Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Grand Junction VA Medical Center Grand Junction, Colorado

Report No. 06-00637-104 **March 21, 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 facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

The Office of Inspector General conducted a Combined Assessment Program (CAP) review of the Grand Junction VA Medical Center (the medical center), Grand Junction, CO, during the week of August 21–24, 2006. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and integrity awareness training to 41 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 19.

Results of Review

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

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

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

- Involve patients and families in the contract community nursing home selection process.
- Strengthen the QM program by consistently identifying corrective actions, including provider-specific data in the reprivileging process, and ensuring that the Peer Review Committee meets at least quarterly and reports to the designated oversight committee.

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

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans (see Appendixes A and B, pages 10–13, for the full text of the Directors' comments). We will follow up on the planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. The Grand Junction VA Medical Center (the medical center) is a tertiary care medical center that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at a community based outpatient clinic located in Montrose, CO. The medical center is part of Veterans Integrated Service Network (VISN) 19 and serves a veteran population of about 36,832 in a primary service area that includes 17 counties in western Colorado and southeast Utah.

Programs. The medical center provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center has 23 hospital beds and 30 nursing home beds.

Affiliations and Research. The medical center is not affiliated with any medical schools and does not have any research programs.

Resources. In fiscal year (FY) 2005, medical care expenditures totaled $53.2 million. The FY 2006 medical care budget is $56.9 million. FY 2005 staffing totaled 346.97 full-time equivalent employees (FTE), including 20 physician and 109 nursing FTE.

Workload. In FY 2005, the medical center treated 10,517 unique patients. The inpatient care workload totaled 1,418 discharges. The average daily census, including nursing home patients, was 45. The outpatient workload was 89,211 visits.

Objectives and Scope of the Combined Assessment Program 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 and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care administration 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 six activities:

- Breast Cancer Management
- Contract Community Nursing Homes (CNHs)
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care
- QM
- Survey of Healthcare Experiences of Patients (SHEP)

The review covered facility operations for FYs 2004–2006, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on the recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, Colorado,* Report No. 03-02290-012, November 4, 2003).

During this review, we also presented fraud and integrity awareness briefings for 41 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we summarize selected focused inspections and state opportunities for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the Other Review Topics section have no reportable conditions.

Results of Review

Organizational Strength

Patient Safety Incident Reporting System

The medical center developed a local database to encourage patient safety incident reporting. This system has resulted in increased reporting in all areas. It also provides a more comprehensive review of an incident and allows for a significant amount of free text description by the reporter. This provides the patient safety officer, supervisors, and root cause analysis teams with valuable details that may be lost when incidents are aggregated for quarterly review. Also incorporated into the incident reports are fields to collect staffing effectiveness information. This provides data on the mix of staff that was actually present on the unit at the time of the incident. The templates also capture all the data that the National Center for Patient Safety gathers for their aggregate reports. Overall, this reporting system has enhanced the medical center's ability to review incidents in a timely fashion and has improved the patient safety program.

Opportunities for Improvement

Quality Management – Corrective Action Plans, Reprivileging Data, and Peer Review Needed Strengthening

Conditions Needing Improvement. The QM program was generally effective and provided appropriate oversight of clinical care. However, program managers needed to consistently analyze data and develop action plans for improvement. Clinical managers needed to use provider-specific data to evaluate clinician performance during the reprivileging process and ensure that the Peer Review Committee meets at least every quarter and submits reports to the designated oversight committee.

The following areas needed specific improvements:

Corrective Action Plans. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires hospitals to analyze performance improvement data and make recommendations to improve care. The Clinical Executive Board (CEB) was the medical center oversight committee for QM operations. Although data was presented to the CEB, there was a discrepancy between analysis of data and recommendations for corrective action. The CEB discussed Veterans Health Administration (VHA) performance measures that fell below established thresholds but did not consistently identify corrective actions for improvement for all of those measures. Although the medical center overall has above average performance measure scores, they can further improve patient care by identifying recommendations and corrective actions for any measures that is below fully satisfactory.

Provider-Specific Reprivileging Data. Reprivileging is the process of renewing independent providers' clinical privileges. It is performed at least every 2 years. VHA and JCAHO require supervisors to evaluate clinical competence and professional performance at the time providers request renewal of their clinical privileges. Although required by medical center policy, clinical supervisors did not review provider-specific performance data to evaluate providers' performance. Supervisors stated they would use this information if it were available.

