Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00819-143

Combined Assessment Program Review of the VA Salt Lake City Health Care System Salt Lake City, Utah

June 10, 2008

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of March 24–28, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the VA Salt Lake City Health Care System (the system), Salt Lake City, UT. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 234 system employees. The system is part of Veterans Integrated Service Network (VISN) 19.

Results of the Review

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

- Electronic Morning Report.

We made recommendations in two of the activities reviewed. For these activities, the system needed to:

- Ensure that processing times for root cause analyses (RCAs) are improved.
- Ensure that all clinically active staff have current cardiopulmonary resuscitation (CPR) and advanced cardiac life support (ACLS) training, as required by Veterans Health Administration (VHA) and local policy.
- Require that computerized patient record system business rules are in compliance with VHA policy and Office of Information (OI) guidance.

The system complied with selected standards in the following three activities:

- Environment of Care (EOC).
- Pharmacy Operations.
- Survey of Healthcare Experiences of Patients (SHEP).

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

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–12, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The system is a tertiary care facility located in Salt Lake City, UT, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at eight community based outpatient clinics located in Ogden, Orem, St. George, Roosevelt, Nephi, and Fountain Green, UT, and in Pocatello, ID, and Ely, NV. The system is part of VISN 19 and serves a veteran population of 171,851 throughout most of Utah and parts of Idaho and Nevada.

Programs. The system provides primary and tertiary care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. It has 121 hospital beds and no nursing home beds.

Affiliations and Research. The system is affiliated with the University of Utah and provides training for 123 residents, as well as other disciplines, including dentistry, pharmacy, social work, psychology, occupational and physical rehabilitation, audiology, physician assistant, dietetics, and podiatry. In fiscal year (FY) 2007, the system research program had 270 projects and a budget of $11 million. Important areas of research include geriatrics, mental health, nephrology, neuroimmunology, dermatology, infectious diseases, cardiovascular disease, audiology/speech therapy, and bone and joint diseases.

Resources. In FY 2007, medical care expenditures totaled $258 million. The FY 2008 medical care budget is $280 million. FY 2007 staffing was 1,251 full-time employee equivalents (FTE), including 89 physician and 359 nursing FTE.

Workload. In FY 2007, the system treated 40,727 unique patients and provided 32,512 inpatient days in the hospital. The inpatient care workload totaled 5,380 discharges, and the average daily census was 90. Outpatient workload totaled 415,379 visits.

Objectives and Scope

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following five activities:

- Business Rules for Veterans Health Information Systems.
- EOC.
- Pharmacy Operations.
- QM.
- SHEP.

The review covered system operations for FY 2007 and FY 2008 through March 28, 2008, 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 system (*Combined Assessment Program Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah*, Report No. 05-01248-170, July 8, 2005). The system had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 234 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. The activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Electronic Morning Report

In 2004, the system created a 15-minute system-wide electronic morning report to executive leadership from department managers and supervisors. The report provides a quick overview of the past 24 hours and serves as a tool for system leadership to follow daily activities, identify opportunities for improvement, and comply with regulatory standards. It also holds staff accountable for decisions that impact the system's daily mission. Components and information presented in the report include:

1. Emergency department activity data.
2. Daily bed census by unit.
3. Patient transfers and pending transfers.
4. Number of surgeries scheduled and cancellations.
5. Patient deaths (expected or unexpected).
6. Patient falls.
7. Patients in isolation and indications.
8. Patients in seclusion or restraints.
9. Irregular discharges and patients leaving against medical advice.
10. Medication and treatment discrepancies.
11. Critically ill patients.
12. Ward comments.
13. Primary care clinic availability.

The report serves as a mechanism for enhanced, open communication among staff, patients, families, and executive leadership. Also, it enables the system to identify opportunities to improve customer service.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the system's Director, Chief of Staff, Chief Nurse Executive, and Chief of QM. We also interviewed QM personnel and several other service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the system's quality of care. Appropriate review structures were in place for 13 of the 15 program activities reviewed. However, we identified two areas that needed improvement.

Root Cause Analysis. RCAs are designed to identify and resolve the root cause of system and/or process deficiencies involved in an actual or potential adverse event. We found one element of the RCA process that did not comply with VHA guidelines. In the 24-month period January 2006–January 2008, the system initiated 34 RCAs. Staff only completed five RCAs within the required timeframe of 45 days. Without timely identification, reporting, and analysis of significant patient outcomes and events, managers could not be assured of a comprehensive and efficient patient safety process.

