Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03657-62

Combined Assessment Program Review of the Grand Junction VA Medical Center Grand Junction, Colorado

January 12, 2012

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.

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
EOC	environment of care
facility	Grand Junction VA Medical Center
FY	fiscal year
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, CO

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 October 17, 2011.

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

- Coordination of Care
- Medication Management
- Quality Management

The facility's reported accomplishments were increasing staff awareness of resource allocation and improving patient access to care in rural areas through the use of telehealth technology.

Recommendations: We made recommendations in the following three activities:

Colorectal Cancer Screening: Notify patients with positive screening test results within the required timeframe, and document notification. Ensure responsible clinicians develop follow-up plans or document that no follow-up is indicated within the required timeframe. Ensure patients with positive screening test results receive diagnostic testing within the required timeframe. Notify patients of diagnostic test results within the required timeframe, and document notification. Notify patients of biopsy results within the required timeframe, and document notification.

Environment of Care: Conduct a vulnerability risk assessment of the employee parking lot, and pursue actions based on the risk assessment results. Perform annual preventive maintenance on the community living center's elopement prevention system. Require the anesthesia supply room to adhere to VA requirements for clean/sterile supply storage, and monitor compliance. Ensure all laser users and operating room staff complete all annual laser safety training modules, and monitor compliance.

Polytrauma: Ensure interdisciplinary teams use the required template to document the treatment plan. Maintain minimum staffing levels.

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.

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 six activities:

- Coordination of Care
- CRC Screening
- EOC
- Medication Management
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2010, FY 2011, and FY 2012 through October 20, 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 Grand Junction VA Medical Center, Grand Junction, Colorado,* Report No. 08-02415-151, June 25, 2009). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 105 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 211 responded. Survey results were shared with facility managers.

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

Integrated Ethics

The facility's FY 2010 integrated ethics staff survey indicated that the facility had not adequately educated staff regarding resource allocation. As a result, facility leadership and the Ethics Committee developed and implemented an action plan, which included conducting all-employee forums and circulating a "Fiscal Tip of the Month." The forums provide staff at all levels the opportunity to ask senior leadership questions related to resource allocation, acceptance of gifts, and other ethical concerns. The facility Director also meets with every department to ensure management's resource allocation decisions are aligned with staff expectations and patient needs. As a result, Ethics Committee case consults increased between FY 2010 and FY 2011 because employees are asking more questions and becoming more involved.

TeleHealth

The facility improved access to basic health care services in rural areas through the use of telehealth technology. During FY 2010, the Telehealth Outreach Clinics provided 1,888 telehealth encounters, and during FY 2011, the clinics provided more than 4,800 telehealth encounters. Telehealth Outreach Clinics offer both primary and mental health care. This innovative model of care significantly reduces the distance veterans need to travel to receive services.

Results

Review Activities With Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Patients were notified of positive CRC screening test results within the required timeframe.
X	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
X	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[1] Three patients' records did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[2] Three patients did not have a documented follow-up plan within the required timeframe.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[3] Four of the 14 patients who received diagnostic testing did not receive that testing within the required timeframe.

[1] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[2] VHA Directive 2007-004.
[3] VHA Directive 2007-004.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[4] Seven of the 14 patients who received diagnostic testing did not have documented evidence of timely notification in their medical records.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[5] Of the four patients who had a biopsy, one record did not contain documented evidence of timely notification.

Recommendations

1. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

2. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

3. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

4. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

5. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[4] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[5] VHA Directive 2007-004.

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 post-anesthesia care, inpatient mental health, medical/surgical intensive care, medical, and prosthetics units and the polytrauma, primary care, and dental outpatient clinics. We also inspected the CLC, the operating room, and the emergency department. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
X	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
X	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Mental Health Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	Mental Health Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Employee Safety. VHA requires that facility Directors ensure a safe work environment for all VHA staff and volunteers.[6] Employees who park in the designated employee parking lot are potentially at risk of injury. The facility documented four employee injuries (three in 2009 and one in 2011) caused by errant golf balls from a bordering public golf course. Additionally, staff told us cars in the parking lot were frequently damaged, and inspectors observed auto glass on the ground and cars with golf ball

[6] VHA Directive 7701, *Occupational Safety and Health (OSH),* August 9, 2010.

dents. The facility had not conducted a vulnerability risk assessment based on documented employee injuries or property damage.

