



Department of Veterans Affairs Office of Inspector General

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

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 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.

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.

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

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted a Combined Assessment Program (CAP) review of the Louis A. Johnson VA Medical Center, Clarksburg, West Virginia (the medical center) during the week of June 12–16, 2006. The purpose of the review was to evaluate selected system operations focusing on patient care administration, quality management (QM), and administrative management controls. During the review, the Office of Investigations provided 4 fraud and integrity awareness briefings to 25 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 4.

Results of Review

This review focused on seven areas. The medical center complied with selected standards in the following four areas:

- Breast Cancer Management
- Business Rules for Veterans Health Information Systems
- Diabetes and Atypical Antipsychotic Medications
- Survey of Healthcare Experiences of Patients (SHEP)

We identified three areas that needed additional management attention. To improve operations we made the following recommendations:

- Strengthen internal administrative controls over the Contract Nursing Home (CNH) program.
- Improve and document adverse event disclosure to patients and families.
- Strengthen environment of care and monitoring of Interim Life Safety Measures (ILSM).

This report was prepared under the direction of Mr. Randall Snow, JD, Associate Director, and Ms. Donna Giroux, RN, BSN, CPHQ, Health Systems Specialist, Washington, DC Office of Healthcare Inspections.

VISN and Medical Center Director Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–16, 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

Medical Center Profile

Organization. The Louis A. Johnson VA Medical Center is located in Clarksburg, WV, and serves a veteran population of approximately 70,000 in West Virginia and adjacent counties in Maryland, Ohio and Pennsylvania. In addition, the medical center operates three community based outpatient clinics (CBOCs) in Parsons, Parkersburg, and Gassaway, WV.

Programs. The medical center provides comprehensive health care through primary, tertiary, and long term care in the areas of medicine, surgery, hematology-oncology, cardiology, nephrology, rheumatology, dental, dermatology, otolaryngology, prosthetics, psychiatry, and residential rehabilitation programs for substance abuse and post-traumatic stress disorder. The medical center has 99 inpatient beds.

Affiliations and Research. The medical center's major academic affiliation is with the West Virginia University Schools of Medicine and Dentistry. It is also affiliated with West Virginia University for clinical and counseling psychology, pharmacy, nursing, social work, occupational and physical therapy, medical technology, dietetics, and speech pathology and audiology.

Resources. In fiscal year (FY) 2005, the medical center medical care expenditures totaled \$95,557,000. FY 2005 staffing was 640 full-time equivalent employees (FTE), including 55 physician and 113 registered nurse FTE.

Workload. In FY 2005, the system treated 19,428 unique patients. The inpatient care workload totaled 3,301 admissions and outpatient care workload was 201,202 visits.

Objectives and Scope of the CAP Review

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, quality management, and administrative controls.
- 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, QM, and management controls. 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. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

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

- Breast Cancer Management
- Business Rules for Veterans Health Information Systems
- Contract Nursing Home Program
- Environment of Care (EOC)
- Diabetes and Patients on Atypical Antipsychotic Medications
- Quality Management
- Survey of Healthcare Experiences of Patients

The review covered facility operations for FY 2005 through June 12, 2006, 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 medical center (*Combined Assessment Program Review of the Louis A. Johnson VA Medical Center Clarksburg, West Virginia*, Report No. 03-03136-69, January 28, 2004).

During this review, we presented 4 fraud and integrity awareness briefings for 25 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 summarize selected focused inspections and 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 section titled “Other Observation” have no reportable conditions.

Results of Review

Opportunities for Improvement

Contract Nursing Home Program – Oversight of CNH Program Needed To Be Improved

Conditions Needing Improvement. CNH Program Managers needed to improve monitoring and oversight of CNH activities and amend local policies to ensure that veterans receive quality care in safe environments.

Oversight Committee. Veterans Health Administration (VHA) policy requires oversight of the CNH Review Team to ensure that veterans receive quality care. Facilities with CNH programs must establish a CNH multidisciplinary oversight committee with upper management representation from social work, nursing, quality management, acquisition, and medical staff, to effectively administer and monitor the program. The committee is established by the Medical Center Director and is responsible for completing and monitoring mandated CNH reviews. The facility had not established a CNH oversight committee, and the local policy needed to be updated to reflect the establishment of the CNH Oversight Committee.

