Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 10-02124-232

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

August 25, 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 crime awareness briefings 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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Glossary

CAP	Combined Assessment Program
C&P	credentialing and privileging
CBOC	community based outpatient clinic
CLC	community living center
CNL	clinical nursing leader
COC	coordination of care
CRD	chronic renal disease
EMS	Environmental Management Service
EOC	environment of care
ESA	erythropoiesis-stimulating agent
facility	Southern Arizona VA Health Care System
FTE	full-time employee equivalents
FY	fiscal year
g/dL	grams per deciliter
ISO	Information Security Officer
JC	Joint Commission
MH	mental health
MRI	magnetic resonance imaging
OIG	Office of Inspector General
OSHA	Occupational Safety and Health Administration
PI	performance improvement
PRRTP	Psychosocial Residential Rehabilitation Treatment Program
QM	quality management
RME	reusable medical equipment
SERV	Supportive Education for Returning Veterans
SOPs	standard operating procedures
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VIS	Vaccine Information Statement
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of June 7, 2010.

Review Results: The review covered eight activities. We made no recommendations in the following activities:

- Coordination of Care
- Magnetic Resonance Imaging Safety
- Physician Credentialing and Privileging
- Quality Management
- Reusable Medical Equipment
- Suicide Prevention Safety Plans

The facility's reported accomplishments were the Supportive Education for Returning Veterans Program and the Falls University project. The Supportive Education for Returning Veterans Program provides education on managing stress, improving memory, and solving problems. The Falls University project is a mandatory class for all new nursing staff that is designed to reduce patient injuries.

Recommendations: We made recommendations in the following two activities:

Medication Management: Clinicians need to consistently take and document appropriate actions when chronic renal disease patients' hemoglobin levels exceed the established threshold and must consistently document all required influenza vaccine elements.

Environment of Care: All required disciplines need to participate in environment of care rounds.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and have taken acceptable corrective actions. We consider all recommendations closed.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

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 crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- COC
- EOC
- Medication Management
- MRI Safety
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through June 11, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior

CAP review of the facility (*Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona,* Report No. 07-02557-50, January 3, 2008). The facility had corrected all findings from our previous review.

During this review, we also presented crime awareness briefings for 499 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.

Reported Accomplishments

SERV

The facility and the University of Arizona jointly developed a pilot curriculum to assist in the transition of veterans using the SERV approach of cohort-based veteran education and a recovery model orientation. The curriculum—three 3-credit hour courses addressing resiliency, learning, teaching, and leadership—is intended to enhance a veteran's ability to manage stress while improving memory and problem-solving skills. An additional 1-credit hour course on family resilience is offered to the spouses or family members of returning veterans.

Falls University Project

The Falls University project is a result of CNLs evaluating the falls policy and data. It is mandatory training for all new nursing staff and must be attended within 90 days of hire. Due to the success of the Falls University training, between FY 2008 and FY 2009, there was a 78 percent reduction in minor injuries and an 80 percent reduction in major injuries. In addition, CNLs debuted a newly developed rounding tool in February of 2009 that reduced falls on the telemetry unit by 47 percent.

Results

Review Activities With Recommendations

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 for outpatients and CLC residents. We identified the following areas that needed improvement.

Management of ESAs. In November 2007, the U.S. Food and Drug Administration issued a safety alert stating that for CRD patients, ESAs[1] should be used to maintain hemoglobin levels between 10 and 12g/dL. Hemoglobin levels greater than 12g/dL increase the risk of serious conditions and death. We reviewed the medical records of 10 outpatients with CRD who had hemoglobin levels greater than 12g/dL. Clinicians documented an action to address the hemoglobin level in 8 (80 percent) of the 10 cases. During our site visit, the facility created a computer report to be reviewed weekly by Nephrology Service to ensure that hemoglobin results for contract or fee basis dialysis patients in the community are addressed.