Patient Safety. VHA requires preventive maintenance to be performed annually on elopement prevention systems in CLCs.[7] Annual preventive maintenance was not performed on the elopement prevention system in the CLC during FY 2011.

Infection Prevention. VA requires that clean/sterile supplies are separated from dirty items.[8] Additionally, food and personal items are prohibited in clean/sterile supply storage areas to prevent microorganism growth and contamination. In the anesthesia supply room, where clean/sterile supplies are stored, we found a partially filled biohazard waste container, a desk with personal items and food on top, and employee clothing items hung on clean/sterile storage shelving.

Laser Safety Training. Local policy requires that all laser users and operating room staff complete annual laser safety training. We reviewed six employee training records and found that none of the employees completed all required laser safety training modules during FY 2011.

Recommendations

6. We recommended that the facility conduct a vulnerability risk assessment due to documented employee injuries and property damage and pursue actions based on the risk assessment results.

7. We recommended that processes be strengthened to ensure that annual preventive maintenance is performed on the CLC's elopement prevention system.

8. We recommended that the anesthesia supply room adhere to VA requirements for clean/sterile supply storage and that compliance be monitored.

9. We recommended that all laser users and operating room staff complete all annual laser safety training modules and that compliance be monitored.

[7] VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
[8] VA Handbook 7176, *Supply, Processing and Distribution (SPD) Operational Requirements*, August 16, 2002.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, training records, and we interviewed key staff. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings.
	Case Managers were assigned to outpatients and provided frequent, timely communication.
X	Outpatients had templated treatment plans developed that included all required elements.
X	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that a specific interdisciplinary treatment plan be developed.[9] The interdisciplinary team must use a template plan that addresses specific elements, including the skills needed to maximize independence and the recommended type of vocational rehabilitation. The template was not used in nine of the medical records reviewed.

Staffing. VHA requires that minimum staffing levels are maintained.[10] The facility did not meet the minimum staffing requirement because it had not appointed a Polytrauma-Traumatic Brain Injury Medical Director or rehabilitation nurse. Additionally, although the facility employed a rehabilitation physician and speech-language

[9] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[10] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

pathologist, the positions were staffed less than the minimally required 0.5 full-time equivalent.

Recommendations

10. We recommended that processes be strengthened to ensure that polytrauma interdisciplinary teams use the required template to document the treatment plan.

11. We recommended that minimum polytrauma staffing levels be maintained.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to determine whether patients with a primary discharge diagnosis of heart failure received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of heart failure management key components.

We reviewed 30 heart failure patients' medical records and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 30 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent providers complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
	There was a medical record quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

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 18–25 for the full text of the Directors' comments.) We consider Recommendations 7 and 9 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[11]		
Type of Organization	VA medical center	
Complexity Level	2	
VISN	19	
Community Based Outpatient Clinics	Montrose, CO	
Veteran Population in Catchment Area	38,523	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	31	
• **CLC/Nursing Home Care Unit**	30	
• **Other**	0	
Medical School Affiliation(s)	University of Colorado School of Medicine	
• **Number of Residents**	0	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$96.6	$86.4
• **Medical Care Expenditures**	$96.0	$86.2
Total Medical Care Full-Time Employee Equivalents	566.4	543.6
Workload:		
• **Number of Station Level Unique Patients**	12,781	12,312
• **Inpatient Days of Care:**		
o **Acute Care**	6,038	5,835
o **CLC/Nursing Home Care Unit**	8,947	8,051
Hospital Discharges	1,724	1,693
Total Average Daily Census (including all bed types)	41.1	38.1
Cumulative Occupancy Rate (in percent)	67.4	62.5
Outpatient Visits	162,946	146,301