Documentation. VHA policy requires that each CNH review team and oversight committee establish a working relationship with the appropriate Veterans Benefit Office and the local Ombudsman office to discuss subjects of mutual interest and concern. At a minimum, a yearly meeting will be held with each office and confirmation of these meetings will be indicated on the certification report. There was no documentation of these annual meetings and three out of five CNHs reviewed had insufficient documentation regarding the initial and annual review process. At the time of our visit steps were taken to improve documentation and comply with VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*.

Recommended Improvement Action 1: We recommend that the VISN Director ensure that the Medical Center Director: (a) establish a CNH Oversight Committee with multidisciplinary upper-management level representation, (b) amend local policy to reflect the establishment of the CNH Oversight Committee, and (c) strengthen documentation as directed in VHA Handbook 1143.2.

Environment of Care – Interim Life Safety Measures Needed Increased Monitoring

Conditions Needing Improvement. VHA regulations require that the hospital environment present minimal risk to patients, employees, and visitors, and that infection control practices are employed to reduce the risk of hospital-acquired infections. The

Safety Management Program assures a safe environment by requiring and supporting the establishment and maintenance of an effective safety management program. The medical center was not in compliance with their ILSM policy. Required program inspections for the 3rd quarter of FY 2006 were not completed due to the extended leave of absence of the Safety and Occupational Health Specialist.

The following areas needed attention:

- Providing a written monthly report to the Environment of Care Committee on all ILSMs throughout the facility.
- Insuring approved ILSMs are implemented by inspecting all construction sites daily and recording observations in the daily log.
- Identifying problems with the implemented ILSMs, and stopping work until an abatement plan is developed and implemented.
- Developing procedures for enforcement, monitoring, and maintenance of documentation relevant to the ILSMs.
- Reviewing and monitoring the ILSMs implemented throughout the facility on a weekly basis.
- Monthly inspecting and testing of temporary systems.
- Conducting a minimum of two fire drills per shift, per quarter.
- Increasing hazard surveillance of buildings, grounds, and equipment with special attention given to excavations, construction areas, and construction storage and field offices.
- Conducting organization-wide safety education programs.

The Safety and Occupational Health Specialist's responsibilities had not been designated to another qualified individual, which resulted in failure to identify unsafe conditions at the medical center. For example, we found during our EOC inspection, that the entrance hallway to the Women's Clinic—an area adjacent to ongoing construction—was dirty; blocked by a chair; and ceiling tiles were missing, buckled, and broken. Also documentation showed that fire drills and safety educational programs had not been conducted since February 2006.

Recommended Improvement Action 2: We recommend that the VISN Director ensure that the Medical Center Director requires action to (a) appoint an acting Safety & Occupational Health Specialist and (b) correct identified safety and maintenance program deficiencies.

Quality Management – Disclosure of Adverse Events Needed To Be Improved

Conditions Needing Improvement. The QM program was generally effective with appropriate review structures in place for 13 of the 14 program activities reviewed. However, the disclosure of adverse events needed improvement.

Adverse Event Disclosure. When serious adverse events occur as a result of patient care VHA policy requires staff to discuss the events with patients, inform them of their right to file tort or benefit claims, and document the notification in the patient's medical record. In a sample of four patients who experienced adverse events from January 2005 through May 2006, we found all four patient medical records with documentation of patient notification of the adverse event, but only one with documented advisement of the right to file tort or benefit claims.