CLC Influenza Vaccinations. VHA policy[2] requires several elements to be documented for each influenza vaccine given, including the Centers for Disease Control and Prevention VIS edition. We reviewed 10 CLC residents' medical records. Two residents refused the influenza vaccination, and one resident enrolled in a hospice program was excluded. The remaining seven residents who received the influenza vaccine had no documentation of the VIS edition in their medical records. During our site visit, the facility created an influenza vaccine template that includes all required elements.

Recommendations

1. We recommended that clinicians consistently take and document appropriate actions when CRD patients' hemoglobin levels exceed the established threshold.

2. We recommended that clinicians consistently document all required influenza vaccine elements.

EOC

The purpose of this review was to determine whether 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, OSHA, National Fire Protection Association, and JC standards.

We conducted onsite inspections of the hemodialysis unit; the locked MH unit; the emergency department; two

[1] Drugs that stimulate the bone marrow to make red blood cells; used to treat anemia.
[2] VHA Directive 2009-058, *Seasonal Influenza Vaccine Policy for 2009–2010*, November 12, 2009.

outpatient clinic areas; the inpatient medical, surgical, and intensive care units; the CLC; and the rehabilitation and hospice units. The facility maintained a generally clean and safe environment. We identified the following area that needed improvement.

EOC Rounds. VHA policy[3] requires the Director or Associate Director to lead weekly EOC rounds. Additionally, the policy requires that managers in nursing, building management, engineering, safety, patient safety, and infection control be included as well as the ISO and others, as required. EOC rounds conducted by the facility's inspection team allow the disciplines participating to identify and correct discrepancies, unsafe working conditions, and other regulatory violations. Representation from each discipline enables the team to cover the facility in depth. We reviewed the weekly rounds roster for the past 2 quarters and noted that nursing management participated in only 4 (16 percent) of 25 EOC rounds.

Recommendation

3. We recommended that staff ensure that all required disciplines participate in EOC rounds.

Review Activities Without Recommendations

COC

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

VHA[4] requires that facilities have a policy that ensures the safe, appropriate, and timely transfer of patients and that transfers are monitored and evaluated as part of the QM program. We determined that the facility had an appropriate transfer policy and that acceptable monitoring was in place.

VHA requires specific information (such as the reason for transfer and services required) to be recorded in the transfer documentation. We reviewed documentation for 10 patients who transferred from the facility's emergency department to another facility. We determined that clinicians consistently

[3] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.
[4] VHA Directive 2007-015, *Inter Facility Transfer Policy*, May 7, 2007.

documented the required information for the patient transfers reviewed.

VHA policy[5] and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required elements. Also, we found that follow-up appointments occurred within the timeframes specified. We made no recommendations.

MRI Safety

The purpose of this review was to evaluate whether the facility 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 facility had adequate safety policies and had appropriately conducted a risk assessment of the environment, as required by The JC.

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

[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Physician C&P

The purpose of this review was to determine whether VHA facilities had consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and physician profiles.[6] 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.

QM

The purpose of this review was to evaluate whether the facility 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 the facility's Director, the Chief of Staff, and QM personnel.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for most program activities reviewed. We made no recommendations.

RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, OSHA, and JC standards.

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

We inspected the SPD area, the dialysis unit, and the special procedures unit. We determined that the facility had appropriate policies and procedures and consistently monitored compliance with established guidelines. Also, the facility had a process in place to track RME should a sterilization failure occur.

For 10 pieces of RME, we reviewed the SOPs, staff competency forms, and manufacturer instructions for reprocessing. We also observed selected employees demonstrate the correct cleaning procedures described in the SOP and/or on the competency form. We reviewed the competency folders and training records of the employees who demonstrated the cleaning procedures and found that annual competencies and training were well developed, current, and consistently documented.

VHA requires[7] that all RME have device-specific SOPs that are consistent with manufacturer instructions. Four SOPs required minor changes in procedure steps to accurately reflect manufacturer instructions and local competencies. These changes were made while we were onsite; therefore, we made no recommendation.

VA requires[8] that SPD areas have a written daily cleaning schedule. We found that the cleaning schedule posted in SPD did not include EMS cleaning duties. While we were onsite, a schedule was developed and posted. Therefore, we made no recommendation.

