Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the St. Cloud VA Medical Center St. Cloud, Minnesota

Report No. 07-00708-170

July 18, 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 and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

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

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

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Executive Summary

Introduction

During the week of February 26–March 2, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the St. Cloud VA Medical Center (the medical center), St. Cloud, MN. The purpose of the review was to evaluate selected operations, focusing on quality management (QM) and patient care administration. During the review, we provided fraud and integrity awareness training to 208 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 23.

Results of Review

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

- Survey of Healthcare Experiences of Patients (SHEP).
- Community based outpatient clinics (CBOCs).
- Patient transportation services (follow-up from the previous CAP review).

We identified the following organizational strengths:

- Community partnership event wins Veterans Health Administration (VHA) award.
- Scheduling call center surpasses timeliness goal.

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

- Establish an effective peer review process that complies with VHA policy.
- Ensure that computerized patient record system (CPRS) business rules comply with VHA policy and Office of Information (OI) guidance.
- Replace rope-style emergency call system cords in the medical center.

This report was prepared under the direction of Ms. Verena Briley-Hudson, Director, and Ms. Wachita Haywood, Associate Director, Chicago Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 9–12, for the full text of the Directors' comments.) We will follow up on planned improvement actions until they are completed.

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

Introduction

Medical Center Profile

Organization. Located in St. Cloud, MN, the St. Cloud VA Medical Center provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two CBOCs located in Brainerd and Montevideo, MN. The medical center is part of VISN 23 and serves a veteran population of about 60,029 veterans in a primary service area that includes 18 counties the State.

Programs. The medical center provides medical, acute and chronic mental health, extended care, and outpatient specialty care services. There are 15 operating (35 authorized) hospital beds, 45 Psychosocial Residential Rehabilitation Treatment Program (PRRTP) beds, 103 Domiciliary Residential Rehabilitation Treatment Program (DRRTP) beds, and 217 Nursing Home Care Unit (NHCU) beds. The medical center has no sharing agreements; however, fee-basis services are provided by St. Cloud Hospital, St. Joseph's Medical Center in Brainerd, and Chippewa County-Montevideo Hospital in Montevideo.

Affiliations and Research. The medical center provides training opportunities for students in registered and licensed practical nursing, physical and occupational therapies, chaplaincy, social work, pharmacy, dietetics, and psychology. In fiscal year (FY) 2006, the medical center's research program had four active studies and two new studies submitted for consideration. The medical center has a general post fund for research and education. An important area of research is post-traumatic stress disorder.

Resources. In FY 2006, medical care expenditures totaled $112.6 million. FY 2007 staffing includes 985.9 full-time equivalent (FTE) employees, including 27.2 physician and 312.2 nursing FTE.

Workload. In FY 2006, the medical center treated 30,210 unique patients, a 5.6 percent increase from FY 2005. The inpatient care workload included 799 discharges. There were 315 PRRTP discharges, 498 DRRTP discharges, and 669 NHCU discharges. The average daily census, including NHCU patients, was 326. The outpatient workload was 238,257 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 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 QM and patient care administration. QM is the process of monitoring the quality of care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. In addition, we conducted follow-up on selected aspects of our previous CAP review (*Combined Assessment Program Review of the VA Medical Center, St. Cloud, Minnesota*, Report No. 04-00059-110, March 18, 2004).

It is of note that VHA's Office of the Medical Inspector (OMI) published a report March 13, 2007, titled *Final Report: Site Visit to the Minneapolis Veterans Affairs Medical Center and the St. Cloud Veterans Affairs Medical Center, Department of Veterans Affairs, VISN 23*. This report covered the circumstances of the healthcare delivered to, and the suicide of, an Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veteran who had been receiving care from the Minneapolis VA Medical Center and had sought care at the St. Cloud VA Medical Center. The OIG also issued a report on the same case, titled *Healthcare Inspection – Review of the Care and Death of a Veteran Patient, VA Medical Centers St. Cloud and Minneapolis, Minnesota*, 07-01349-127, issued May 10, 2007. Because of the issues involved in this case, follow-up will be done separately and is not being done as part of this CAP report.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered selected aspects of the following programs and activities:

CBOCs	Patient Transportation Services
CPRS Business Rules	QM Program
Environment of Care	SHEP

The review covered medical center operations for FY 2006 and FY 2007 through February 23, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews.

