Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-02264-225

Combined Assessment Program Review of the Amarillo VA Health Care System Amarillo, Texas

September 22, 2009

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 July 27–31, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Amarillo VA Health Care System (AVAHCS), Amarillo, TX. 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 277 AVAHCS employees. AVAHCS is part of Veterans Integrated Service Network (VISN) 18.

Results of the Review

The CAP review covered six operational activities. We identified the following organizational strengths and reported accomplishments:

- Veteran and Spouse Flu Vaccine Clinic.
- Suicide Prevention Collaborative Effort.

We made recommendations in two of the activities reviewed. For these activities, AVAHCS needed to:

- Require compliance with Veterans Health Administration (VHA) policy in regards to requesting and granting peer review extensions.
- Require that designated staff maintain current Heartsaver, Basic Life Support (BLS), and/or Advanced Cardiac Life Support (ACLS) certification in accordance with local policy and that compliance be consistently documented, reviewed, and tracked.
- Require that nurses consistently document PRN (as needed) pain medication effectiveness in the Bar Code Medication Administration (BCMA) record using a numeric value, as specified by local policy.

AVAHCS complied with selected standards in the following four activities:

- Contract/Agency Registered Nurses (RNs).
- Coordination of Care.
- Environment of Care (EOC).
- Physician Credentialing and Privileging (C&P).

This report was prepared under the direction of Linda G. DeLong, Director, Dallas Office of Healthcare Inspections.

Comments

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

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

Introduction

Profile

Organization. AVAHCS is a primary medical and surgical facility located in Amarillo, TX, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics located in Lubbock, Stratford, and Childress, TX; Clovis, NM; and Liberal, KS. AVAHCS is part of VISN 18 and serves a veteran population of about 66,700 throughout 52 counties in the Texas and Oklahoma panhandles, eastern New Mexico, and southern Kansas.

Programs. AVAHCS provides medical, surgical, mental health, geriatric, and rehabilitation services and substance abuse treatment. It has 55 hospital beds and 120 community living center (CLC) beds.[1]

Affiliations and Research. AVAHCS is affiliated with Texas Tech University (TTU) Health Sciences Center and provides training for 50 residents in areas that include internal medicine and family practice. It also offers a geriatric fellowship. In addition, AVAHCS provides training for other disciplines, including nursing, pharmacy, optometry, and social work, and for various allied health programs. The AVAHCS research program was officially closed in 2008.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled $133 million. The FY 2009 medical care budget is $159 million. FY 2008 staffing was 882 full-time employee equivalents (FTE), including 43 physician and 270 nursing FTE.

Workload. In FY 2008, AVAHCS treated 24,890 unique patients and provided 11,017 inpatient days in the hospital and 43,016 inpatient days in the CLC. The inpatient care workload totaled 2,818 discharges, and the average daily census, including CLC patients, was 147. Outpatient workload totaled 207,565 visits.

Objectives and Scope

Objectives. CAP reviews are one element of 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:

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

- 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 six activities:

- Contract/Agency RNs.
- Coordination of Care.
- EOC.
- Medication Management.
- Physician C&P.
- QM.

The review covered AVAHCS operations for FY 2008 and FY 2009 through July 27, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on selected recommendations from our prior CAP review of AVAHCS (*Combined Assessment Program Review of the VA Health Care System, Amarillo, Texas,* Report No. 06-02815-37, December 8, 2006). AVAHCS had corrected all findings related to health care from the prior CAP review.

We also followed up on recommendations from a prior OIG inspection (*Assessment of Legionnaire's Disease Risk in Veterans Health Administration Inpatient Facilities,* Report No. 07-00029-151, June 20, 2007). The inspection surveyed inpatient facilities, including AVAHCS, for Legionnaire's disease (LD) prevention strategies. We found that AVAHCS has a written plan that addresses the prevention of LD and

that AVAHCS is consistently performing monthly LD risk assessments. We consider AVAHCS to be in compliance with the recommendations.

During this review, we also presented fraud and integrity awareness briefings for 277 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 Strengths

Veteran and Spouse Flu Vaccine Clinic

In an effort to improve the health of the community, AVAHCS partnered with TTU's School of Pharmacy in Amarillo, TX, to increase the number of veterans receiving the flu vaccine. This collaborative effort provided a way for pharmacy students trained by TTU to administer flu vaccines to veterans' spouses during the vaccine clinics set up for veterans. The vaccine and labor costs for veterans' spouses were supplied by TTU, and billing for Medicare reimbursement was provided for those spouses who were eligible. This effort resulted in a 12 percent increase in the number of veterans receiving the flu vaccine as compared to the same 3-week period in the previous year. Also, more than 800 spouses were vaccinated during this 3-week period. Veterans and their spouses expressed appreciation for this convenience.