[11] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Ensure the Peer Review Committee meets and reports in accordance with VHA requirements.	The Peer Review Committee meets as required and reports to the Clinical Executive Board on a quarterly basis.	N
2. Ensure all clinical services collect relevant practitioner-specific data for use in privileging decisions.	Clinical services document collection of relevant data and document the use of the data during privileging decisions.	N
EOC		
3. Ensure all staff appropriately label and store medication.	Tracers demonstrate medications are labeled and stored as required.	N
4. Require all designated team members to participate in weekly EOC rounds	All required team EOC team members meet weekly and participate in weekly rounds.	N
5. Ensure all required staff members receive training on environmental hazards that represent a threat to suicidal patients.	All locked mental health unit employees receive annual environmental hazard training.	N
6. Ensure staff complete emergency cart checks.	Emergency carts are checked, and checks are documented as required.	N
7. Ensure staff members monitor nourishment refrigerator temperatures.	A Temp Track system now monitors all nourishment refrigerator temperatures. Paper documentation is used if the Temp Track system is down.	N
8. Require staff to update the local hand hygiene policy, monitor compliance, and provide feedback to health care workers.	The hand hygiene policy was revised, and compliance is monitored as required.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Coordination of Care		
9. Require that staff revise the discharge documentation policy and document discharges	Behavioral health processes were refined and include required components. A new template for documentation was implemented in the Computerized Patient Record System in July 2009.	N
10. Ensure emergency department staff complete inter-facility transfer documentation.	The inter-facility transfer form was implemented and is used consistently by providers. The Patient Safety Manager monitors use of the form.	N
Medication Management		
11. Require nurses to document the effectiveness of all pain medications within the required timeframe.	Nurses document pain medication effectiveness as required. The Bar Code Medication Administration coordinator tracks compliance and reports this information to senior leadership.	N

VHA Satisfaction Surveys

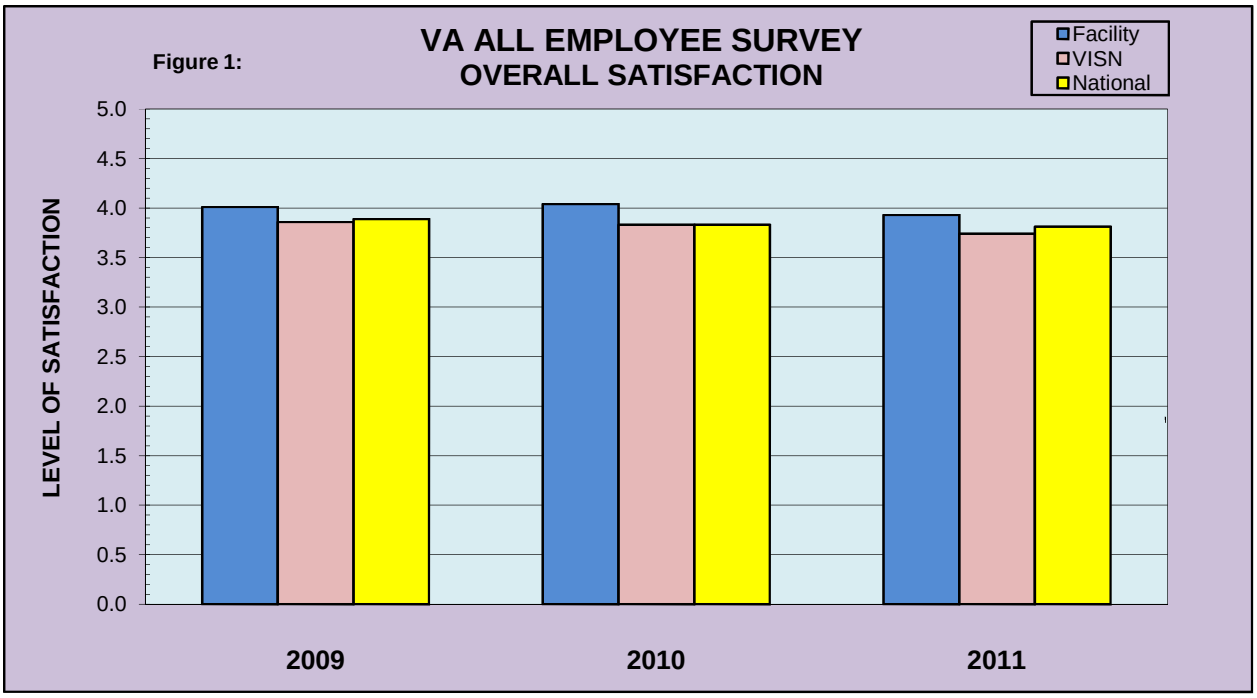
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	68.0	66.2	75.7	59.5	57.0	68.8
VISN	64.8	52.3	61.4	51.3	52.5	51.8
VHA	64.1	54.4	63.9	55.9	55.3	54.2

