Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Cheyenne VA Medical Center Cheyenne, Wyoming

Report No. 06-01519-78 **February 6, 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 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 and benefits 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

The Office of Inspector General conducted a Combined Assessment Program (CAP) review of the Cheyenne VA Medical Center (the medical center), Cheyenne, WY, during the week of July 10–14, 2006. 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 54 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 19.

Results of Review

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

- Breast Cancer Management.
- Diabetes and Atypical Antipsychotic Medications.
- Survey of Healthcare Experiences of Patients.

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

- Strengthen the Contract Community Nursing Homes (CNH) oversight process by complying with oversight committee requirements, performing annual CNH reviews, and completing monthly visits to CNH patients.
- Separate clean equipment from contaminated equipment in the prosthetics department.
- Strengthen the QM program by documenting a planned, systematic, organization-wide approach to performance improvement that includes consistent data analysis and evaluation of follow-up actions.

This report was prepared under the direction of Ms. Virginia Solana, Director, and Ms. Dorothy Duncan, Associate Director, Kansas City Regional Office of Healthcare Inspections.

VISN 19 and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the CAP review findings and provided acceptable improvement plans (see Appendixes A and B, pages 11–15, 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

Medical Center Profile

Organization. The Cheyenne VA Medical Center (the medical center) provides inpatient and outpatient services in Cheyenne, WY, and provides outpatient care at community based outpatient clinics located in Fort Collins and Greeley, CO, and Sidney, NE. The medical center is part of Veterans Integrated Service Network (VISN) 19 and serves a veteran population of approximately 69,000 in a primary service area that includes five counties in Wyoming, six counties in Colorado, and seven counties in Nebraska.

Programs. The medical center provides primary and secondary inpatient services in medicine and general surgery, as well as outpatient services in medicine, surgery, and psychiatry. The medical center has 21 inpatient beds and 50 nursing home beds.

Affiliations. The medical center is affiliated with the University of Wyoming Family Practice Residency Program and supports four resident positions. Other affiliates include programs from the University of Wyoming and the University of Northern Colorado for nursing, audiology, dental, pharmacy, psychology, radiology, speech pathology, physical medicine/rehabilitation, dietetics, and social work students.

Resources. In fiscal year (FY) 2005, the medical center budget was $52.8 million, a 10.5 percent increase over the FY 2004 budget. Staffing in FY 2005 was 423.6 full-time equivalent employees (FTE), including 23 physician and 98 nursing FTE.

Workload. In FY 2005, the medical center treated 14,113 unique patients, a 2.7 percent increase over FY 2004. The medical center's inpatient care workload totaled 954 discharges, and the average daily census was 14. The nursing home average daily census was 37. The FY 2005 outpatient workload totaled 137,879 visits.

Objectives and Scope of the Combined Assessment Program Review

Objectives. Combined Assessment Program (CAP) reviews are one element of the Office of Inspector General's (OIG's) efforts to ensure that our Nation's veterans receive high quality VA health care and benefits services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care and quality management (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:

- Breast Cancer Management
- Contract Community Nursing Homes (CNH)
- Diabetes and Atypical Antipsychotic Medications
- Environment of Care
- QM
- Survey of Healthcare Experiences of Patients (SHEP)

The review covered facility operations for FYs 2005 and 2006 through June 30, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on the recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Cheyenne VA Medical Center, Cheyenne, Wyoming,* Report No. 03-02029-45, December 19, 2003).

During this review, we also presented fraud and integrity awareness briefings for 54 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 summarize selected focused inspections and 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 section titled “Other Review Topics” have no reportable conditions.

Results of Review

Opportunities for Improvement

Contract Community Nursing Homes – Program Oversight Needed To Be Strengthened

Condition Needing Improvement. The CNH Oversight Committee needed to have representation from QM and meet at least quarterly. The CNH review team needed to perform Veterans Health Administration (VHA) required annual reviews at all contracted facilities. A social worker and registered nurse needed to alternate monthly follow-up visits to all CNH patients or document alternatives to monthly visits.

VHA policy defines the CNH Oversight Committee responsibilities, membership, and frequency of meetings. A QM representative must be a member of the committee, and the committee must meet at least quarterly. According to committee minutes, there was no QM representation, and the committee met once in the last 12 months. The current medical center CNH policy does not include QM representation on the committee and designates meeting frequency as annually.

