Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Carl T. Hayden VA Medical Center Phoenix, Arizona

Report No. 07-00282-140 **June 1, 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 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 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

During the week of November 13–17, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Carl T. Hayden VA Medical Center (the medical center). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 312 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 18.

Results of Review

The CAP review focused on eight operational areas. The medical center complied with selected standards in seven areas.

- Breast Cancer Management.
- Cardiac Catheterization Laboratory Standards.
- Community Based Outpatient Clinics (CBOCs).
- Contract Community Nursing Home (CNH) Program.
- Environment of Care (EOC).
- QM.
- Survey of Healthcare Experiences of Patients (SHEP).

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

- Diabetes and Atypical Antipsychotic Medications – Improve interventions and education for weight control management, document diabetes risk factors, monitor and provide intervention for elevated hemoglobin A1c (HbA1c), and monitor and manage blood pressure.

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

Comments

The VISN 18 and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 11–15 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

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

Introduction

Medical Center Profile

Organization. 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 five CBOCs located in Mesa, Sun City, Buckeye, Show Low, and Payson, AZ. The medical center is part of VISN 18 and serves a veteran population of about 321,541 in a primary service area that includes Maricopa, La Paz, Gila, and Navajo counties in Arizona.

Programs. The medical center has 192 hospital beds and 104 nursing home beds and provides medical, surgical, mental health, geriatric, rehabilitation, and diagnostic services. The medical center has sharing agreements with Luke Air Force Base, the State of Arizona, Phoenix Memorial Hospital, and the Shriner's Childrens Hospital.

Affiliations and Research. The medical center is affiliated with the University of Arizona School of Medicine and six other universities to support 75 medical resident positions in medicine, surgery, and psychiatry. In fiscal year (FY) 2005, the medical center research program had 98 projects and a budget of $1.46 million. Important areas of research include diabetes, gastroenterology, podiatry, and cardiology.

Resources. In FY 2005, medical care expenditures totaled $282 million. The FY 2006 medical care budget was $261 million. Staffing in FY 2005 was 1,908 full-time employee equivalents (FTE), including 142 physician and 382 nursing FTE.

Workload. In FY 2005, the medical center treated 65,092 unique patients. The medical center provided 44,900 inpatient days of care in the hospital and 28,555 inpatient days of care in the Nursing Home Care Unit. Inpatient care workload totaled 8,351 discharges with an average daily census of 201, including nursing home patients. Outpatient workload totaled 582,503 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 services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care and 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 activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical records. The review covered the following eight programs:

- Breast Cancer Management
- Cardiac Catheterization Laboratory Standards
- CBOCs
- CNH Program
- Diabetes and Atypical Antipsychotic Medications
- EOC
- QM
- SHEP

The review covered facility operations for FYs 2005 and 2006 and was done in accordance with OIG standard operating procedures for CAP reviews. During this review, we also presented fraud and integrity awareness briefings for 312 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Programs needing improvement are discussed in the Opportunities for Improvement section (page 3). Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Follow-Up on Prior Combined Assessment Program Review Recommendations

An analysis of our prior CAP review of the medical center (*Combined Assessment Program Review of the Carl T. Hayden VA Medical Center*, Report Number 04-01456-181, August 13, 2004) identified no recommendations that required follow-up by healthcare inspectors.

Results of Review

Opportunities for Improvement

Diabetes and Atypical Antipsychotic Medications

Conditions Needing Improvement. 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). Clinicians needed to improve: (1) intervention and education for weight control (to include diet and exercise); (2) documentation of diabetes risk factors in the medical record; (3) monitoring and implementation of strategic interventions for elevated HbA1c in patients with diabetes; and (4) monitoring of blood pressure on a consistent basis and provision of intervention, when elevated.

