Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03039-62

Combined Assessment Program Review of the VA Sierra Nevada Health Care System Reno, Nevada

January 14, 2010

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 November 2–5, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Sierra Nevada Health Care System (the system), Reno, NV. 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 71 system employees. The system is part of Veterans Integrated Service Network (VISN) 21.

Results of the Review

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

- Discharge Call Program.
- Provider Dashboard.

We made recommendations in six of the activities reviewed. For these activities, the system needed to ensure that:

- The patient safety manager (PSM) is added as a member of the Quality Executive Council (QEC).
- An annual written adverse event disclosure report is provided to senior managers.
- The privileging process complies with Veterans Health Administration (VHA) regulations.
- Intra-facility transfer documentation is completed, as required by local policy.
- Staff complies with local policy for multiple-dose medication vials.
- PRN (as needed) pain medication effectiveness is consistently assessed and documented in inpatient medical/surgical units within the timeframe specified by local policy.
- Contracted/agency registered nurses (RNs) have documentation of completed background investigations prior to providing patient care.

The system complied with selected standards in the following activity:

- Magnetic Resonance Imaging (MRI) Safety.

This report was prepared under the direction of Virginia L. Solana, Director, Denver Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 13–17, for the 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. The system is a tertiary care facility located in Reno, NV, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics in Fallon and Minden, NV, and in Auburn, CA. The system is part of VISN 21 and serves a veteran population of about 120,000 throughout northern Nevada and northeastern California.

Programs. The system provides primary care, inpatient medical/surgical, geriatric, and rehabilitation services. It has 64 hospital beds and 60 community living center (CLC) beds.

Affiliations and Research. The system is affiliated with the University of Nevada's School of Medicine and with the University of California, San Francisco's, East Bay Surgery Program. Approximately 30 medical, surgical, and psychiatry residents rotate annually through the system. Additionally, the system supports pharmacy students through partnerships with Idaho State University, the University of Southern Nevada's Schools of Pharmacy, and the American Society of Health Systems Pharmacists' residency program. In fiscal year (FY) 2009, the system research program had 30 projects and a budget of approximately $415,000. Important areas of research included pulmonary, oncology, and cardiac studies.

Resources. In FY 2009, medical care expenditures totaled about $186 million. FY 2009 staffing was 959 full-time employee equivalents (FTE), including 62 physician and 256 nursing FTE.

Workload. In FY 2009, the system treated 27,238 unique patients and provided 16,448 inpatient days in the hospital and 19,605 inpatient days in the CLC unit. The inpatient care workload totaled 4,177 discharges, and the average daily census, including CLC patients, was 105. Outpatient workload totaled 303,365 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 seven activities:

- Contracted/Agency RNs.
- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- MRI Safety.
- Physician Credentialing and Privileging (C&P).
- QM.

The review covered system operations for FY 2008 and FY 2009 through September 21, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Sierra Nevada Health Care System, Reno, Nevada*, Report No. 06-03484-96, March 14, 2007). The system had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 71 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

Discharge Call Program

The system has recently undertaken a 100 percent post-discharge call back program. An RN calls each discharged patient within 24–48 hours after discharge. The RN helps the patient understand his or her health status changes and discharge and follow-up instructions and can refer the patient immediately to a pharmacist, dietician, and home health or specialty clinic nurse if needed. This effort has improved the system's post-discharge appointment process, ensuring timely post-hospital follow-up. The newly implemented program has achieved an 81 percent patient contact rate.