VHA requirements state that a CNH team, consisting of at least nursing, safety, and social work, must conduct and document reviews of all CNHs every 12 months. The team must complete the annual reviews no more than 90 days prior to expiration of contracts. Information gained from these reviews is used to examine the nursing homes' compliance with quality standards and for comparison with other homes in the state. These reviews must designate areas of deficiency and actions taken to resolve problems. The medical center contracts with six CNHs. Annual reviews had not been completed in two of the six CNHs during the previous 5 years. In addition, the team did not consistently include all required disciplines.

VHA requires that a social worker and a registered nurse must alternate visits and see VA patients in CNHs every 30 days, unless otherwise indicated in the patients' individual treatment plans. We reviewed the charts of four CNH patients. Monthly visits for one patient had not been conducted for 12 months. Program managers reported that this was because the assigned social worker had been ill, and supervisors had not assigned an alternate social worker to complete the visits.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) include QM representation on the CNH Oversight Committee, ensure the committee meets quarterly, and update local policy to meet VHA oversight committee requirements; (b) define the members included in the annual CNH review team and ensure they complete required evaluations; and (c) ensure that staff complete monthly CNH visits according to VHA guidelines.

The VISN and Medical Center Directors agreed with the findings and recommendations. The medical center revised their policy to meet VHA standards and defined membership of the CNH review team. The CNH Oversight Committee will meet quarterly. The Quality Manager will monitor monthly and annual CNH inspections. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Environment of Care – Clean and Contaminated Equipment Needed To Be Stored Separately

Condition Needing Improvement. Clean and contaminated equipment were stored next to each other in the prosthetics department. The contaminated equipment items included wheelchairs and adaptive devices that patients had used and returned. VHA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require that clean and contaminated equipment be clearly identified and stored separately to avoid the risk of potential infection.

The medical center generally had a clean and safe environment for patients and employees. Inpatient and outpatient units and waiting rooms were clean and free from clutter. We randomly selected eight pieces of medical equipment to evaluate cleanliness, safety, and maintenance. The medical equipment was clean, working properly with operational alarms, and had evidence of current preventive maintenance checks.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the prosthetics department store clean equipment separate from contaminated equipment.

The VISN and Medical Center Directors agreed with the findings and recommendation. A process has been developed to pick up contaminated equipment. A storage closet for contaminated equipment will be constructed in the near future. Infection Control will monitor the process. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Quality Management – Program Coordination and Processes Needed Improvement

Condition Needing Improvement. The medical center needed to implement a planned, systematic, organization-wide approach to performance improvement. Program managers needed to ensure that designated committees consistently analyze data in order to identify trends and make recommendations for improvement. In addition, they needed to evaluate the effectiveness of implemented improvement activities. JCAHO requires hospitals to transform data into information in order to make recommendations to improve care. The QM program generally provided appropriate oversight of clinical

care; however, committees needed to analyze data, define follow-up actions, and evaluate the effectiveness of those actions. Similar findings were noted in the 2003 CAP report.

The medical center QM plan was vague and did not include a description of the reporting structure or the model used for performance improvement. Although the plan included specific service monitors, it did not include all QM activities, and it was not clear how leadership was involved in setting priorities for improvement activities. The Performance Improvement Executive Group (PIEG) was the oversight committee for QM operations. Although data was presented to the committee, it was not consistently trended and analyzed to identify opportunities for improvement.

The following program areas needed specific improvements:

Resuscitation Review. The medical center collected data and reported on individual resuscitation events but had not trended the events over time by area, shift, day of the week, or outcome, as required by VHA policy.

Peer Review. VHA policy requires that clinicians meet at least quarterly and complete peer reviews within 120 days from determination that a peer review is necessary. Clinicians had not completed peer reviews within the required timeframe and had not met quarterly, as required by VHA policy.

Disclosure Process. When serious adverse events occur as a result of patient care, VHA and local policies require staff to discuss the events with patients and, with input from Regional Counsel, inform them of their right to file tort or benefit claims. The medical center reported they had not documented that they advised patients about their right to file claims, although a local policy delineated the process and included a template for documentation.

Patient Complaints. The program manager was reporting patient complaint data to the PIEG, but the committee did not document actions taken for improvement. The QM Coordinator reported that actions had been taken and gave examples but agreed that the actions were not documented. This was a repeat finding from the previous CAP report.

