Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Louis A. Johnson VA Medical Center Clarksburg, West Virginia

Report No. 03-03136-69

January 28, 2004

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices 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 and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

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
Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of October 20, 2003, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we provided 3 fraud and integrity awareness briefings to 40 employees.

Results of Review

Areas reviewed in contract administration, controlled substances accountability, emergency preparedness, human subjects research, and patient care administration were adequate. We recommended that the VA Stars and Stripes Healthcare Network [Veterans Integrated Service Network (VISN) 4] Director require that the Medical Center Director improve:

- QM program monitoring, data analysis, and documentation processes.
- Information technology security.

We also made suggestions to improve the Community Residential Care Program, patient transportation services, environment of care, and the Government Purchase Card Program.

Acting VISN Director and Medical Center Director Comments

The Acting VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 9 – 12 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed. This report was prepared under the direction of Mr. James R. Hudson, Director, Atlanta Audit Operations Division.

(original signed by:)

RICHARD J. GRIFFIN
Inspector General

Introduction

Medical Center Profile

Organization. The Louis A. Johnson VA Medical Center, Clarksburg, West Virginia, is an acute and intermediate care hospital that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community-based outpatient clinics located in Braxton, Tucker, and Wood counties in West Virginia. The medical center is part of VISN 4, and serves a veteran population of about 74,500 in a primary service area that includes 33 counties in West Virginia, Ohio, Pennsylvania, and Maryland.

Programs. The medical center provides medical, surgical, mental health, and long-term care. The medical center has 71 hospital beds and opened a 27-bed nursing home care unit (NHCU) in July 2003, and operates specialty treatment programs, including a substance abuse program and a post-traumatic stress disorder (PTSD) program.

Affiliations and Research. The medical center has affiliation agreements with 5 colleges and universities in 9 training programs, and supports 16 medical resident positions from the West Virginia University School of Medicine. At the time of our review, the medical center had six research projects with a budget of over $762,000, including about $657,000 in grants from the National Institutes of Health. Important areas of research include prostate cancer, the role of Leptin in cancer growth, and cardiac myocytes.

Resources. In FY 2003, medical care expenditures totaled over $68 million. The FY 2004 medical care budget is about $72 million. The FY 2003 staffing totaled 595 full-time equivalent employees (FTEE), including 38 physician and 182 nursing FTEE.

Workload. In FY 2003, the medical center treated 18,382 unique patients. The inpatient care workload totaled 2,881 discharges, and the average daily census was 54 for the hospital and 10 for the NHCU. The outpatient workload was 182,842 visits.

Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected medical center operations, focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of QM, patient care administration, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered medical center operations from October 1, 2001, through October 23, 2003, and was done in accordance with OIG standard operating procedures for CAP reviews.

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

Community Residential Care Program
Contract Administration
Controlled Substances Accountability
Emergency Preparedness
Environment of Care
Government Purchase Card Program
Human Subjects Research
Information Technology Security
Patient Care Administration
Patient Transportation Services
Quality Management

Activities needing improvement are discussed in the Opportunities for Improvement section (pages 3–8). For these activities, we made recommendations or suggestions. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN and medical center management until corrective actions are completed. For the activities not discussed in the Opportunities for Improvement section, there were no reportable deficiencies.

During the review, we also presented three fraud and integrity awareness briefings for medical center employees. These briefings, attended by 40 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Results of Review

Opportunities for Improvement

Quality Management – Important Functions Needed Improvement

Condition Needing Improvement. Two critical committees did not meet or perform their functions in FY 2003, and analysis of patient restraint data and reviews of documentation supporting resident supervision were inadequate. The following conditions required management attention:

- The Cardio-Pulmonary Resuscitation (CPR) Committee did not meet in FY 2003 and did not evaluate Code Team performance and outcomes of resuscitation efforts. In FY 2003, 23 Code Blue events occurred; however, the Quality Manager told us that the CPR Committee did not review the performance of Code Teams or code outcomes. Medical center policy requires the CPR Committee to review post-code documentation and report to the Medical Executive Committee. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also requires facilities to monitor resuscitation outcomes and process performance.