Criteria. VHA clinical practice guidelines for the management of diabetes suggests that: (a) diabetic patients' 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 (poor glycemic control) – 15 percent or lower (lower percent is better)
- Blood pressure less than or equal to 140/90mmHg – 75 percent or higher (higher percent is better)
- LDL-C less than 120mg/dL – 75 percent or higher (higher percent is better)

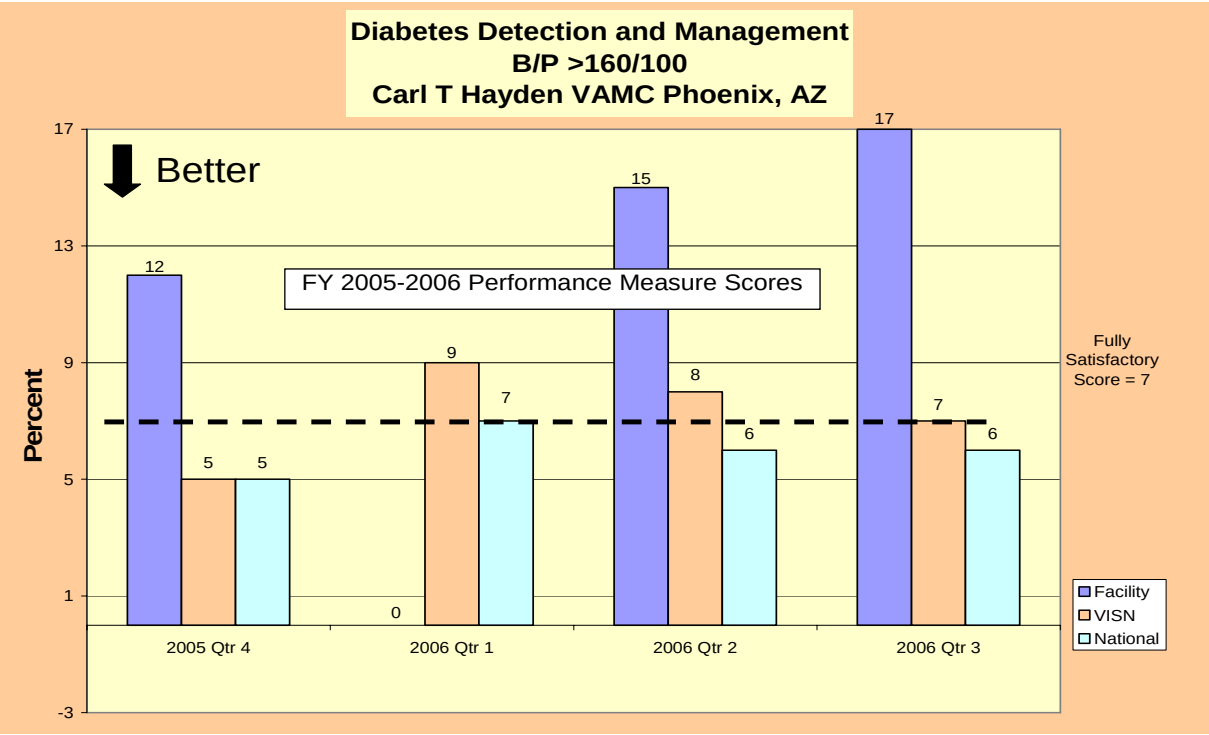
VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1 to 3 years. A normal FBG is less than or equal to 110mg/dL. Patients with FBG values greater than 110mg/dL but less than 126mg/dL should be counseled about prevention strategies (calorie-restricted diets and exercise). A FBG value that is greater than or equal to 126mg/dL on at least two occasions is diagnostic for diabetes mellitus.

Findings. We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days. Twelve of 13 patients had a body mass

index with a classification of overweight or obese. Clinical managers could not provide medical record documentation to support interventions for weight control management, including diet and exercise, for seven patients, three of which had a diagnosis of diabetes mellitus. The medical records revealed inconsistencies and lack of documentation of diabetes risk factors for 6 of the 13 patients reviewed. Diabetes risk factors include components, such as a family history of diabetes, tobacco use, weight status, an abnormal glucose tolerance test, and a diagnosis of hypertension.

