and (b) the Athens CBOC mental health emergency plan is updated.

Contract Community Nursing Home Program

We reviewed the Contract CNH Program to assess compliance with VHA guidance in the selection of contract facilities, the review process for contract renewal, and the monitoring of patients in nursing homes. We evaluated whether patients received contracted services as ordered (such as speech, physical, or occupational therapy) and whether there were effective processes in place to more closely monitor the nursing homes where deficiencies had been identified.

The medical center currently contracts with 21 nursing homes. We selected five nursing homes for document review and visited three of them. We interviewed the administrators at these three sites, toured the facilities, reviewed medical records, and interviewed veterans and care providers.

The Contract CNH Program staff utilized the exclusion report (which summarizes quality indicators and results of state and other inspections) to complete their annual review of each nursing home. Contract renewal recommendations were based on these reviews. We found that Contract CNH Program staff recommended increased monitoring,

suspension of placements, or contract termination when appropriate. Documentation of contracting decisions in the Contract CNH Program staff meeting minutes was comprehensive.

Families and CNH staff told us that a medical center nurse or social worker visited patients at least monthly. We found documentation of these visits in the patients' medical records, indicating patient assessment and discussion of concerns with the CNH staff or administrator when indicated. The administrators, nursing directors, and patients told us that the Contract CNH Program staff was accessible and responsive to their needs and concerns. We also confirmed that patients received contracted services, as ordered.

We identified the following opportunities to improve the Contract CNH Program.

Review Team. The Contract CNH Program staff provided appropriate and comprehensive oversight of the nursing homes caring for veterans. While required annual reviews were conducted, documentation for initial reviews of the five nursing homes we assessed was not available due to the age of the existing contracts. Required annual meetings with the local state Ombudsman and the Veterans Benefits Administration (VBA) office were not held.

Oversight Committee. VHA facilities with CNH programs must establish a multidisciplinary oversight committee with management representation from social work, nursing, QM, acquisition, and medical staff to effectively administer and monitor the program. The committee is to be established by the medical center Director and is responsible for completing and monitoring mandated CNH reviews. The local policy did not properly establish a CNH Oversight Committee or properly define selection and movement of veterans between VA facilities and nursing homes. Historically, the CNH review team reported to the Medical Staff Executive Committee through the Geriatric and Extended Care Committee.

Recommended Improvement Action 3: We recommended that the VISN Director ensure that the Medical Center Director takes action to require: (a) annual meetings between the Contract CNH Program staff, VBA, and the local state Ombudsman, (b) the establishment of a CNH Oversight Committee with multidisciplinary management representatives, and (c) the amendment of the local policy to meet applicable requirements.

Environment of Care

VHA regulations require that the medical center maintain a safe and clean patient care environment. We inspected selected patient care areas, including a sample of occupied and unoccupied patient rooms and restrooms. We reviewed a sample of biomedical equipment and determined that it was in working order and properly cleaned, maintained, and tested. The medical center was generally clean and effectively maintained.

However, maintenance of several specialty clinic areas and compliance with National Fire Protection Association (NFPA) standards required management attention.

- Sleep Clinic – mold on walls, ceiling, and stairwell area.
- Pulmonary Clinic stairwell exit – mold, peeling paint, and foundation separation.
- Inpatient Psychiatry – mold on ceiling tiles.
- Connecting corridors to clinics – water damage, peeling paint, and cracks in walk ways.
- Bulk Oxygen Utility System – There were no signs prohibiting smoking posted at the outdoor oxygen location, and an area with an ash tray and a cigarette disposal container was within 25 feet of the oxygen equipment. NFPA standards require that medical gases be stored away from open flames, cigarette smoking be permitted only beyond 25 feet, and signs prohibiting smoking be posted around the outdoor oxygen storage/dispensing area.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the Medical Center Director requires (a) the repair of identified maintenance items and (b) compliance with NFPA standards of posted "No Smoking" signs and elimination of smoking near the bulk oxygen utility system.