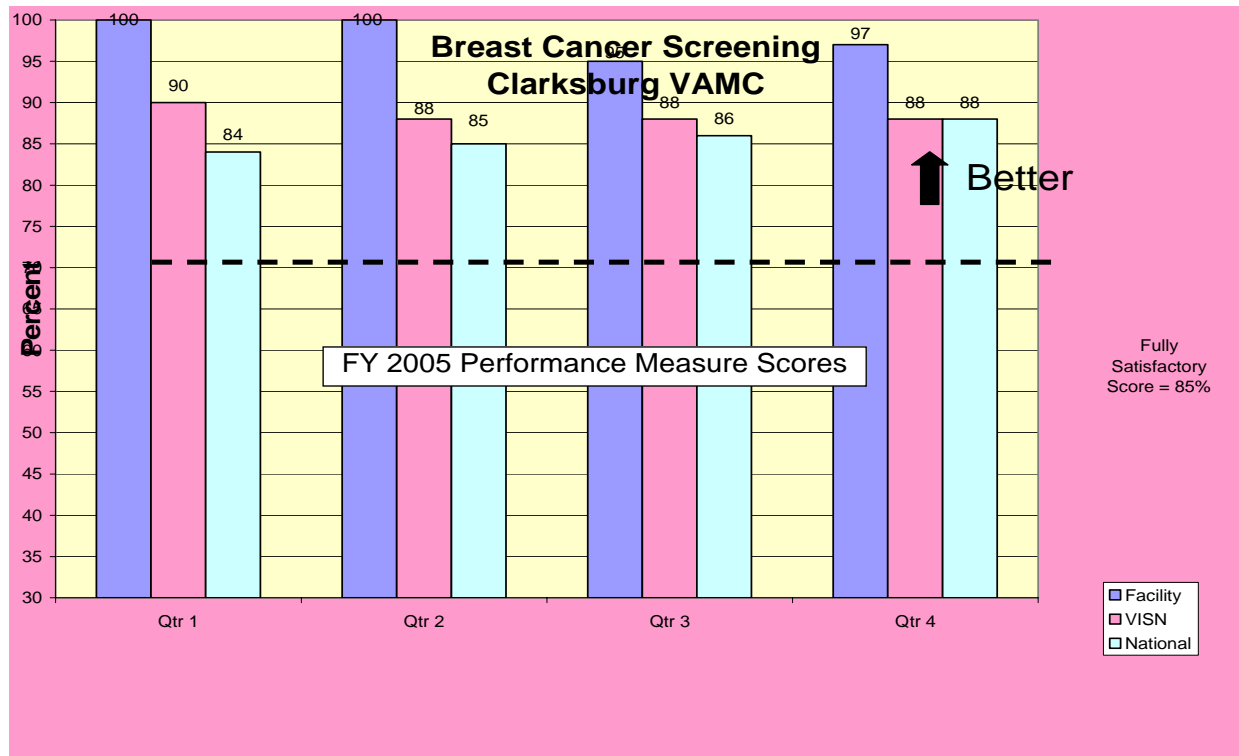
Recommended Improvement Action 3: We recommend that the VISN Director ensure that the Medical Center Director requires responsible clinicians to fully inform patients who experience adverse events of tort and benefit remedies.

Other Observations

Breast Cancer Management – Processes were Timely and Appropriate

The medical center met the VHA performance measure for breast cancer screening, provided timely radiology, surgery and oncology consultative and treatment services, promptly informed patients of diagnoses and treatment options, and developed coordinated interdisciplinary treatment plans.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center was above VHA and national standards for FY 2005. Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. There were no patients who were diagnosed with breast cancer during FY 2005. The following chart shows the medical center FY 2005 Performance Measure scores:



Business Rules for Veterans Health Information Systems

On June 7, 2006, VHA released a memorandum to all VISN Directors that all VAMC facilities were to comply with informational patch USR *1*26, that was released by VHA's Office of Information October 2004, which required all VAMC facilities to assure that the ability to edit a signed medical record document be explicitly restricted to the institution's privacy officer. All VAMCs were required to take immediate action to remove any unacceptable business rules (rules defining what roles certain groups or individuals are allowed to perform) from their Veterans Integrated Health Systems Technology and Architecture (VistA) systems by June 14, 2006. We reviewed the business rules of the medical center, and found them to be in compliance with the VHA directive.

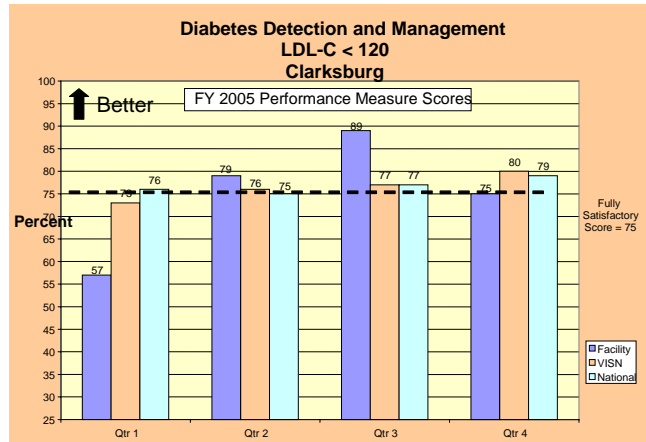
Diabetes and Atypical Antipsychotic Medications

Mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes) require effective diabetes screening, monitoring, and treatment.