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. 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 received hospital care.[12] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[13]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	**	11.7	10.0	**	20.2	17.7
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[12] A heart attack occurs 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 timely, the heart muscle becomes damaged. Congestive heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[13] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 13, 2011

From: Director, VA Rocky Mountain Network (10N19)

Subject: **CAP Review of the Grand Junction VA Medical Center, Grand Junction, CO**

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

Director, Management Review Service (VHA 10A4A4 Management Review)

Please accept this current submission from the Grand Junction VAMC in response to the OIG CAP review of their facility. I have reviewed the responses as currently compiled. We will continue to work with them not only on these responses but on their corrective actions.

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

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 12, 2011

From: Director, Grand Junction VA Medical Center (575/00)

Subject: **CAP Review of the Grand Junction VA Medical Center, Grand Junction, CO**

To: Director, VA Rocky Mountain Network (10N19)

I have reviewed the submitted corrective actions and concur with the findings and recommendations.

Terry S. Atienza

Director, Grand Junction VAMC

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: January 31, 2012

IMPLEMENT REDUNDANT PROVIDER NOTIFICATION PROCESS

Effective December 9, 2011, the Grand Junction VAMC laboratory will notify in writing to the Chief of Medicine, all positive FOBT results within 5 working days of the test results. The Chief of Medicine will distribute to each provider the positive FOBT results they have ordered. This process is to assure provider notification and strengthen the process for provider notification to patients within 14 days.

Medical Service has reviewed relevant VHA Directives and Medical Center Policy, including VHA DIRECTIVE 2009-019, *Ordering and Reporting Test Results*, VHA DIRECTIVE 2007-004 *Colorectal Cancer Screening*, and Grand Junction VAMC MCM No. 113-3 *Reporting Critical Values*.

STAFF EDUCATION

Medical Service has created a service letter, Grand Junction VAMC Medical Service Letter 111-12-02 *Medical Service Reporting of Test Results to Patients*. All Medical Service providers have been advised of the specific requirements outlined in the service letter and will be asked to add their signature to a document noting they have received a copy of the above Medical Service Letter. This was reviewed and discussed during Medical Service staff meeting December 6, 2011.

CPRS has a shared template for fecal occult blood test (FOBT) POSITIVE LETTER for providers to use to notify patients in writing of positive test results. Shared Templates were reviewed with Medical Service Providers during staff meeting December 6, 2011.

QUALITY OVERSIGHT PROCESSES

The Medical Service Administrative Officer (or alternate) will conduct monthly audits on 100 percent of patients with a positive FOBT that they are notified within 14 days. These results will be reported monthly to the Quality Manager and Chief of Medicine, and quarterly to Clinical Executive Board.

December 1, 2011, Medical Service will review records of all patients with positive FOBT for CPRS documentation of timely patient notification. All missing items will be tracked until adequate documentation is recorded in CPRS.

Grand Junction VAMC initiated on December 1, 2011, weekly tracking of positive FOBT for compliance on patient notification within 14 days. The providers will be notified if no documentation of written notification is found for immediate correction. Ongoing tracking and trending will be conducted. If the notification is not present by next day close of business, the supervisor will be notified. To strengthen the process of Patient Notification, the Chief of Medicine will be notified if the provider is not available to immediately correct the notification, and the Chief of Medicine will notify the patient.

A facility review will be completed by the Medical Administrative Officer on all FOBT positive patients in FY11 to verify that the patients have been notified of their results. The Chief of Medicine will notify identified patients by the date of December 31, 2011.

Recommendation 2. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: January 31, 2012

Medical Service has reviewed relevant VHA Directives and Medical Center Policy, including VHA DIRECTIVE 2009-019 *Ordering and Reporting Test Results*, VHA DIRECTIVE 2007-004 *Colorectal Cancer Screening*, and Grand Junction VAMC MCM No. 113-3 *Reporting Critical Values*.