  Code Team members did not adequately document Code Blue events. Quality Improvement Data Forms for Codes were only completed for 7 (30 percent) of 23 reported Code Blue events. In one case, a Physician Code Team Leader did not complete or sign the form. In another case, an outdated form was used which did not document the process as outlined in the medical center policy. There was no evidence that the form was completed for the remaining 16 Code Blue events.

- The Peer Review Committee did not meet in FY 2003 and did not perform peer reviews in accordance with VISN and medical center policies. The Chief of Staff told us that critical peer reviews were sent to the VISN or other medical centers to be performed. The VISN policy requires that medical centers and clinics establish and maintain a program of peer reviews in support of clinical care programs and professional services. Medical center policy requires the Peer Review Committee to meet monthly to perform peer reviews and to make recommendations to the Medical Executive Committee.

- Nursing Service managers did not systematically analyze data collected on clinicians' use of restraints. Although incidences of restraint use were reported, the data were not systematically analyzed, as required by JCAHO.

- The Medical Record Review Committee did not review documentation supporting attending physician supervision of residents. We found no evidence that the committee reviewed whether attending physicians co-signed discharge summaries. Veterans Health Administration (VHA) policy requires that a minimum sample of 5 percent of the medical

center's discharged patients' records are reviewed quarterly to ensure that residents are receiving adequate supervision. We did not find documentation of resident supervision reviews in the Medical Record Review Committee minutes for 3 of 4 quarters reviewed.

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that:

a. The CPR Committee meets as required and Code Blue events are evaluated and appropriately documented.

b. The Peer Review Committee meets and performs mandated functions.

c. Nursing Service managers analyze patient restraint data.

d. The Medical Record Review Committee reviews documentation supporting physician supervision of residents.

The Acting VISN Director and the Medical Center Director agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Information Technology Security – Security Needed Improvement

Condition Needing Improvement. Security of the medical center's automated information system needed improvement. The following conditions needed management attention:

- The medical center's four major systems' contingency plans did not identify the disaster recovery teams or the roles the members would play during disaster recovery efforts.

- The contingency plans for the Veteran Health Information Systems and Technology Architecture (VISTA), the Local Area Network, and the overall facility did not include the pager and cell phone numbers of key medical center personnel who would take part in activation of the plans.

- Human Resources staff did not request background investigations for the Medical Center Director and the Public Branch Exchange contractor employee, as required.

- Signage identifying entrances to areas containing sensitive information and automated systems posed a potential security risk.

- VISTA accounts for non-VA employees that had never been used, and generic accounts not required for system operations had not been identified and terminated. At our request, the Chief Information Officer and the Information Security Officer reviewed 13 individual accounts and 5 generic accounts. Review of the accounts resulted in the termination of four

individual accounts and two generic accounts. The remaining 12 accounts needed to remain active.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director takes action to ensure that:

a. Disaster recovery teams' and the members' responsibilities are included in the contingency plans for major systems.

b. Contingency plans include the pager and cell phone numbers of key medical center personnel.

c. Sensitive positions at the medical center are identified and background investigations requested.

d. Signage identifying the locations of sensitive information and automated systems is removed.

e. VISTA accounts for non-VA employees who no longer need them, and generic accounts not required for system operations are systematically identified and terminated.

The Acting VISN Director and the Medical Center Director agreed with the findings and recommendations, and the Acting VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Community Residential Care Program – Clinical Activities and Administrative Oversight Needed Improvement

Condition Needing Improvement. Clinical assessments, monthly follow-up visits, performance improvement activities, and annual home inspections needed improvement. The Community Residential Care (CRC) Program provides veterans with room, board, and general supervision in local private homes or congregate living facilities. We reviewed 10 patients' medical records and 9 CRC home inspection records, and interviewed the medical center's CRC Program Coordinator. The following conditions needed management attention:

- Seven medical records did not contain psychosocial assessments; six did not contain medical evaluations; and six did not contain mental health evaluations, all of which are necessary to ensure appropriate placements.