Provider Dashboard

The system has expanded the use of dashboard tools that are based on VHA's dashboard, which measures performance based on clinical guidelines and prevention indicators. The system's dashboard gives primary care providers (PCPs) and pharmacists 100 percent sampling of their patient population in the areas of diabetes, hyperlipidemia, and hypertension. Lists of patients not meeting the measures are distributed to the respective providers so that they can gauge their overall performance, track progression, and identify individual patients requiring intervention. The system's dashboard supports collaborative drug therapy management by balancing provider access and patient needs. It helps clinicians manage care in the mission critical diseases by providing additional focused management and by reducing visits to PCPs. One significant outcome of the system's dashboard was a 37 percent improvement in the patient diabetic control measure, which improved patient access and treatment.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to determine whether (a) the system had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) senior managers actively supported QM efforts and appropriately responded to QM results. To evaluate QM processes, we interviewed senior managers, the QM Chief, and key personnel. To assess compliance with QM requirements, we reviewed the QM self-assessment, plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the system's quality of care. Also, it was evident that senior managers supported the program through participation in and evaluation of performance improvement initiatives. We found that 10 of the 12 areas reviewed were in compliance with VHA and accreditation requirements. However, we found opportunities for improvement in the following two areas.

QM Oversight. We found that the PSM is not a member of the QEC. According to VHA[1] and local policy, the PSM must be a member of the QEC.

Adverse Event Disclosure. We found that senior managers do not receive an annual written report on disclosure information. The Joint Commission (JC) requires that senior managers receive a written report regarding the disclosure of adverse events to patients at least once a year.

Recommendation 1

We recommended that the VISN Director ensure that the System Director requires that the PSM is added as a member of the QEC.

The VISN and System Directors concurred with the finding and recommendation. The PSM is now a QEC member, and in December 2009, the PSM presented the annual report on patient safety to the QEC. The PSM will continue as a QEC member and will report on ongoing patient safety issues.

[1] VHA Directive 2009-043, *Quality Management System*, September 11, 2009.

The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that an annual written adverse event disclosure report is provided to senior managers.

The VISN and System Directors concurred with the finding and recommendation. The FY 2009 adverse event disclosure report was presented to the Executive Leadership Board in writing in November 2009. This report will be submitted to the board annually. The corrective actions are acceptable, and we consider this recommendation closed.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for C&P of physicians. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[2] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been appropriately obtained. Documentation of provider-specific Ongoing Professional Practice Evaluation (OPPE) or Focused Professional Practice Evaluation (FPPE) data for the 10 physicians privileged or reprivileged within the past year was not sufficient to meet current requirements. We identified the following areas that needed improvement.

OPPE. VHA regulations require specific competency criteria for OPPE for all privileged physicians. We found that for the 2-year period prior to reprivileging, OPPE data for seven of the eight reprivileged physicians were not specific and did not support the additional privileges granted. In addition, we found that Medical Executive Council (MEC) minutes used the same standard statement for all providers and did not contain service chief evaluation of OPPE data to ensure competency prior to recommending reprivileging.

FPPE. Also known as proctoring, FPPE is a review process to ensure the competence of newly hired physicians and of currently privileged physicians requesting new privileges. We reviewed the C&P files of two physicians hired in the

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

past 12 months. We found the following: (1) the service chief did not recommend FPPE for the two physicians, (2) the timeframe for FPPE was not clearly documented, and (3) criteria were not developed to determine the type of monitoring to be conducted.

Recommendation 3 We recommended that the VISN Director ensure that the System Director requires that the privileging process complies with VHA regulations.

The VISN and System Directors concurred with the findings and recommendation. Effective December 2009, all service chiefs will present OPPE reports to the MEC twice a year. The chair of the MEC will request OPPE data on each physician being reviewed for renewal of privileges prior to the MEC completing the privileging action. Service chiefs will conduct FPPE for all newly privileged providers and will present results to the MEC at the end of each physician's first 6 months of service. A generic FPPE template has been made available to all services, and they have been instructed to individualize the template for their specific needs. The corrective actions are acceptable, and we consider this recommendation closed.

Coordination of Care

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

We reviewed the medical records of discharged patients and found that 11 (92 percent) of the 12 records had appropriate documentation. In one record, the discharge instructions were not consistent with the discharge summary and did not include discharge medications.