Quality Management

The QM program generally provided comprehensive oversight of the quality of care. To evaluate QM activities, we interviewed the medical center Director, Chief of Staff, and QM personnel, and we evaluated plans, policies, and other relevant documents. We found that the QM program generally provided appropriate oversight of patient care. However, the following areas needed improvement.

Follow-Up on Corrective Actions. It was difficult to determine the effectiveness of performance improvements because committee minutes did not clearly document all actions and evaluate corrective actions for effectiveness. There was a lack of consistency and standardization of reporting among the program components. It was difficult to follow committee meeting minutes because there was no standardized, systematic reporting format. Not all reports identified action items and assigned responsibility and time frames for completion and re-evaluation. For example, committee meeting minutes identified the need for training, but no one was assigned responsibility to accomplish the training, no target date was established for completion of the training, and no follow-up to ensure that the training had corrected the problem was noted.

Peer Review. When conducted systematically and credibly, peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in an individual provider's practice. This ultimately contributes to organizational performance and optimal patient outcomes. VHA directives require that the Peer Review Committee meets at least quarterly and that all members and ad-hoc members be formally trained regarding the peer review process, member responsibilities, and the organization's ethical and legal responsibilities. The committee did not meet quarterly in FY 2006, and four out of eight committee members and four ad-hoc members did not receive the required formal training.

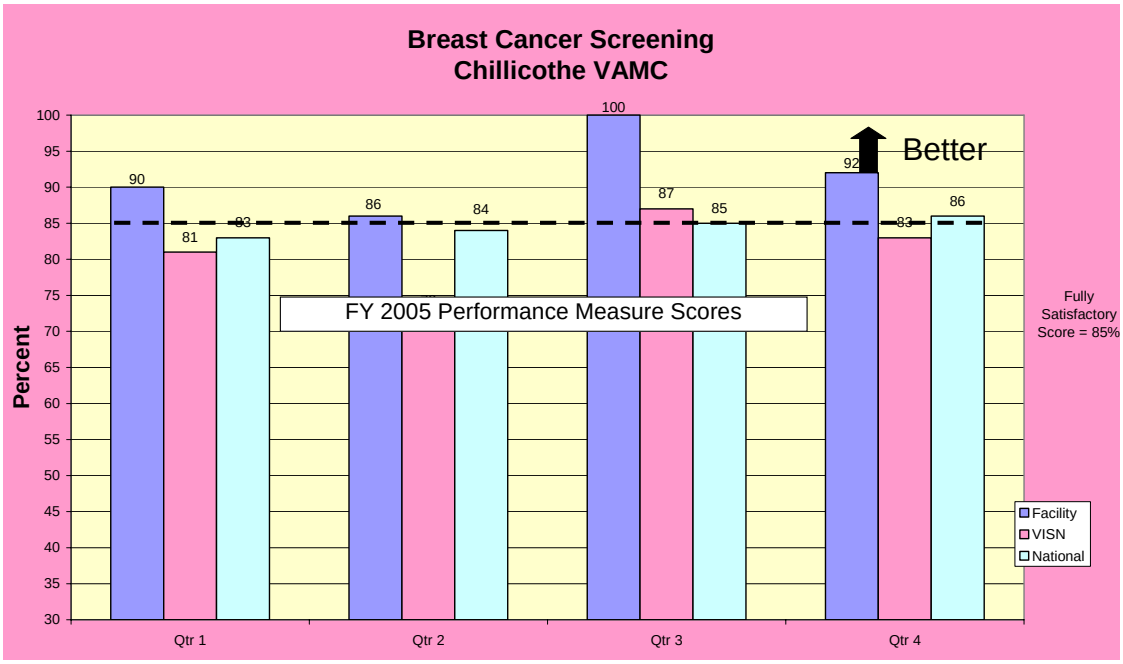
When a peer review indicates problems or opportunities for improvement, the provider must be notified and given the opportunity to submit written comments and/or address the committee prior to the final committee recommendation. There was no evidence in the committee meeting minutes that providers had been given the opportunity to submit written comments or to address the committee.

