
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 12-02602-79**

# Combined Assessment Program Review of the Huntington VA Medical Center Huntington, West Virginia

**January 7, 2013**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
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# Glossary

| | |
|---|---|
| CAP | Combined Assessment Program |
| CRC | colorectal cancer |
| ECMS | Executive Committee of the Medical Staff |
| EHR | electronic health record |
| EOC | environment of care |
| facility | Huntington VA Medical Center |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| HF | heart failure |
| MH RRTP | Mental Health Residential Rehabilitation Treatment Program |
| MSDS | Material Safety Data Sheets |
| OIG | Office of Inspector General |
| POCT | point-of-care testing |
| PR | peer review |
| QM | quality management |
| SCI | spinal cord injury |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

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# Executive Summary: Combined Assessment Program Review of the Huntington VA Medical Center, Huntington, WV

**Review Purpose:** The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of August 20, 2012.

**Review Results:** The review covered nine activities. We made no recommendations in the following four activities:

- Coordination of Care
- Medication Management
- Point-of-Care Testing
- Polytrauma

The facility's reported accomplishments were the establishment of a Homeless Veterans Resource Center and recognition for a score of 10 out of 10 on their first external peer review.

**Recommendations:** We made recommendations in the following five activities:

*Quality Management:* Ensure that peer review analysis summary reports are discussed quarterly at the Executive Committee of the Medical Staff and that the discussion is documented in meeting minutes. Consistently report Focused Professional Practice Evaluation results to the Executive Committee of the Medical Staff. Develop a local policy mandating a Cardiopulmonary Resuscitation Committee.

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

*Environment of Care:* Ensure that smoking occurs in designated areas only and that staff are able to locate Material Safety Data Sheets for hazardous materials used in their areas.

*Nurse Staffing:* Require the annual staffing plan reassessment process to ensure that each unit has a unit-based expert panel and that each panel includes members from all nursing roles. Ensure all required staff are facility expert panel members.

*Moderate Sedation:* Include all required elements in pre-sedation assessment documentation.

## Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

# Objectives and Scope

## Objectives

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

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

## Scope

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

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following nine activities.

- Coordination of Care
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

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

The review covered facility operations for FY 2011 and FY 2012 through August 17, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Huntington VA Medical Center, Huntington, West Virginia,* Report No. 08-03087-20, November 5, 2009).

During this review, we presented crime awareness briefings for 109 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 132 responded. We shared survey results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

# Reported Accomplishments

## Homeless Veterans Resource Center

The facility established a Homeless Veterans Resource Center, which serves as a cornerstone of services and outreach for veterans who are homeless or at risk for homelessness. The Homeless Veterans Resource Center has a donation center, shower, and laundry facilities as well as onsite education and counseling services. The facility was recognized by the Commission on Accreditation of Rehabilitation Facilities for the relationships it established with veterans in the program.

## Mental Health Documentation Best Practice

The facility was recognized by VA's Office of Mental Health Services for scoring 10 out of 10 on their mental health EHR documentation. Reviews were conducted in conjunction with VHA's External PR Program to review documentation required by the 2008 Uniform Mental Health Services handbook.

# Results
## Review Activities With Recommendations

### QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

| Noncompliant | Areas Reviewed |
|---|---|
| | There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated. |
| | Overall, if significant issues were identified, actions were taken and evaluated for effectiveness. |
| | Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months. |
| | Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months. |
| | The facility complied with any additional elements required by local policy. |

PR Reports. VHA requires that the ECMS review a summary of the PR Committee's analysis quarterly.[1] Although we found brief mention of PR results in ECMS meeting minutes, we only found 1 full quarterly summary report over the past 12 months.

FPPE. VHA requires that the results from FPPEs be reported to the ECMS for consideration in making the recommendation on privileges for newly hired licensed independent practitioners.[2] We reviewed the profiles of 10 newly hired licensed independent practitioners and found that for 4 of the practitioners, results were not reported to the ECMS.

