Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-00517-97

Combined Assessment Program Review of VA Butler Healthcare Butler, Pennsylvania

March 16, 2009

Washington, DC 20420

Why We Did This Review

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

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

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

Table of Contents

Executive Summary

Introduction

During the week of January 12–16, 2009, the OIG conducted a Combined Assessment Program (CAP) review of VA Butler Healthcare (the facility), Butler, PA. 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 188 facility employees. The facility is part of Veterans Integrated Service Network (VISN) 4.

Results of the Review

The CAP review covered six operational activities. We identified the following organizational strengths and reported accomplishments:

- Project Life Saver.
- Automated tracking of environmental rounds findings.

We made recommendations in three of the activities reviewed; one was a repeat recommendation from the prior CAP report. For these activities, the facility needed to:

- Conduct daily inspections of construction sites and document contractor oversight.
- Require that fire extinguisher signage comply with VA policy.
- Ensure that discharge instructions are consistent with discharge summaries.
- Require that contract physicians' privileges do not extend beyond the length of the contract and that contracts are appropriately renewed.

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

- Medication Management.
- Patient Satisfaction.
- Suicide Prevention Program.

This report was prepared under the direction of Randall Snow, JD, Associate Director, Washington, DC, Office of Healthcare Inspections.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 10–15, 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 facility is an ambulatory care facility located in Butler, PA, that provides inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) in Foxburg, Hermitage, Kittanning, and New Castle, PA. The facility is part of VISN 4 and serves a veteran population of about 73,000 throughout Armstrong, Butler, Clarion, Lawrence, and Mercer counties in western Pennsylvania.

Programs. The facility provides primary care, behavioral health, specialized extended care, physical rehabilitation, and residential substance abuse treatment services. It has 60 community living center (CLC)[1] beds, 10 compensated work therapy (CWT) beds, and 56 domiciliary beds.

Affiliations. The facility is affiliated with 44 colleges and universities. Currently, affiliation agreements cover a variety of university and professional school programs in the fields of audiology, psychology, nursing, social work, counseling, pharmacy, occupational and physical therapy, recreation, information technology, nutrition, community health, medical assistant, and phlebotomy. The educational levels range from certificates to associate, bachelor, masters, and doctoral degrees. The facility also has an affiliation agreement with a local vocational/technical school. During the past year, 31 students from the colleges and universities completed internships.

Resources. In fiscal year (FY) 2008, medical care expenditures totaled $71 million. The FY 2009 medical care budget is $78.7 million. FY 2008 staffing was 554 full-time employee equivalents (FTE), including 15 physician and 140 nursing FTE.

Workload. In FY 2008, the facility treated 17,547 unique patients. The CLC provided 20,302 inpatient days, had 245 discharges, and had an average daily census of 55.5. The domiciliary provided 17,094 inpatient days, had 213 discharges, and had an average daily census of 48.9. Outpatient workload totaled 122,621 visits.

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

Objectives and Scope

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

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

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

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

- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- Patient Satisfaction.
- QM.
- Suicide Prevention Program.

The review covered facility operations for FY 2008 and FY 2009 through January 15, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Medical Center, Butler, Pennsylvania,* Report No. 05-01941-117, March 29, 2006). We had identified improvement opportunities in EOC and controlled substances accountability. During our follow-up review, we found sufficient evidence that program managers had implemented

the appropriate actions in the area of controlled substances accountability, and we consider that issue closed. However, since desired outcomes for EOC had not yet been achieved at the time of this CAP review, we reissued a recommendation for this area (see pages 4 and 5).

During this review, we also presented fraud and integrity awareness briefings for 188 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strengths

Project Life Saver

Project Life Saver is like a global positioning system for patients who have been identified as potential wanderers. The patients wear tracking bracelets, and their personally identifiable information is shared with VA police. Additionally, unannounced missing patient drills are conducted quarterly. A device is attached to an old resuscitation mannequin. The mannequin is then hidden on the facility's grounds. The CLC is notified that a "patient" is missing, and a search is conducted. The results are evaluated and documented. Project Life Saver and the unannounced drills afford an additional level of security for a vulnerable population.

