Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-00732-124

Combined Assessment Program Review of the Jack C. Montgomery VA Medical Center Muskogee, Oklahoma

May 12, 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 March 16–19, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Jack C. Montgomery VA Medical Center (the medical center), Muskogee, OK. 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 527 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 16.

Results of the Review

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

- Dental Service Consultation Completion.

We made recommendations in four of the activities reviewed. For these activities, the medical center needed to:

- Complete initial peer reviews within the timeframe specified by Veterans Health Administration (VHA) policy.
- Require that provider performance improvement (PI) data is collected, analyzed, reviewed, considered as part of the reprivileging process, and recorded in Professional Standards Board (PSB) minutes.
- Update the local policy for emergency response and certification and ensure that designated staff maintain Basic Life Support (BLS) and/or Advanced Cardiac Life Support (ACLS) certification.
- Document pain medication effectiveness in accordance with local policy.
- Provide annual training on the environmental hazards that represent a threat to suicidal patients to all staff who work on the locked behavioral health unit and to members of the Multidisciplinary Safety Inspection Team.
- Document that patients discharged from the emergency department (ED) receive a written copy of discharge instructions and verbalize understanding.

The medical center complied with selected standards in the following three activities:

- Coordination of Care.
- Suicide Prevention Program.
- Survey of Healthcare Experiences of Patients (SHEP).

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

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided 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 medical center is a primary medical and surgical facility located in Muskogee, OK, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics (CBOCs) in Hartshorne and Tulsa, OK. The medical center is part of VISN 16 and serves a veteran population of more than 56,400 throughout eastern Oklahoma.

Programs. The medical center provides medical, surgical, primary care, and mental health (MH) services. It has 91 hospital beds. The medical center does not have a community living center.[1]

Affiliations and Research. The medical center is affiliated with Oklahoma State University's College of Osteopathic Medicine and the University of Oklahoma's College of Medicine and provides training for six medical residents per month. It also provides training for other disciplines, including physical therapy, nursing, radiation technology, phlebotomy, physician assistants, nurse practitioners, social work, optometry, and psychology. In fiscal year (FY) 2008, the medical center research program had four projects and a budget of $17,700 for staffing. An important area of research was heart disease.

Resources. In FY 2008, medical care expenditures totaled $138 million. The FY 2009 medical care budget is $164 million. FY 2008 staffing was 963 full-time employee equivalents (FTE), including 65 physician and 207 nursing FTE.

Workload. In FY 2008, the medical center treated 32,817 unique patients and provided 23,877 inpatient days. The inpatient care workload totaled 4,041 discharges, and the average daily census was 65. Outpatient workload totaled 311,794 visits.

[1] A community living center (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.

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:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- Environment of Care (EOC).
- Medication Management.
- QM.
- SHEP.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and FY 2009 through March 16, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Muskogee VA Medical Center, Muskogee, Oklahoma,* Report No. 06-00896-212, September 18, 2006). The medical center had corrected all findings related to health care from the prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 527 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 Strength

Dental Service Consultation Completion

In FY 2007, dental consultation requests averaged 27 days for completion. A daily walk-in clinic was established in the 1st quarter of FY 2008 for all inpatients and eligible outpatients with emergency dental treatment needs and for veterans with a compelling medical need, such as insulin dependent diabetes mellitus and pre-surgical evaluation. Since the clinic was established, dental consultation completion times have improved and now average 7 days.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the medical center had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, PI data, and other relevant documents. We interviewed appropriate senior managers and the QM Coordinator.

The medical center's 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 that initial reviews are completed within 45 days. In FY 2008, 8 (14 percent) of 58 peer reviews exceeded 45 days for the initial review. For

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

FY 2009 through March 16, 2009, 4 (8 percent) of 52 peer reviews exceeded 45 days for the initial review. The peer review process needed to be improved to ensure timely completion of initial reviews.

Provider Performance Monitoring. VHA regulations[3] and Joint Commission (JC) standards require that clinical managers develop plans for continuous performance monitoring of the medical staff. According to the requirements, performance data should be ongoing, include indicators for continuing qualifications and competencies, be reviewed and considered during the reprivileging process, and be recorded in PSB minutes. At the time of our site visit, plans for ongoing physician competency monitoring had been developed. We reviewed credentialing and privileging (C&P) folders and corresponding PI data for 17 providers reprivileged in the past 12 months. We found that 15 (88 percent) of 17 providers had inadequate data recorded in PSB minutes to support the privileges granted.

