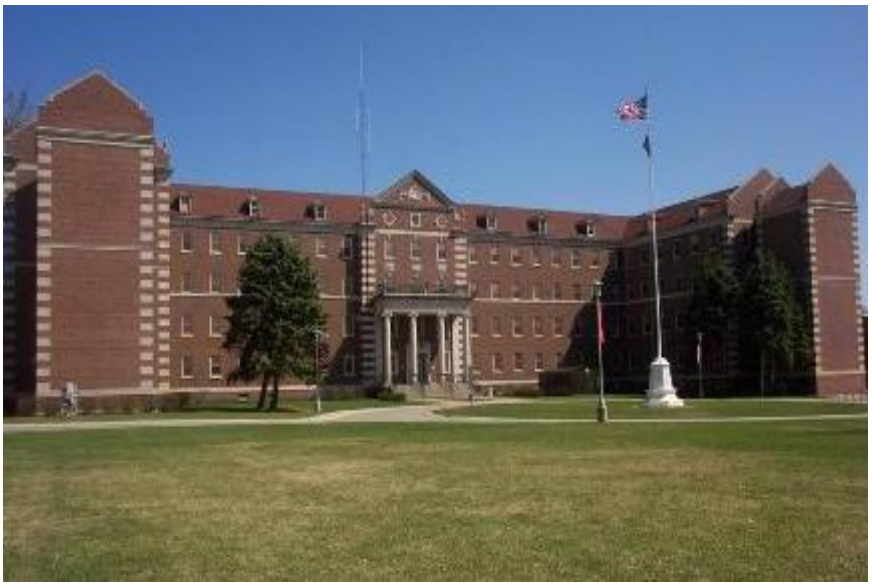
Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-00169-166

Combined Assessment Program Review of the Fargo VA Medical Center Fargo, North Dakota



July 11, 2007

Washington, DC 20420

Why We Did This Review

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 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 April 30–May 4, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Fargo 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 136 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 23.

Results of the Review

The CAP review covered five operational activities. We identified the following organizational strength and reported accomplishment:

- Collaborative Surgical Communication.

We made recommendations in one of the activities reviewed, business rules governing computerized patient record system (CPRS). For this activity, the medical center needed to:

- Update business rules as necessary, and delete business rules no longer in use.
- Perform a periodic review of all business rules to ensure full compliance with Veterans Health Administration (VHA) policy.

The medical center complied with selected standards in the following four activities:

- Community Based Outpatient Clinic (CBOC).
- Environment of Care (EOC).
- QM.
- Survey of Healthcare Experiences of Patients (SHEP).

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

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, pages 9–11, for the full text of the Directors' comments.) We consider all actions appropriate and completed and all recommendations closed.

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

Introduction

Profile

Organization. The medical center is a primary care facility that is part of VISN 23 and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four CBOCs in Grafton, Bismarck, and Minot, ND, and in Fergus Falls, MN. A new CBOC is scheduled to open in Bemidji, MN, in July 2007. There are three VA outpatient clinics located in Williston, Jamestown, and Dickinson, ND. The medical center serves a veteran population of approximately 89,000 in a primary service area that includes 53 counties in North Dakota, 19 counties in Minnesota, and 2 counties in South Dakota.

Programs. The medical center provides medical, surgical, mental health, and extended care services. It has 59 hospital beds and 50 Nursing Home Care Unit (NHCU) beds and operates referral and treatment programs, including the Healthcare for Homeless Veterans Program, the Substance Abuse Treatment Program, and the Partial Hospitalization Program. The medical center also has sharing agreements with the United States Air Force, 5th Medical Group, Minot Air Force Base, Minot, ND, and the 319th Medical Group, Grand Forks Air Force Base, Grand Forks, ND.

Affiliations. The medical center is affiliated with the University of North Dakota School of Medicine and Health Sciences and supports 22 medical resident positions in internal medicine, surgery, and psychiatry. The medical center is affiliated with other colleges and universities to train nursing and other allied health students.

Resources. In fiscal year (FY) 2006, medical care expenditures totaled $97.5 million. The FY 2007 medical care budget is $110 million, 2.5 percent more than FY 2006. In FY 2006, the medical center had 647 full-time employee equivalents (FTE), including 40 physician and 157 nursing FTE.

Workload. During FY 2006, the medical center treated 26,685 unique patients. The average inpatient daily census was 28, and the average NHCU daily census was 30. The outpatient workload was approximately 145,500 visits.

Objectives and Scope

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 administration 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 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 five activities:

- Business Rules.
- CBOC.
- EOC.
- QM.
- SHEP.

The review covered medical center operations for FY 2006 and FY 2007 through April 30, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Fargo, North Dakota,* Report No. 04-03071-62, January 6, 2005).