OSHA requires that an eyewash station be available for immediate use in areas where employees could be exposed to injurious, corrosive chemicals. We noted that corrosive chemicals are regularly used in cleaning equipment in the preparation room, but there was no eyewash station within the immediate vicinity. A permanent eyewash station was installed while we were onsite. Therefore, we made no recommendation.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should

[7] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[8] VA Handbook 7176; *Supply, Processing and Distribution (SPD) Operational Requirements*; August 16, 2002.

have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[9]

A previous OIG review of suicide prevention programs in VHA facilities[10] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings.

We reviewed the medical records of 10 patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans. We made no recommendations

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and have taken acceptable corrective actions. (See Appendixes C and D, pages 11–13, for the full text of the Directors' comments.) We consider all recommendations closed.

[9] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.

[10] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities, January–June, 2009*; Report No. 09-00326-223; September 22, 2009.

Facility Profile[11]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	18	
CBOCs	Tucson, AZ Casa Grande, AZ Green Valley, AZ Safford, AZ Yuma, AZ	
Veteran Population in Catchment Area	173,000	
Type and Number of Total Operating Beds: • **Hospital, including PRRTP**	169	
• **CLC/Nursing Home Care Unit**	96	
• **Other**	34 (rehabilitation center)	
Medical School Affiliation(s)	University of Arizona College of Medicine, Nursing, and Pharmacy	
• **Number of Residents**	700	
	Current FY (2010) (through June)	**Prior FY (2009)**
Resources (in millions):		
• **Total Medical Care Budget**	$376.1	$338.1
• **Medical Care Expenditures**	$372.8	$329.2
Total Medical Care FTE	2,266	2,200
Workload:		
• **Number of Station Level Unique Patients**	45,513	50,656
• **Inpatient Days of Care:**		
o **Acute Care**	23,224	49,840
o **CLC/Nursing Home Care Unit**	19,672	26,087
Hospital Discharges	29,272	8,100
Total Average Daily Census (including all bed types)	216.5	241.5
Cumulative Occupancy Rate	80%	82%
Outpatient Visits	436,481	500,000

[11] All data provided by facility management.

VHA Satisfaction Surveys

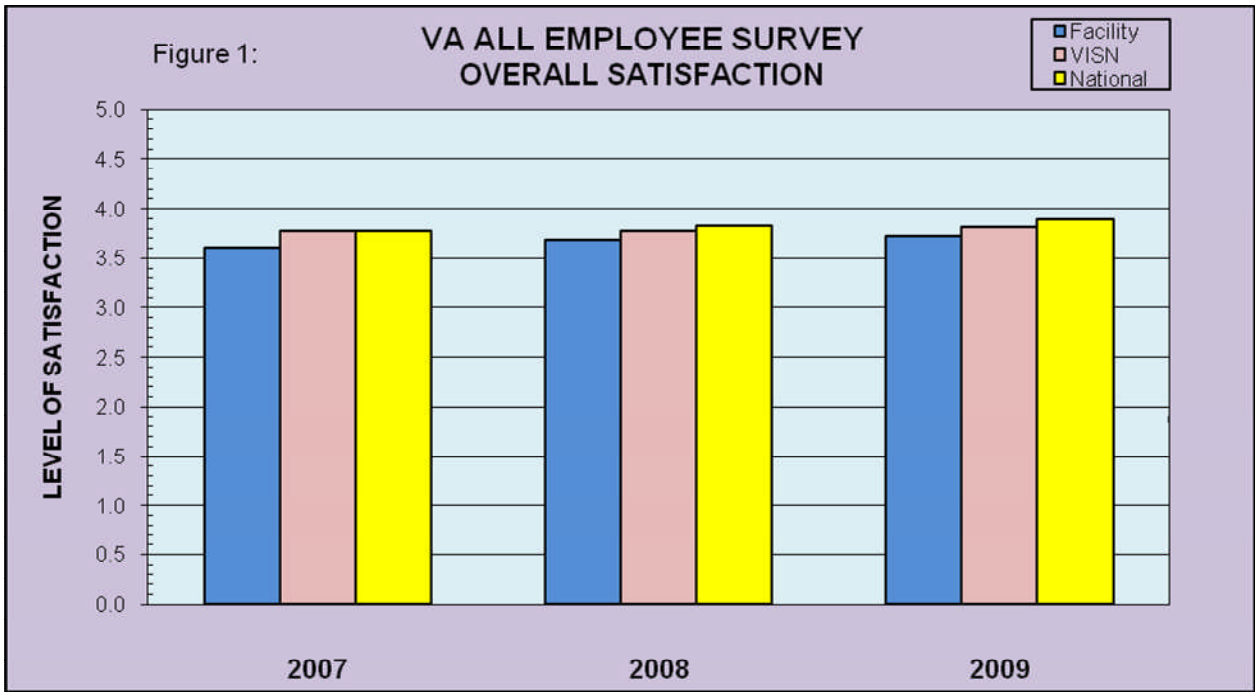
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. VHA is currently in the process of transitioning to the Consumer Assessment of Healthcare Providers and Systems survey. As a result, data for FY 2009 have been summarized for the entire year. Table 1 below shows the facility's and VISN's calibrated overall inpatient and outpatient satisfaction scores for FY 2009 and overall outpatient satisfaction score and target for the 1st quarter of FY 2010.

