Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center Saginaw, Michigan

Report No. 07-01229-165

July 11, 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 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 16–20, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Aleda E. Lutz 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 provided fraud and integrity awareness training to 67 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 11.

Results of Review

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

- Community Based Outpatient Clinics (CBOCs).
- Survey of Healthcare Experiences of Patients (SHEP).
- QM Program.

We identified the following organizational strengths:

- Great Lakes Palliative Care Unit.
- One-Stop Telephone Service for Primary and Specialty Care.

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

- Computerized Patient Record System (CPRS) Business Rules.
- Environment of Care.

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 concurred with the CAP review findings and recommendations and provided acceptable improvement plans. (See pages 11–16 for the full text of the Directors' comments.) Based on implementation actions taken, we consider all recommendations closed.

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

Introduction

Medical Center Profile

Organization. The Aleda E. Lutz VA Medical Center provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three CBOCs located in Gaylord, Oscoda, and Traverse City, MI. The medical center is part of VISN 11 and serves a veteran population of about 170,455 in a primary service area that includes 35 counties in Michigan's Lower Peninsula.

Programs. The medical center provides primary medical, secondary medical, ambulatory surgical, primary care, skilled care, rehabilitation, geriatric, palliative, and mental health services. The medical center has 25 hospital beds, which includes an 8-bed intensive care unit (ICU). The skilled care and rehabilitation unit has 81 beds, and the palliative care unit has 9 operating beds. The medical center also offers physical medicine and rehabilitation, oncology, cardiology, pulmonary, podiatry, optometry, and ophthalmology services.

Affiliations and Research. The medical center is affiliated with Michigan State University's College of Human Medicine and with Synergy Medical Education Alliance, which provides clinical training to physician residents in internal medicine. The medical center also has affiliations with Wayne State University and with Kresge Eye Institute, which provides clinical training to ophthalmology residents. There are associated health education affiliations with Saginaw Valley State University for nurses and nurse practitioners. Additionally, the medical center has affiliations with Central Michigan University for physician assistants and dietetic interns; Ferris State University for pharmacist and optometry interns; Delta College for nurses, dental hygienists, and physical therapy assistants; Michigan State University for social workers; and the University of Florida Working Professional Doctor of Pharmacy Degree Program.

Resources. In fiscal year (FY) 2006, the medical center's medical care expenditures totaled $87.5 million. The FY 2007 medical care budget is $93.3 million (pending VISN allocation), 6 percent more than FY 2006 expenditures. FY 2006 staffing was 619.1 full-time employee equivalents (FTE), including 29 physician, 4 physician assistant, 19 nurse practitioner, 1 certified nurse anesthetist, and 208 nursing FTE.

Workload. In FY 2006, the medical center treated 25,386 unique patients, a 3 percent increase from FY 2005. The inpatient care workload totaled 1,491 discharges, and the average daily census, including skilled care and rehabilitation unit patients, was 72.3. The outpatient workload was 198,038 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 medical center 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 Aleda E. Lutz VA Medical Center, Saginaw, Michigan*, Report No. 03-03038-168, July 15, 2004).

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

CBOCs	QM Program
CPRS Business Rules	SHEP
Environment of Care	

The review covered medical center operations for FYs 2006 and 2007 through April 20, 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 67 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 that are significant enough to be monitored by the OIG until corrective actions are implemented. Areas needing improvement are discussed in the Opportunities for Improvement section (pages 5–8).

Results of Review

Organizational Strengths

Great Lakes Palliative Care Unit

Palliative care is provided for the chronically and terminally ill veteran. The name, Great Lakes Palliative Care Unit, was chosen by staff who decided to decorate the patient rooms with themes that are all related to the State of Michigan's Great Lakes. Veteran organizations and family members adopted unit rooms. Each sponsored room includes furnishings of wallpaper, wall hangings, bedspreads, valances, privacy curtains, and recliners that relate to selected themes.

The family lodge room is designed as a community room for families to visit and relax. It includes amenities, such as a refrigerator, coffee pot, and microwave. Voluntary Service staff purchase snacks and beverages through volunteer donations. The palliative care team continues to grow and learn and is excited to be able to provide end-of-life care to veterans in very pleasant surroundings.

One-Stop Telephone Service for Primary and Specialty Care

During the third quarter of FY 2006, patients and staff voiced concerns with the telephone system. Calls were delayed, misrouted to multiple locations, or dropped. Initial data showed that incoming calls were answered at a rate of 59 percent of the total call volume, which affected patients' access to care. Patient care and flow were also interrupted or delayed while staff answered incoming calls, resulting in an increase in patient waiting times. In March 2006, a process improvement team was established to address the concerns about answering incoming calls, with the goal set at a 98 percent answer rate.