Resuscitation and Outcomes. Local policy requires the medical center to have a mechanism in place to consistently review staff compliance with current BLS and/or ACLS certification. We reviewed documentation for staff required to have current BLS certification and found that 10 (2 percent) of 535 certifications had expired. Also, we identified that 1 (1 percent) of 115 staff required to have ACLS certification had an expired certification. Additionally, review of the local policy for cardiopulmonary resuscitation and response to medical emergency situations identified the need for the policy to be updated to place an emphasis on airway management.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that initial peer reviews are completed within the timeframe specified by VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. If the initial peer review is not completed within 21 days, the Risk Manager will ensure that a message is sent to the appropriate individuals to alert them of the timeframe. Additionally, the timeframe for completion of the final review has been shortened to ensure compliance with VHA policy. The corrective action is acceptable, and we consider this recommendation closed.

[3] VHA Handbook 1100.19, *Credentialing and Privileging,* October 2, 2007.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that provider PI data be collected, analyzed, reviewed, considered as part of the reprivileging process, and recorded in PSB minutes.

The VISN and Medical Center Directors concurred with the findings and recommendation. The PSB minutes format has been changed to incorporate specific PI data. The improvement plan is acceptable, and we will follow up on the action to ensure completion.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that the local policy for emergency response and certification is updated and that designated staff maintain current BLS and/or ACLS certification.

The VISN and Medical Center Directors concurred with the findings and recommendation. Local policy will be updated to include the process for tracking BLS and/or ACLS certification. Reminders will be sent to employees and service chiefs prior to the expiration of certification. Service chiefs will monitor certification and will report monthly to the Executive Committee of the Medical Staff (ECMS). The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the intensive care, MH, and rehabilitation units and in two medicine units. We found appropriate use of patient armbands to correctly identify patients prior to medication administration. However, we identified one area that needed improvement.

Pain Medication Effectiveness. VHA regulations[4] and local policy require that the effects of pain medication are monitored. Local policy requires the use of a pain scale for documentation of a patient's initial pain level and for follow-up of pain medication effectiveness. We found that all 133 administered doses of pain medication reviewed had an

[4] VHA Directive 2003-021, *Pain Management*, May 2, 2003.

initial pain score documented. However, for 38 (29 percent) of the 133 doses, documentation for follow-up of pain medication effectiveness did not include a pain score.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to document pain medication effectiveness in accordance with local policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. The medical center developed a PowerPoint presentation that includes examples of how to document pain medication effectiveness. The presentation was provided to inpatient nurses. Pain medication effectiveness will be monitored and reported to the ECMS. The corrective action is acceptable, and we consider this recommendation closed.

Environment of Care

The purpose of this review was to determine if the medical center maintained a safe and clean health care environment. The medical center is required to provide a comprehensive EOC program that fully meets VA National Center for Patient Safety, Occupational Safety and Health Administration, and JC standards. The infection control (IC) program was evaluated to determine compliance with VHA directives based on the management of data collected and processes in which the data were used to improve performance.

We inspected the intensive care, medical and surgical, locked behavioral health, and rehabilitation units. We also inspected the ED and the dental clinic. The medical center maintained a clean and safe environment. The IC program monitored and reported data to clinicians for implementation of quality improvements. However, we identified one area that needed improvement.

Locked Behavioral Health Unit. All staff who work on the locked behavioral health unit and members of the Multidisciplinary Safety Inspection Team should receive the required annual training on environmental hazards that represent a threat to suicidal patients.[5] Initial training was provided at new employee orientation; however, specific ongoing annual training was not provided.

[5] Deputy Under Secretary for Health for Operations and Management, memorandum to VISN Directors, August 27, 2007.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires that all staff who work on the locked behavioral health unit and members of the Multidisciplinary Safety Inspection Team receive annual training on the environmental hazards that represent a threat to suicidal patients.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Suicide Prevention Coordinator (SPC) provided training to members of the Multidisciplinary Safety Inspection Team and to locked behavioral health unit staff. Training will continue to be provided annually. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of care and operations in VHA EDs and/or urgent care clinics, such as hours of operation, clinical services, consults, inter-facility transfers, staffing, and staff competencies. In addition, we inspected the ED and triage environments for cleanliness and safety.