During this review, we also presented three fraud and integrity awareness briefings attended by 208 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. Some reviews with no findings are not further discussed. Areas needing improvement are discussed in the "Opportunities for Improvement" section (pages 4–6).

Results of Review

Organizational Strengths

Community Partnership Event Wins Veterans Health Administration Award

In August 2005, the medical center partnered with 59 local businesses and organizations to host the first Operation Welcome Home event honoring returning Operation Enduring Freedom/Operation Iraqi Freedom veterans. During this event, both veterans and their families were honored for their service and sacrifices. Participants attended educational sessions on accessing VA benefits, health care, and services and sessions on readjustment and stress management. The medical center continues to be actively involved with ongoing outreach efforts. Since the event, the medical center has enrolled over 1,380 veterans of these conflicts.

As a result of their efforts, in August 2006, the medical center received a first place award in the national VHA Excellence in Public Affairs Awards Program competition in the category of Communications Programs – Special Events.

Scheduling Call Center Surpasses Timeliness Goal

The medical center established a performance measure of answering incoming telephone calls that come into the Primary Care/Specialty Care scheduling call center within 90 seconds or less. With a target score of 80 percent, the medical center has consistently met or exceeded the measure. During FY 2006, the call center received 9,098 more calls than in FY 2005. Despite the increased volume, call center staff increased the percentage of calls answered within 90 seconds or less by 21 percent during the same time frame.

Opportunities for Improvement

Quality Management Program

Condition Needing Improvement. The QM program was comprehensive and generally effective in providing oversight of the quality of care. Senior managers actively supported and participated in the program's activities. We identified one program area that required management attention.

Peer Review. The peer review process did not include all components required by VHA Directive 2004-054, *Peer Review for Quality Management*.[1] Peer review is a confidential, non-punitive, and systematic process to evaluate the quality of care at the individual provider level. The peer review process includes an initial review by a peer of the same discipline to determine the level of care,[2] with subsequent Peer Review Committee (PRC) evaluation and concurrence with the findings.

Education. VHA policy requires that all individuals involved in the peer review process receive formal education regarding the peer review process, their responsibilities, and the medical center's legal and ethical requirements. Clinical staff members of the Medical Executive Board function as the PRC, and all clinical staff at the medical center may serve as peer reviewers. None had received this education.

Timeliness. VHA policy requires that initial peer reviews must be completed within 45 days from the date of determination that a peer review is necessary. Of the six peer reviews initiated since January 2006, two were not completed within this timeframe. One required 5 months to complete, and the second required 9 months to complete. VHA policy requires that final evaluations by the PRC be completed within 120 days from the date of determination that a peer review is necessary. VHA policy also requires that initial peer reviews resulting in a Level 2 or 3 be evaluated by the PRC. None of the six peer reviews had been evaluated by the PRC, and three of those peer reviews were designated Level 3 by the initial peer reviewer.

Documentation. VHA policy requires that formal discussions about peer reviews be recorded in formal meeting minutes. The medical center's PRC had no recorded minutes for the 12 months prior to this CAP review.

Quarterly Tracking. VHA policy requires that quarterly tracking of peer reviews include the number of reviews, outcome levels, number of changes from one level to another,

[1] Issued September 24, 2004.
[2] Peer review levels: Level 1 – Most experienced, competent practitioners would have managed the case similarly; Level 2 – Most experienced, competent practitioners might have managed the case differently; Level 3 – Most experienced, competent practitioners would have managed the case differently.

follow-up actions, and recommendations that result from completed peer reviews. There was no tracking of peer review activity.