Improvement actions included:

- Opening a call center in a non-patient care area.
- Adding additional telephone lines.
- Rotating clinic staff to cover the call center.
- Updating the call-in telephone number on all patient handouts.
- Rewording the incoming call message to simplify the patients' options.
- Routing all pharmacy calls to the automatic refill line.
- Training pharmacy technicians to enter progress notes into CPRS to request refills in order to decrease call transfers.
- Developing a sub-group to advertise the My Health**e**Vet Program http://www.myhealth.va.gov/.

Process improvement team results included:

- Increased staff satisfaction and process ownership.
- Reduced patient complaints.
- Increased incoming call answer rate (from 59 percent in March 2006 to 92 percent in March 2007).
- Increased medical center SHEP scores for Access to Care for the 4th quarter of FY 2006 and the 1st quarter of FY 2007.

Opportunities for Improvement

Computerized Patient Record System Business Rules

The health record, as defined in Veterans Health Administration (VHA) Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, includes both the electronic medical record and the paper record and is also known as the

legal health record. It includes items, such as physician orders, chart 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 accurately reflecting the times and dates recorded.

A software informational patch was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers, providing guidance on a number of issues relating to the editing of electronically signed documents in the electronic medical record. 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." On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all 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 the medical record. The OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed electronic medical record to the medical center's Privacy Officer. We reviewed VHA policy and interviewed Information Resource Management Service staff.

Condition Needing Improvement. The medical center had two business rules that allowed editing of a signed note by users other than the author. Four additional rules needed to be changed to limit retraction, amendment, or deletion of notes to the Privacy Officer or the Chief of Health Information Management Service. Medical center staff took immediate action to edit and remove these business rules.

Recommendation 1. We recommended that the VISN Director ensure the Medical Center Director requires compliance with VHA policy and the October 2004 OI guidance.

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. Medical center staff removed or changed the identified business rules by April 17, 2007. Based on these actions, we consider this recommendation closed.

Environment of Care

Conditions 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, the Ambulatory Procedure Unit, the canteen food service area, and the Gaylord CBOC. Managers were responsive to our concerns and took immediate steps to address deficiencies. We identified the following conditions that required management attention.

Emergency Call System Cords. Emergency call system cords, often located in shower areas and near commodes and sinks, must be accessible and easily cleaned. We observed rope-style emergency call system cords, which are difficult to clean, in patient and public restrooms throughout the medical center. We also identified that some cords were too short to be accessible from the floor. We recommended that the rope-style cords be replaced with plastic cords that are easily cleaned and accessible from the floor.

Gaylord CBOC's public restrooms had push buttons located above handrails to activate the emergency call system. We recommended that cords be installed so that the system is accessible from the floor.

Patient Privacy. Patients' personal health information must be protected from unauthorized access. On two inpatient care units, we observed staff using clipboards located at the foot of the beds to document vital signs and other health care information. Some of the documents had the patient's name, full social security number, and date of birth. We recommended that sensitive patient information be protected from unauthorized access.

Cleaning Practices. To determine the effectiveness of cleaning, we inspected unoccupied inpatient rooms that had been prepared for new admissions on all units. Improved floor cleaning, especially along baseboards and in corners, on the medical unit, and in the ICU, was needed. There was dust accumulation on top of cardiac monitors in the ICU. Tray table bases in the skilled care and rehabilitation unit required better cleaning. We recommended that managers ensure that housekeeping staff address these problematic areas when cleaning patient rooms.

Hazard Surveillance Inspections. Medical center policy requires that all direct patient care areas, including CBOCs, be inspected semiannually by a team comprised of the Safety Manager, the Chief of Facilities Management Service (or designee), an American Federation of Government Employees representative (when scheduling permits), a housekeeping representative, an Infection Control nurse, the Patient Safety Manager, and an area supervisor. The inspection schedule shows that only annual inspections were done. We recommended that hazard surveillance inspections be conducted semiannually.