We interviewed program managers, transfer coordinators, and physicians. We reviewed documents, including local policies, C&P folders, competency files, medical records of patients seen in the ED, and certified time schedules.

The ED is open 24 hours a day, 7 days a week. Emergency services provided are within the facility's patient care capabilities, and a policy is in place for managing patients whose care exceeds the medical center's capability. Our review demonstrated that clinical services, consults, staffing, and nursing competencies were documented appropriately. However, we identified one area that needed improvement.

Discharge Instructions. We reviewed the medical records of six MH patients discharged from the ED. We found no documentation that these patients received written discharge instructions and verbalized understanding of the instructions. The program manager informed us that a template was used to document discharge instructions; however, the template did not include whether a patient received a written copy of the instructions and verbalized understanding. Management updated the template while we were onsite.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires ED clinicians to document

that patients receive a written copy of discharge instructions and verbalize understanding.

The VISN and Medical Center Directors concurred with the findings and recommendation. Nurses are giving patients discharge instructions and will document patient understanding in the electronic medical record. The corrective action is acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether VHA facilities had adequate processes to ensure coordination of care across the continuum of patient services. We reviewed three aspects of care: (1) patient consults, (2) patient intra-facility transfers, and (3) patient discharges. We found that providers managed all three aspects appropriately. We made no recommendations.

Suicide Prevention Program

The purpose of this review was to determine whether VHA health care facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed SPCs at facilities and very large CBOCs,[6] and we evaluated whether SPCs fulfilled all required functions. Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags,[7] documented safety plans that addressed suicidality, and documented collaboration between MH providers and SPCs.

We interviewed the SPCs and MH providers. We reviewed pertinent policies and the medical records of 10 patients determined to be at risk for suicide. We found that documentation was complete in all 10 medical records. Senior managers had appropriately appointed SPCs, and the SPCs fulfilled the required functions. We made no recommendations.

[6] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled.
[7] A Category II Patient Record Flag is an alert mechanism that is displayed prominently in electronic medical records.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA facilities use quarterly survey results of patients' health care experiences with VHA to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure (PM) target results for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. Facilities are expected to address areas that fall below target scores. Figures 1 and 2 (below and on the next page) show the medical center's SHEP PM results for inpatients and outpatients, respectively.

Figure 1:

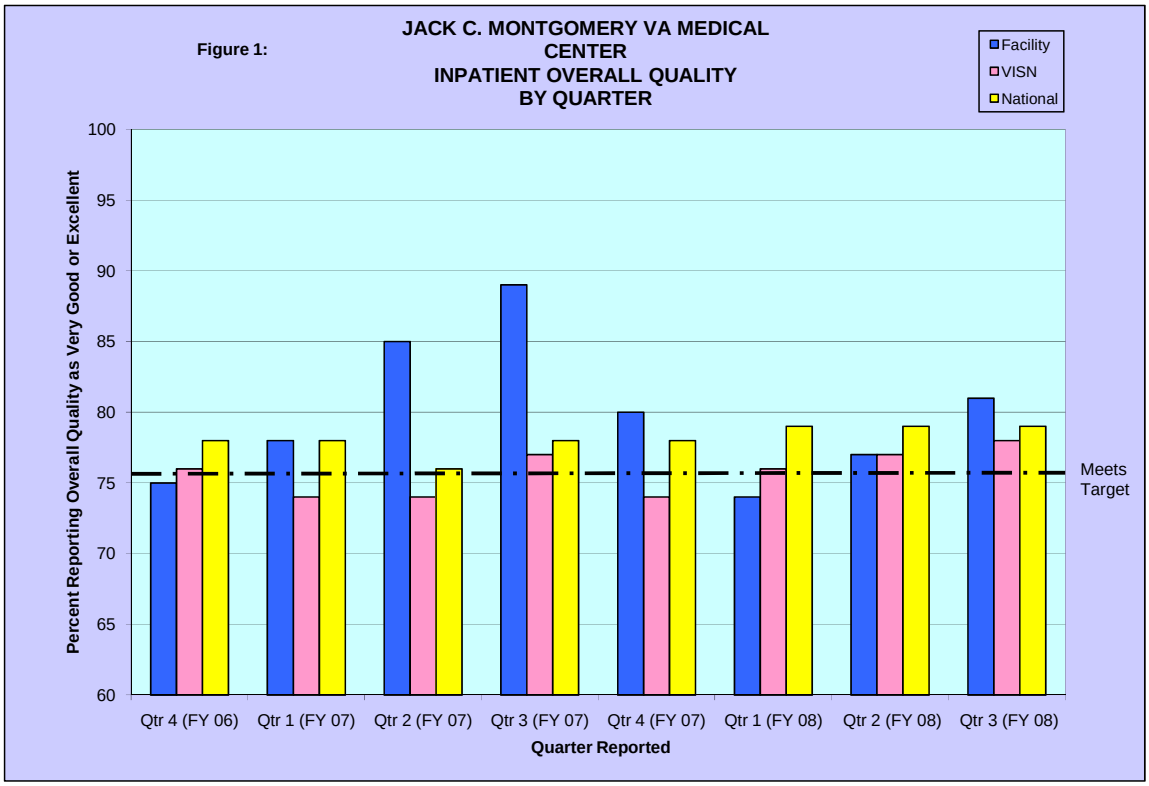
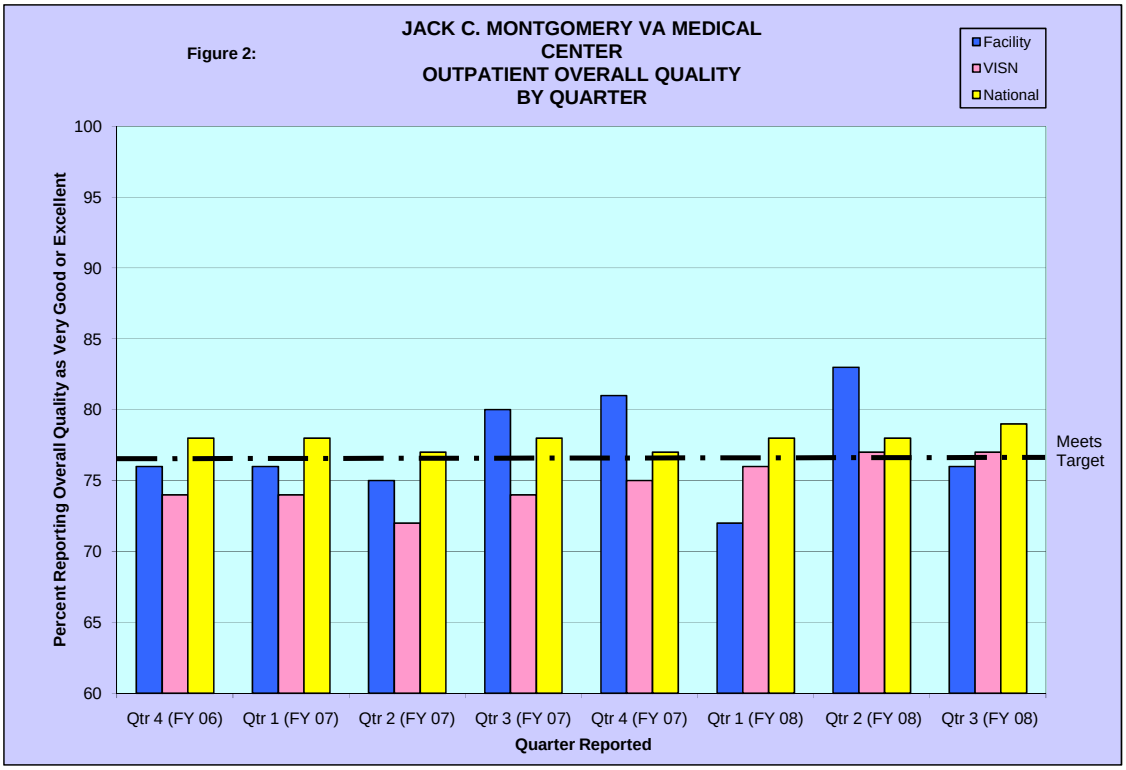


Figure 2:



The medical center did not meet the established target for 2 of the last 8 quarters of available data for inpatient satisfaction and 5 of the last 8 quarters of available data for outpatient satisfaction. However, managers had identified opportunities for improvement based on the SHEP survey scores and had developed action plans targeting specific services and departments. The action plans were implemented, and there was evidence of ongoing activities and evaluation for effectiveness. Therefore, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 16, 2009

From: Director, South Central VA Health Care Network (10N16)

Subject: **Combined Assessment Program Review of the Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma**

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

Director, Management Review Service (10B5)

1. The CAP Report for Jack C. Montgomery VAMC has been reviewed. Hospital leadership is in concurrence with the report, and recommendations have been addressed with corrective action.

2. If you have further questions, please contact Mary Jones, VISN 16 Health System Specialist, at 601-364-7871.

(original signed by:)
George H. Gray, Jr.

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 2, 2009

From: Director, Jack C. Montgomery VAMC, Muskogee, OK (623/00)

Subject: **Combined Assessment Program Review of the Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma**

To: Network Director, VISN 16

We concur with the recommendations.

(original signed by:)
ADAM C. WALMUS

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that initial peer reviews are completed within the timeframe specified by VHA policy.

Concur Target Completion Date: April 3, 2009

Action Plan: Peer Review process is monitored closely by the Risk Manager regarding the initial peer review 45-day timeframe and the 120-day timeframe to Peer Review Committee. If the initial Peer Review is not completed within 21 days, an Outlook message will be sent to the appropriate provider responsible for the initial Peer Review, Service Chief, Chief of Staff, Quality Manager, and the Medical Center Director to alert everyone involved of the timeframe. If the Peer Review has not been presented at the Peer Review Committee within 75 days, an Outlook message will be sent to Service Chief, Chief of Staff, Quality Manager, and the Medical Center Director to alert everyone involved of the timeframe. The timeframe has been shortened to ensure compliance with the VHA policy. Recommend that Recommendation 1 be closed.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that provider PI data be collected, analyzed, reviewed, considered as part of the reprivileging process, and recorded in PSB minutes.

Concur Target Completion Date: April 13, 2009

Action Plan: PSB minutes format has been changed to reflect specific PI data. Recommend that Recommendation 2 be closed.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the local policy for emergency response and certification is updated and that designated staff maintain current BLS and/or ACLS certification.

Concur Target Completion Date: May 31, 2009

Action Plan: Local policy will be updated to reflect the process for tracking BLS and/or ACLS certification. Reminders are sent out to employees and

Service Chiefs prior to the expiration. BLS and/or ACLS certification will be monitored by Service Chiefs and reported monthly at ECMS.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires clinicians to document pain medication effectiveness in accordance with local policy.

Concur Target Completion Date: May 31, 2009

Action Plan: A PowerPoint presentation was developed with appropriate examples of how to document pain medication effectiveness utilizing a pain score. This PowerPoint presentation was provided to the inpatient RNs and LPNs. Pain medication effectiveness will be monitored and reported to ECMS.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that all staff who work on the locked behavioral health unit and members of the Multidisciplinary Safety Inspection Team receive annual training on the environmental hazards that represent a threat to suicidal patients.

Concur Target Completion Date: May 31, 2009

Action Plan: The Suicide Prevention Coordinator presented a PowerPoint on the environmental hazards that represent a threat to suicidal patients to the Multidisciplinary Safety Inspection Team and the locked behavioral health unit staff. A presentation on environmental hazards that represent a threat to suicidal patients will be presented to new staff on the Multidisciplinary Safety Inspection Team and to new staff on the locked behavioral health unit and annually.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires ED clinicians to document that patients receive a written copy of discharge instructions and verbalize understanding.

Concur Target Completion Date: April 13, 2009

Action Plan: The patients are given discharge instructions by the nurse and documenting the patient's understanding. This will then be documented in the electronic medical record in the nursing discharge note. Recommend that Recommendation 6 be closed.

OIG Contact and Staff Acknowledgments

Contact	Linda DeLong, Director Dallas Office of Healthcare Inspections (214) 253-3331
Contributors	Shirley Carlile, Team Leader Cathleen King Karen Moore Wilma Reyes Jacki Billings, Office of Investigations

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