Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03313-59

Combined Assessment Program Review of the Phoenix VA Health Care System Phoenix, Arizona

January 11, 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.

Table of Contents

Executive Summary

Introduction

During the week of October 26–30, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Phoenix VA Health Care System (the system), Phoenix, AZ. 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 302 system employees. The system 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:

- Managing Veterans' Belongings.
- Podiatry Access.

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

- Require that nurses consistently document PRN (as needed) pain medication effectiveness in the Bar Code Medication Administration (BCMA) record within the timeframe specified by local policy.
- Require that the Information Safety Officer (ISO) consistently attend environment of care (EOC) rounds.

The system complied with selected standards in the following four activities:

- Coordination of Care (COC).
- Magnetic Resonance Imaging (MRI) Safety.
- Physician Credentialing and Privileging (C&P).
- QM.

This report was prepared under the direction of Linda G. DeLong, Director, Dallas 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 11–14, 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 Phoenix, AZ, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at seven community based outpatient clinics in Phoenix, Mesa, Buckeye, Payson, Globe, Sun City, and Show Low, AZ. The system is part of VISN 18 and serves a veteran population of about 321,400 throughout the Arizona counties of Maricopa, Gila, and Navajo.

Programs. The system provides medical, surgical, mental health (MH), geriatric, rehabilitation, and diagnostic services. It has 197 hospital beds and 104 community living center (CLC) beds.

Affiliations and Research. The system is affiliated with the University of Arizona's College of Medicine (in partnership with Arizona State University) and with the multidisciplinary Phoenix Independent Residency Programs. It provides training for 83 residents in medicine, surgery, and psychiatry. In fiscal year (FY) 2009, the system research program had 110 projects and a budget of approximately $3 million. Important areas of research included diabetes, obesity, gastroenterology, nephrology, podiatry, and drug utilization.

Resources. In FY 2009, medical care expenditures totaled $397 million. (The medical care budget was $400 million.) FY 2009 staffing was 2,499 full-time employee equivalents (FTE), including 240 physician and 506 nursing FTE.

Workload. In FY 2009, the system treated 75,071 unique patients and provided 29,444 inpatient days in the hospital and 22,515 inpatient days in the CLC units. The inpatient care workload totaled 5,416 discharges, and the average daily census, including CLC patients, was 142. Outpatient workload totaled 688,447 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 six activities:

- COC.
- EOC.
- Medication Management.
- MRI Safety.
- Physician C&P.
- QM.

The review covered system operations for FY 2009 and FY 2010 through October 26, 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 Carl T. Hayden VA Medical Center, Phoenix, Arizona,* Report No. 07-00282-140, June 1, 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 302 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

Managing Veterans' Belongings

The "Bag & Tag" system was implemented in an effort to safely and accurately secure patient clothing, valuables, luggage, and effects upon admission. The old process required that nursing admissions staff complete a detailed inventory, which was burdensome and impinged on patient care time. This led to errors in inventory, unverifiable claims, and frustrated patients. A team was assembled, and its goals were to simplify the process for patients and staff to reduce errors, claims, and staff time and to improve security and customer satisfaction.

The revised process has each veteran secure their own belongings in a bag; admissions staff witness and oversee the process. During the first year, implementation of this system resulted in a 54 percent reduction in total clothing room claims and a reduction of 1,309 staff time hours (an estimated value of $37,464). In addition, there were no theft or loss claims.

Podiatry Access

Timely access to the podiatry clinic was identified as a concern primarily due to delays, missed opportunities, and patient flow issues. Using system redesign principles, an in-depth analysis was initiated by podiatry clinic staff (physician, nurses, and support staff), and root causes of the inefficiencies were identified.

Changes to the process included:

- Modifying the scheduling package to prevent overload at 8 a.m. and 1 p.m.
- Providing patients with the clinic phone number to request appointment cancellations.
- Completing preliminary clinical requirements at the time of the consult.
- Instituting reminder phone calls 2 days prior to appointments.
- Providing alternatives to face-to-face visits (for example, mail delivery of prosthetic devices).
- Discontinuing automatic rescheduling of "no shows."