Four of the 13 patients had diabetes. All diabetic patients had elevated HbA1c with no documented clinical interventions in the medical records. One diabetic patient had the last HbA1c, which was elevated, drawn in November of 2004 with no documented intervention or follow-up noted in the medical record. However, the patient continues to receive health services from the medical center. Immediate contact and appropriate intervention with this patient occurred during our inspection. The documentation for all four patients also failed to support referrals to the diabetic nurse educator. Medical records did not support blood pressure monitoring on a regular basis. Additionally, there were no documented attempts to manage elevated blood pressures, as reflected in the medical center's performance measure scores (see graph on next page).

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
75 percent (3/4)	50 percent (2/4)	75 percent (3/4)	67 percent (6/9)	33 percent (3/9)



">" indicates greater than
"B/P" stands for blood pressure

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to improve interventions and education for weight control management, document diabetes risk factors, monitor and provide intervention for elevated HbA1c, and monitor and manage blood pressure.

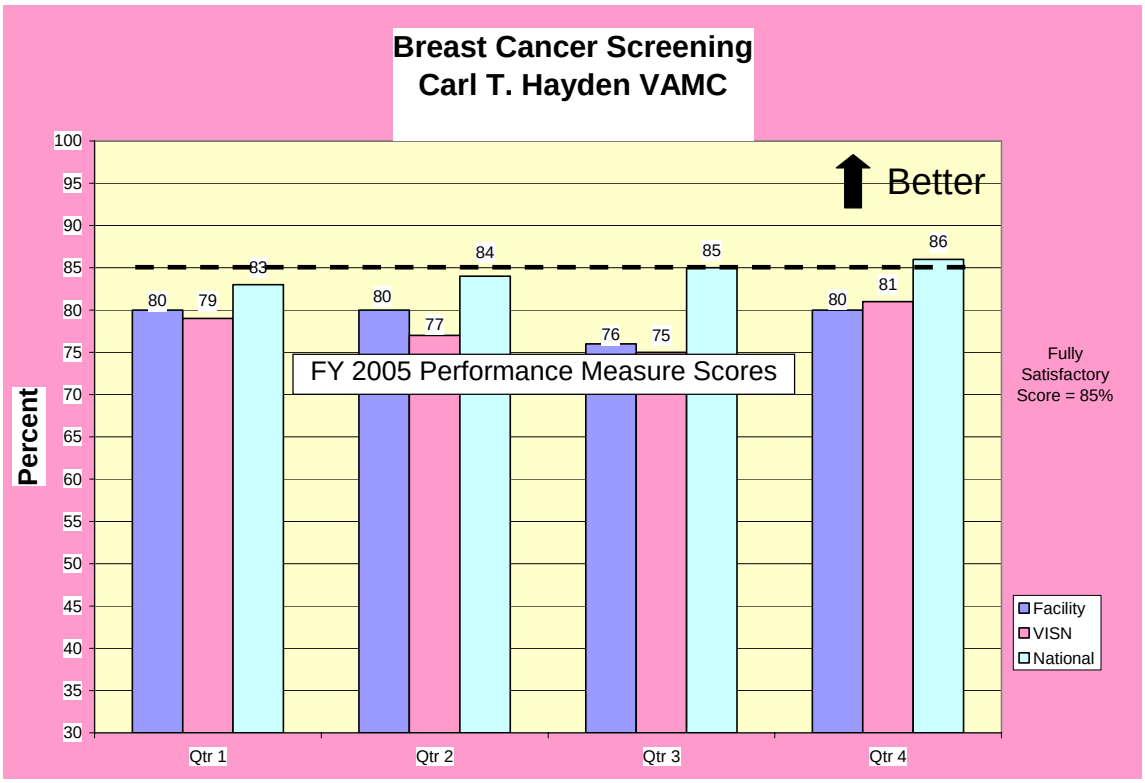
Other Observations

Breast Cancer Management

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes.

Findings. Mammogram services were offered to patients by 17 fee-basis providers. Timely radiology, consultative, and treatment services were provided to patients. When indicated, an interdisciplinary treatment plan was developed, and providers promptly informed patients of diagnoses and treatment options.