When conducted systematically and credibly, peer reviews can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual providers' practices. When peer review is not conducted in accordance with policy, managers cannot be assured that patients consistently receive treatment and services according to accepted community standards.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to establish an effective peer review process that complies with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that they are developing processes to comply with VHA peer review policy. We will follow up on the planned actions until they are completed.

Computerized Patient Record System Business Rules

Condition Needing Improvement. We found that one medical center business rule was not in compliance with VHA and medical center information and technology policies. A software informational patch was sent from the VHA OI on October 20, 2004, to all medical centers, addressing a number of issues relating to the editing of electronically signed documents in the Veterans Integrated Health Systems Technology and Architecture system. 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." 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.

Business rules define what functions certain groups or individuals are allowed to perform in CPRS. OI has recommended institution of a VHA-wide software change that limits the ability to edit or delete a signed medical record document to the medical center's Privacy Officer. The medical center had one rule that allowed the deletion of a medical record document by a clinical coordinator. The medical center staff took action to remove this business rule during the CAP review.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that CPRS business rules comply with VHA policy and OI guidance.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that the business rule allowing deletion of a medical record document by a clinical coordinator was removed February 28, 2007, and the medical center is in

compliance with VHA policy and OI guidance. We consider this recommendation closed.

Environment of Care

Condition Needing Improvement. VHA policy requires that medical centers be clean, sanitary, and maintained to optimize infection control and patient safety. We inspected four inpatient units, four primary care areas, and the CBOC in Brainerd. Employees at all levels were committed to keeping the medical center clean and effectively maintained. Infection control practices were consistent, and during FY 2006, the hospital-acquired rate for Methicillin-resistant Staphylococcus Aureus infection was 0.0002 per 1000 bed days of care. We identified one condition that required management attention.

Emergency Call System Cords. Emergency call system cords must be accessible and easily cleaned, as they are often located in shower areas and near commodes and sinks. The medical center generally used plastic cords; however, we observed rope-style emergency call system cords, which are difficult to clean, in public restrooms in the primary care area. We recommended that the rope-style cords be replaced with the same type of plastic cords used in the inpatient units.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires all rope-style emergency call cords to be replaced.

The VISN and Medical Center Directors agreed with the finding and recommendation and reported that Facilities Management Service completed the emergency call cord installation on March 15, 2007. We consider this recommendation closed.

Other Areas Reviewed

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, as defined by patients. In 1995, VHA began surveying patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. The Performance Analysis Center for Excellence of the Office of Quality & Performance is the analytical, methodological, and reporting staff for the SHEP. Performance Measure 21 of the VHA Executive Career Field Performance Plan for FY 2006 states that in FY 2006, the percent of patients reporting overall satisfaction as Very Good or Excellent will meet or exceed targets for the performance period October 2005–June 2006 in: (Figures in the tables below represent percentages %).

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

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

St. Cloud VAMC Inpatient SHEP Results

	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	81.35	78.90	89.90	67.92	65.97	75.95	83.43	74.66	70.11	**
VISN	84.70	80.80	90.20	68.10	66.00	76.00	85.70	74.80	69.60	**
Medical Center	86.90	86.80	91.20	70.80	67.90	84.80	78.70	76.50	71.40	**

**Not reported

St. Cloud VAMC 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	81.1	77.9	94.7	72.8	83.1	75.6	81.9	65.9	81.4	80.7	84.4
VISN	85.9	76.3	96.9	72.2	83.8	75.6	83.4	72.2	81.2	80.2	86.7
Outpatient Clinics	90.5	75.1	97.7	72.2	84	73.3	85.2	72.5	83.9	80.5	87.3

The medical center's inpatient SHEP scores were significantly better than the national averages for eight dimensions of care and were above the target score as defined by Performance Measure 21 in six of the nine dimensions reported. Outpatient SHEP scores were significantly better than the national averages for 2 dimensions of care and surpassed the target scores in 7 of 11 dimensions. SHEP results were discussed and compared with patient advocate data monthly at Customer Service Council meetings. SHEP results were communicated to employees through town hall meetings, service-level meetings, electronic mail messages, and a newsletter. The medical center Director meets with new employees during their first week of employment to emphasize the importance of customer service and conducts annual meetings with all employees in groups of 50 to inform them of medical center accomplishments and customer service initiatives. We made no recommendations.