Automated Tracking of Environmental Rounds Findings

Facility staff developed a computerized program to specifically track environmental rounds findings until closure. The program provides automatic notification to the work order clerk when a discrepancy is entered; a second notice is sent when the work order is completed. The program generates reports that contain the following information: (1) the average number of days to close items, (2) the number of open versus closed items, and (3) the categories of findings. Automated reports of items open for more than 30 days are forwarded to the leadership team. The database has greatly improved work order turnaround times.

Results

Review Activities With Recommendations

Environment of Care

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment. VHA regulations require that health care facilities provide clean and safe environments in all patient care areas and establish comprehensive EOC programs that fully meet VA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

We inspected the CLC and the outpatient clinics. We also followed up on recommendations from our prior CAP review. The facility was very clean and well maintained. However, we identified the following conditions that required attention.

Daily Interim Life Safety Inspections. The Facility Management Contracting Officer's Technical Representative (COTR) did not conduct daily inspections of all construction sites and failed to provide contractor oversight.[2] We had a similar finding during our prior CAP review and recommended that preventative maintenance inspections and contractor oversight be performed in accordance with VHA policy.

At one construction site, we found that fire extinguisher cabinets were difficult to open because they had been painted shut. At another construction site, where new ceiling lights were being installed, we found a lack of temporary lighting in an outpatient clinic hallway outside of an elevator. The facility's Director took corrective actions at both construction areas while we were onsite. However, it appears that COTR position turnover and extended absence resulted in decreased daily inspections of construction sites.

Fire Extinguisher Signage. VA policy requires that signage identifying the locations of fire extinguishers be clear and easily identifiable for patients, visitors, and staff.[3] Fire extinguisher locations could not be identified from a distance.

[2] VHA Directive 2004-012, *Safety and Health During Construction Activities,* April 5, 2004.
[3] Department of Veterans Affairs, *Fire Protection Design Manual*, 4th ed., November 2005.

Recommendation 1 We recommended that the VISN Director ensure that the Facility Director requires that the COTR conduct daily inspections of construction sites and that contractor oversight is documented.

Recommendation 2 We recommended that the VISN Director ensure that the Facility Director requires that fire extinguisher signage comply with VA policy.

The VISN and Facility Directors concurred with the findings and recommendations and have taken action to consolidate relevant safety logs, designate manpower backup, update COTR performance standards, and implement an EOC performance monitor to improve oversight of construction projects. Temporary fire extinguisher signage has been posted, and permanent signage has been ordered. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

The purpose of this review was to evaluate whether selected aspects of care, such as consultations, intra-facility transfers, and discharges, were coordinated appropriately over the continuum of care. Timely responses to consults, effective management of patient transfers, and appropriate discharge instructions are essential to optimal patient outcomes. We found that providers managed patient consults and intra-facility transfers appropriately. However, we identified the following area that needed improvement.

Patient Discharges. VHA regulations[4] require that specific information be included in both discharge summaries and patient discharge instructions. We reviewed medical record documentation for 6 patients discharged from inpatient care. All discharge summaries were completed within 30 days of discharge, and documentation indicating that patients received and understood discharge instructions was complete. However, we found that three of the six medical records we reviewed contained medication inconsistencies between patient discharge instructions and discharge summaries.

Recommendation 3 We recommended that the VISN Director ensure that the Facility Director requires that discharge instructions are consistent with discharge summaries.

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

The VISN and Facility Directors concurred with the finding and recommendation and directed that providers who complete discharge instructions also complete the discharge summary. This process will be reviewed monthly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purpose of this review was to evaluate whether the facility had a comprehensive QM program designed to monitor patient care quality and whether senior managers actively supported the program's activities. We interviewed the facility's Director, Chief of Staff, and the QM manager. We evaluated policies, performance improvement data, and other relevant documents.

The QM program was generally effective in providing oversight of the quality of care at the facility. However, we identified the following area that needed improvement.

Physician Privileging. VHA regulations[5] require that clinical privileges granted to contractors not extend beyond the contract period. Each new contract period requires reappraisal and reprivileging. We reviewed privileging documentation for five contract physicians. All five had privileges that extended beyond the length of the contract. In addition, four had expired contracts. Facility staff were not able to provide any documentation to indicate that the contracts had been renewed or extended.