Restraint Usage. Restraint usage was restricted to the intensive care unit (ICU). Documentation for restraint usage was sporadic and did not always indicate that staff had considered preventive strategies, alternatives, and least restrictive methods prior to each episode. The medical center had contract staff to observe patients in restraints, but they did not always complete the required forms. JCAHO requires specific documentation and assessment of restraint usage in order to minimize the use of restraints and ensure each episode is clinically justified.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the QM plan be written to include a description of all

performance improvement requirements and an overview of reporting processes for all program areas; (b) program managers consistently trend and analyze data, document recommendations, and evaluate follow-up actions; (c) responsible clinicians trend resuscitation data as required; (d) the Peer Review Committee meet quarterly and complete all reviews within the required timeframe; (e) responsible staff members fully inform patients who experience adverse events and document the discussions; (f) the PIEG analyze patient complaints and document recommendations and actions for improvement; and (g) responsible staff complete required documentation for each restraint episode.

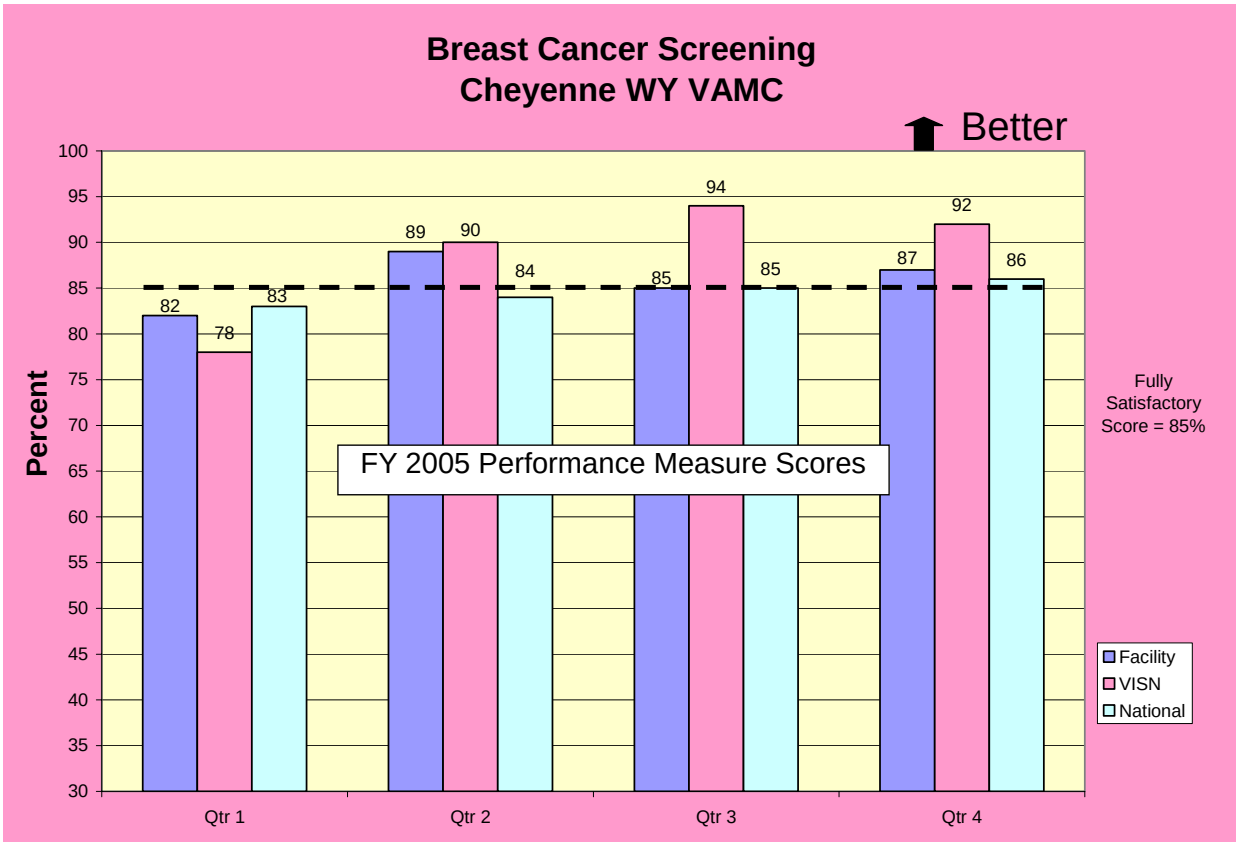
The VISN and Medical Center Directors agreed with the findings and recommendations. The Medical Center revised their Performance Improvement Plan to require program managers to trend and analyze data, document recommendations, and evaluate follow-up actions. QM will review the program minutes for a minimum of 6 months to ensure compliance with the plan. The ICU Committee will trend resuscitation data. The Peer Review Committee will meet quarterly and clinicians will complete peer reviews within 120 days. Responsible staff members will disclose adverse actions to patients and document discussions in the patients' medical records. Clinicians will complete required documentation for each restraint episode, and the ICU Committee will monitor restraint episodes on a monthly basis. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Other Review Topics

