Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-01297-222

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

July 12, 2011

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

AD	advance directive
C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
EMR	electronic medical record
EN	enteral nutrition
EOC	environment of care
facility	Cheyenne VA Medical Center
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Cheyenne VA Medical Center, Cheyenne, WY

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 May 9, 2011.

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

- Enteral Nutrition Safety
- Management of Workplace Violence
- Medication Management
- Registered Nurse Competencies

The facility's reported accomplishments were the Compensation and Pension Examination Redesign Project, which reduced the examination waiting time from 35 to 15 days or less, and the mobile tele-health clinic, which provides weekly primary care and mental health tele-health services to more than 900 veterans in 5 rural communities.

Recommendations: We made recommendations in the following four activities:

Quality Management: Require that airway assessments are documented prior to procedures requiring moderate sedation and that compliance is monitored. Consistently monitor the use of the copy and paste functions in the electronic medical record.

Physician Credentialing and Privileging: Ensure that Focused Professional Practice Evaluations are completed for all newly hired physicians and that results are reported to the Executive Committee of the Medical Staff.

Environment of Care: Ensure that annual N95 respirator fit testing and bloodborne pathogens training are completed and that compliance is monitored.

Coordination of Care: Require that the local policy for management of advance care planning/advance directives is consistent with current Veterans Health Administration policy and that compliance with the policy is monitored.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

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 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

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
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through May 11, 2011, 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 facility (*Combined Assessment Program Review of the Cheyenne VA Medical*

Center, *Cheyenne, Wyoming*, Report No. 08-02413-34, December 3, 2008). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 96 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

Compensation and Pension Examination Redesign Project

In early FY 2010, the completion rate for compensation and pension examinations exceeded the national goal of 30 days by an average of 5 days. To improve the efficiency and quality of the examinations, the facility chartered a systems redesign team whose main goal was to reduce examination wait times to less than 30 days.

By December 2010, the team had met the goal and subsequently set a new goal to reduce the examination wait times to 14 days. In January 2011, examination wait times were 15 days or less. The facility is now applying lessons learned from this redesign project to other redesign projects.

Mobile Tele-Health Clinics

To expand services to rural veterans, the facility opened a mobile tele-health clinic in August 2009. The clinic provides weekly primary care and mental health tele-health services as well as nursing care and laboratory services. It serves 771 veterans located in Torrington, Wheatland, Sterling, and Laramie, WY. The facility also opened a mobile tele-health clinic in Rawlins, WY, to serve an additional 221 veterans. The Rawlins clinic provides primary care and mental health services, tele-health weight management, and tele-retinal imaging. It also provides nursing care and laboratory services.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with

applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

Moderate Sedation. VHA requires providers to document a complete history and physical within 30 days of a procedure and to re-evaluate the patient immediately prior to sedation.[1] These evaluations must include an assessment of the airway. We reviewed the medical records of 10 patients who underwent selected procedures where moderate sedation was used and found that 9 of the pre-sedation evaluations did not contain airway assessments.

Medical Record Review. VHA requires that each facility monitor the use of the copy and paste functions in the EMR.[2] In January 2011, the facility implemented a process to monitor open and closed medical records on an ongoing basis. Prior to this time, the facility did not consistently monitor the use of the copy and paste functions in the EMR.

Recommendations

1. We recommended that processes be strengthened to ensure that airway assessments are documented prior to procedures requiring moderate sedation and that compliance be monitored.

2. We recommended that the use of the copy and paste functions in the EMR be consistently monitored.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed 15 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

FPPE. VHA requires that an FPPE be completed for all physicians who have been newly hired and that the results be reported to the Executive Committee of the Medical

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[2] VHA Handbook 1907, *Health Information Management and Health Records*, August 25, 2006.

Staff.[3] One of four newly hired physicians did not have an FPPE implemented. Additionally, results for the three completed FPPEs were not reported to the Executive Committee of the Medical Staff.

Recommendation

3. We recommended that FPPEs be completed for all newly hired physicians and that FPPE results be reported to the Executive Committee of the Medical Staff.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the medical/surgical, intensive care, and post acute care units; the CLC; the eye and dental outpatient clinics; and the emergency department. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Infection Control. The Occupational Safety and Health Administration requires that employees with occupational exposure risk receive annual training on the Bloodborne Pathogens Rule. We reviewed 25 employee training records and found that 20 employees did not have this training documented.