Peer Review Committee. VHA and JCAHO require peer review to measure, assess, and improve performance on an organization-wide basis. Peer review is intended to promote confidential and systematic processes that contribute to improvement efforts in a non-punitive manner. Results can be used for education and training. According to medical center policy, the Peer Review Committee is required to meet at least quarterly and submit minutes to the CEB for review. The Peer Review Committee only met 3 of 4 quarters in FY 2006 and did not submit reports to the CEB.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the CEB identify corrective action plans for all performance measures below the fully satisfactory threshold, (b) clinical supervisors develop a process to collect provider-specific performance data and use this data in the reprivileging process, and (c) the Peer Review Committee meet at least quarterly and report results to the CEB.

The VISN and Medical Center Directors agreed with the findings and recommendations. The performance measure action plan that CEB develops will now include interventions for each measure. The medical center has developed a provider-specific database to track actual performance based on clinical factors. This database will be used in the reprivileging process. The Peer Review Committee is scheduled to meet quarterly and submit quarterly reports to the CEB. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Contract Community Nursing Homes – Patient and Family Involvement in the Selection Process Needed Strengthening

Condition Needing Improvement. The Community Extended Care Evaluation Committee generally provided appropriate oversight of the Contract CNH Program. Program managers evaluated CNHs prior to patient placement, and once patients were placed in CNHs, a social worker and registered nurse routinely monitored their care. However, there was no documentation that patients and/or family members were involved in the selection process prior to placement in a CNH.

VHA provides nursing home care under contract agreements. VHA recognizes the rising concerns over quality of care in our Nation's nursing homes and the need to implement quality monitoring. Medical center CNH program staff were clearly involved in assessing the quality of care patients received and had initiated corrective actions when necessary. The medical center had patients in three CNHs at the time of our review. We toured two CNHs and met with their administrators. We reviewed 10 patients' medical records and interviewed four patients regarding their care. There was no documentation that patients or their families had been included in the choice of the CNH. VHA policy maintains the importance of some level of patient choice in choosing a CNH. Patients were pleased with their care but none of the patients interviewed felt that they had been included in the decision-making process.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that patients and/or families are included in the choice of the CNH and that social workers document that opportunity in the medical record.

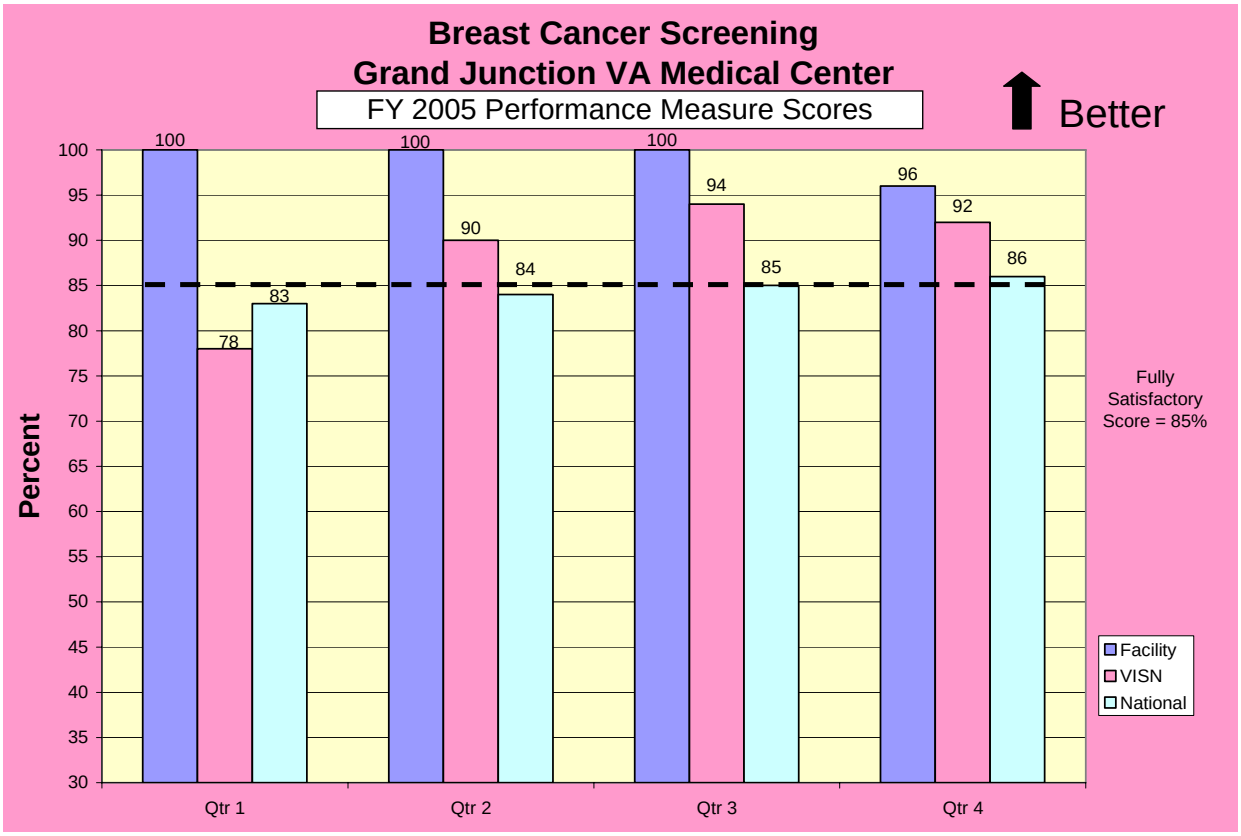
The VISN and Medical Center Directors agreed with the findings and recommendations. Medical center social workers were instructed to inform patients and families of their nursing home choices and are now documenting this in the medical record. The Chief of