- Seeing patients who arrive late to appointments instead of rescheduling.
- Improving telephone consultation process.
- Discharging patients back to primary care.

As a result of these changes, the podiatry clinic now maintains a 99 percent rate for new patient visits within 30 days. Also, missed opportunities are rare (2 percent).

Results

Review Activities With Recommendations

Medication Management

The purpose of this review was to evaluate whether the system had developed effective and safe medication management practices. We reviewed selected medication management processes in the inpatient medical (which includes oncology and spinal cord injury), inpatient surgical, telemetry, medical intensive care, surgical intensive care, and short stay units and in two MH and two 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 pain score within 240 minutes of administration. We reviewed the BCMA records of 50 patients who received a total of 158 doses of PRN pain medications. We found that 133 (84 percent) of the 158 doses administered had effectiveness documented within the timeframe specified by local policy.

Recommendation 1

We recommended that the VISN Director ensure that the System Director requires that nurses consistently document PRN pain medication effectiveness in the BCMA record within the timeframe specified by local policy.

The VISN and System Directors concurred with the finding and recommendation. On November 30, 2009, nursing staff

initiated hourly rounds to assess and document PRN pain medication effectiveness. Documentation will be monitored monthly, and results will be reported to the Nursing Quality Council and reviewed by the Patient Care Services Quality Council. Any trends and required actions will be reported to the Performance Improvement Board and the Executive Quality Council. The corrective actions are acceptable, and we consider this recommendation closed.

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 Joint Commission (JC) standards.

We inspected the inpatient medical, inpatient surgical, MH, medical intensive care, surgical intensive care, hemodialysis, and CLC units. We also inspected the outpatient clinic; the emergency department; the supply, processing, and distribution department; the pulmonary and gastroenterology clinics; and the prosthetics and sleep laboratories. The system maintained a generally clean and safe environment. However, we identified the following condition that needed improvement.

EOC Rounds. EOC rounds conducted by the system's inspection team allow each discipline participating to identify and correct discrepancies, unsafe working conditions, and other regulatory violations. Representation from each discipline enables the team to cover the system in depth. A Deputy Under Secretary for Health for Operations and Management memorandum issued on March 5, 2007, requires the ISO to be included as a team member on EOC rounds. The ISO or the ISO's designee participated in 20 (67 percent) of 30 weekly EOC rounds.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires that the ISO consistently participate in EOC rounds.

The VISN and System Directors concurred with the finding and recommendation. Since October 1, 2009, the ISO has attended all EOC rounds. EOC rounds attendance is reported at the monthly EOC Committee meetings, and any trends will be addressed by the Associate Director. The

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

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient intra-facility transfers, discharges, and post-discharge 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 documentation for 21 intra-facility transfers and determined that clinicians appropriately managed all 21. 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 20 patients who were discharged and found that all patients received appropriate written discharge instructions. We also found documentation that the patients understood those instructions.

Additionally, we reviewed the medical records of six patients recently discharged from the acute MH units. 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. We made no 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 12 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, five 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.

Physician Credentialing and Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for C&P physicians. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[1] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found 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 requested privileges. We made no recommendations.

Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the

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

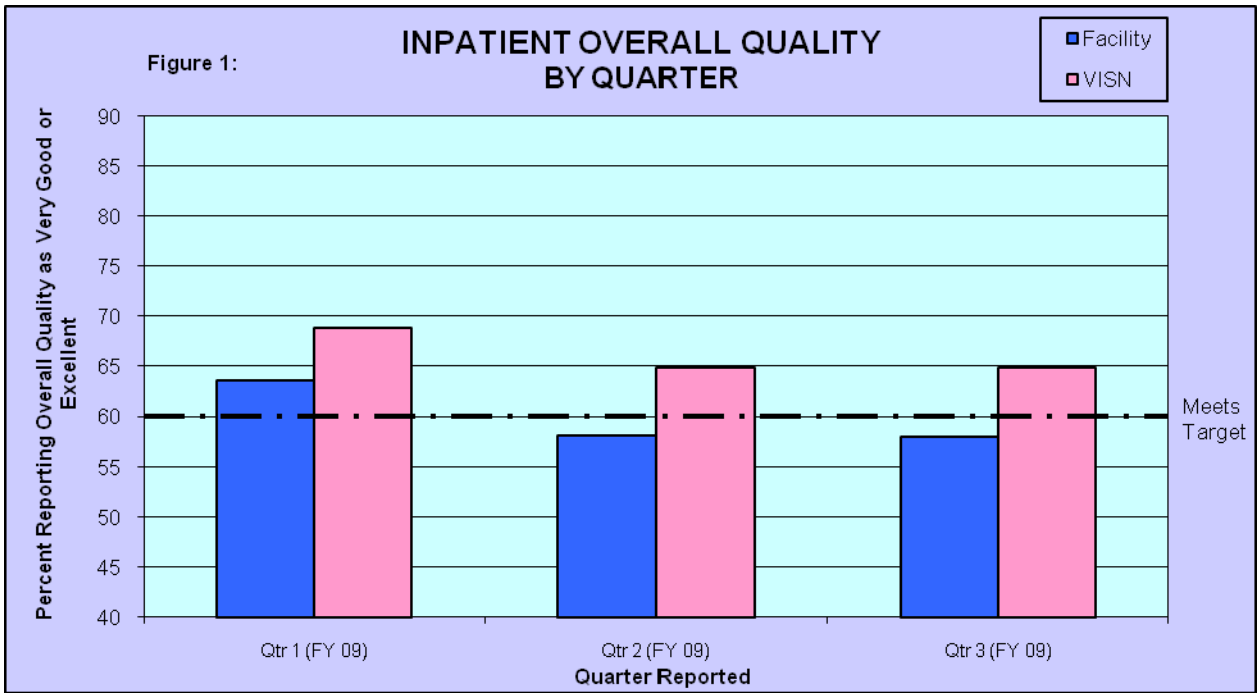
system's Director and Chief of Staff, and we interviewed QM personnel. We evaluated plans, policies, performance improvement data, and other relevant documents.

The system's QM program was effective and well managed. Senior managers supported the program through participation in and evaluation of performance improvement initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. We made no recommendations.