If facilities use N95 respirators, the Occupational Safety and Health Administration requires that designated employees are fit tested annually. We reviewed 25 employee training records and found that 19 designated employees did not have the required annual fit testing.

Recommendation

4. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

COC

The purpose of this review was to evaluate whether the facility managed advance care planning and ADs in accordance with applicable requirements.

We reviewed patients' medical records for evidence of AD notification, AD screening, and documentation of advance care planning discussions. We also reviewed the facility's policy to determine whether it was consistent with VHA

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

policy. We identified the following area that needed improvement.

Advance Care Planning/AD Policy. VHA requires that health care staff follow specific procedures for advance care planning/ADs. Local policy was not consistent with current VHA policy. Patient notification of the right to accept or refuse medical treatment, to designate a Health Care Agent, or to document treatment preferences in an AD was not consistently documented. Additionally, staff did not consistently:

- Ensure appropriate witnesses signed ADs created using the VA form.
- Ensure AD notes were linked to the current ADs in the EMR.
- Document patients received a hard copy of the AD when the AD was created using the VA form.
- Use correct progress note titles.

Recommendation

5. We recommended that local policy for management of advance care planning/ADs be consistent with current VHA policy and that compliance with the policy be monitored.

Review Activities Without Recommendations

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. While conducting the EOC review, we also inspected areas where EN products were stored, and we interviewed key employees. We determined that the facility generally met EN safety requirements. We made no recommendations.

Management of Workplace Violence

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and

management of disruptive behavior training. We made no recommendations.

Medication Management

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transportation, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policy and processes, interviewed nurse managers, and reviewed initial and ongoing competency assessment and validation documents for RNs. We determined that the facility had established an effective process to ensure that RN competencies were assessed and validated and that a plan was in place to take action if deficiencies were identified. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 12–15, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[4]		
Type of Organization	Medical center	
Complexity Level	3	
VISN	19	
Community Based Outpatient Clinics	Greeley, CO Ft. Collins, CO Sidney, NE	
Veteran Population in Catchment Area	68,800	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	21 hospital	
• **CLC/Nursing Home Care Unit**	50	
• **Other**	N/A	
Medical School Affiliation(s)	University of Wyoming Family Practice	
• **Number of Residents**	6	
	Current FY (through February 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$107.5	$108.5
• **Medical Care Expenditures**	$84.3	$83.1
Total Medical Care Full-Time Employee Equivalents	603	582
Workload:		
• **Number of Station Level Unique Patients**	14,749	18,329
• **Inpatient Days of Care:**		
o **Acute Care**	2,743	5,655
o **CLC/Nursing Home Care Unit**	5,994	13,657
Hospital Discharges	509	1,312
Total Average Daily Census (including all bed types)	16.4 hospital 39.7 CLC	15.5 hospital 37.4 CLC
Cumulative Occupancy Rate (in percent)	78.7	74.3
Outpatient Visits	95,497	201,690

[4] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Ensure QM data is trended, analyzed, and reported to the appropriate oversight board.	Minute taking education was provided for those taking minutes, and a minute template was distributed. Also, a committee reporting structure was finalized with appropriate routing to oversight boards.	Y	N
2. Ensure adverse events are documented and communicated.	Adverse event disclosures are now tracked by the patient safety manager.	Y	N
EOC			
3. Ensure emergency carts are checked.	A survey readiness Tier Three Tracer Program monitors and provides education regarding emergency cart checks.	Y	N
4. Ensure medication refrigerators are monitored.	A survey readiness Tier Three Tracer Program monitors and provides education regarding refrigerator checks. We are currently obtaining bids for a centralized temperature and humidity monitoring system.	Y	N
5. Ensure hand hygiene compliance data is collected.	A survey readiness Tier Three Tracer Program monitors and provides education regarding hand hygiene.	Y	N