We also reviewed the medical records of three patients recently discharged from the locked MH unit. We found documentation that patients received information about accessing emergency MH care and that patients were given MH clinic appointments within 2 weeks of discharge. We also found documentation that MH providers either arranged for follow-up appointments or contacted the patients by

phone within 7 days of discharge. However, we identified the following area that needed improvement.

Intra-Facility Transfers. Local policy requires that a nursing assessment is documented by the receiving unit. We reviewed medical records for 12 intra-facility transfers and found that 4 (33 percent) of the records did not have the documentation required by local policy.

Recommendation 4 We recommended that the VISN Director ensure that the System Director requires staff to complete intra-facility transfer documentation, as required by local policy.

The VISN and System Directors concurred with the finding and recommendation. Patient Care Services (PCS) has educated nursing staff on local policy. PCS will sample medical records on a monthly basis to ensure compliance and will report results to the QEC quarterly until sustained improvements are demonstrated. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine if the system 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 all outpatient clinics, the intensive care unit (ICU), the inpatient medical/surgical units, the emergency department, the locked MH unit, and the CLC unit. We found that the system maintained a generally clean and safe environment. However, we identified the following area that needed improvement.

Multiple-Dose Medication Vials. JC standards and local policy require that all medications are labeled with the contents, expiration date, and any applicable warnings and that they are removed when expired or damaged. In various refrigerators throughout the system, we found a total of seven multiple-dose medication vials that were open, outdated, or unlabeled.

Recommendation 5 We recommended that the VISN Director ensure that the System Director requires compliance with local policy regarding multiple-dose medication vials.

The VISN and System Directors concurred with the findings and recommendation. In December 2009, the system implemented a "Beyond Use Date" label for all multiple-dose medication vials. Pharmacy staff will affix labels when the vials leave the pharmacy. Service chiefs have been notified, and they have educated their staff. Pharmacy Service will conduct monthly ward inspections, and a report regarding compliance with this new process will be presented monthly to the QEC. PCS will address any compliance issues. The corrective actions are acceptable, and we consider this recommendation closed.

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/surgical units, the locked MH unit, the ICU, and the CLC unit.

We found that the system had a designated Bar Code Medication Administration (BCMA) Program Coordinator who had appropriately identified and addressed problems. We also found that pharmacy staff completed monthly medication reviews for CLC patients. 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 within 2 hours after administration. We reviewed the medical records of 20 patients who received a total of 77 doses of pain medications. We found that effectiveness was appropriately documented in the ICU, MH, and CLC units. However, in the inpatient medical/surgical units, we found that only 14 (67 percent) of 21 doses had effectiveness documented in the BCMA system within the timeframe required by local policy.

Recommendation 6 We recommended that the VISN Director ensure that the System Director requires that inpatient medical/surgical unit nurses consistently assess and document PRN pain medication effectiveness within the timeframe specified by local policy.

The VISN and System Directors concurred with the findings and recommendation. PCS in now running PRN pain medication effectiveness reports, which are being monitored for compliance by the Nurse Executive and nurse managers. PCS will report results to the QEC quarterly until sustained improvement is demonstrated. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Contracted/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 part of VHA facility staff. We reviewed documents for several required components, including licensure, training, competencies, and background investigations. Also, we reviewed 10 files of contracted/agency RNs who worked at the system within the past year. We identified one area that needed improvement.

Background Investigations. U.S. Government agencies are required to complete background investigations for employees in sensitive positions.[3] We found documentation of completed background investigations for 7 (70 percent) of the 10 contracted/agency RNs.

Recommendation 7 We recommended that the VISN Director ensure that the System Director requires nursing managers to validate that contracted/agency RNs have documentation of completed background investigations prior to providing patient care.

The VISN and System Directors concurred with the finding and recommendation. The system is now only using contracted/agency RNs who have adjudicated Special Agreement Checks (SAC). The PCS Contracting Officer's Technical Representative will ensure that a copy of the e-mail with the adjudicated SAC is printed and filed prior to a contracted/agency RN providing patient care. PCS will report results to the QEC quarterly. The corrective actions are acceptable, and we consider this recommendation closed.