Recommended Improvement Action 5: We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) committee meeting minutes be standardized, and action items and persons assigned responsibility for tracking time frames for completion and evaluation be identified; (b) the Peer Review Committee meets quarterly; (c) Peer Review Committee members and ad-hoc members complete formal peer review training; and (d) the Peer Review Committee notifies providers of the opportunity to submit written comments and/or address the committee and documents the notification in committee minutes.

Other Observations

Breast Cancer Management

VHA's breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. The medical center met or exceeded the VHA performance measure for breast cancer screening in all four quarters in FY 2005, as indicated in the following graph.

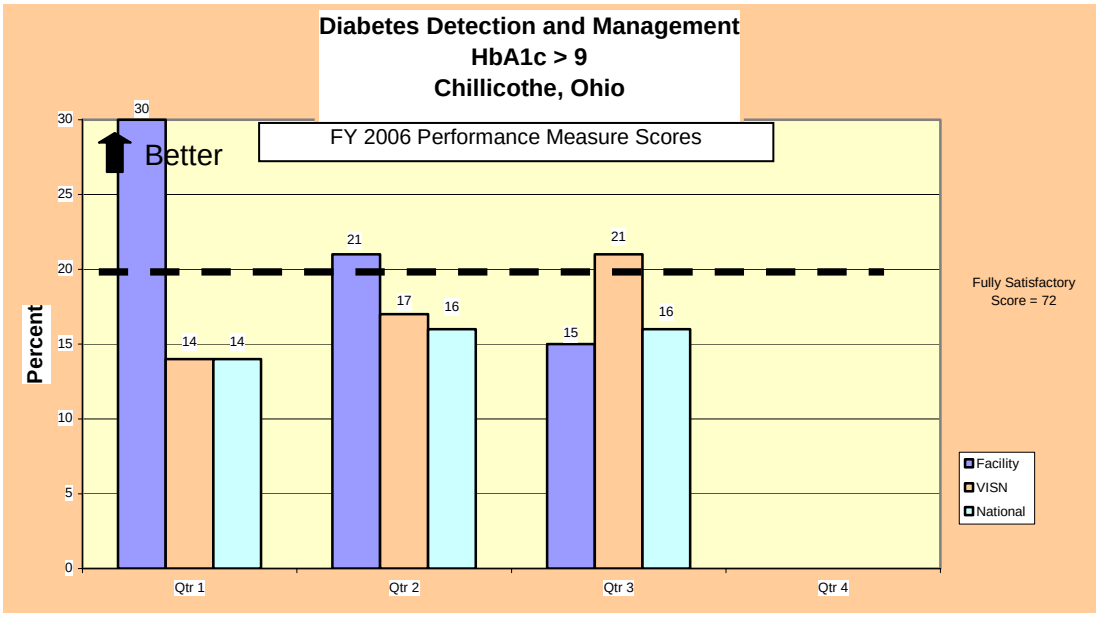


The medical center provided timely referrals for Radiology, Surgery, and Oncology consultative and treatment services. Therefore, we made no recommendations.

Diabetes and Atypical Antipsychotic Medications

Mental Health patients receiving a specific type of medication known as atypical antipsychotics experience fewer neurological side effects than with other antipsychotic medications. However, atypical antipsychotic medications increase the patient's risk for the development of diabetes and require effective diabetes screening, monitoring, and treatment.

VHA clinical practice guidelines suggest that diabetic patients' blood glucose levels (as measured by a test known as HbA1c) be less than 9 percent; 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). The medical center has shown consistent improvement in all three performance standards for FY 2006 (4th quarter data was not available at the time of the review), as shown in the following graphs.