- Five medical records did not contain evidence that the CRC caregivers were given information and instructions for patient care upon admission or after hospitalizations or clinic visits by veterans.

- Four medical records did not contain evidence that the medical center's case managers assessed the patients' adjustments to placement within 30 days of placement.

- None of the medical records contained evidence of monthly case manager visits, as required.
- Five patients had VA-appointed fiduciaries to protect VA funds; however, there was no documentation that the medical center's case manager discussed these cases annually with a Veterans Benefits Administration (VBA) field examiner.
- Seven CRC home inspection files did not contain evidence of annual fire safety inspections, and two did not contain evidence that previously identified deficiencies were corrected.
- No CRC-specific performance improvement monitors were in place, as required.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director takes action to require that medical center CRC Program employees:

a. Complete and document psychosocial, medical, and mental health assessments prior to patients' placements in CRC homes.

b. Provide CRC caregivers with instructions for patient care when patients are admitted and following hospitalizations and clinic visits, and document the medical record accordingly.

c. Assess patients' adjustments to placement within 30 days of CRC placement.

d. Conduct and document monthly case manager visits to CRC patients.

e. Document annual discussions with VBA field examiners about the status of incompetent patients in CRC homes.

f. Conduct annual fire safety inspections, and ensure that all identified inspection deficiencies are corrected.

g. Develop and implement CRC-specific performance improvement monitors.

The Acting VISN Director and the Medical Center Director agreed with the findings and suggestions, and the Acting VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans.

Patient Transportation Services – Driver Training Needed Improvement

Condition Needing Improvement. Employees and volunteers who transported patients via Government vehicles did not receive training required to ensure patient safety. VA and medical center policies require that drivers receive annual motor vehicle safety training, including safe driving practices and defensive driving techniques. In addition, medical center policy requires annual Cardio-Pulmonary Resuscitation (CPR) certification for employees, and first aid and emergency procedures training for volunteers.

We reviewed training records of six employees (five Motor Vehicle Operators and one Recreation Therapist) and three volunteer drivers for training completed within the past 2 years. We found no documentation that employees or volunteers received the required annual motor vehicle safety, CPR, or first aid training.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director takes action to ensure that employee and volunteer drivers receive the required annual motor vehicle safety, CPR, and first aid training, and the training is documented.

The Acting VISN Director and the Medical Center Director agreed with the finding and suggestion, and the Acting VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans.

Environment of Care – Safety, Maintenance, and Confidentiality Issues Needed Improvement

Condition Needing Improvement. Generally, Facility Management Service maintained a clean medical center. However, we noted some safety, maintenance, and confidentiality concerns that needed management attention.

- A serrated cake knife on top of the PTSD group room refrigerator posed a safety hazard. Ward staff removed the knife immediately.
- The locked psychiatry unit did not have breakaway showerheads, as required by JCAHO.
- The Primary Care Gold clinic utility room had a leaking water pipe.
- The PTSD unit had missing tiles in the handicapped shower.
- Some hand and kick rails were pulling away from the walls and were missing caps, and some walls had small holes, cracked and chipped paint, and missing plaster.
- Confidential patient information was plainly visible on wall trays in the Primary Care and Ophthalmology Clinics, and on computer screens in the PTSD unit.

VHA policies and JCAHO standards require facilities to provide safe, clean, and well-maintained patient care environments, and to protect against disclosure of confidential patient information.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director takes action to:

a. Correct identified safety and maintenance deficiencies.

b. Protect confidential patient information from inadvertent disclosure.