STAFF EDUCATION

Medical Service has created a service letter, Grand Junction VAMC Medical Service Letter 111-12-02, *Medical Service Reporting of Test Results to Patients*. All Medical Service providers have been advised of the specific requirements outlined in the service letter and will be asked to add their signature to a document noting they have received a copy of the above Medical Service Letter.

CPRS has a Surgical Consult for SURG ENDOSCOPY for the provider to plan care for the patient with a POSITIVE FOB. This consult allows the provider to select colonoscopy and it includes the time frame of within 1 month. This CPRS Consults was reviewed with Medical Service during staff meeting on December 6, 2011.

QUALITY OVERSITE PROCESSES

The Medical Service Administrative Officer (or alternate) will conduct monthly audits on 100 percent of patients with a positive FOBT that they have a plan of care or no follow-up is required. These results will be reported monthly to the Quality Manager and Chief of Medicine, and quarterly to Clinical Executive Board.

December 1, 2011, Medical Service will review records of all patients with positive FOBT for CPRS documentation of timely planning of care or no follow-up is required. All missing items will be tracked until adequate documentation is recorded in CPRS.

Grand Junction VAMC initiated on December 1, 2011, weekly tracking of positive FOBT for compliance on planning care within14 days of test results. The providers will be notified if no documentation of written notification found for immediate correction. Ongoing tracking and trending will be conducted. If the plan of care is not present by next day close of business, the supervisor will be notified. To strengthen the process of Patient Notification, the Chief of Medicine will be notified if the provider is not available to immediately correct planning the care within 14 days and documentation.

A facility review will be completed by the Medical Administrative Officer on all FOBT positive patients in FY11 to verify that the patients have a completed plan of care. The Chief of Medicine will complete the plans of care by the date of December 31, 2011.

Recommendation 3. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: January 31, 2012

A facility review will be completed by the Surgical Administrative Officer on all FOBT positive patients in FY11 to verify that the patients have received a colonoscopy as appropriate by the date of 01/31/12.

A tracking tool was implemented to follow the processing of each +FOBT patient. Beginning the week of December 12, 2011, the Surgery Administrative Officer will conduct a weekly status check of all +FOBT patients identified after October 1, 2011. The Surgery Administrative Officer will monitor to ensure +FOBT patients are scheduled for a colonoscopy within the 60 days of identification as positive. The Surgery Administrative Officer will ensure patients are scheduled promptly after receipt of the consult by coordinating with the Endoscopy RN and Endoscopy Scheduler if not scheduled within 14 days of consult receipt. Any issues that arise which may preclude the patient from receiving a colonoscopy within 60 days of +FOBT will be immediately raised to the Chief of Surgery.

We are following the national directive and a local policy will be written and implemented by January 31, 2012. A quarterly report (due by January 13, 2012) will be submitted to the Chief of Surgery, Quality Management, and Clinical Executive Board.

A copy of VHA Directive 2007-004, Colorectal Cancer Screening was sent to all general surgeons on October 13, 2011, and again on December 12, 2011, with request to confirm the directive was reviewed.

Recommendation 4. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: January 31, 2012

A facility review will be completed by the Surgical Administrative Officer on all patients in FY11 to verify that the patients have received a verbal communication on the finding of the colonoscopy and notification by letter as appropriate by the date of January 31, 2012.

Beginning the week of December 12, 2011, the Surgery Administrative Officer will conduct a weekly status check of all patients identified after October 31, 2011, for verbal communication on the findings of the colonoscopy and that a letter will be sent within 14 days from the colonoscopy if no biopsy is done. The Surgery Administrative Officer will monitor to ensure all positive FOBT patients receive initial findings of the colonoscopy orally at the time of testing and a written report of findings forwarded within 14 days of the colonoscopy if no biopsy is taken. Providers will be reminded to submit written report of findings if not completed by day 12. Ongoing tracking and trending will be conducted. If the notification is not present by next day close of business, the Chief of Surgery will be notified. If the provider is not available to immediately correct the notification, the Chief of Surgery will notify the patient.