Suicide Prevention Collaborative Effort

AVAHCS implemented a process to improve coordination of care for veterans admitted to the local psychiatric hospital. The AVAHCS suicide prevention team is granted limited clinical access through an agreement with the psychiatric hospital. A team member makes daily rounds on all admitted veterans, communicates clinical information or concerns, and develops initial suicide safety plans that are made available to the veteran at the time of discharge. Coordination of care through discharge is a key function of this process. This process has resulted in 100 percent of veterans receiving mental health follow-up appointments at AVAHCS within 7 days of discharge. Also, a contact visit

with the suicide prevention team at AVAHCS is scheduled by a team member prior to a veteran's discharge.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether AVAHCS had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed AVAHCS's Director, Chief of Staff, and QM Chief. We evaluated plans, policies, performance improvement (PI) data, and other relevant documents.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. However, we identified the following areas that needed improvement.

Peer Review Process. Once the need for a peer review is determined, VHA policy[2] requires facilities to complete the peer review within 120 days. Any exception or extension beyond 120 days must be requested in writing and approved by the Director, who is responsible for monitoring and reviewing the number of extensions twice a year.

AVAHCS successfully managed internal peer reviews but required one external peer review extension for FY 2009 through July 27, 2009. However, the process for requesting this extension did not comply with VHA policy.

Life Support Training. We found that AVAHCS did not have a mechanism in place to ensure that designated staff maintained compliance with current Heartsaver, BLS, and/or ACLS certification, as required by local policy. Compliance with local policy for life support training certifications needed to be consistently documented, reviewed, and tracked.

Recommendation 1 We recommended that the VISN Director ensure that the AVAHCS Director requires compliance with VHA policy in regards to requesting and granting peer review extensions.

[2] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

The VISN and AVAHCS Directors concurred with the findings and recommendations. AVAHCS's peer review policy has been revised to comply with VHA Directive 2008-004 for requesting extensions. The corrective action is acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director ensure that the AVAHCS Director requires that designated staff maintain current Heartsaver, BLS, and/or ACLS certification in accordance with local policy and that compliance be consistently documented, reviewed, and tracked.

The VISN and AVAHCS Directors concurred with the findings and recommendations. AVAHCS's policy will be revised to clearly define clinically active staff requirements for maintaining Heartsaver, BLS, and/or ACLS certification. The Chief of Education Service will be responsible for monitoring and reporting monthly compliance rates to the Performance Improvement Board. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes in the inpatient medical and surgical, intensive care, and CLC units.

We reviewed documentation provided and found that the designated BCMA Program Coordinator had appropriately identified and addressed problems. In addition, pharmacists consistently performed and documented monthly medication reviews for all 10 CLC unit residents whose records we reviewed. However, we identified the following area that needed improvement.

Pain Medication Effectiveness Documentation. Local policy requires that nurses assess and document the effectiveness of PRN pain medications in the BCMA record using a numeric value. We reviewed the BCMA records of 23 patients who received a total of 60 doses of pain medications and found that only 42 (70 percent) of the doses administered had effectiveness documented as specified by local policy.

Recommendation 3 We recommended that the VISN Director ensure that the AVAHCS Director requires that nurses consistently

document PRN pain medication effectiveness in the BCMA record using a numeric value, as specified by local policy.

The VISN and AVAHCS Directors concurred with the finding and recommendation. All nursing staff administering PRN pain medications have been given refresher training on timeliness and appropriate pain scale documentation. Nurse managers and charge nurses will monitor for consistency. A goal of 90 percent compliance has been established for January 2010. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Contract/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as VHA employees. We reviewed documents for several required components for seven contract/agency RNs. We found that managers had verified current licensure, BLS certification, completed competencies, required information security and privacy training, and completion of background checks. We made no recommendations.

Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers and discharges are essential to an integrated ongoing care process and optimal patient outcomes.