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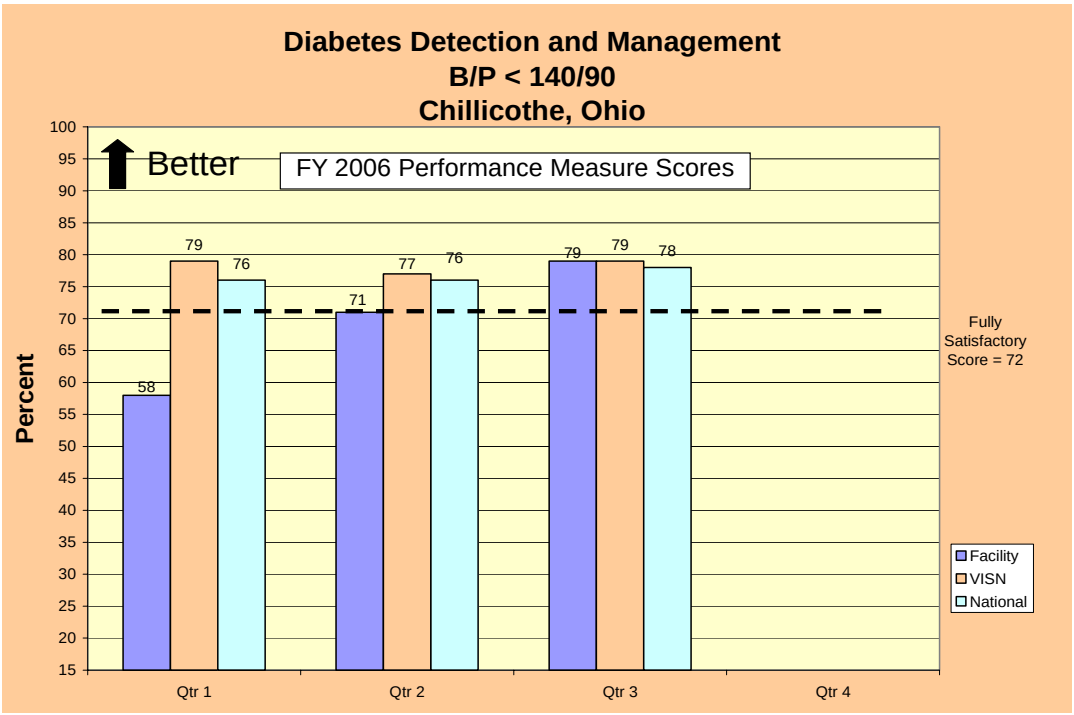

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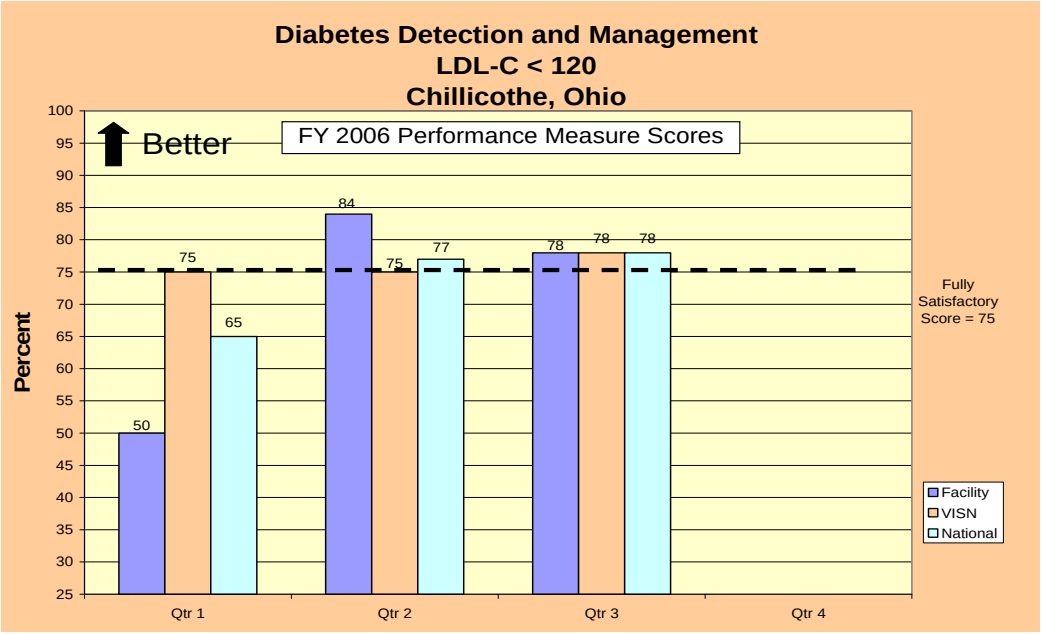