Recommendations	Current Status of Corrective Actions Taken	In Compliance Y/N	Repeat Recommendation? Y/N
COC			
6. Ensure complete discharge documentation.	Chart review forms were updated to include discharge documentation, and discharge policies were updated.	Y	N
Emergency/Urgent Care Operations			
7. Ensure complete inter-facility transfer documentation.	An additional signer was added to the transfer form, and completed documentation is verified by the RN Assistant Manager. The Emergency Department/Ambulatory Care Manager reviews the data.	Y	N
Pharmacy Operations			
8. Appoint a non-clinical Controlled Substance Coordinator.	A non-clinical Controlled Substance Coordinator is currently appointed.	Y	N
9. Ensure the Facility Director signs appointment letters for controlled substances inspectors.	The Director signs all appointment letters.	Y	N
10. Repair the pharmacy vault day gate.	The pharmacy vault day gate was repaired.	Y	N
11. Ensure pharmacy refrigerator temperatures are monitored and documented.	A survey readiness Tier Three Tracer Program monitors and provides education regarding refrigerator checks. An action group is currently in place and obtaining bids for a centralized temperature and humidity monitoring system.	Y	N

VHA Satisfaction Surveys

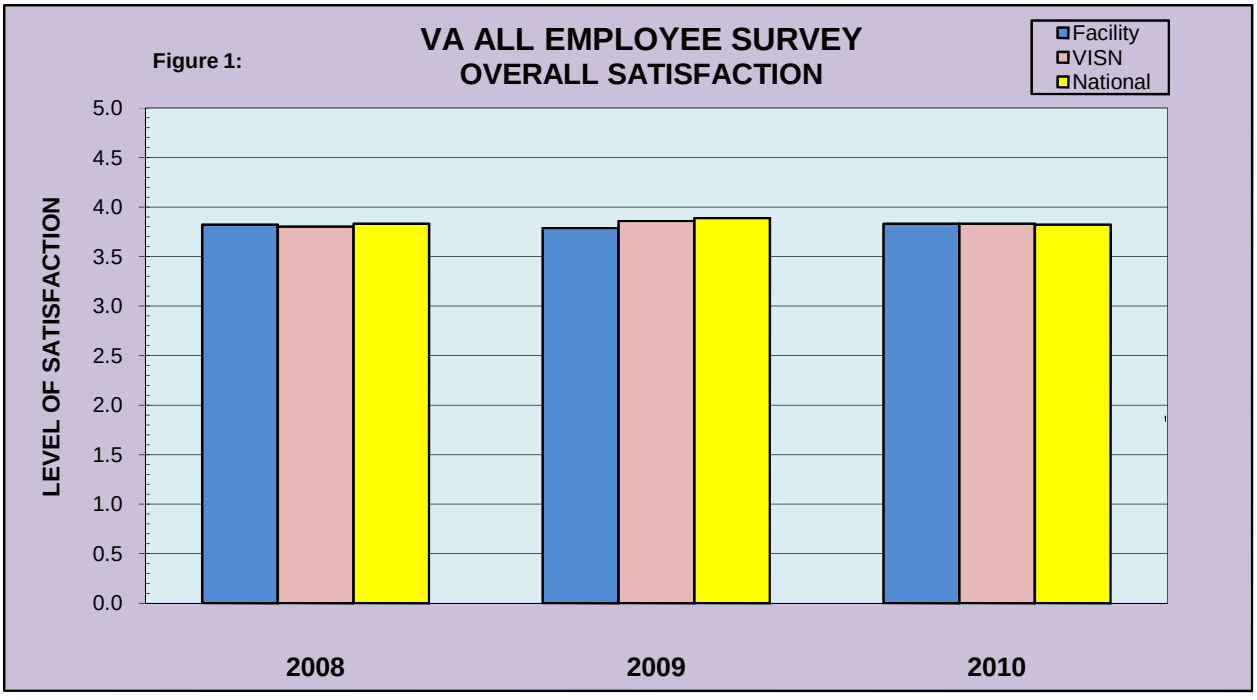
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	69.4	69.3	71.9	68.8	68.2	61.1	50.6	55.4
VISN	65.9	62.5	64.0	65.5	53.9	52.8	52.6	52.3
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions[5] received hospital care. The mortality (or death) rates focus on whether patients died within 30 days of their hospitalization. The rates of readmission focus on whether patients were hospitalized again within 30 days. Mortality rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting. The hospital mortality rates and rates of readmission are based on people who are 65 and older. These comparisons are "adjusted" to take into account their age and how sick patients were before they were admitted to the VA facility. Table 2 below shows the facility's Hospital Outcome of Care Measures for FYs 2006–2009.