We reviewed medical record documentation for 10 intra-facility transfers and determined that all transfers were appropriately managed by clinicians. We found transfer notes from sending to receiving units and documentation that nursing assessments were performed by the receiving units in accordance with established timeframes.

We reviewed the medical records of 10 patients who were discharged and found that all received appropriate written discharge instructions. We also found documentation that the patients understood those instructions. We made no recommendations.

Environment of Care

The purpose of this review was to determine if VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association, and JC standards.

We inspected the inpatient medical and surgical units, the intensive care unit, the emergency department, the CLC units, and the ambulatory care clinics. AVAHCS maintained a generally clean and safe environment. We found that the infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met, and risk assessments were in compliance with VHA standards. We made no recommendations.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[3] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 C&P files with profiles and found that licenses were verified as current and that primary source verification was documented. Appropriate implementation of Focused Professional Practice Evaluation for newly hired physicians had occurred. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. There was sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requests for privileges. We made no recommendations.

VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figures 1 and 2 on the next page show the AVAHCS, VISN, and national overall inpatient and outpatient satisfaction scores for FYs 2007 and 2008. Target scores are noted on the graphs.

[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Figure 1:

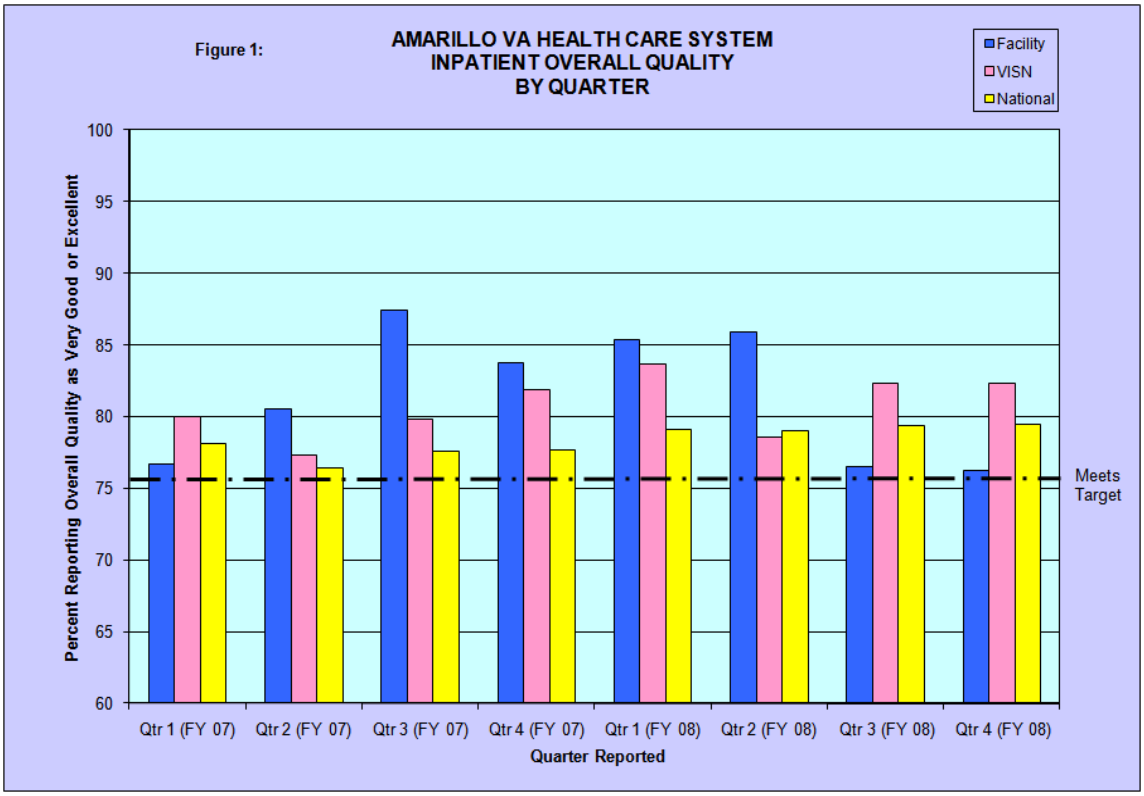
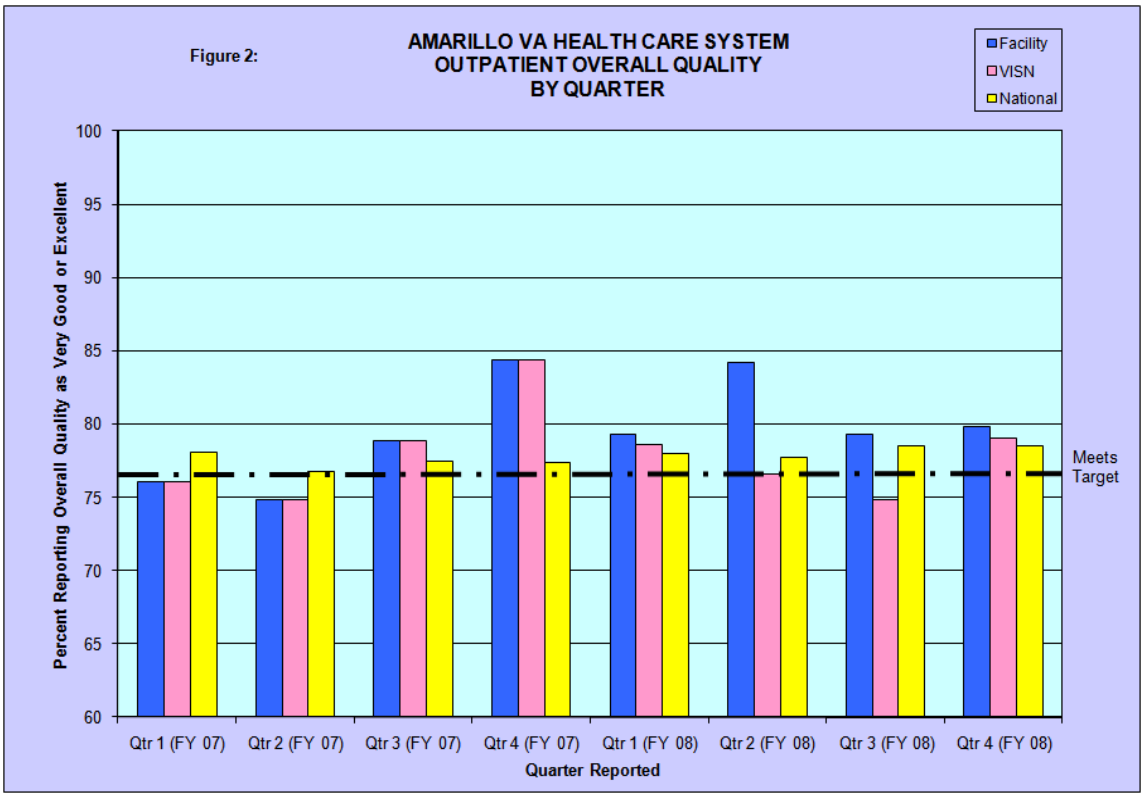
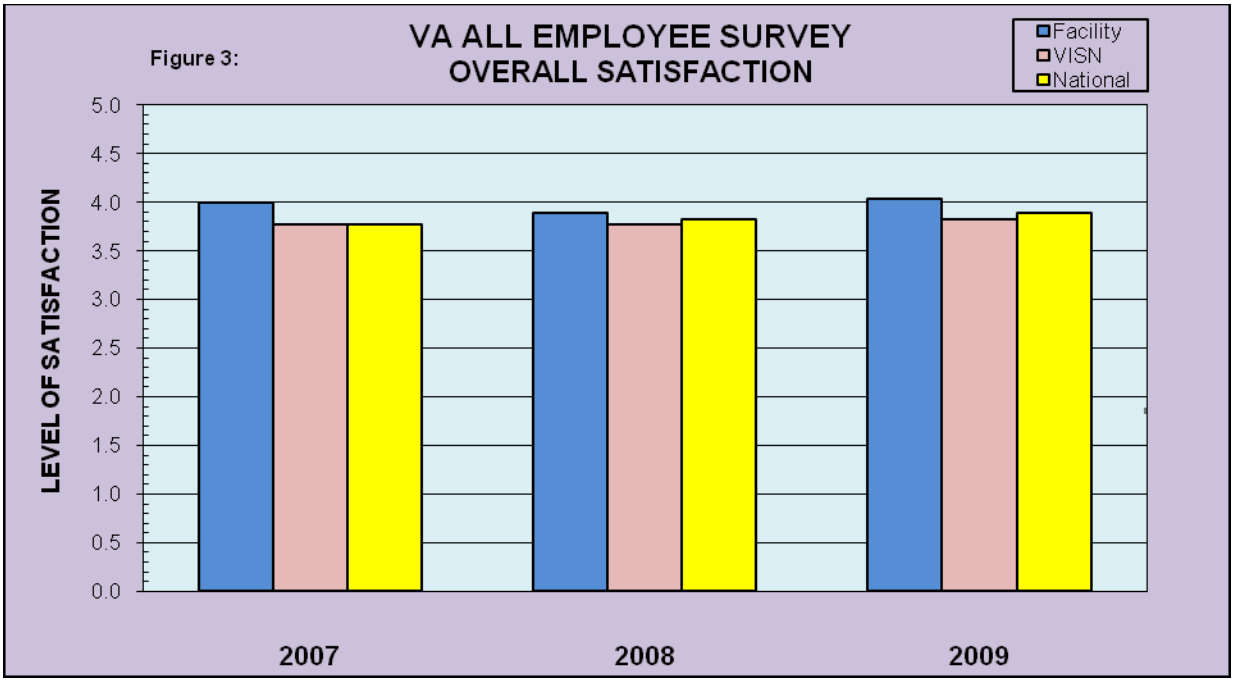