[3] Executive Order 10450, *Security Requirements for Government Employment*, April 27, 1953, Sec. 3.

Review Activities Without Recommendations

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the system maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. We determined that the system had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC.

The system had appropriate signage and barriers to prevent unauthorized or accidental access to the MRI area. Patients in the magnet room are directly observed at all times. Two-way communication is available between the patient and the MRI technologist, and the patient has access to a push-button call system while in the scanner. Additionally, mock fire and emergency response drills have been conducted in the MRI area.

Local policy requires that personnel who have access to the MRI area receive appropriate MRI safety training. We reviewed the training records of 21 personnel and found that all had completed required safety training.

We reviewed the medical records of 10 patients who received an MRI. In all cases, patients received appropriate screening. In addition, three patients who had an MRI with contrast media had signed informed consents prior to their procedures, in accordance with local policy. 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. Figure 1 on the next page shows the system's and VISN's overall inpatient satisfaction scores for quarters 1, 2, and 3 of FY 2009. Figure 2 on the next page shows the system's and VISN's overall outpatient satisfaction scores for quarter 3 of FY 2009.[4] The target scores are noted on the graphs.

[4] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included for comparison.

Figure 1:

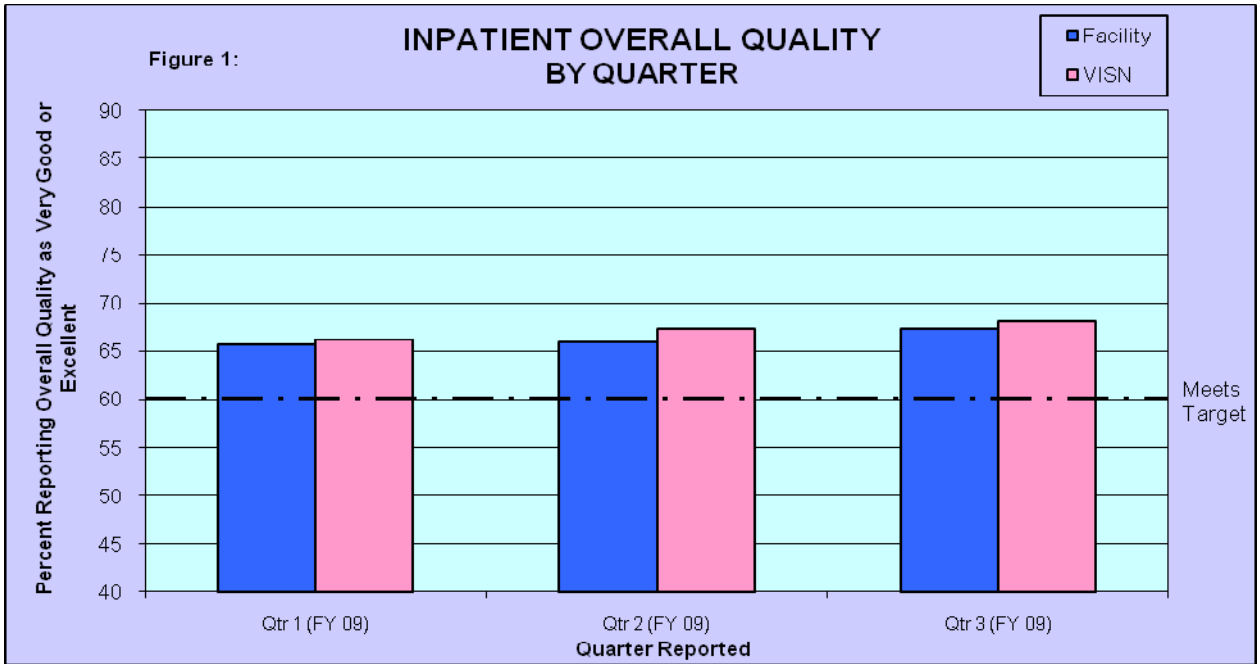
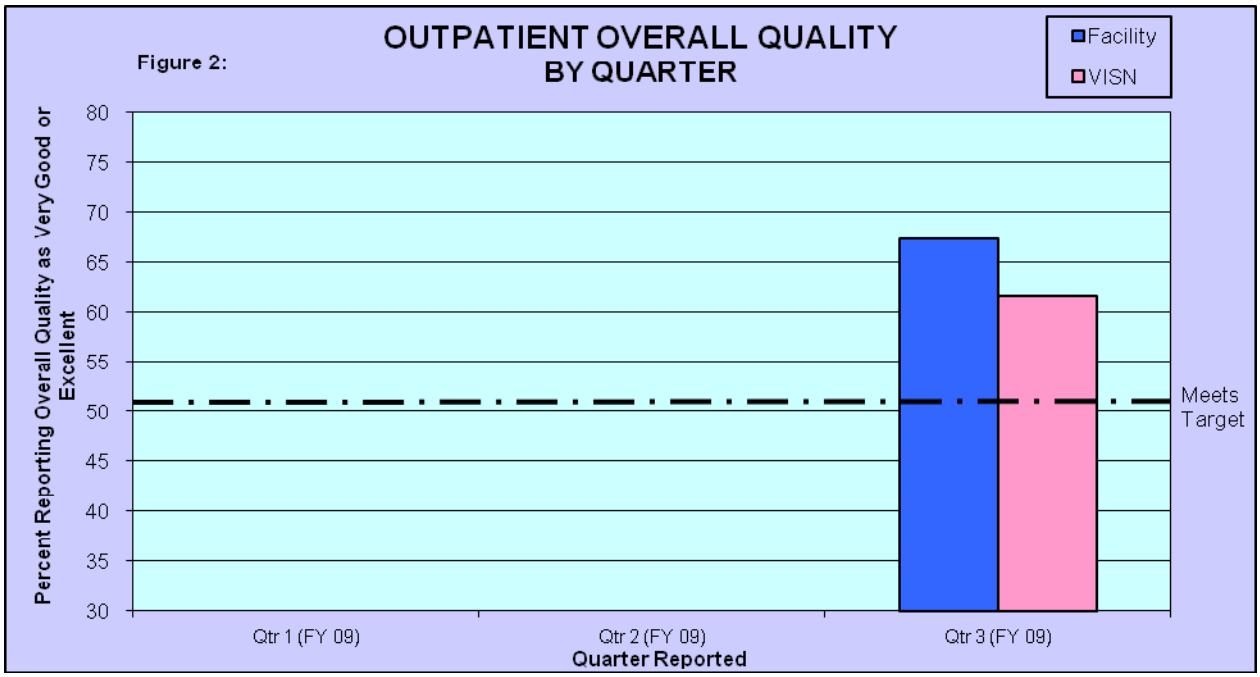
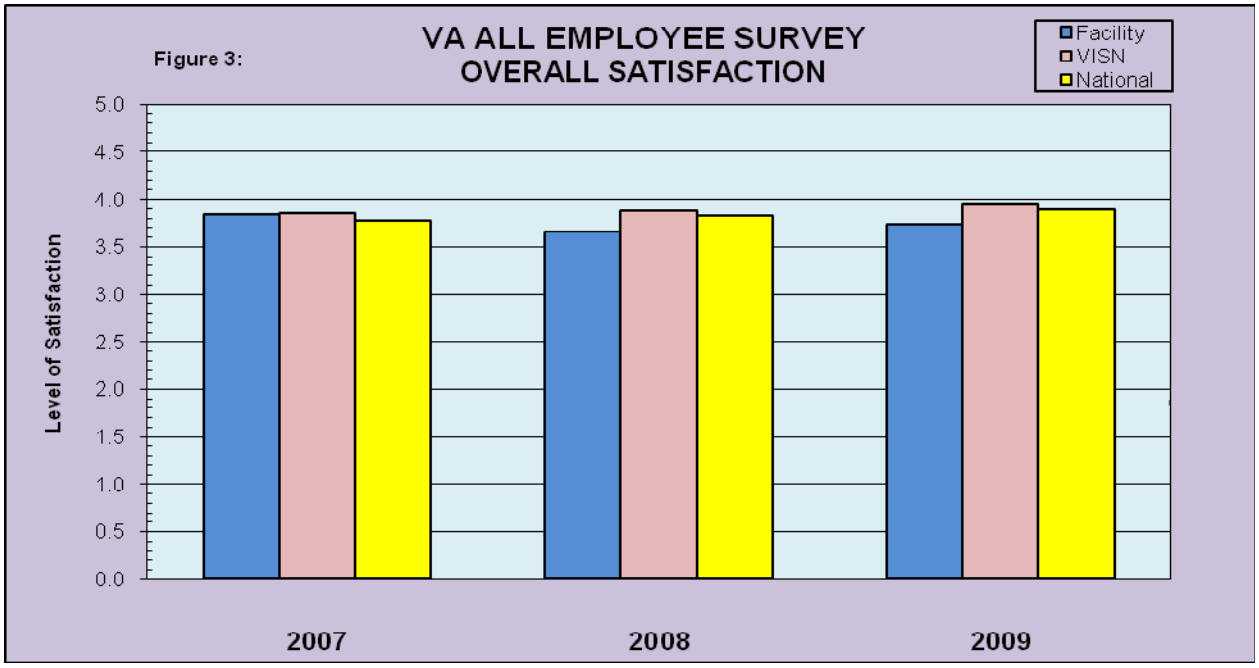