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	*	9.34	13.19	*	21.04	14.99
VHA	13.31	9.73	15.08	20.57	21.71	15.85

* Not enough cases

[5] Congestive heart failure is a weakening of the heart's pumping power. With heart failure, the body does not get enough oxygen and nutrients to meet its needs. A heart attack (also called acute myocardial infarction) happens when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored in a timely manner, the heart muscle becomes damaged from lack of oxygen. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 21, 2011

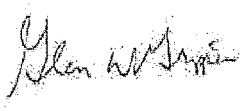
From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the Cheyenne VA Medical Center, Cheyenne, WY**

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

Director, Management Review Service (10A4A4)

I have reviewed and concur on the attached response from the Cheyenne VAMC regarding the Draft Report of the Combined Assessment Program Review. If you have any additional questions, please contact Ms. Susan Curtis, VISN 19 HSS at (303) 639-6995.



Glen W. Grippen, FACHE
Director, Rocky Mountain Network (10N19)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 16, 2011

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

Subject: **CAP Review of the Cheyenne VA Medical Center, Cheyenne, WY**

To: Director, Rocky Mountain Network (10N19)

1. The Cheyenne VAMC would like to express our appreciation for the opportunity to work with the Office of Inspector General and to review the report on the CAP Review of the Cheyenne VA Medical Center.

2. Please find attached our response to each recommendation provided in the report.

3. If there are any questions regarding the response to the recommendations or any additional information is required, please contact Ms. Lisa Adamson, Chief of Quality Management, (307) 433-3621 or at Lisa.Adamson@va.gov.

Cynthia McCormack
CYNTHIA MCCORMACK
Medical Center Director
Attachments:

1. Comments to the Office of Inspector General's Report

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 processes be strengthened to ensure that airway assessments are documented prior to procedures requiring moderate sedation and that compliance be monitored.

Concur

Target date for completion: May 11, 2011

An airway assessment tool was added to the template for moderate sedation history and physical documentation. The providers have been educated regarding use of this template. Furthermore, the documentation in the chart will be monitored and tracked monthly and results reported to Medical Record Committee.

Recommendation 2. We recommended that the use of the copy and paste functions in the EMR be consistently monitored.

Concur

Target date for completion: June 7, 2011

Monitoring of the copy and paste functions in the EMR have been added to the monthly chart review forms and reported by each department to the Medical Record Committee. This information will be reported quarterly to the Medical Executive Board for analysis and action.

Recommendation 3. We recommended that FPPEs be completed for all newly hired physicians and that FPPE results be reported to the Executive Committee of the Medical Staff.

Concur

Target date for completion: June 7, 2011

This recommendation was presented to the Medical Executive Board on June 7, 2011. All newly hired physicians requesting privileges or requests for new privileges presented to the Medical Executive Board will be accompanied by an FPPE plan and timeline. The minutes have been updated to include the tracking of FPPE to closure. Administrative Officers for the clinical service lines will be tracking the FPPE timelines to ensure completion.

Recommendation 4. We recommended that annual bloodborne pathogens training and N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date for completion: July 30, 2011

Bloodborne Pathogen training is being monitored by the DLO and will be uploaded into TMS for tracking of completion. Currently 5% have completed training.

Staff required by current policy have been trained in the proper use, fitting instructions, inspection, storage, and respirator limitations of the Powered Air Purifying Respirator system and/or the N95 masks. In addition, a fit testing team has been developed and trained to provide fit testing. These staff will be available if the need should arise for additional fit testing of staff for either the Powered Air Purifying Respirator system or the N95 masks. The completion of this training is being entered into TMS for compliance monitoring and reminder to staff and supervisor.

Recommendation 5. We recommended that local policy for management of advance care planning/ADs be consistent with current VHA policy and that compliance with the policy be monitored.

Concur

Target date for completion: July 15, 2011

The Cheyenne VAMC Advance Directive policy memorandum has been updated to be consistent with the current VHA directive and is currently in the concurrence process. Training was completed for 100% of scanning staff on how to link reports and when to contact Social Work regarding issues with Advance Directives. An audit will be completed in approximately six (6) months to monitor compliance.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Contributors	Stephanie Hensel, RN, JD, Project Leader Cheryl Walker, FNP, MBA, Team Leader Clarissa Reynolds, CNHA, MBA Ann Ver Linden, RN, MBA Laura Dulcie, BSEE, Lead Program Specialist Randy Rupp, Resident Agent In Charge, Office of Investigations

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