Recommendation 4 We recommended that the VISN Director ensure that the Facility Director requires that contract physicians' privileges do not extend beyond the length of the contract and that contracts are appropriately renewed.

The VISN and Facility Directors concurred with the findings and recommendation and have modified providers' privileges to match the terms of the providers' contracts. Also, the facility created a database to track contracts that are due for renewal or extension. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

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

Review Activities Without Recommendations

Medication Management

The purpose of this review was to evaluate whether VHA facilities had adequate medication management processes to ensure safe ordering, dispensing, administering, and monitoring of medications. We reviewed medication management processes on inpatient units, and we interviewed nurse managers and other nursing staff. Additionally, we observed nurses administering medications, and we asked patients if nurses scanned their wristbands prior to administering their medications.

VHA regulations and The Joint Commission require that clinicians monitor PRN[6] medications for effectiveness. Additionally, the facility's policy for pain assessment requires that reassessments of PRN medications be documented within 4 hours after administration. We reviewed 89 administered doses of PRN pain medications. We found that for 82 (92 percent) of the doses, reassessments for effectiveness were documented within the required timeframe.

We found adequate management of medications brought into the facility by patients or their families. Additionally, we found that the processes for reconciling controlled substances discrepancies at the unit level were adequate. We made no recommendations.

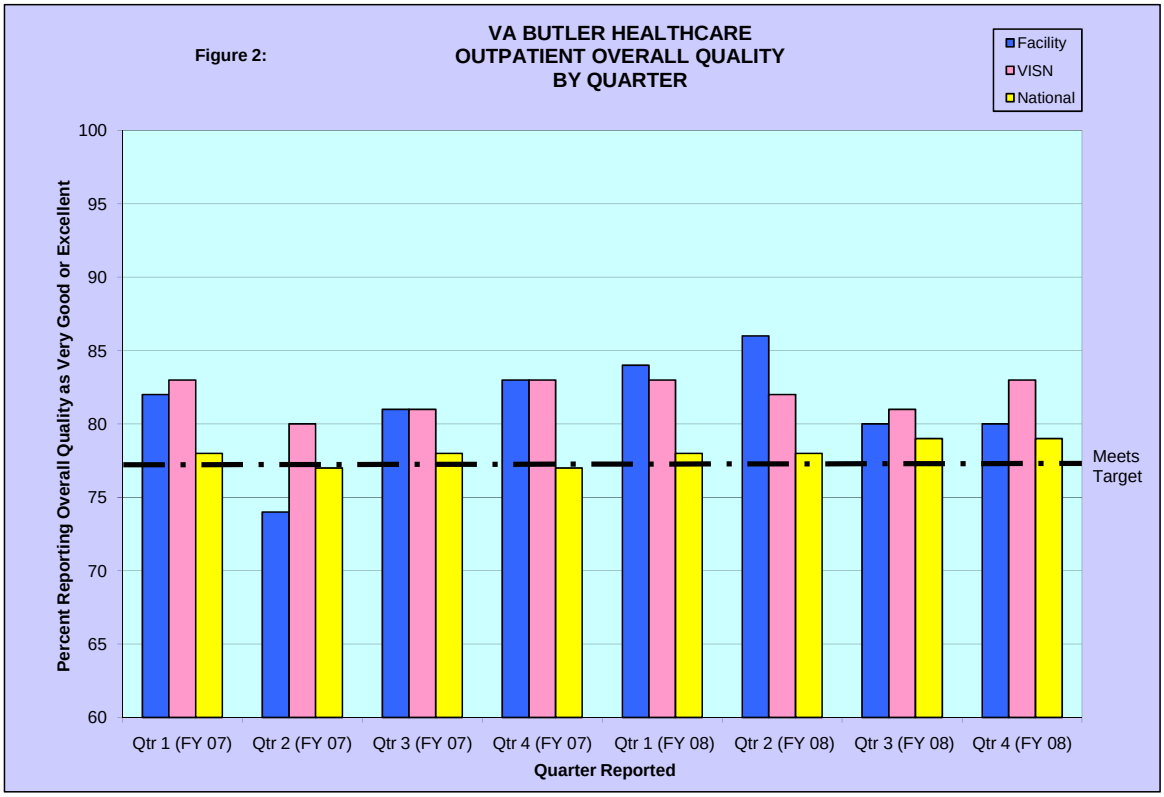
Patient Satisfaction

The purpose of this review was to assess the extent that VHA medical facilities use the quarterly or semi-annual Survey of Healthcare Experiences of Patients (SHEP) results to improve patient care and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure goals for patients reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