The Acting VISN Director and the Medical Center Director agreed with the findings and suggestions, and the Acting VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans.

Government Purchase Card Program – Controls Needed To Be Strengthened

Condition Needing Improvement. Controls over the Government Purchase Card Program needed strengthening. During the 23-month period ending August 20, 2003, cardholders completed 21,127 transactions totaling $10.2 million. Monthly reviews of cardholder accounts had not been performed in the last year. VA Medical Center Coatesville provided acquisition services to the medical center. When the Coatesville employee responsible for conducting the reviews retired, the responsibilities were not reassigned. VA policy requires the Program Coordinator, Billing Officer, and Head of the Contracting Activity to conduct monthly joint reviews to verify compliance with VA policy.

Suggested Improvement Action. The VISN Director should ensure that monthly joint reviews of cardholder accounts are performed.

The Acting VISN Director and the Medical Center Director agreed with the finding and suggestion, and the Acting VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director provided acceptable improvement plans.

Appendix A

Acting VISN Director's Comments

Department of Veterans Affairs **Memorandum**

Date: December 2, 2003

From: Acting Network Director, VA Stars & Stripes Healthcare Network (10N4)

Subj: Combined Assessment Review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia

To: Director, Office of Inspector General, Office of Audit (52AT)

1. I have reviewed the report of the Combined Assessment Program Review performed at Clarksburg in October of 2003 as well as the comments submitted by the Director of that facility.

2. I concur with the plans outlined by the Director and anticipate no barriers to the completion of the activities that are already underway at that facility.

CHARLEEN R. SZABO, FACHE

Appendix B

Medical Center Director's Comments

The following Director's comments are submitted in response to the recommendation and suggestions in the Office of Inspector General Report:

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that:
a. The CPR Committee meets as required and Code Blue events are evaluated and appropriately documented.
b. The Peer Review Committee meets and performs mandated functions.
c. Nursing Service managers analyze patient restraint data.
d. The Medical Record Review Committee reviews documentation supporting physician supervision of resident.

Concur Target Completion Date: January 2004

a. CPR Committee meetings will be held at routine intervals to evaluate the process, outcomes, and documentation of Code events. A meeting was held on November 12, 2003.
b. Peer Review Committee meetings will be held at routine intervals conduct the mandated functions. A meeting was held on November 20, 2003.
c. Restraint usage as tracked by our facility is minimal. Future review of restraint usage will include joint analysis by nursing service managers and quality management specialists. Quarterly meetings will be conducted for this purpose.
d. Medical Record Committee will revise the format of resident supervision review. The reporting schedule for these reports will be maintained. The first revised report was reported at the November Medical Record Committee.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director takes action to ensure that:
a. Disaster recovery teams' and the members' responsibilities are included in the contingency plans for major systems.
b. Contingency plans include the pager and cell phone numbers of key medical center personnel.
c. Sensitive positions at the medical center are identified and background investigations requested.
d. Signage identifying the locations of sensitive information and automated systems is removed.
e. VISTA accounts for non-VA employees who no longer need them, and generic accounts not required for system operations are systematically identified and terminated.

Concur Target Completion Date: January 2004

a. Clarksburg contingency plans for major systems will reflect the recovery team and the member responsibilities.
b. Clarksburg plans will include the pager and cell phone numbers of key medical center personnel.
c. Background checks will be requested for the Medical Center Director and the Public Branch Exchange contractor. In addition, a system is ongoing to evaluate sensitive positions for background checks.
d. Signage to areas containing sensitive information and automated systems that poses a potential security risk will be removed.
e. A routine system will be implemented to identify and terminate VISTA accounts for non-VA employees who no longer need them.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director takes action to require that medical center CRC Program employees:
a. Complete and document psychosocial, medical, and mental health assessments prior to patients' placements in CRC homes.
b. Provide CRC caregivers with instructions for patient care at the time of admission and following hospitalizations and clinic visits, and document the medical record accordingly.
c. Assess patients' adjustments to placement within 30 days of CRC placement.
d. Conduct and document monthly case manager visits to CRC patients.
e. Document annual discussions with VBA field examiners about the status of incompetent patients in CRC homes.
f. Conduct annual fire safety inspections, and ensure that all identified inspection deficiencies are corrected.
g. Develop and implement CRC-specific performance improvement monitors.