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Actions taken to improve these measures included intensive education efforts and sharing of performance measure scores with individual practitioners in the Primary Care clinics. As of FY 2007, the medical center has instituted pay for performance for providers based on performance measure results.

We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days. Two of the 13 patients had diabetes, none of these cases developed after the initiation of atypical antipsychotic medications. Two patients had significant weight gains after the initiation of atypical antipsychotic medications. One patient had blood pressure higher than 140/90 mmHg. The patients were screened and managed appropriately. See the table below for a summary of the results.

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
0/2	1/2	0/2	11/11

The medical center recognizes the potential for serious side effects associated with certain medications and has a policy that limits the ordering and dispensing of specified medications for outpatients to no more than a 30-day supply. The policy is reviewed, and the medication list is updated on a regular basis. Limiting the actual number of pills that can be dispensed promotes patient safety by providing the opportunity to evaluate the

patients for potential problems on a regular basis and is a commendable practice. Therefore we made no recommendations.

Survey of Healthcare Experiences of Patients

Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. To meet the FY 2006 performance measure, the medical center needed to achieve patient satisfaction scores of very good or excellent in 77 percent of outpatients and 76 percent of inpatients surveyed. The following tables show the medical center's SHEP results for inpatients and outpatients.

Chillicothe 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	81.70	79.40	89.40	67.30	64.3-	76.20	82.50	72.1-	69.00	**
Medical Center	84.2+	83.5+	90.90	70.30	65.50	76.20	85.3+	73.20	65.6-	**

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

Chillicothe Outpatient SHEP Results
Q3 FY 2006

	Access	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.90	72.00	83.00	75.1	81.1	64.4	81.3	80.5	84.1
VISN	82.00	70.80	81.50	74.7	84.7	69.6	80.4	80.5	85
Outpatient Clinics - Overall	84.10	63.20	72.5 -	71.4	86.4	79	79.5	74.1	82.7
Chillicothe Clinic	79.8	60.8	69.6 -	67.8	*	79.9	77.1	*	79.1
Athens Clinic	91.7 +	70.5	85.8	74.5	81.9	*	86.5	82.9	89
Portsmouth Clinic	86.9	57.6	66.7 -	76.5	74.7	*	78.6	*	85.1
Marietta Clinic	88.3	73.7	85.8	77.2	85.5	*	84.6	80.1	92.6 +
Lancaster Clinic	94.5 +	65.6	72.5	79.2	80.4	*	83.7	74.5	87.2

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

For the inpatient SHEP, the medical center scored above the 76 percent threshold in 5 of the 10 areas, and 3 areas (Access, Coordination of Care, and Physical Comfort) were significantly above the national average. The medical center was below the threshold of 76 percent in three areas (Education and Information, Emotional Support, and Preferences).

For the outpatient SHEP, the medical center scored above the 77 percent threshold in 5 of the 9 areas. The overall clinic score was below the threshold of 77 percent in 4 areas (Education and Information, Emotional Support, Overall Coordination, and Specialist Care). The score for Emotional Support was significantly worse than the national average.

Medical center analysis of SHEP survey results had identified these areas as opportunities for improvement. The facility will be implementing an intensive, ongoing program titled "Building a Healthy Culture" that targets service recovery opportunities, reward and recognition efforts, and staff education regarding both the SHEP and the All Employee Survey results. A Service Level Advocate Program is being established and had 20 volunteers at the time of the CAP visit. The volunteers will be trained to problem solve customer concerns on the spot. We found these actions to be acceptable and made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 7, 2006

From: Director, Veterans Integrated Service Network 10 (10N10)

Subject: **Combined Assessment Program Review of the Chillicothe VA Medical Center, Chillicothe, Ohio**

To: Peggy Seleski, Director, Management Review Service (10B5)

1. I concur with the comments and action plans submitted by the Medical Center Director at Chillicothe, Ohio, in response to the OIG CAP Review conducted in October 2006. The staff found the review educational and appreciated the professionalism of the OIG Team.