The performance measures for FY 2005 reflected an overall average of 79 percent, which was below the established goal of 85 percent. However, the medical center had taken action to improve breast cancer management. At the time of our visit, the FY 2006 performance measures averaged 84 percent, reflecting considerable improvement. Based on our medical record reviews and the facility's efforts to improve breast cancer management, we had no findings.



Cardiac Catheterization Laboratory Standards

A cardiac catheterization is a special procedure performed in the catheterization laboratory to diagnose defects in the heart chambers, valves, and blood vessels. The purpose of this review was to determine if the medical center's cardiac catheterization laboratory practices were consistent with the American College of Cardiology and the Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards and VHA Handbook 1004.1. These standards define requirements for provider procedure volumes, laboratory procedure volumes, cardiac surgery resources, QM, the informed consent process, and cardiac pulmonary resuscitation (CPR) training. We reviewed these practices and found the medical center in compliance with these standards.

Findings. The medical center's cardiac catheterization laboratory completed 515 diagnostic coronary procedures in FY 2005. All of the attending physicians privileged in this area performed the procedures without complications and had received the required CPR training. The medical center has an ongoing quality improvement process that tracks, trends, and analyzes cardiac catheterization procedures to improve patient outcomes. In addition, we reviewed 10 medical records of patients who had a cardiac catheterization procedure in FY 2005 and found that informed consent documentation was appropriately completed. We had no reportable findings or recommendations.

Community Based Outpatient Clinics

The purpose of this review was to: (1) assess the effectiveness of CBOC operations and VHA oversight; (2) determine whether CBOCs are in compliance with selected standards of operations (patient safety, QM, credentialing and privileging, emergency plan); and (3) determine whether CBOCs improve access, convenience, and timeliness of VA health care services.

VHA Handbook 1006.1 establishes consistent planning criteria and standardized expectations for CBOC operations. It defines the CBOC, staffing options, and services provided. VHA Directive 2002-074, *National Dual Care Policy*, establishes a system-wide approach to the coordination and provision of medical care that optimizes the quality, appropriateness, and efficacy of care and medications provided to eligible veterans who are seen by both VA and community providers. VHA Handbook 1100.19, *Credentialing and Privileging*, defines the process for all individuals who are permitted by law and the facility to provide patient care services independently. VHA Directive 0710, *Personnel Suitability and Security Program*, establishes requirements to perform background checks—or at a minimum a Special Agreement Check—on all appointees, health care contractors, and most volunteers prior to their entry on duty at a VHA facility.

Findings. We interviewed key individuals at the parent facility and the CBOC in Mesa, AZ. We reviewed documentation and self-assessment tools on descriptions of services provided, including warfarin clinic services. We determined that the parent facility warfarin clinic, which is directed by a pharmacist, and the CBOC warfarin clinic, which is managed by a pharmacist, maintain the same standards and expectations. CBOC patients attend an initial education class at the parent facility before they receive their first dose of warfarin. CBOC patients' laboratory tests and follow-up are provided by the pharmacist-managed warfarin clinic, with primary care oversight. Patients receive a handbook that contains a toll-free telephone number to help facilitate prompt reporting of new medications and other vital information.

The Mesa CBOC EOC inspection demonstrated a clean facility that meets the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Health Insurance Portability and Accountability Act, and Life Safety requirements. The emergency management plan was current, and clinical staff were educated and knowledgeable about rendering emergency care to the veterans. All clinical staff were certified in Basic Life Support or Advanced Cardiac Life Support. The emergency response cart was inspected, and documentation was up-to-date. An automated external defibrillator was readily available to trained staff for use as needed. We had no reportable findings or recommendations.

Contract Community Nursing Home Program

The purpose of the CNH Program review was to assess VHA facility compliance with requirements defined in VHA Handbook 1143.2, *Community Nursing Home Procedures*, regarding the selection, placement, and monitoring of patients in contract CNHs and the inclusion of patients and family members in this process.