Leadership. We found that the system did not have a mechanism in place to ensure that all clinically active staff (including physicians, mid-level providers, and nurses) have CPR training, as required by VHA.[1] Additionally, critical service areas identified by the system, such as intensive care units, that require ACLS training were not consistently reviewed for compliance with local policy. We reviewed the credentialing files of 55 providers in four service areas (gastroenterology, cardiology, dental, and radiology). We identified 23 providers conducting intravenous conscious sedation procedures; 4 did not have current ACLS certification as required.

[1] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training For Staff*, February 6, 2008.

Recommendation 1 We recommended that the VISN Director ensure that the System Director improves processing times for RCAs.

The VISN and System Directors concurred with the finding and recommendation. A second registered nurse has been assigned to support the Patient Safety Program. RCA completion is now monitored by the Patient Safety Committee. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2 We recommended that the VISN Director ensure that the System Director requires all clinically active staff to have current CPR and ACLS training, as required by VHA and local policy.

The VISN and System Directors concurred with the findings and recommendation. Two policies outlining the requirements of VHA policy have been written and are currently in place. One policy includes the training requirements for clinically active staff. A training log has been established, and a schedule of course offerings has been identified. Two summer hire positions have been designated to serve as basic life support instructors. The target date for completion is September 30, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Business Rules for Veterans Health Information Systems

The purpose of this review was to determine whether business rules governing the patient health record (electronic and paper) complied with VHA policy.[2] The health record includes entries, such as physician orders, progress notes, and test reports. Once entries are signed, they must be maintained in unaltered form. New information or corrections may be added to the record as addenda to the original notes or as new notes. Business rules define what functions certain groups or individuals are allowed to perform in the health record.

In October 2004, VHA's OI provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. The OI also recommended that the ability to edit signed records be limited to a facility's Privacy Officer. On

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

June 7, 2006, VHA instructed all facilities to comply with the OI guidance.

We reviewed VHA and local policies and examined more than 736 business rules. We identified two business rules that allowed individuals other than the Chief of Health Information Management Service or the Privacy Officer to amend signed documents. System staff took action to remove these business rules while we were onsite.

Recommendation 3

We recommended that the VISN Director ensure that the System Director requires compliance with VHA policy and the October 2004 OI guidance.

The VISN and System Directors concurred with the finding and recommendation. System staff removed the two business rules while we were onsite. The corrective action is acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine if the system maintained a safe and clean health care environment. VHA facilities are required to provide a comprehensive EOC program that fully meets VHA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

We evaluated the infection control (IC) program to determine compliance with VHA directives based on the management of data collected and processes in which the data was used to improve performance. Additionally, the locked inpatient mental health unit was inspected to determine if managers identified environmental hazards that pose a threat to patients and ensured that staff received specialized training.

We conducted onsite inspections of medical-surgical intensive care units, specialty care clinics (hematology, oncology, podiatry, orthopedics), and the locked inpatient mental health unit.

Overall, we found that the system maintained a generally clean and safe environment. The IC program monitored and reported data to clinicians for implementation of quality improvements. Safety guidelines were met, and risk assessments complied with VHA standards. Furthermore, managers on the locked inpatient mental health unit

complied with safety regulations, and staff were trained to identify environmental hazards. We made no recommendations.

Pharmacy Operations

The purpose of this review was to evaluate whether VHA facilities had adequate controls to ensure the security and proper management of controlled substances (CS) and the pharmacies' internal physical environments. We also assessed whether clinical managers had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We reviewed VHA regulations[3] governing pharmacy and CS security, and we assessed whether the system's policies and practices were consistent with VHA regulations. We inspected inpatient and outpatient pharmacies for security, EOC, and IC concerns, and we interviewed appropriate pharmacy and police personnel, as necessary. Additionally, we reviewed policies and procedures and interviewed appropriate personnel to determine if clinical pharmacists monitored patients prescribed multiple medications to avoid polypharmacy.

Pharmacy Controls. Our review showed that the system had appropriate policies and procedures to ensure the security of the pharmacies and CS. CS inspections were conducted according to VHA regulations. Training records showed that the 2 CS Coordinators and 18 inspectors received appropriate training to execute their duties. The pharmacies' internal environments were secure, clean, and well maintained. The clean room,[4] where sterile intravenous medications were prepared, complied with VHA regulations[5] and IC standards.

Polypharmacy. Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the

[3] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.
[4] A room in the inpatient pharmacy where the concentration of airborne particles is controlled by proper construction and use of controlled temperature, humidity, and air pressure.
[5] VHA Handbook 1108.6.

number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[6] Some literature suggests that that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[7]

Our review showed that managers developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA facilities use SHEP data to improve patient care, treatment, and services. VHA relies on the Performance Analysis Center for Excellence of the Office of Quality and Performance and their analysis of the survey data to make administrative and clinical decisions to improve the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of experiences as "very good" or "excellent." VHA facilities are expected to address areas in which they are underperforming.