Community Based Outpatient Clinics

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

We interviewed employees at the medical center and the Brainerd CBOC and reviewed documentation and self-assessment tools on descriptions of services provided, including the warfarin clinic. The medical center and CBOC warfarin clinics were both managed by a pharmacist, with primary care physician oversight, and maintained the same standards and expectations. CBOC patients received education from a pharmacist before they received their first dose of warfarin. Patients' laboratory values and follow-up care were managed by a pharmacist with primary care physician oversight. Patients received a brochure with a toll-free telephone number to help facilitate prompt reporting of new medications or other vital information.

The CBOC was clean and effectively maintained with no safety or infection control vulnerabilities. The emergency management plan was current, and all clinical providers were educated in and knowledgeable about rendering emergency care to veterans. All clinical providers were certified in cardio-pulmonary resuscitation. The automated electronic heart defibrillator was inspected, and functionality documentation was up to date. A review of four CBOC clinical providers' credentialing and privileging files and two CBOC nurses' official personnel folders showed that appropriate background screenings were completed.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 27, 2007

From: Network Director, VA Midwest Healthcare Network – VISN 23, Minneapolis, MN

Subject: **Combined Assessment Program Review of the St. Cloud VA Medical Center, St. Cloud, Minnesota**

To: Office of Inspector General

I have reviewed the findings of the Combined Assessment Program Review submitted from the Department of Veterans Affairs (VA) Medical Center, St. Cloud, Minnesota. I am in agreement with the findings of the review, corrective action plan, and completion dates.

If you need further information, please contact Mr. Barry Bahl, St. Cloud Medical Center Director, at (320) 255-6315.

Robert A. Petzel

ROBERT A. PETZEL, M.D.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 26, 2007

From: Director, St. Cloud VA Medical Center (656/00)

Subject: **Combined Assessment Program Review of the St. Cloud VA Medical Center, St. Cloud, Minnesota**

To: Office of Inspector General

I have reviewed the findings within the report of the Combined Assessment Program Review of the St. Cloud VA Medical Center, St. Cloud, Minnesota. I am in agreement with the findings of the review.

Corrective action plans have been established with planned completion dates, as outlined in the attached report.

(original signed by:)

BARRY BAHL

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

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to establish an effective peer review process that complies with VHA policy.

Concur **Target Completion Date:** April 30, 2007

Planned Action: Membership on the Peer Review Committee will be reviewed and changed. The Peer Review Committee will be scheduled to meet on a quarterly basis and report to the Medical Executive Board. All peer reviews completed since the last meeting will be reviewed and discussed. Minutes of the Peer Review Committee will be maintained by the secretary to the Chief of Staff. Members of the medical staff that can be assigned to perform a peer review and clerical and management staff involved in the peer review process will receive annual education regarding the peer review process, their responsibilities, and the medical center's legal and ethical requirements. This education will be conducted at a special medical staff meeting by the Chief of Staff and recorded in training records. The QM Program Analyst will continue to track all requested peer reviews and facilitate timely completion by the peer reviewers. A quarterly report will be prepared and forwarded to the Peer Review Committee.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that CPRS business rules comply with VHA policy and OI guidance.

Concur **Completion Date:** February 28, 2007

Planned Action: The business rule that had allowed the deletion of a medical record document by a clinical coordinator was removed by 2/28/07. The medical center is in compliance with VHA policy and OI guidance.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Medical Center Director requires all rope-style emergency call cords to be replaced.

Concur **Completion Date:** March 15, 2007

Planned Action: Facilities Management Service completed the installation of the nurse call cords on 3/15/07.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, Director Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	Judy Brown Paula Chapman Wachita Haywood Stefan Larese Jennifer Reed Leslie Rogers Randy Rupp

Appendix D

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