2. If you have questions regarding the response, please contact Douglas A. Moorman, Medical Center Director, at (740)773-1141, extension 7002.

(original signed by:)
JOHN BARILICH

Director, Veterans Integrated Service Network

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 3, 2006

From: Director, Chillicothe VA Medical Center

Subject: **Combined Assessment Program Review of the Chillicothe VA Medical Center, Chillicothe, Ohio**

To: Director, Veterans Integrated Service Network 10 (10N10)

1. Attached is the response from the VA Medical Center, Chillicothe, Ohio, to the OIG CAP Review in October 2006. We found the review educational and helpful in preparation for our upcoming JCAHO survey. We also appreciated the professionalism of the review team.

2. If you have any questions about the response imbedded in the report above, please feel free to contact me.

(original signed by:)
DOUGLAS A. MOORMAN

Medical Center Director

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

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

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires compliance with all applicable guidance.

Facility Response: Concur. Bullets 2–4 have already been changed to comply with the handbook. Bullet 1 applies to unsigned summaries and should be able to be edited by the provider who may be the cosigner. Ongoing monitoring has been assigned to the Medical Records Committee.

Recommended Improvement Action 2: We recommend that the VISN Director ensure that the Medical Center Director ensures that (a) human resources staff collect and maintain background investigations for CBOC providers and (b) the Athens CBOC mental health emergency plan is updated.

Facility Response: Concur. HRMS has collected the background checks on those deficient. The mental health emergency plan for the Athens CBOC is being updated and will be completed by December 1, 2006.

Recommended Improvement Action 3: We recommend that the VISN Director ensure that the Medical Center Director takes action to require: (a) annual meetings between the Contract CNH Program staff, VBA, and the local state Ombudsman, (b) the establishment of a CNH Oversight Committee with multidisciplinary management representatives, and (c) the amendment of local policy to meet applicable requirements.

Facility Response: Concur. Annual meeting is being set up with VBA and the local state Ombusdman. The committee is being established, and the policy is being updated. Estimated completion date is December 31, 2006.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires (a) the repair of identified maintenance items and (b) compliance with NFPA standards of posted "No Smoking" signs and elimination of smoking near the bulk oxygen utility system.

Facility Response: Concur. The roof will be replaced and the walls and ceiling repaired in the Sleep Clinic and Pulmonary Clinic by November 30, 2006. The ceiling tiles in inpatient psychiatry have already been replaced. The floors and paint in the connecting corridors will be repaired by November 30, 2006. The ash tray has been removed from the area of the bulk oxygen, and signs were installed.

Recommended Improvement Action 5: We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) committee meeting minutes be standardized, and action items and persons assigned responsibility for tracking time frames for completion and evaluation be identified; (b) the Peer Review Committee meets quarterly; (c) Peer Review Committee members and ad-hoc members complete formal peer reviewing training; and (d) the Peer Review Committee notifies providers of the opportunity to submit written comments and/or address the committee and documents the notification in committee minutes.

Facility Response: Concur. Examples of templates for minutes are being sought from other VA facilities. Implementation estimated by January 31, 2007. The peer review committee will meet quarterly, and if a meeting must be cancelled, it will be rescheduled within the same quarter. Formal training for members is being scheduled and is estimated to be completed by February 2007. The provider notification statement has been added to the quarterly meeting minutes.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Randall Snow, Associate Director Office of Healthcare Inspections, Washington, D.C. 202-565-8452
Acknowledgments	Gail Bozzelli Donna Giroux Richard Horansky Gavin McClaren Carol Torczon

Appendix D

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