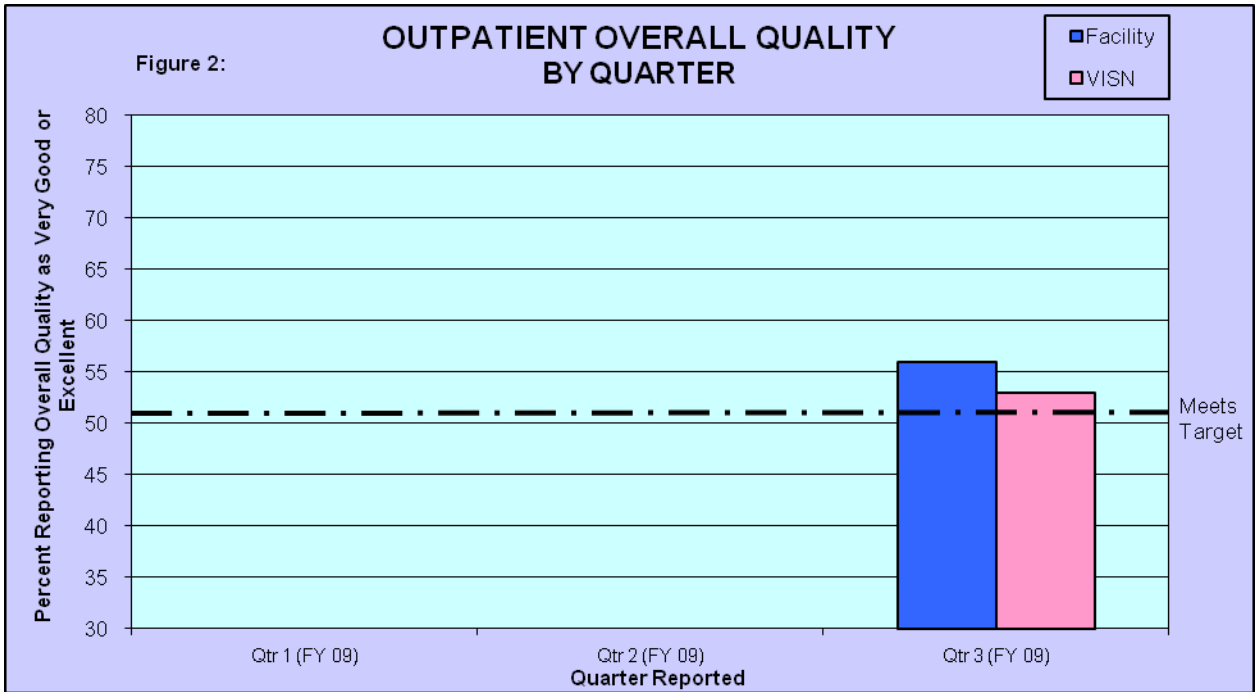
VHA Satisfaction Surveys

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 below 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.[2] Target scores are noted on the graphs.

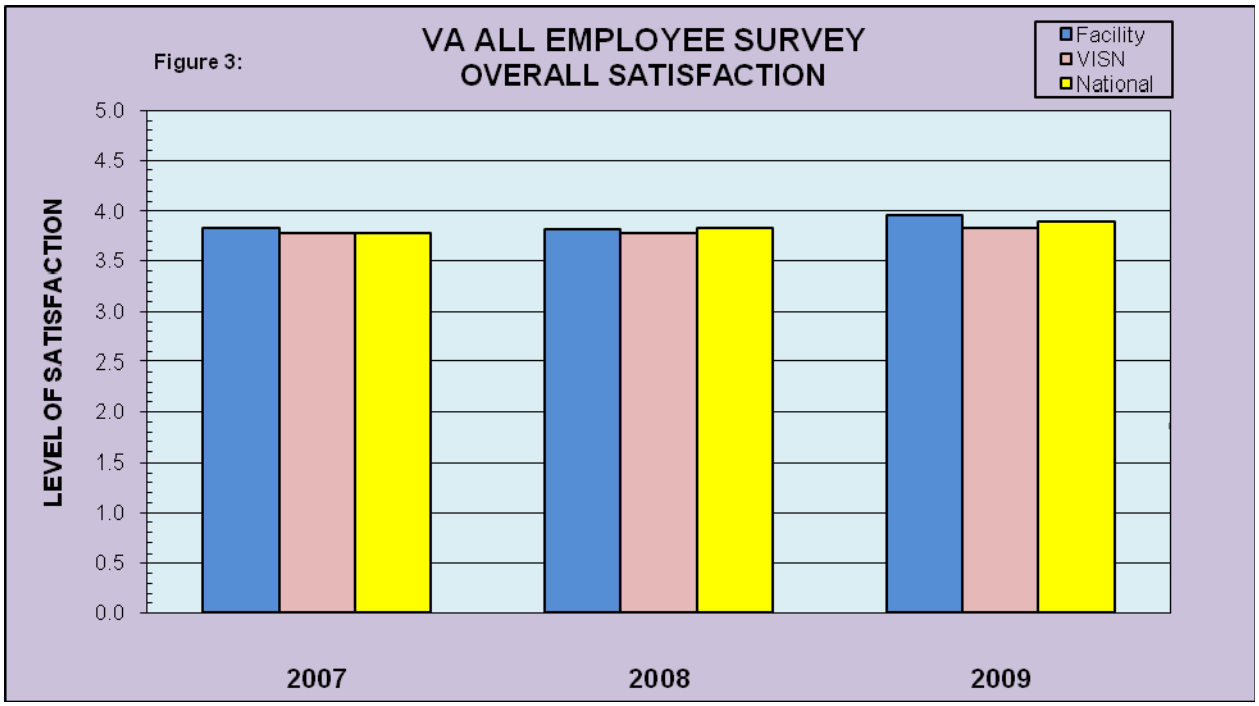
Figure 1:



[2] 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.