Clinical Support Services is monitoring documentation. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Other Review Topics

Breast Cancer Management

The medical center exceeded the VHA performance measure for breast cancer screening. The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center achieved the fully satisfactory level for all quarters in FY 2005.



Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. In order to assess these processes, we requested names of patients who had abnormal mammography findings during FYs 2004 and 2005. Because there were no patients with abnormal mammography findings for those FYs, we were unable to complete that portion of the review. However, clinicians were able to articulate their processes for performing timely diagnostic procedures, promptly informing patients of results, and providing timely follow-up services. Therefore, we made no recommendation.

Diabetes and Atypical Antipsychotic Medications

We found that clinicians appropriately screened and managed mental health patients receiving atypical antipsychotic medications. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggests that: a diabetic patient's hemoglobin A1c (HbA1c)[1] should be less than 9 percent; blood pressure should be 140/90 millimeters of mercury (mmHg) or less; and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl). To receive fully satisfactory ratings for the diabetes performance measures, the medical center must achieve the following scores:

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

The medical center did not meet the fully satisfactory level for VHA diabetes performance measures for FY 2005. Clinicians were aware of the deficiency and had identified areas for improvement and implemented appropriate corrective action plans.

We reviewed the medical records of 13 randomly selected patients who were on one or more atypical antipsychotic medications for at least 90 days in FY 2005. Clinicians had screened all patients for diabetes. None of the 13 patients had diabetes. One patient did not receive diabetes prevention counseling. Physicians reported that this patient was noncompliant with treatment.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with blood pressure less than 140/90mm/Hg	Diabetic patients with LDL-C less than 120mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
N/A	N/A	N/A	13/13	12/13

Because senior managers had analyzed performance measure results and supported the corrective actions for meeting these measures, we made no recommendation.

[1] HbA1c reflects the average blood glucose level over a period of time and should remain in control to prevent complications.

Environment of Care

The medical center's environment of care was clean and safe. VHA and JCAHO regulations require that the hospital environment present minimal risk to patients, employees, and visitors and that infection control practices are employed to reduce the risk of hospital-acquired infections. We inspected occupied and unoccupied patient rooms, bathrooms, supply closets, medication rooms, waiting areas, and the supply and processing distribution area.

We randomly selected eight pieces of biomedical equipment to evaluate cleanliness, safety, and maintenance. The equipment was clean and maintained appropriately, with properly functioning alarms. Preventive maintenance checks were current and followed VHA and local policies. We made no recommendation.

Survey of Healthcare Experiences of Patients

SHEP scores exceeded national targets in all categories except one. Veteran patient satisfaction surveying is designed to promote healthcare quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit healthcare surveying group. VHA set FY 2006 SHEP target results of 76 percent of inpatients and 77 percent of outpatients report their experiences as Very Good or Excellent. The following tables show the medical center's inpatient and outpatient SHEP results compared to VISN 19 and national survey results:

Grand Junction Inpatient SHEP Results
1st and 2nd Quarter FY 2006

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
VA National	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03
VISN 19	85.6+	83+	92.9+	71.7+	69+	78.5+	86.6+	78.1+	72.9+
Medical Center	91.3+	90.4+	95.9+	82.7+	80.3+	86.3+	92.1+	88.5+	80.9+