Resuscitation. VHA requires that the facility have a local policy mandating a Cardiopulmonary Resuscitation Committee responsible for the quality and management of processes related to cardiopulmonary arrest occurring at the facility.[3] Although the facility's Critical Care Committee reviewed cardiopulmonary arrest events, the facility lacked the required local policy.

## Recommendations

**1.** We recommended that PR analysis summary reports be discussed quarterly at the ECMS and that the discussion be documented in meeting minutes.

**2.** We recommended that processes be strengthened to ensure that results from FPPEs are consistently reported to the ECMS.

**3.** We recommended that the facility develop a local policy mandating a Cardiopulmonary Resuscitation Committee.

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

## CRC Screening

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

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

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

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests and that clinician's document notification.[4] Five patients' EHRs did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[5] Five patients did not have a documented follow-up plan within the required timeframe.

### Recommendations

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

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

[4] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[5] VHA Directive 2007-004.

## EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the emergency department; the primary care (blue), mental health, dental, women's health, and physical medicine and rehabilitation outpatient clinics; and the intensive care and medical/surgical (4S and 5S) inpatient units. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

| Noncompliant | Areas Reviewed for General EOC |
|---|---|
| | EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure. |
| | Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up. |
| | Patient care areas were clean. |
| X | Fire safety requirements were met. |
| X | Environmental safety requirements were met. |
| | Infection prevention requirements were met. |
| | Medication safety and security requirements were met. |
| | Sensitive patient information was protected, and patient privacy requirements were met. |
| | The facility complied with any additional elements required by local policy. |
| | **Areas Reviewed for Dental EOC** |
| | If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met. |
| | General infection control practice requirements in the dental clinic were met. |
| | Dental clinic infection control process requirements were met. |
| | Dental clinic safety requirements were met. |
| | The facility complied with any additional elements required by local policy. |
| | **Areas Reviewed for SCI EOC** |
| | EOC requirements specific to the SCI Center and/or outpatient clinic were met. |
| | SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic. |
| | The facility complied with any additional elements required by local policy. |
| | **Areas Reviewed for MH RRTP** |
| | There was a policy that addressed safe medication management, contraband detection, and inspections. |
| | MH RRTP inspections were conducted, included all required elements, and were documented. |
| | Actions were initiated when deficiencies were identified in the residential environment. |

| | Areas Reviewed for MH RRTP (continued) |
|---|---|
| | Access points had keyless entry and closed circuit television monitoring. |
| | Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks. |
| | The facility complied with any additional elements required by local policy. |

Fire Safety. VHA requires that smoking areas be clearly marked and located greater than 35 feet from the building and away from flammable and/or combustible substances.[6] We found an unauthorized smoking area less than 35 feet away from the building and situated between a 55-gallon drum of cooking grease and a recycling container filled with cardboard boxes.

Environmental Safety. The Occupational Safety and Health Administration requires staff to know how to access MSDS in areas where hazardous chemicals are used. Staff in the emergency department, the primary care clinic (blue), and the medical/surgical (5S) unit could not locate MSDS for hazardous chemicals in their areas.

## Recommendations

**6.** We recommended that processes be strengthened to ensure that smoking occurs in designated areas only.

**7.** We recommended that processes be strengthened to ensure that staff are able to locate MSDS for hazardous chemicals used in their areas.

[6] VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.

## Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and 14 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (4 South) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| X | The unit-based expert panels followed the required processes. |
| X | The facility expert panel followed the required processes. |
| | Members of the expert panels completed the required training. |
| | The facility completed the required steps to develop a nurse staffing methodology by the deadline. |
| | The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day. |
| | The facility complied with any additional elements required by local policy. |

Unit-Based Expert Panel Process. VHA requires that unit-based expert panels are comprised of staff who work on the unit and of all nursing roles (registered nurse, licensed practical nurse, nursing assistant, and health technician).[7] The facility combined all inpatient units into one unit-based expert panel comprised of registered nurses only.