Breast Cancer Management

The medical center met the VHA performance measure for breast cancer screening; provided timely radiology, surgery, and oncology consultative and treatment services; promptly informed patients of diagnoses and treatment options; and developed coordinated interdisciplinary treatment plans.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center achieved the fully satisfactory level in 3 of 4 quarters in FY 2005, as shown in the subsequent chart.



Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We reviewed these items in a random sample of 10 patients who had abnormal mammography findings during FY 2005. Because clinicians had appropriately screened all patients, performed timely diagnostic procedures, promptly informed patients of results, and provided timely follow-up services, as shown in the following table, we did not make any recommendations.

Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
10/10	10/10	10/10	10/10	10/10

Diabetes and Atypical Antipsychotic Medications

Clinicians appropriately screened and managed mental health patients receiving atypical antipsychotic medications. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving

atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes).

VHA clinical practice guidelines for the management of diabetes suggest that a diabetic patient's hemoglobin A1c (HbA1c)[1] should be less than 9 percent; blood pressure (BP) should be 140/90 millimeters of mercury (mmHg) or less; and low density lipoprotein cholesterol (LCL-C) should be less than 120 milligrams per deciliter (mg/dl). To receive fully satisfactory ratings for the diabetes performance measures, the medical center must achieve the following scores:

- HbA1c greater than 9 percent – 15 percent or lower
- BP less than or equal to 140/90mmHg – 72 percent or higher
- Cholesterol (LDL-C) less than 120mg/dl – 75 percent or higher

We reviewed a sample of 13 randomly selected patients who were on one or more atypical antipsychotic medications for at least 90 days. Four of the 13 patients had diabetes. We were unable to find a current BP reading on one of the four diabetic patients. Clinicians stated that this was because the patient was a "no-show" for his primary care appointments. Because the patient kept his mental health clinic appointments, they agreed with our suggestion to record his vital signs before those appointments.

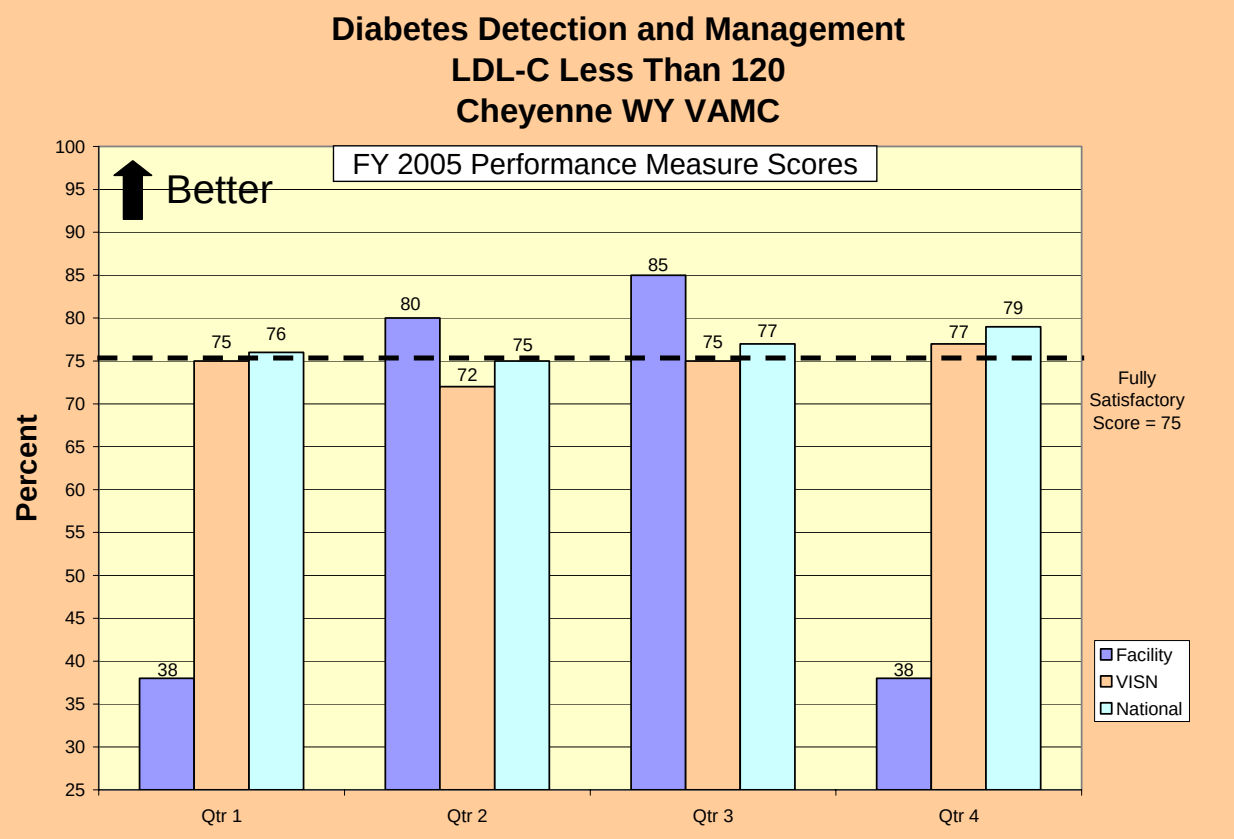
Diabetic patients with BP less than 140/90mm/Hg	Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with LDL-C less than 120mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
3/4	0/4	1/4	8/9	8/9