Figure 2:



Employees are surveyed annually. Figure 3 below shows AVAHCS's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 2, 2009

From: Director, VA Southwest Health Care Network (10N18)

Subject: **Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas**

To: Director, Dallas Healthcare Inspections Division (54DA)

Director, Management Review Service (10B5)

I concur with the attached facility draft responses to the recommendations for improvement contained in the Combined Assessment Program review at the Amarillo VA Health Care System. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2699.

(original signed by Nancy Waite for:)

Susan P. Bowers

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 31, 2009

From: Director, Amarillo VA Health Care System (504/00)

Subject: **Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas**

To: Director, VA Southwest Health Care Network (10N18)

Please find attached our response to the OIG/CAP review of the Amarillo VA Health Care System conducted July 27–31, 2009.

I concur with the findings and submit actions to each recommendation.

(original signed by:)

ANDREW M. WELCH, MHA, 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 AVAHCS Director requires compliance with VHA policy in regards to requesting and granting peer review extensions.

Concur

The facility Peer Review for Quality Management policy (105-02) has been revised to include the following expectations in VHA Directive 2008-004, "Peer Review for Quality Management:"

The exception for a delay or an extension beyond the initial 45 days may be requested in writing and approved by the Chief of Staff prior to the due date.

The exception for a delay, or an extension beyond 120 days, needs to be requested in writing, and approved by the Director**,** who is responsible for monitoring and reviewing the number of extensions twice a year.

We recommend this item be closed.

Target Completion Date: Completed

Recommendation 2. We recommended that the VISN Director ensure that the AVAHCS Director requires that designated staff maintain current Heartsaver, BLS, and/or ACLS certification in accordance with local policy and that compliance be consistently documented, reviewed, and tracked.

Concur

Facility policy (MCM OOED–15) will be revised to clearly define that:

It is the policy of the VA and this medical center that designated clinically active staff maintain current Heartsaver, BLS, and/or ACLS certification in accordance with local policy and that compliance be consistently documented, reviewed and tracked.

The Chief, Education Service is responsible for monitoring and reporting monthly compliance rates to the Performance Improvement Board.

Target Completion Date: October 2009

Recommendation 3. We recommended that the VISN Director ensure that the AVAHCS Director requires that nurses consistently document PRN pain medication effectiveness in the BCMA record using a numeric value, as specified by local policy.

Concur

1. All nursing staff administering PRN pain medication will be given refresher training by their unit educator or the Nursing ADPAC on timeliness and appropriate pain scale documentation for PRN effectiveness in BCMA. Training accomplished on 8/28/09.

   Target Completion Date: Completed

2. The Nurse Managers and Charge Nurses will monitor their respective nursing units for consistent documentation of PRN pain medication effectiveness using a numeric value in the BCMA record on a daily basis. Monitoring and documenting has been implemented and is ongoing.

   Target Completion Date: Completed

3. A goal of 90% compliance with documentation of a numeric value for PRN pain medication effectiveness has been established.

   Target Completion Date: Goal of 90% by January 2010

OIG Contact and Staff Acknowledgments

Contact	Linda DeLong, Director Dallas Office of Healthcare Inspections (214) 253-3331
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