The graphs on the next page show the system's performance in relation to national and VISN performance. Figure 1 shows the system's SHEP performance measure results for inpatients, and Figure 2 shows the system's SHEP performance measure results for outpatients.

[6] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times,* December 2004.
[7] Terrie, *Pharmacy Times*, December 2004; Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

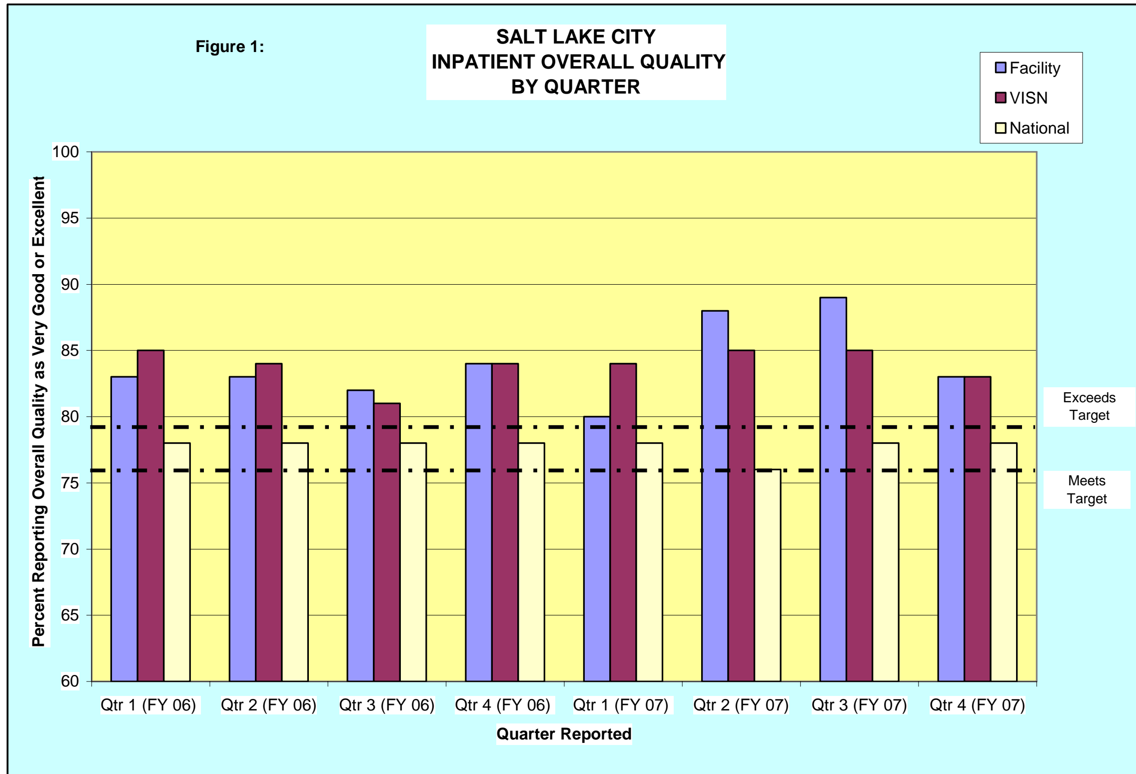
Figure 1:
SALT LAKE CITY
INPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 1 (FY 06)
Qtr 2 (FY 06)
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Quarter Reported