Legend
+ Indicate results that are significantly better than the national average

Grand Junction Outpatient SHEP Results
2nd Quarter FY 2006

Facility Name	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
VA National	80.7	78.1	94.8	72.6	83.3	75.8	81.5	65.5	81.7	80.8	84.7
VISN 19	82	76.9	95	73.9	86.7 +	76.9	84.8	71.9	82.8	79.1	87.6 +
Grand Junction Outpatient Clinic- Overall	84.1	77.7	94.8	77.9	91.4 +	78.8	91.5	60.1	85.6	85.4	88.4
Grand Junction Outpatient Clinic	84	77.6	94.9	78	91.7 +	79	*	59.9	85.8	85.5	88.4
Montrose Outpatient Clinic	87.8 +	82.9	90.3	72.9	81.5	73	84.5	*	80.2	84.1	87.5

Legend
+ Indicate results that are significantly better than the national average
**** Less than 30 respondents***

The medical center continuously strives to improve patient satisfaction and SHEP scores. For the category of Pharmacy Pick-up, the medical center has implemented actions to improve their performance. The medical center trends and analyzes SHEP data, disseminates the data to the staff, and develops an action plan for improvements. Therefore, we made no recommendation.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 22, 2006

From: Director, Veterans Integrated Service Network (10N19)

Subject: **Grand Junction VA Medical Center, Grand Junction, CO**

To: Director, Kansas City Regional Office of Healthcare Inspections (54KC)

1. Attached is the facility response to the OIG CAP Site Review of the Grand Junction VAMC.

2. I have reviewed and concur with all the facility Director's comments.

3. If you have any questions, please contact the Quality Manager at the Grand Junction VAMC, Mr. Charles Hensel, at 970-242-0731, x2234.

(original signed by:)

LAWRENCE A. BIRO
Network Director
VISN 19 Rocky Mountain Network

cc: Director, Management Review Office (10B5)

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 21, 2006

From: Director, Grand Junction VA Medical Center (575/00)

Subject: **Grand Junction VA Medical Center Grand Junction, CO**

To: Director, Veterans Integrated Service Network 19 (10N19)

1. Attached is the action plan for the recommendations from the recent Grand Junction VAMC OIG visit.

2. If you have any questions or need additional information, please contact Charles Hensel at 970-242-0731, x2234.

(original signed by:)

MICHAEL W. MURPHY, Ph.D.
Medical Center Director

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

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

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) the CEB identify corrective action plans for all performance measures below the fully satisfactory threshold, (b) clinical supervisors develop a process to collect provider-specific performance data and use this data in the reprivileging process, and (c) the Peer Review Committee meet at least quarterly and report results to the CEB.

Concur **Target Completion Date:** (a) December 15, 2006; (b) October 2006; (c) December 15, 2006

a. Performance measures are reviewed in CEB monthly, and items falling below fully satisfactory thresholds are identified for corrective actions. An action plan listing each such measure is documented and attached to the CEB minutes along with the tables of data. All action plans for CEB now clearly document needed interventions and will continue in the future.

b. We have developed a provider-specific database that tracks actual performance of each provider across agreed upon clinical factors. The data is considered for the reprivileging process for providers who were due for renewal of privileges. Aspects of this database are also linked to the physicians pay bill incentives. VISN 19 has endorsed the database, and other facilities within VISN 19 are considering importing the tool.

c. The Peer Review Committee met during first, second, and fourth quarters in FY06 prior to the OIG visit in August. Peer Review Committee has since met in first quarter FY07 and

will continue to fulfill the quarterly meeting requirements. A report was made to CEB on August 18, 2006, but minutes were not available for OIG to review during the site visit. A report was made to CEB December 15, 2006. Quarterly meetings of the Peer Review Committee and quarterly reports to CEB are scheduled into the future on an ongoing basis.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director requires that patients and/or families are included in the choice of the CNH and that social workers document that opportunity in the medical record.

Concur **Target Completion Date:** September 2006

During the OIG visit, the Social Workers were informed to clearly document in CPRS the choices available regarding placements. Since the OIG visit in August, Chief of Clinical Support Services has reviewed the medical record of every patient placed in a Community Nursing Home. Documentation was present in each instance of the patient/family being provided a choice in selecting a nursing home for placement.

Appendix C

OIG Contact and Staff Acknowledgments

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

Appendix D

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