Figure 2:



Employees are surveyed annually. Figure 3 below shows the system'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.

Figure 3:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 23, 2009

From: Director, Sierra Pacific Network (10N21)

Subject: **Combined Assessment Program Review of the VA Sierra Nevada Health Care System, Reno, Nevada**

To: Director, Denver Office of Healthcare Inspections (54DV)

Director, Management Review Service (10B5)

1. I appreciate the opportunity to review the draft report on the Combined Assessment Program Review of the VA Sierra Nevada Health Care System (VASNHCS), conducted during the week of November 2–5, 2009. I concur with the recommendations, and VASNHCS staff has completed five of the seven recommendations resulting from the review. We will ensure the remaining two recommendations are addressed and implemented as described in the attached plan by the established target dates.

2. If you have any questions regarding the responses and actions outlined in the implementation plan, please contact Ms. Terry V. Sanders, VISN 21 Associate Quality Management Officer at (707) 562-8370.

(original signed by:)
Sheila M. Cullen

Attachments

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 23, 2009

From: Director, VA Sierra Nevada Health Care System (654/00)

Subject: **Combined Assessment Program Review of the VA Sierra Nevada Health Care System, Reno, Nevada**

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to comment on the draft report of the Combined Assessment Program review of the VA Sierra Nevada Health Care System. In brief, we concur with the findings and suggested improvements, which are already in progress.

2. We would like to express our thanks to the CAP review team. The collective interest and efforts of the CAP review team have helped improve our organizational practices at VASNHCS.

(*original signed by:*)
Kurt W. Schlegelmilch, M.D., 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 System Director requires that the PSM is added as a member of the QEC.

Concur

Facility's Response: The Patient Safety Manager was added back to the Quality Executive Council on November 5, 2009. On December 15, 2009, the PSM presented the annual report on Patient Safety to the Council. The PSM will continue to be a member of this Council and will report on ongoing patient safety issues.

Target Completion Date: Completed December 15, 2009.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that an annual written adverse event disclosure report is provided to senior managers.