Canteen Food Service. We inspected the Veterans Canteen Service (VCS) food service area as a follow-up to deficiencies identified during our previous CAP review. In the food service kitchen, there was a double sink being used for multiple purposes, which may present a cross-contamination risk if not cleaned and sanitized between uses. One side of the sink had a container with lettuce soaking in water, and the other side of the sink had the remains of ice that was used to keep egg products cold. The ice was visibly contaminated with egg product. Dirty food preparation pans were placed on the ice machine cabinet and on the floor near the pot and pan sink. The trash receptacle in the area was full and uncovered. Empty cardboard boxes were on the floor under the food preparation sink. There were broken wall tiles behind the ovens/warmers. There was a

large hole in a window behind the ovens/warmers. A mop and bucket were stored near the food preparation area. We recommended that managers address these issues and perform more frequent inspections of the food service area to ensure compliance with VCS food service standards.

Recommendation 2. We recommended that the VISN Director ensure the Medical Center Director requires that rope-style emergency call system cords be replaced with plastic cords that are accessible from the floor; sensitive patient information is protected from unauthorized access; cleaning practices are reinforced with housekeeping staff; hazard surveillance inspections are conducted semiannually; and VCS maintains food service standards.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. Managers initiated actions to replace and correct rope-style emergency call systems cords, protect sensitive patient information at the bedside, reinforce housekeeping cleaning practices, conduct semiannual inspections at the CBOCs, and ensure food service standards are maintained in the VCS. Based on these actions, 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:

	Meets Target Percent	**Exceeds Target Percent**
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:

Aleda E. Lutz VAMC Inpatient Q3 & Q4 FY 2006 SHEP Results										
Saginaw, MI	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	82.30	78.80	90.10	68.10	66.00	75.00	84.10	75.20	69.50	**
Medical Center	88.7+	85.2+	93.2+	72.3+	75.3+	79.00	91.8+	80.2+	81.1+	**

**Not reported

+Significantly better

Aleda E. Lutz VAMC Outpatient Q1 FY 2007 SHEP Results											
Saginaw, MI	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	82.4	78.8	94.7	71.3	82	75.9	83.4	67.4	81.7	81.6	85.1
Outpatient Clinics	86.3	78.5	95.4	74.8	86.6	80.1	91	75.6	83	81.5	88.9

The medical center's inpatient SHEP scores were significantly better than national averages for eight dimensions of care and were above the target score as defined by Performance Measure 21 in seven of the nine dimensions reported. Outpatient SHEP scores surpassed the target score in 9 of 11 dimensions. SHEP results were compared with patient advocate data. SHEP results were communicated to employees through town hall meetings, service-level meetings, electronic mail, and newsletters and posted in the lobby and on unit display boards. Medical center managers identified problems with provider wait times (Access) at the Gaylord CBOC and took immediate action to resolve the issues. The interventions worked so well that managers implemented similar improvements at other CBOCs, resulting in an increased SHEP score for Access. We did not make any 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, and 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 Gaylord CBOC and reviewed documentation and self-assessment tools regarding descriptions of services provided, including warfarin clinic services. The medical center and CBOC warfarin clinics were managed by a pharmacist, with primary care physician oversight, and maintained the

same standards and expectations. 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 facility was clean and effectively maintained. 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. We inspected the automated electronic heart defibrillator operational documentation and found that it was up to date. A review of three CBOC clinical providers' credentialing and privileging files and two CBOC nurses' official personnel folders showed that appropriate background screenings were completed. We did not make any recommendations.

Quality Management Program

To evaluate QM activities, we interviewed managers and evaluated plans, policies, and other relevant documents. We also evaluated monitoring and improvement efforts in each of the program areas, consistent with Joint Commission[1] standards. These efforts included the following:

- Identifying problems or potential improvements.
- Gathering and critically analyzing the data.
- Comparing the data analysis with established goals and 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 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 medical center compliance with VHA guidance.

We found that the QM program provided comprehensive oversight of the quality of care. Generally, when problems were identified, actions were taken and adequately evaluated. We found excellent senior management support and clinician participation. We did not make any recommendations.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 9, 2007

From: Network Director, VISN 11 (10N11)

Subject: **Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Per your request, attached is the status report from Saginaw VAMC. If you have any questions, please contact Jim Rice, VISN 11 QMO, at (734) 222-4314.

(original signed by:)
Linda W. Belton, FACHE

Attachment

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 3, 2007

From: Medical Center Director, Saginaw VA Medical Center (655/00)

Subject: **Combined Assessment Program Review of the Aleda E. Lutz VA Medical Center, Saginaw, Michigan**

To: Director, Chicago Office of Healthcare Inspections (54CH)

1. We appreciate the opportunity to review the draft report of the CAP review completed April 16–20, 2007, for the Aleda E. Lutz VA Medical Center in Saginaw, Michigan.

2. Attached are comments regarding actions taken to complete identified items and those that are currently in process to improve and resolve non-compliance in areas cited. Many of the cited areas were resolved during the time of the audit.