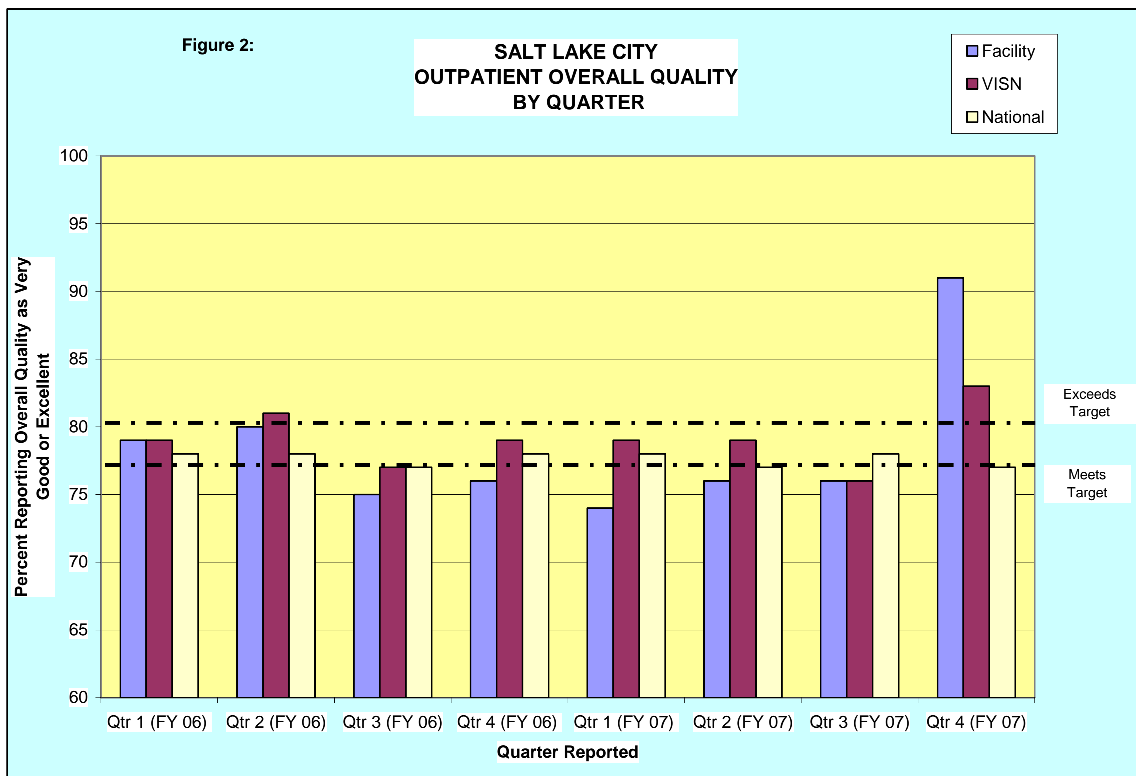
Figure 2:
SALT LAKE CITY
OUTPATIENT OVERALL QUALITY
BY QUARTER
Facility
VISN
National
Percent Reporting Overall Quality as Very Good or Excellent
100
95
90
85
80
75
70
65
60
Exceeds Target
Meets Target
Qtr 1 (FY 06)
Qtr 2 (FY 06)
Qtr 3 (FY 06)
Qtr 4 (FY 06)
Qtr 1 (FY 07)
Qtr 2 (FY 07)
Qtr 3 (FY 07)
Qtr 4 (FY 07)
Quarter Reported

The system exceeded the inpatient overall quality expectations for all 8 quarters of available data. The system met the outpatient overall quality expectations in 2 quarters of FY 2006 and exceeded expectations in the last quarter of FY 2007. The system had developed and implemented action plans to address patient complaints that impacted outpatient overall satisfaction. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 2, 2008

From: Director, VASLCHCS (00/660)

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

Subject: **Combined Assessment Program Review of the VA Salt Lake City Health Care System, Salt Lake City, Utah**

To: **Director, Operational Support Division (53B)**

Director, Management Review Service (10B5)

1. Attached is the updated response to the OIG CAP Site Review of the Salt Lake City Health Care System (VA SLC HCS).
2. I have reviewed and concur with all of the Facility Director's comments.
3. If you have any questions, please contact Mr. James Floyd, Medical Center Director at 801-584-1211. Thank you.

System Director Comments

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director improves processing times for RCAs.

Concur

The RCAs reviewed by the survey team during the specified timeframe did not meet the 45-day requirement for completion. The problem has been corrected with the addition of a second registered nurse (RN) assigned to support the Patient Safety program. The second RN was serving in this capacity during the survey period. The completion of RCAs within the 45-day timeframe is now monitored in the Patient Safety Committee.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires clinically active staff to have current CPR and ACLS training, as required by VHA and local policy.

Concur

Two station policies outlining the requirements of the VHA Directive have been written and are currently in place. The policy includes the training requirements for the clinically active staff. The training log and schedule of course offerings has been identified. Two summer hire positions were designated to serve as BLS instructors to support this effort. The target date to complete this requirement is September 30, 2008.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires compliance with VHA policy and the October 2004 OI guidance.

Concur

The two business rules identified by the survey team to not be in compliance during the time of the survey were immediately removed when identified. Therefore, this recommendation has already been corrected.

OIG Contact and Staff Acknowledgments

Contact	Linda DeLong, Director Dallas Office of Healthcare Inspections (214) 235-3331
Contributors	Karen Moore, Associate Director Wilma Reyes, Healthcare Inspector

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