Findings. The CNH Program staff provided comprehensive management of the contracted nursing facilities and the veterans residing in those facilities. Appropriate actions were taken when problems were identified that adversely affected patient safety and quality of care. We also determined that patients and family members were involved sufficiently in the CNH placement process, provided applicable choices regarding CNH selection, and engaged in ongoing communication regarding care.

The medical center currently has 16 contracted CNHs and 64 veterans residing in those facilities. Ten medical record reviews were conducted, and five patients were interviewed. Additionally, five nursing facilities were reviewed, and two onsite surveys were conducted in order to interview staff and evaluate EOC. The CNH Program complied with local and VHA policies. We had no reportable findings or recommendations.

Environment of Care

The purpose of the evaluation was to determine if the medical center maintained a safe and clean health care environment. The medical center must establish a comprehensive EOC Program that fully meets all VHA, Occupational Safety and Health Administration, and JCAHO standards. To evaluate EOC, we inspected clinical and non-clinical areas for cleanliness, safety, infection control, and general maintenance.

Findings. The medical center maintained an exceptionally clean and safe environment. We had no reportable findings or recommendations.

Quality Management

The purpose of this review was to evaluate whether the medical center's QM Program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center Director, Chief of Staff, Chief Nurse Executive, and QM personnel. We evaluated plans, policies, and other relevant documents.

Findings. We found that the QM Program was generally effective and provided comprehensive oversight of the quality of care in the medical center. Appropriate review structures were in place for all program activities reviewed. Generally, when problems were identified, actions were taken and adequately evaluated. We found good senior management support and clinician participation. We had no reportable findings or recommendations.

Survey of Healthcare Experiences of Patients

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

Findings. The following graphs show the medical center's SHEP results for inpatients and outpatients:

Carl T. Hayden VA Medical Center INPATIENT SHEP RESULTS									
FY 2006 Quarters 1 and 2	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	81.31	78.63	89.95	68.02	65.8	75.85	83.41	74.49	**
VISN	81.10	78.30	90.70	67.90	66.80	77.6+	75.00	72.6+	**
Medical Center	85.1+	81.3+	91.9+	69.30	68.00	78.40	75.50	71.00	**

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

Carl T. Hayden VA Medical Center OUTPATIENT SHEP RESULTS											
FY 2006 Quarter 3	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.9	77.00	94.6	72	83	75.1	81.1	64.4	81.3	80.8	84.1
VISN	78.4	78.40	93.3	70.5	82.8	73.3	79.4	58.2	79.7	78.4	81.4
Outpatient Clinics - Overall	94.6	71.50	87.5	67.5	81.7	66.9	80.5	72.3	76.1	71.9	78.2

The medical center Director was aware of the SHEP report results for the first and second quarters of FY 2006, and results had been communicated to the employees. Medical center analysis of the survey results identified four areas targeted for improvement. The medical center developed action plans based on these results to improve patient access to appointments, emotional support, education and information, and pharmacy pick-up services. Action plans have been implemented for areas identified as needing improvement. We had no reportable findings or recommendations.

Appendix A

VISN Director's Comments

Department of Veterans Affairs **Memorandum**

Date: January 4, 2007

From: Network Director, VISN 18 (10N18)

Subject: **CAP Review of the Carl T. Hayden VA Medical Center, Phoenix, Arizona**

To: Assistant Inspector General for Healthcare Inspections

THRU: Director, Management Review Service (10B5)

I concur with the facility response, and all actions are completed. See Medical Center Director's Comments for specific actions. For questions, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18 at 602.222.2692.

Patricia A. McKlem

PATRICIA A. MCKLEM

Network Director

Appendix B

Medical Center Director's Comments

Department of Veterans Affairs **Memorandum**

Date: December 27, 2006

From: Medical Center Director, Carl T. Hayden VA Medical Center (644/00)

Subject: **CAP Review of the Carl T. Hayden VA Medical Center, Phoenix, Arizona**

To: VHA Management Review Service (10B5), VA Central Office, Washington, DC

Thru: Network Director, VA Southwest Health Care Network (10N18), Mesa, AZ

1. The recommendations made during the Office of Inspector General Combined Assessment Program Review conducted November 13–17, 2006, have been reviewed, and our comments and implementation plan are noted below. All actions have been completed.