Because the facility does not provide acute inpatient care, no inpatient SHEP survey data was collected. We reviewed outpatient survey results for FYs 2007 and 2008. Figure 1 on the next page shows the facility's outpatient scores, which

[6] Latin abbreviation of *pro re nata*, which means as needed or as the circumstances require.

met or exceeded VHA's target goals in 7 out of 8 quarters. We made no recommendations.



Suicide Prevention Program

The purpose of this review was to determine whether VHA health care facilities had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs) at facilities and very large CBOCs.[7] Also, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[8] documented safety plans that addressed suicidality, and documented collaboration between mental health (MH) providers and SPCs.

We interviewed the facility's SPC and the MH providers on the Suicide Risk Group Committee, and we reviewed pertinent policies and the medical records of five facility patients and five CBOC patients determined to be at risk for suicide. We found that senior managers had appropriately appointed the SPC and that the SPC fulfilled the required

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

functions. We also found that documentation was complete in all medical records reviewed. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 6, 2009

From: VISN Director

Subject: **Combined Assessment Program Review of VA Butler Healthcare, Butler, Pennsylvania**

To: Director, Washington, DC, Healthcare Inspections Division (54DC)

Director, Management Review Service (10B5)

1. I have reviewed the response to the OIG recommendations made by the Butler VA Medical Center and concur with all actions. We appreciate the opportunity for review of our processes at the medical center.

(original signed by:)

MICHAEL E. MORELAND, FACHE

Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 6, 2009

From: Facility Director

Subject: **Combined Assessment Program Review of the VA Butler Healthcare, Butler, Pennsylvania**

To: Network Director, VA Stars and Stripes Healthcare Network (10N4)

Attached are responses to the draft OIG CAP report from the survey conducted at VA Butler Healthcare from January 12–16, 2009.

There is concurrence with all recommendations and corrective action has been initiated.

Thank you for the opportunity to participate in this review.

Patricia Nealon

PATRICIA NEALON

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 Facility Director requires that the COTR conduct daily inspections of construction sites and that contractor oversight is documented.

Concur

Actions completed to date:

1. Project Safety Files, including ICRA's, ILSM's, and daily safety inspection logs are consolidated in one location for quick review. Complete.

2. Provide formal project manpower backup support to provide safety inspection continuity during staff absences. Complete.

Actions planned, not yet complete

1. Add mandatory daily safety inspections to project COTR performance standards. Completion planned for February 15, 2009.

2. Implement an EOC life safety code performance monitor to document monthly review of files by the project supervisor. Completion planned for February 15, 2009.

N= # of daily inspections of project construction sites completed by the COTR project manager.

D= # of project construction sites each day.

Report performance to the Safety/Environment of Care Committee.

Recommendation 2. We recommended that the VISN Director ensure that the Facility Director requires that fire extinguisher signage comply with VA policy.

Concur

Actions completed to date:

Signage that is parallel to the wall was purchased and installed to label each fire closet. It is our point of view that this conforms with VA Policy which references NFPA 10, Section D-2-2.2. Complete.

Actions planned but not yet complete:

Order fire extinguisher signs that are mounted perpendicular to the wall to better identify the fire extinguisher locations, as suggested by the OIG investigator. Vendor located and order placed. This is planned to be completed by March 1, 2009 ** We believe this exceeds VA requirements, again referencing NFPA 10, Section D-2-2.2.

Oversight of implementation of actions will be completed at the Safety/Environment of Care Committee.

Recommendation 3. We recommended that the VISN Director ensure that the Facility Director requires that discharge instructions are consistent with discharge summaries.