During this review, we also presented fraud and integrity awareness briefings for 136 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. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities without Recommendations" section have no reportable findings.

Organizational Strength

Collaborative Surgical Communication

The medical center's Surgical Service developed communication processes that facilitate clear and timely communication among the surgical team. One of the Joint Commission's[1] patient safety goals is to improve the effectiveness of communication among caregivers, because poor communication is often cited as a factor in health care adverse events and close calls.

One communication process includes a preoperative and postoperative debriefing that utilizes a tool containing the key communications that need to occur among the surgical team. Surgical Service collects and analyzes data from this tool for performance improvement. This process has standardized communication, resulting in improved patient care.

All general surgery staff, surgical residents, medical students, anesthesia staff, operating room nurses, and the surgery scheduler attend weekly preoperative rounds to thoroughly discuss every scheduled elective case for the next week. This collaborative process has led to improved efficiencies and quality initiatives and has been an instrumental factor in the medical center's consistently positive outcomes with the National Surgical Quality Improvement Program.

Results

Review Activities with Recommendations

Business Rules

The purpose of this review was to determine whether business rules governing CPRS comply with VHA policy. CPRS business rules define what functions certain groups or individuals are allowed to perform in the health record. We

[1] The Joint Commission was formerly called the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

reviewed VHA and medical center information and technology policies and interviewed the CPRS Clinical Coordinator. We found four rules that needed to be deleted.

The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records,* issued August 25, 2006, includes both the electronic medical record and the paper record. It includes items, such as physician orders, progress notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes—all accurately reflecting the time and date recorded.

On October 20, 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. The OI 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." Following this guidance, OI has recommended that any editing of signed records be limited to the medical center's Privacy Officer. On June 7, 2006, VHA issued a memorandum to all VISN Directors, instructing all VA medical centers to comply with the informational patch sent in October 2004.

Although the medical center had reviewed their CPRS business rules following the issuance of the guidance and had deleted rules, we found four rules that allowed editing of a signed note by users other than the author. Medical center staff took action to remove these business rules while we were onsite.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires program staff to update business rules as necessary, and delete business rules no longer in use.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that they have taken appropriate actions to remove the identified business rules that allowed editing. The Clinical Applications Coordinator is responsible for ensuring that CPRS business rules are current and updated when indicated. The

improvement plan is acceptable, and we consider the issue resolved.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires program staff to perform periodic reviews of all business rules to ensure full compliance with VHA policy.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that CPRS business rules will be reviewed annually and at the time any changes occur in VHA policy. The medical center has assigned oversight responsibility to the Clinical Informatics Council. The improvement plan is acceptable, and we consider the issue resolved.

Review Activities without Recommendations

Community Based Outpatient Clinic

The purpose of this review was to assess the effectiveness of CBOC operations and to determine whether CBOCs are in compliance with selected standards of operation.

We selected the CBOC located in Grafton, ND, for review. We interviewed key staff at the medical center and the CBOC; reviewed documentation and self-assessment tools; and reviewed credentialing, education, and background checks for five selected clinicians. Two medical provider and three nurse files were selected for review. All files contained documentation of licensure, credentialing, mandatory education, and background checks.

We interviewed 10 patients who were being treated at the CBOC the day of our inspection. All the patients reported a high level of satisfaction with their providers and the care they receive at the CBOC. We reviewed the management of patients on warfarin and found evidence that the same standards of care provided to patients at the medical center are in effect at the CBOC. Mental health services are provided at the CBOC by a nurse practitioner.

We also inspected the CBOC's EOC. The facility was clean and safe with current emergency preparedness plans in place. Staff were educated in and knowledgeable about providing emergency care to patients.

We found that the CBOC was in compliance with all expected regulations and standards. We made no recommendations.

Environment of Care

The medical center maintained a generally clean and safe environment. The medical center is required to establish a comprehensive EOC program that fully meets the National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards. We inspected waiting areas, occupied and unoccupied patient rooms, bathrooms, outpatient examination rooms, and the supply and processing distribution area. Areas were well maintained, and managers conducted regular EOC rounds.

We evaluated the infection control program to determine compliance with VHA directives, which require management to collect and analyze data to improve performance. The infection control program appropriately monitored, trended, analyzed, and reported infection control data to clinicians for implementation of quality improvements. We made no 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, Associate Director for Patient Care, and QM personnel. We also evaluated plans, policies, and other relevant documents. For the purpose of this review, we defined a comprehensive QM program as including the following program areas:

- QM and performance improvement (PI) committees, activities, and teams.
- Patient safety functions (including healthcare failure mode and effects analyses, root cause analyses, aggregated reviews, and patient safety goals).
- Risk management (including disclosure of adverse events and administrative investigations related to patient care).
- Utilization management (including admission and continued stay appropriateness reviews).
- Patient complaints management.
- Medication management.