2. We would like to commend the OIG CAP Review Team that conducted our review. The team, led by Karen Moore and including team members Dr. Wilma Reyes, Marilyn Walls, and Linda DeLong, was consultative and professional and provided excellent feedback to our staff.

3. If you have any questions, please contact Sally Compton, QM Program Manager, Quality Management Department at 602.277.5551, ext. 6777.

(original signed by:)

DONALD F. MOORE, RPh, MBA

Medical Center Director

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

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to improve interventions and education for weight control management, document diabetes risk factors, monitor and provide intervention for elevated HbA1c, and monitor and manage blood pressure.

Concur **Target Completion Date:** Completed

Provide appropriate intervention and education for weight management:

- An instruction letter was mailed to 270 veterans who were currently prescribed atypical antipsychotic medications. Patients are instructed to report to the Mental Health Clinic for weights, blood pressure monitoring, and laboratory testing required at specific intervals.
- Monitoring for weight management of veterans with Body Mass Index (BMI) greater than 29 was implemented with a nutrition consult generated for completion of the VA MOVE multifactor assessment.
- Referrals are available for education by the Diabetes Nurse Educators. Class attendance by patients is currently tracked through the Patient Education Services.

Document risk factors for diabetes in the medical record:

- Beginning November 1, 2006, all Psychiatrists were required to begin use of the standardized template in CPRS for documentation of diabetic risk factors and initial monitoring of metabolic changes associated with prescribing an atypical antipsychotic medication. The diabetic risk factor documentation on the template includes family history of diabetes, weight management, glucose testing, lipid and hypertension management, and patient education.
- Additionally, a baseline blood sugar and cholesterol, height, weight, and blood pressure are obtained and documented on the template during the initial patient visit.
- Atypical Antipsychotic Order Sets were designed to immediately follow the CPRS template. The order sets include laboratory tests for fasting blood sugar, fasting lipid panel, and HgbA1c. The order sets also automatically generate a consult to Nutrition Services for Diabetic Education classes, if appropriate.
- Pharmacy maintains a database of all patients on atypical antipsychotic medications. Each month, Pharmacy generates a list for Psychiatry Service to monitor the documentation of interventions provided for the treatment of weight control, diabetes, hypertension, and cholesterol in patients prescribed the atypical antipsychotic medications.

Monitor and provide intervention for elevated HbA1c in all patients with diabetes who are receiving atypical antipsychotic medications:

- In addition to the automatic order sets that follow the CPRS template for documentation previously described, an atypical antipsychotic monitoring graph is available to all CPRS authorized users in order to monitor HgbA1c and intervene as appropriate in the patient's care and treatment.

- The values graphed include the name of the antipsychotic medication, prescription duration, patient weight, glucose, HgbA1c, and LDL Cholesterol (both calculated and direct).

And to monitor and manage blood pressure:

- As stated previously, an instruction letter was mailed to 270 veterans that were currently prescribed atypical antipsychotic medications. New patients will also receive the same letter. Patients are instructed to report to the Mental Health Clinic for weights, blood pressure monitoring, and laboratory testing required at specific intervals.
- Based on the patient's history, the CPRS provider template allows for ongoing evaluation of the patient who has a current prescription for ACE-I for control of blood pressure.
- Blood pressures are monitored at each patient visit. Significant changes in blood pressure at any visit require an evaluation by the psychiatrist in the mental health clinic.

Patient education programs implemented by mental health staff have been designed to provide education regarding the relationship of the use of atypical antipsychotic medication, body weight, diabetes, blood pressure medication management, and the importance of ongoing monitoring to maintain both emotional and physical health.

Appendix C

OIG Contact and Staff Acknowledgments

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

Appendix D

Report Distribution

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Director, Carl T. Hayden VA Medical Center (644/00)

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