Concur

Actions taken to date: The same provider who completes the discharge instructions will also complete the discharge summary to ensure consistency. Implemented 1/20/09.

A monitor of effectiveness of actions has been developed, and record review began for January 2009.

N=total # of discharges with consistency between instructions and summaries.

D=total # of medical records reviewed with discharge instructions.

Sample size = 15 records each month beginning January 2009. Goal = 100% sustained over 3 months. This will be monitored through the Medical Records Committee monthly.

Recommendation 4. We recommended that the VISN Director ensure that the Facility Director requires that contract physicians' privileges do not extend beyond the length of the contract and that contracts are appropriately renewed.

Concur

As detailed below, the Medical Staff Bylaws were amended in August 2007 to reflect the requirement to privilege contract physicians for a period not to exceed the contract relationship.

Article III, Section 2, paragraph o. *"Clinical privileges granted to contractors will not extend beyond the contract period. Each new contract period requires reappraisal and reprivileging. Reappraisal may be required more frequently for contractors, depending upon the length of the contract period.*

(1) Where a contract is renewed or the period of performance extended, the contractor or subcontractor will be credentialed and privileged similar to the initial credentialing process, with the exception that non-time limited information, e.g., education and training, does not need to be reverified.

(2) Medical Staff appointments and privileges will not be granted for a period longer than the formal relationship with the facility. If a contract is terminated prior to expiration of the contract, privileges must be terminated since there is no legal agreement for the practitioner to be providing care. Where the contract is terminated early based on substandard care, professional incompetence or professional misconduct, privileges should be revoked and a report made to the NPDB, following appropriate due process procedures. Where substandard care, professional incompetence or professional misconduct is not involved in the early termination of the contract, privileges will be terminated without regard to the due process requirements for privileging actions. This termination is not reportable to the NPDB.

(3) Independent contractors/subcontractors acting on behalf of the Butler Veterans Affairs Medical Center are subject to the provisions of VA policies on credentialing and privileging and NPDB reporting."

The Chief of Staff's Office and the COTR's will assure adherence to this policy, and the contracting officers will assure that when possible, extensions are negotiated for a period longer than 90 days to allow for the privileging process to be completed.

Actions taken to date:

At the January 20, 2009, meeting of the Medical Executive Committee, action was taken to reduce the approved privilege period for the contract pathologist through the end of the current contract period which is March 31, 2009. The Chief of Staff's Office was notified by the contracting officer that a contract extension was approved for the period of April 1, 2009, through September 30, 2009. An application was mailed to the physician to apply for reprivileging for the period of April 1, 2009, through September 30, 2009.

Contract extensions through September 30, 2009, were also negotiated for the two CBOC contracts which had expired without extension on November 30, 2008, and December 31, 2008. Re-privileging packages were mailed to the four contract physicians for reprivileging through September 30, 2009. Approved privileges will be in place for all providers by March 30, 2009.

New requests and Scopes of Work have been submitted to contracting for CBOC contracts to include a base year and 4 option years.

New contract milestones have been established to include the following:

* The Credentialing and Privileging Coordinator will be notified 60 days in advance of contract extensions or option years that will be exercised.

* Butler contracting recently implemented an Access database to enhance contracting's ability to follow contracts due for renewal and option extensions.

* COTR's and Contracting will complete quarterly assessments to monitor what contracts are due for renewal or options exercising.

Actions planned, but not yet complete:

Reprivilege pathologist and four contract CBOC physicians by March 30, 2009

New CBOC contracts will be awarded for a base year and 4 option years by September 30, 2009.

The Medical Executive Committee will follow action plans and effectiveness.

OIG Contact and Staff Acknowledgments

Contact	Randall Snow, J.D., Associate Director Washington, DC, Office of Healthcare Inspections (202) 461-4665
Contributors	Gail Bozzelli, RN, Team Leader Donna Giroux, RN, BSN, CPHQ Tim Barry, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network 4 (10N4)
Director, VA Butler Healthcare (529/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Robert P. Casey, Jr.; Arlen Specter
U.S. House of Representatives: Jason Altmire, John Murtha, Glen W. Thompson

This report is available at http://www.va.gov/oig/publications/reports-list.asp.