Concur Target Completion Date: January 2004

a. Clarksburg will revise process and orient staff to responsibilities related to the documentation of psychosocial, medical, and mental health assessments prior to patients' placements in CRC homes.
b. Clarksburg will implement process to ensure that CRC caregivers receive instructions for patient care at the time of admission and following hospitalization and clinic visits. This process will include appropriate documentation in the medical record.
c. Clarksburg CRC staff will assess and document the patients' adjustment to placement within 30 days of the placement.
d. Clarksburg will ensure that monthly case manager visits are conducted and documented.
e. Clarksburg CRC staff will routinely review documentation to ensure that annual discussions with the VBA field examiners related to the status of incompetent patients is conducted.
f. Clarksburg will ensure that all annual fire safety inspections and associated follow-up for the correction of deficiencies are documented and tracked to closure.
g. The Clarksburg CRC program staff will identify specific performance improvement monitors and communicate these monitors to the appropriate committees.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director takes action to ensure that employee and volunteer drivers receive required annual motor vehicle safety, CPR, and first aid training, and the training is documented.

Concur Target Completion Date: July 2004

Clarksburg will implement a process to deliver and document the required motor vehicle safety, CPR, and first aid training to employees and volunteer drivers.

Suggested Improvement Action. The VISN Director should ensure that the Medical Center Director takes action to:
a. Correct identified safety and maintenance deficiencies.
b. Protect confidential patient information from inadvertent disclosure.

Concur Target Completion Date: January 2004

a. Clarksburg has addressed the issue of two non-breakaway shower heads on the locked psychiatry unit, leaking pipe in Primary Care, and the missing tiles in the PTSD handicapped shower. Clarksburg has evaluated all showed facilities on the locked psychiatry units. All shower heads have been replaced with state-of-the-art anti-tamper showerheads. Loose hand and kick rails identified during the review have been repaired. A process for interdisciplinary rounds throughout the hospital has been implemented to routinely inspect for safety and maintenance deficiencies. Any future deficiencies detected through the interdisciplinary rounds will be followed to closure.
b. Clarksburg will eliminate the use of wall trays for holding patient care information and re-educate all clinic staff regarding confidentiality regulations. Screen shield will be purchased for the PTSD computer screen.

Suggested Improvement Action. The VISN Director should ensure that monthly joint reviews of cardholder accounts are performed.

Concur Target Completion Date: January 2004

Joint reviews of cardholder accounts in Clarksburg will be conducted as required by the Program Coordinator, Billing Officer, and the Head of Contracting Activity.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	James Hudson, Director, Atlanta Audit Operations Division 404.929.5921
Acknowledgements	Floyd Dembo, CGFM, Audit Manager (CAP Coordinator) Victoria Coates, Director, Atlanta Office of Healthcare Inspections Christa Sisterhen, Deputy Director, Atlanta Office of Healthcare Inspections Judy Lawhead, Healthcare Inspections Team Leader Bertha Clarke Harvey Hittner Patrick McCormack Tina Mitchell

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Stars and Stripes Healthcare Network (10N4)
Director, Louis A. Johnson VA Medical Center Clarksburg, WV (540/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on VA, HUD, and Independent Agencies
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on HUD-Independent Agencies
Senate Committee on Government Affairs
National Veterans Service Organizations
General Accounting Office
Office of Management and Budget
Senator Robert C. Byrd
Senator John D. Rockefeller IV
Congressman Alan B. Mollohan

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.