All of the diabetic patients we reviewed had controlled HbA1c levels. Three of the four diabetic patients had LDL-C levels greater than the desired level, and the medical center did not meet VHA performance goals for this measure as shown in the chart on the following page. Because the Chief of Staff was able to demonstrate plans the medical center had implemented to decrease cholesterol levels in all their patients, we did not make a recommendation for this measure.

Of the nine non-diabetic patients, clinicians had documented that eight patients had been appropriately screened for diabetes and received prevention counseling. The one patient who did not was another mental health patient who did not keep his primary care appointments. Clinicians stated they would begin performing fasting blood glucose tests and diabetes prevention counseling at mental health clinic appointments for any patients

[1] HbA1c reflects the average blood glucose level over a period of time and should remain in control to prevent complications.

who were at risk and non-compliant with primary care appointments. We agreed with their plans and did not make any recommendations.



Survey of Healthcare Experiences of Patients

The Survey of Healthcare Experiences of Patients (SHEP) scores either met national targets, or the medical center had initiated improvement plans in areas where targets were not met. Veteran patient satisfaction surveying is designed to promote healthcare quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit healthcare surveying group. VHA set FY 2006 SHEP target results of patients reporting overall satisfaction of Very Good or Excellent at 76 percent for inpatients and 77 percent for outpatients. The following tables show the medical center's inpatient and outpatient SHEP results compared to VISN 19 and national survey results.

Cheyenne VA Medical Center
Inpatient SHEP Results 1st and 2nd Quarter FY 2006

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03
VISN	85.6+	83+	92.9+	71.7+	69+	78.5+	86.6+	78.1+	72.9+
Medical Center	**87.9+**	**83.7+**	**93.8+**	**74.6+**	**73.8+**	**76.30**	**86.8+**	**81.4+**	**73.6+**

Legend: + Significantly better than national average

Cheyenne VA Medical Center
Outpatient SHEP Results 2nd Quarter FY 2006

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.7	78.1	94.8	72.6	83.3	75.8	81.5	65.5	81.7	80.8	84.7
VISN	82	76.9	95	73.9	86.7 +	76.9	84.8	71.9	82.8	79.1	87.6 +
Outpatient Clinics - Overall	86.7	87	99.2 +	82.8	95.8 +	88.6 +	*	66.1	91.2 +	80	94.4 +
Sidney Outpatient Clinic	*	*	*	*	*	*	*	*	*	*	*
Fort Collins Outpatient Clinic	87.1 +	79.9	93.6	68.1	85.2	72.8	83.9	*	82.6	82.3	84.6
Greeley Outpatient Clinic	88.1 +	85.4	97.6 +	74.9	88.7	80.4	84.8	*	86.8	76.9	83.5

Legend: * Less than 30 respondents
+ Significantly better than national average

The medical center continuously strives to improve patient satisfaction and SHEP scores. Managers have shared results with employees at service level meetings and stressed the importance of customer service. We did not make any recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 20, 2006

From: Director, Veterans Integrated Service Network (10N19)

Subject: **Cheyenne VA Medical Center, Cheyenne, Wyoming**

To: Director, Management Review Service (10B5)

Thru: Director, Kansas City Regional Office of Healthcare Inspections (54KC)

1. Attached is the facility response to the OIG CAP Site Review of the Cheyenne VAMC.

2. I have reviewed and concur with all the facility Director's comments.

3. If you have any questions, please contact Dr. Kilpatrick, MD, Medical Center Director, Cheyenne VAMC, at 307-778-7300.