A quarterly report (due by January 13, 2012) will be submitted to the Chief of Surgery, Quality Management, and Clinical Executive Board. A copy of VHA Directive 2007-004, Colorectal Cancer Screening was sent to all general surgeons on October 13, 2011, and again on December 12, 2011, with request to confirm the directive was reviewed. We are following the national directive and a local policy will be written and implemented by January 31, 2012.

Recommendation 5. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: January 31, 2012

A facility review will be completed by the Surgical Administrative Officer on all patients in FY11 to verify that the patients have received a verbal communication on the finding of the colonoscopy and notification by letter as appropriate by the date of January 31, 2012.

Beginning the week of December 12, 2011, the Surgery Administrative Officer will conduct a weekly status check of all patients identified after October 31, 2011, that a letter is sent within 14 days of biopsy results. The Surgery Administrative Officer will

monitor to ensure the patients receive initial findings of the colonoscopy orally at the time of testing and a written report of findings forwarded within 14 days of receipt of biopsy test, when taken. Providers will be reminded to submit written report of findings if not completed by day 12. Ongoing tracking and trending will be conducted. If the notification is not present by next day close of business, the Chief of Surgery will be notified. If the provider is not available to immediately correct the notification, the Chief of Surgery will notify the patient.

A quarterly report (due by January 13, 2012) will be submitted to the Chief of Surgery, Quality Management, and Clinical Executive Board. A copy of VHA Directive 2007-004, Colorectal Cancer Screening was sent to all general surgeons on October 13, 2011, and again on December 12, 2011, with request to confirm the directive was reviewed. We are following the national directive and a local policy will be written and implemented by January 31, 2012

Recommendation 6. We recommended that the facility conduct a vulnerability risk assessment due to documented employee injuries and property damage and pursue actions based on the risk assessment results.

Concur

Target date for completion: September 30, 2012

A Risk Assessment was completed on November 15, 2011, for the hazard of being struck by a golf ball. Ongoing mitigation and safety measures are in place, and will be continued until the issue is adequately addressed. Per risk assessment, an estimated target date of end of FY 2012 for barrier netting is planned, pending approval, funding and awarding of project. Additionally, a parking garage project is planned for FY 2014, pending approval, funding, award and construction of project.

Recommendation 7. We recommended that processes be strengthened to ensure that annual preventive maintenance is performed on the CLC's elopement prevention system.

Concur

Target date for completion: Completed

The WanderGuard system has been removed as of October 20, 2011, and no equipment has been replaced, therefore no preventive maintenance is required at this time. Patients identified as elopement risk are assigned one-on-one staffing until we can find a secure/locked unit for placement.

Recommendation 8. We recommended that the anesthesia supply room adhere to VA requirements for clean/sterile supply storage and that compliance be monitored.

Concur

Target date for completion: Completed

All deficiencies corrected. The space was reviewed by the OIG Team on October 20, 2011, and approved of the corrective action. Ongoing monitoring conducted via EOC rounds. VA Handbook 7176 is the reference used at this facility for clean and sterile storage closets. We have an ongoing audit system to review all inventory

Recommendation 9. We recommended that all laser users and operating room staff complete all annual laser safety training modules and that compliance be monitored.

Concur

Target date for completion: Completed

All OR and EMS staff have completed Laser Safety training. Training will be required annually. Untrained staff is restricted from using equipment until trained.

Recommendation 10. We recommended that processes be strengthened to ensure that polytrauma interdisciplinary teams use the required template to document the treatment plan.

Concur

Target date for completion: We recommend this action be closed.

As of October 31, 2011, the team is using the required template.

Recommendation 11. We recommended that minimum polytrauma staffing levels be maintained.

Concur

Target date for completion: March 31, 2012

Grand Junction VAMC will submit a letter of request to reduce our level to a Polytrauma Point of Contact. Central office discussions took place in September for fact finding. This will eliminate the staffing requirements for a Certified Rehabilitation Nurse and a Speech Language Pathologist. We will continue to pursue recruitment of a Physiatrist. Grand Junction currently meets minimal staffing requirements for a Polytrauma Point of Contact. A transition plan will be developed to move care to Denver. Second level screenings are to occur via V-Tel with Denver.

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