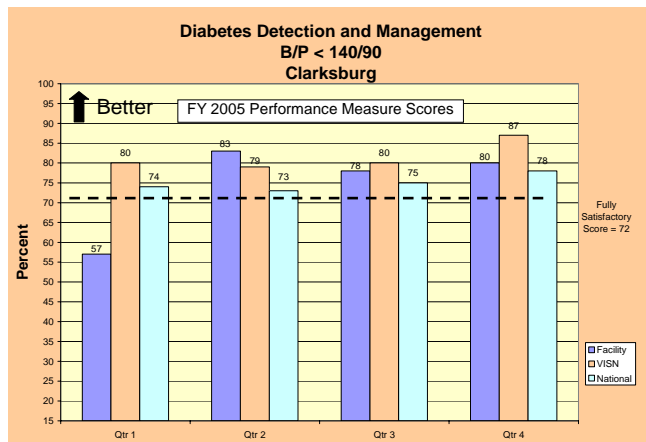
VHA clinical practice guidelines suggest that diabetic patients' blood glucose levels be at a therapeutically acceptable level (Hemoglobin A1c below 9 percent) to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90 mm/Hg; and low

density lipoprotein cholesterol (LDL-C) should be less than 120 mg/dl. The system must meet these standards to receive fully satisfactory ratings for these performance measures.

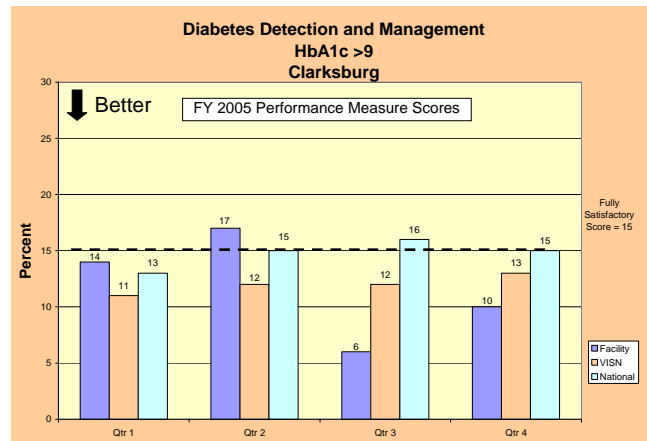
The medical center met or exceeded VHA performance measures for LDL-C of less than (<) 120 mg/dl for the last 3 reporting quarters.



Blood pressure management scores improved in FY 2005 and were fully satisfactory for 3 quarters, as demonstrated in the following charts. The marked improvement of scores after the first quarter reflects the medical center's efforts, including patient education on taking medications appropriately, rechecking blood pressures during visits, and standardizing and updating blood pressure monitoring equipment.



VHA's measure counts the number of patients with HbA1c levels greater than (>) 9, with the goal of a low number. The medical center had fully satisfactory scores for 3 quarters FY 2005 for HbA1c levels. The fully satisfactory (or better) scores in these areas reflect a strong Diabetes program and a collaborative relationship between services.



We reviewed a sample of 13 patients who were on one or more atypical antipsychotic medications for at least 90 days. Two of the 13 had diabetes which developed after the initiation of atypical antipsychotic medications in both patients. See the following table for a summary of results.

Diabetic patient with HbA1c > 9 percent	Diabetic patients with B/P < 140/90 mm/Hg	Diabetic patients with LDL-C < 120mg/dl	Non-diabetic patients appropriately screened
1/3	3/3	1/3	10/13

Survey of Healthcare Experiences of Patients

Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. The Performance Analysis Center for Excellence of the Office of Quality & Performance is the analytical, methodological, and reporting staff for SHEP. To meet Measure 21 of the VHA Executive Career Field Performance Plan for FY 2006, the medical center must achieve patient satisfaction scores of very good or excellent in 77 percent of the outpatients and 76 percent of inpatients surveyed. The following graphs show the medical center's SHEP results:

The medical center has consistently met the VHA targets for satisfactory scores. The medical center also performs ongoing surveys that are closely monitored by the Quality and Performance Monitoring Committee, with no corrective actions recommended due to the high scores.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 22, 2006

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

Subject: **Combined Assessment Program Review of the VA Medical Center Clarksburg, West Virginia**

To: Director, Office of Inspector General, Office of Healthcare Inspections (54DC)

1. I have reviewed the report of the Combined Assessment Program Review performed at Clarksburg in June of 2006 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.