Table 1

	FY 2009		FY 2010
	Inpatient Score	Outpatient Score	Outpatient Score 1st Quarter
Facility	72.53	47.73	57.9 (target 56)
VISN	67.79	46.23	52.2 (target 56)

Employees are surveyed annually. Figure 1 below shows the facility'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 1:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 30, 2010

From: Network Director, VISN 18 (10N18)

Subject: **CAP Review of the Southern Arizona VA Health Care System, Tucson, AZ**

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

Director, Management Review Service (VHA CO 10B5 Staff)

1. I concur with the attached facility draft responses to the recommendations for improvement contained in the Combined Assessment Program Review of the Southern Arizona VA Health Care System (SAVAHCS).

2. If you have additional questions or concerns, please contact Sally Compton, VISN 18 Executive Assistant to the Network Director, at (602) 222-2699.

(original signed by:)
Susan P. Bowers

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 22, 2010

From: Director, Southern Arizona VA Health Care System

Subject: **CAP Review of the Southern Arizona VA Health Care System, Tucson, AZ**

To: Network Director, VISN 18 (10N18)

1. I would like to express my sincere appreciation to the Office of the Inspector General (OIG), Combined Assessment Program (CAP) review team for their professionalism and excellent feedback provided to our staff during the CAP review conducted on June 7–11, 2010.

2. I reviewed the three recommendations and concur with the findings. The recommendations were implemented during your visit. Our comments and completed actions are delineated below.

3. If you have questions or require additional information, please do not hesitate to contact Margaret C. Lumm, Clinical Director, Performance Management at (520) 629-1882.

(original signed by:)
Jonathan H. Gardner, MPA, 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 clinicians consistently take and document appropriate actions when CRD patients' hemoglobin levels exceed the established threshold.

Concur

Target Completion Date: Completed during CAP review.

Action Taken: SAVAHCS created a computer report that is reviewed weekly by Nephrology Service to ensure that hemoglobin results for contract or fee basis dialysis patients in the community are addressed.

Recommendation 2. We recommended that clinicians consistently document all required influenza vaccine elements.

Concur

Target Completion Date: Completed during CAP review.

Action Taken: The facility created a new template to capture all the required elements of the CLC influenza vaccinations to include the VIS edition.

Recommendation 3. We recommended that staff ensure that all required disciplines participate in EOC rounds.

Concur

Target Completion Date: Completed during CAP review.

Action Taken: SAVAHCS had an administrative nurse on the EOC rounds team which we believed met the intent of the DUSHOM memorandum. A clinical nurse manager has now been assigned to the team.

OIG Contact and Staff Acknowledgments

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