(original signed by:)

LAWRENCE A. BIRO
Network Director
VISN 19 Rocky Mountain Network

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 16, 2006

From: Director, Cheyenne VA Medical Center (442/00)

Subject: **Cheyenne VA Medical Center, Cheyenne, Wyoming**

To: Director, Veterans Integrated Service Network (10N19)

The Combined Assessment Program Review of the Cheyenne VA Medical Center has been read and studied. The three recommendations involving Contract Community Nursing Homes, Environment of Care, and Quality Management were reviewed in depth.

I concur with the Office of Inspector General's review and recommendations. Action plans were in place following the CAP review. They have been updated and are attached.

Should you have any questions or concerns, you may contact me (307) 778-7300 or the Quality Manager, Laurel Williams, at (307) 778-7525.

(original signed by:)

DAVID M. KILPATRICK, M.D.
Medical Center Director

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's Report:

OIG Recommendation(s)

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) include QM representation on the CNH Oversight Committee, ensure the committee meets quarterly, and update local policy to meet VA oversight committee requirements; (b) define the members included in the annual CNH review team and ensure they complete required evaluations; and (c) ensure that staff complete monthly CNH visits according to VHA guidelines.

Concur **Target Completion Date:** Complete

a. A new RN chair was appointed. The membership now includes the Chief of Staff, Patient Care Service Line Director, RN Chair, Social Worker, Patient Safety Officer, and Quality Manager. The meetings will be held quarterly. The local policy was updated to meet VA oversight committee requirement: CD11-06-15, Community Care Committee.

b. Members of the CNH review team are the Community Care Coordinator, RN, Social Worker, Patient Safety Officer, and Infection Control Coordinator (others designated as appointed by the Community Care Committee).

c. Annual and monthly inspections will take place in accordance with the VHA Directive 1143.2 and the Cheyenne Center Directive 11-06-16: Contract and Community Nursing Home Program. This will be monitored monthly by the Quality Manager.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the prosthetics department store clean equipment separate from contaminated equipment.

Concur **Target Completion Date:** January 2007

Since no additional space is available for storage of dirty equipment, dirty equipment will be bagged, tagged, and picked up by local DME provider. Spot checks will be performed by the Infection Control Coordinator. A closet will be constructed in the near future for dirty items.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) the QM plan be written to include a description of all performance improvement requirements and an overview of reporting processes for all program areas; (b) program managers consistently trend and analyze data, document recommendations, and evaluate follow-up actions; (c) responsible clinicians trend resuscitation data as required; (d) the Peer Review Committee meet quarterly and complete all reviews within the required timeframe; (e) responsible staff members fully inform patients who experience adverse events and document the discussions; (f) the PIEG analyze patient complaints and document recommendations and actions for improvement; and (g) responsible staff complete required documentation for each restraint episode.

Concur **Target Completion Date:** January 2007

a. A revised Performance Improvement Plan has been written (to include required elements) and approved by the Performance Improvement Executive Group (PIEG). It was then sent through required channels and approved for distribution.

b. Minutes from all program meetings and functional committee minutes will be sent to and reviewed by the Quality Management Department for a minimum of 6 months.

c. Clinicians who are members of the ICU Committee will trend resuscitation data as required.

d. Quarterly Peer Review Committee meetings will be held. In addition, clinicians will complete peer reviews within 120 days from the determination that a peer review is necessary. First quarter ’07 meeting was held October 31, 2006.

e. Responsible staff members will continue to fully inform patients who experience adverse events. In addition, documentation of such discussions will be available in the patient’s medical record.

f. Analysis and documentation of actions taken for improvement must be available in PIEG minutes. The minutes will be monitored monthly by the QM Department.

g. Responsible staff (physicians and nurses) are to complete required documentation for each restraint episode according to Cheyenne Center Directive. The ICU Committee will monitor restraint episodes (and aggregate reviews) on a monthly basis.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections 816/426-2023
Acknowledgments	Dorothy Duncan Jennifer Kubiak Reba Ransom Randy Rupp Marilyn Stones

Appendix D

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