3. It should be noted that the IG Team Leader and Team that conducted the audit did it in a very professional and collegial manner that lent the site visit to be a truly productive one for the VA.

4. If you have any questions regarding the content of this report, please contact me at (989) 497-2500, extension 13000.

(original signed by:)
GABRIEL PÉREZ

Attachment

cc: Ms. Margaret Seleski, Director, Management Review Service (10B5)

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 recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA policy and the October 2004 OI guidance.

Concur **Target Completion Date:** April 17, 2007

Planned Action: The two business rules that allowed editing of a signed note by users other than the author have been removed. Four additional rules that were identified as needing to be changed to limit retraction, amendment, or deletion of notes have been amended to allow access by only the Privacy Officer and the Chief of Health Information Management Service

Medical center staff took immediate action to remove and edit the identified business rules, and action was completed on **April 17, 2007.** A copy of the edited business rules was also provided at the same time.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that:

Rope-style emergency call system cords be replaced with plastic cords that are accessible from the floor.

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

Planned Action: Facilities Management Service had purchased a plastic-style cord as of May 1, 2007. They have started replacing all pull cords throughout the Medical Center

and at Community Outpatient clinics, which is estimated to involve replacement of over 550 cords. Installation staff will ensure that they are accessible from the floor for emergency purposes.

Sensitive patient information is protected from unauthorized access.

Concur **Target Completion Date:** April 23, 2007

Planned Action: Immediate action was taken to limit worksheets at the bedside to those that are required to document patient intake and outpatient worksheets. Nursing staff were instructed to only use the patient's first and last initial, and the last four digits of the social security number as the identifiers on these forms. There will be no other patient identifiers on these forms. This was assessed to be an appropriate and reasonable safeguard, and this is not considered a unique identifier. This change was implemented and completed on **April 23, 2007.**

Cleaning practices are reinforced with housekeeping staff.

Concur **Target Completion Date:** May 4, 2007

Planned Actions: Effective May 1, 2007, Facilities Management Service implemented the following cleaning practices to reinforce cleaning with housekeeping staff:

(1) A cleaning check sheet is being completed by the housekeeper for every room, including patient, administrative, and clinical areas.

(2) A bi-annual baseboard cleaning schedule has been established to ensure baseboard cleaning is conducted throughout the medical center on a recurring schedule to be done every 6 months during the months of May and November of each year.

(3) Recurring cleaning of bedside table bases has been added to the cleaning schedule so that they will be routinely cleaned every week.

(4) Monitoring of these cleaning practices will be checked daily by the Facilities Management Service work leaders and supervisor.

Nursing Service has added a weekly nursing assignment for every Friday to have computer/equipment monitors dusted effective May 4, 2007.

Hazard surveillance inspections are conducted semiannually.

Concur **Target Completion Date:** May 2, 2007

Planned Action: Medical Center Memorandum, Hazard Surveillance Program, has been amended to outline policy to conduct inspections semiannually in all areas of the medical center, including CBOCs. The Hazard Surveillance schedule has been changed to have scheduled dates for each of the CBOC reviews, which will be conducted by the Hazard Surveillance Team in June and November 2007.

VCS maintains food service standards.

Concur **Target Completion Date:** May 15, 2007

Planned Actions:

(1) All VCS Food Service employees have been instructed on proper food processing and handling as outlined in CSS 50-21, Chapter 3-3. Double sink will not be used for any activity other than food preparation and will be cleaned and sanitized between uses. Dirty (contaminated) waste product will be deposited in the waste disposal. All dirty pots, pans, and utensils will be delivered immediately to the cleaning/wash sink. VCS staff has been instructed to keep trash receptacles covered when not in continuous use, as stated in CSS 50-21, 3-6.

(2) A rolling rack will be purchased for use to store dirty preparation equipment and will be placed into use by **May 15, 2007.**

(3) Facilities Management has changed their routine to now pick up trash twice per day in the VCS kitchen at 9:00 a.m. and 1:00 p.m., starting on May 1, 2007.

(4) Facilities Management has replaced the broken wall tile and repaired the hole in window screen as of May 1, 2007.

(5) Weekly and monthly sanitation inspections will be conducted by the new VCS Canteen Chief per CSS 50-22 to ensure compliance with VCS food service standards.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, RN, MN, Director Chicago Office of Healthcare Inspections 708-202-2672
Acknowledgments	Judy Brown Paula Chapman Wachita Haywood John Jones Jennifer Reed Leslie Rogers

Appendix D

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