(original signed by:)

CHARLEEN R. SZABO, FACHE

VISN Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director (a) establish a CNH Oversight Committee with multidisciplinary upper-management level representation, (b) amend local policy to reflect the establishment of the CNH Oversight Committee, (c) strengthen documentation as directed in VHA Handbook 1143.2.

Concur **Target Completion Date:** October 30, 2006

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires action to (a) appoint an acting Safety & Occupational Health Specialist and (b) correct identified safety and maintenance program deficiencies.

Concur **Target Completion Date:** December 31, 2006

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director require responsible clinicians to fully inform patient's who experience adverse events of tort and benefit remedies.

Concur **Target Completion Date:** September 30, 2006

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 21, 2006

From: Medical Center Director, Clarksburg VA Medical Center

Subject: **Combined Assessment Program Review of the VA
Medical Center, Clarksburg, West Virginia**

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

1. I have reviewed the report of the Combined Assessment Review performed at Clarksburg in June of 2006 and am in concurrence with the findings and recommendations for improvement outlined in that report.
2. The actions planned to accomplish the recommended improvements follow.

(original signed by:)

WILLIAM E. COX

Medical Center Director's 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

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director (a) establish a CNH Oversight Committee with multidisciplinary upper-management level representation, (b) amend local policy to reflect the establishment of the CNH Oversight Committee, (c) strengthen documentation as directed in VHA Handbook 1143.2.

Concur **Target Completion Date:** October 30, 2006

Action Plans:

a. CNH Oversight Committee to be chaired by the Associate Director for Patient Care Services and membership will include appropriate representation of various disciplines.
b. Local medical center memoranda (policy statement) outlining the responsibilities of the CNH Oversight Committee to be reviewed, edited and republished.
c. CNH Oversight Committee minutes will reflect adequate documentation of responsibilities mandated in VHA Handbook 1143.2:

- *Initial review of nursing homes*
- *Annual review of nursing homes*
- *CMS – based reviews*
- *Ongoing monitoring and follow-up visits for CNH*
- *Status of annual CNH contracts*
- *Actions against community nursing homes*
- *Quality assurance for the CNH program*

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires action to (a) appoint an acting Safety & Occupational Health Specialist and (b) correct identified safety and maintenance program deficiencies.

Concur **Target Completion Date:** December 31, 2006

Action Plans:

a. The medical center is coordinating with VISN 4 staff to obtain assistance to provide for a Safety & Occupational Health presence during episodes of absence of local staff.

b. Safety and maintenance program deficiencies will be corrected as follows:

- *A written monthly report to the Environment of Care Committee (EOCC) on all ILSMs will be accomplished beginning with August 2006 Committee meeting.*
- *Daily inspection of all construction sites and appropriate daily log entries detailing observations about the need for ILSMs will be required effective August 2006.*
- *Stop work orders and abatement plan documentation will be developed and implemented effective August 2006.*
- *Facility Management SOP will be developed which outlines procedures for the enforcement, monitoring, and maintenance of documentation relevant to the ILSMs by August 2006.*
- *Documentation of weekly review and monitoring of the ILSMs implemented throughout the facility will occur effective August 2006.*
- *Documentation will validate that a minimum of two fire drills per shift per quarter are conducted at the medical center effective August 2006.*
- *Increased hazard surveillance of buildings, grounds and equipment with special attention given to excavations, construction areas, and construction storage and field offices will be conducted and documented via a written report forwarded to the EOCC.*
- *Organization-wide safety education program will be revised and implemented on or before October 31, 2006.*

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director require responsible clinicians to fully inform patient's who experience adverse events of tort and benefit remedies.

Concur **Target Completion Date:** September 30, 2006

Action Plans:

- 1. The use of the documentation tool, CPRS patch 'TIU*I*191', Disclosure of Adverse Event Note, will be reviewed with all medical staff with particular emphasis on the documentation of advisement regarding tort and benefit remedies by September 30, 2006.*
- 2. Quality Management staff will monitor the appropriate use and quality of this CPRS patch note and will provide a feedback report quarterly to the Medical Executive Committee beginning September, 2006.*

OIG Contact and Staff Acknowledgments

OIG Contact	Randall Snow, JD, Associate Director Regional Office of Healthcare Inspections Washington, DC 202 565-8451
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Acknowledgments	Tim Barry
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