- Medical record documentation reviews.
- Blood and blood products usage reviews.
- Operative and other invasive procedures reviews.
- Reviews of patient outcomes of resuscitation efforts.
- Restraint and seclusion usage reviews.
- Advanced clinic access reviews.
- Efficient patient flow reviews.

We evaluated monitoring and improvement efforts in each of the program areas through a series of data management process steps. These steps were consistent with Joint Commission standards and included:

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

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

We found that the QM program provided comprehensive oversight of the quality of care. We found good senior management support and clinician participation. Senior managers had revised committee structure and reporting processes, resulting in improved flow of communication. Generally, when problems were identified, actions were taken and adequately evaluated. We made no recommendations.

Survey of Healthcare Experiences of Patients

The SHEP scores either met national targets, or the system had initiated improvement plans in areas where targets were not met. Veteran patient satisfaction surveying is 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 its

patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. VHA set FY 2006 SHEP target results of patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. The following tables show the system's inpatient and outpatient SHEP results compared to VISN 23 and national survey results:

Fargo VA Medical Center
3rd and 4th Quarters FY 2006

INPATIENT SHEP RESULTS

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	81.35	78.90	89.90	67.92	65.97	75.95	83.43	74.66	70.11
VISN 23	84.7+	80.8+	90.20	68.10	66.00	76.00	85.7+	74.80	69.60
Fargo VAMC	90.2+	85.2+	92.1+	72.2+	68.20	76.90	89.1+	77.4+	65.1-

Fargo VA Medical Center
1st Quarter FY 2007

OUTPATIENT SHEP RESULTS

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	81	77.8	94.9	72.7	83.5	75.7	82	65.3	82	81.1	84.8
VISN 23	83.8+	76.4	96.3	72.7	84.8	74.2	84.7	70	82.2	83.6	87.6+
Fargo Outpatient Clinics-Overall	87	78.8	96.6	78.6	84.3	81	79.5	55.4	84.2	83.1	89.3
Fargo Outpatient Clinic	86.9	81.7	97	79.5	84.2	81.7	78.6	*	84.5	83.3	88.9
Grafton, ND, Outpatient Clinic	92.8+	74	97	79.3	85.7	81.2	84.7	*	86.4	*	92.4+
Bismarck, ND, Outpatient Clinic	82	50-	93.2	67.7	80.5	72.4	79.2	*	77.7	*	89.3
Fergus Falls, MN, Outpatient Clinic	92.8+	79.2	96.2	81.4+	90.7+	84.9+	89.1	*	91+	85.3	93.4+
Minot, ND, Outpatient Clinic	90.9+	77.2	95.6	79.2	89.6	80.8	83.5	*	86.9	*	94.5+

** Less than 30 Respondents*
"+" *Results are Significantly Better than the National Average*
"-" *Results are Significantly Worse than the National Average*

The medical center continuously strives to improve patient satisfaction and SHEP scores. Results are analyzed by the PI Council and the Customer Service Committee. Managers have shared SHEP results with employees through e-mail, service level meetings, posting of results in patient care areas, and the medical center newsletter. Employees receive customer service training, and customer service standards are included in performance evaluations. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 21, 2007

From: Director, Veterans Integrated Service Network (10N23)

Subject: **Combined Assessment Program Review of the Fargo VA Medical Center, Fargo, ND**

To: Director Kansas City Healthcare Inspections Division (54KC)

Director, Management Review Office (10B5)

I have reviewed and concurred with the findings and recommendations outlined in the Combined Assessment Program report. The Fargo VA Medical Center has implemented the improvement actions.

(original signed by:)
ROBERT A. PETZEL, MD

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 21, 2007

From: Director, Fargo VA Medical Center (437/00)

Subject: **Combined Assessment Program Review of the Fargo VA Medical Center, Fargo, ND**

To: Director, Veterans Integrated Service Network (10N23)

Findings and recommendations from the Fargo VAMC Combined Assessment Program review have been reviewed with corrective actions completed.

ROBERT P. McDIVITT, FACHE

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 recommended that the VISN Director ensure that the Medical Center Director requires program staff to update business rules as necessary and delete business rules no longer in use.

Concur

Action was taken immediately at the time of the Combined Assessment Program review to remove the identified business rules that allowed editing. The Clinical Applications Coordinator is assigned to ensure CPRS business rules are maintained current and to coordinate updates as indicated. This is delineated in the role and responsibilities of the position. **Action completed on June 1, 2007.**

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires program staff to perform periodic reviews of all business rules to ensure full compliance with VHA policy.

Concur

An annual review of CPRS business rules and review at the time of any changes occurring in VHA policy has been established with oversight assigned to the Clinical Informatics Council. **Assignment action completed June 11, 2007.**

OIG Contact and Staff Acknowledgments

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