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.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 4, 2009

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

Subject: **Combined Assessment Program Review of the Phoenix VA Health Care System, Phoenix, Arizona**

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

Director, Management Review Service (10B5)

I concur with the facility response to the recommendations for improvement contained in the Combined Assessment Program review of the Phoenix VA Health Care System, Phoenix, Arizona. For questions, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18 at (602) 222-2699.

(original signed by:)

SUSAN P. BOWERS

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 1, 2009

From: Director, Phoenix VA Health Care System (644/00)

Subject: **Combined Assessment Program Review of the Phoenix VA Health Care System, Phoenix, Arizona**

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

1. The recommendations made during the Office of Inspector General Combined Assessment Program Review conducted October 26–30, 2009, have been reviewed, and implementation plans and subsequent actions have been completed.

2. We would like to commend the OIG CAP Review Team that conducted our review. The team, led by Dr. Wilma Reyes including members Karen Moore, Marilyn Walls, Stephanie Hills, Cathleen King, Warren Porter, and Linda DeLong, was consultative and professional and provided excellent feedback to our staff.

3. If you have any questions, please contact Sally Compton, QM Program Manager, Quality Management Department at (602) 277-5551 ext. 6777.

(original signed by:)

GABRIEL PÉREZ
Medical Center Director

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 nurses consistently document PRN pain medication effectiveness in the BCMA record within the timeframe specified by local policy.

Concur

Facility Response: During the week of November 2, 2009, appropriate procedures to document PRN pain medication effectiveness in the BCMA record within the timeframe specified by local policy (4 hours) were discussed by Nurse Managers with staff administering pain medications.

Effective November 30, 2009, nursing staff initiated hourly rounds for nursing units where nursing staff assess PRN effectiveness for patients who have received pain medications within the last hour and will document PRN effectiveness when rounds are completed. Monitoring of PRN pain medication effectiveness documentation will be conducted monthly by nursing staff as part of charts audits with results reported to the Nursing Quality Council and reviewed by the Patient Care Services Quality Council. Trends and any required actions will be reported to the facility Performance Improvement Board and Executive Quality Council.

We recommend this item be closed.

Target Completion Date: Completed

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that the ISO consistently participate in EOC rounds.

Concur

Facility Response: The System Director discussed the requirement for the facility Information Security Officer to attend Environment of Care Rounds with the VISN ISO on November 2, 2009. EOC Rounds attendance records are maintained by the facility's Safety Specialist, and beginning October 1, 2009, the facility ISO has attended all EOC Rounds to date. EOC Rounds attendance is reported at the monthly EOC

Committee, and any trends will be addressed by the Associate Director who is the EOC Committee chairperson, with follow up to the System Director or VISN ISO, as appropriate.

We recommend this item be closed.

Target Completion Date: Completed

OIG Contact and Staff Acknowledgments

Contact	Linda G. DeLong, Director Dallas Office of Healthcare Inspections (214) 253-3331
Contributors	Wilma Reyes, Team Leader Laura Dulcie Stephanie Hills Cathleen King Karen Moore Warren Porter Marilyn Walls Richard Cady, Office of Investigations Diana Cahill, Office of Investigations John Waugh, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Southwest Health Care Network (10N18)
Director, Phoenix VA Health Care System (644/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jon Kyl, John McCain
U.S. House of Representatives: Ed Pastor

This report is available at http://www.va.gov/oig/publications/reports-list.asp.