Concur

Facility's Response: The FY 2009 Adverse Events Disclosure report was presented (verbally and in writing) to the Executive Leadership Board on November 23, 2009. This will be done annually.

Target Completion Date: Completed November 23, 2009.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that the privileging process complies with VHA regulations.

Concur

Facility's Response: The Ongoing Professional Practice Evaluation process was in place at the time of the Office of Inspector General survey, but it was not consistently implemented by all Service Chiefs. Effective December 1, 2009, OPPE reports will be presented to the Medical Executive Council (MEC) twice a year by all Service Chiefs. The chair of MEC will request the OPPE on each person being reviewed for renewal of

privileges. This is mandatory for renewal and will be required prior to the MEC completing the privileging action.

Effective December 21, 2009, Focused Professional Practice Evaluation will be conducted by Service Chiefs for all newly privileged physicians and presented to MEC at the end of a physician's first six months of service. This generic template is made available for all services, and they are instructed to individualize the form for their specific Services and individual physician's privileges.

Target Completion Date: Completed December 21, 2009.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires staff to complete intra-facility transfer documentation, as required by local policy.

Concur

Facility's Response: As of December 21, 2009, Patient Care Services has educated nursing staff as to the local policy. Patient Care Services is monitoring, on a monthly basis, a sampling of medical records to ensure compliance with local policy, and following up with staff that are not compliant. Patient Care Service will report this information to Quality Executive Council on a quarterly basis until sustained improvements are demonstrated, and then the frequency of monitoring will be revised. The quarter one, FY 2010 results will be reported to Quality Executive Council on January 19, 2010.

Target Completion Date: January 19, 2010.

Recommendation 5. We recommended that the VISN Director ensure that the System Director requires compliance with local policy regarding multiple-dose medication vials.

Concur

Facility's Response: Effective December 1, 2009, the system implemented a "Beyond Use Date" label for all multi-dose vials. The label with this date is being applied by Pharmacy staff when the vial leaves the pharmacy. Service Chiefs have received notification from Pharmacy regarding this change and have educated their staff. Ward inspections will be completed monthly by Pharmacy Service, and a report of compliance with the new process will be given monthly in Quality Executive Council beginning January 19, 2010. Patient Care Services will address any issues with compliance upon receipt of this report.

Target Completion Date: Completed December 1, 2009.

Recommendation 6. We recommended that the VISN Director ensure that the System Director requires that inpatient medical/surgical unit nurses consistently assess and document PRN pain medication effectiveness within the timeframe specified by local policy.

Concur

Facility's Response: Effective December 21, 2009, Patient Care Service is running the pain PRN effectiveness reports, which are monitored for compliance by the Nurse Executive and Nurse Managers. Nurse Managers will intervene with staff as needed, as identified in the monitoring. Patient Care Service will report this information to Quality Executive Council on a quarterly basis until sustained improvement is demonstrated, then the frequency of monitoring will be revisited. The Quarter 1, FY 2010 report will be given in the Quality Executive Council on January 19, 2010.

Target Completion Date: January 19, 2010.

Recommendation 7. We recommended that the VISN Director ensure that the System Director requires nursing managers to validate that contracted/agency RNs have documentation of completed background investigations prior to providing patient care.

Concur

Facility's Response: No new contracted/agency RNs have started employment at VASNHCS since the CAP review. Patient Care Service is not utilizing any contracted/agency registered nurses who do not have an adjudicated SAC, including those nurses cited by the Office of Inspector General surveyors. Prior to contracted/agency registered nurses coming on station to provide patient care, Patient Care Services COTR will ensure a copy of the email with the adjudicated SAC will be printed and filed in the Service. Patient Care Service will report this information to Quality Executive Council on a quarterly basis until sustained improvement has been demonstrated, then the frequency of monitoring will be revisited.

Target Completion Date: Completed November 5, 2009.

OIG Contact and Staff Acknowledgments

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