Facility Expert Panel. VHA requires that expert panels are comprised of staff knowledgeable about the facility and able to make staffing judgments.[8] The facility's expert panel did not include staff nurses or other nursing staff providing direct patient care or evening and night supervisory staff.

### Recommendations

**8.** We recommended that the annual staffing plan reassessment process ensures that each unit has a unit-based expert panel and that each panel includes members from all nursing roles.

**9.** We recommended that the annual staffing plan reassessment process ensures that all required staff are facility expert panel members.

[7] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
[8] VHA Directive 2010-034.

## Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 10 EHRs, and training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| | Staff completed competency-based education/training prior to assisting with or providing moderate sedation. |
| X | Pre-sedation documentation was complete. |
| | Informed consent was completed appropriately and performed prior to administration of sedation. |
| | Timeouts were appropriately conducted. |
| | Monitoring during and after the procedure was appropriate. |
| | Moderate sedation patients were appropriately discharged. |
| | The use of reversal agents in moderate sedation was monitored. |
| | If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue. |
| | If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated. |
| | The facility complied with any additional elements required by local policy. |

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[9] Two patients' EHRs did not include all required elements of the history and physical examination, such as a review of substance use and abuse.

### Recommendation

**10.** We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

[9] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

# Review Activities Without Recommendations

## Coordination of Care

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

We reviewed 27 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

## Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[10] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

| Noncompliant | Areas Reviewed |
|---|---|
| | Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications. |
| | If applicable, clinicians prescribed the appropriate formulation of buprenorphine. |
| | Clinicians appropriately monitored patients started on methadone or buprenorphine. |
| | Program compliance was monitored through periodic urine drug screenings. |
| | Patients participated in expected psychosocial support activities. |
| | Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements. |
| | Methadone was properly ordered, stored, and packaged for home use. |
| | The facility complied with any additional elements required by local policy. |

[10] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

## POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

| Noncompliant | Areas Reviewed |
|---|---|
| | The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service. |
| | Procedure manuals were readily available to staff. |
| | Employees received training prior to being authorized to perform glucose testing. |
| | Employees who performed glucose testing had ongoing competency assessment at the required intervals. |
| | Test results were documented in the EHR. |
| | Facility policy included follow-up actions required in response to critical test results. |
| | Critical test results were appropriately managed. |
| | Testing reagents and supplies were current and stored according to manufacturers' recommendations. |
| | Quality control was performed according to the manufacturer's recommendations. |
| | Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations. |
| | The facility complied with any additional elements required by local policy. |

## Polytrauma

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

We reviewed relevant documents, 10 EHRs of patients with positive traumatic brain injury results, 10 EHRs of patients receiving traumatic brain injury outpatient services, and 7 training records, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

# Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 18–23, for the full text of the Directors' comments.) We consider Recommendations 3, 6, and 8 closed. We will follow up on the planned actions for the open recommendations until they are completed.

| Facility Profile[11] | | |
|---|---|---|
| **Type of Organization** | Acute care; Teaching hospital | |
| **Complexity Level** | 2 | |
| **VISN** | 9 | |
| **Community Based Outpatient Clinics** | Charleston, WV<br>Prestonsburg, KY<br>Gallipolis, OH (rural outreach clinic)<br>Chapmanville, WV (rural outreach clinic) | |
| **Veteran Population in Catchment Area** | 74,663 | |
| **Type and Number of Total Operating Beds:**<br>• **Hospital, including Psychosocial Residential Rehabilitation Treatment Program** | 80 beds<br>(intensive care unit – 10 beds,<br>4 South/Telemetry – 30 beds, and<br>5 South – 40 beds) | |
| • **Community Living Center/Nursing Home Care Unit** | 0 | |
| • **Other** | 0 | |
| **Medical School Affiliation(s)** | Marshall University, Joan C. Edwards School of Medicine<br>University of Pikeville College of Osteopathic Medicine | |
| • **Number of Residents** | 88 | |
| | **Current FY (through May 2012)** | **Prior FY (2011)** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $201.6 | $212.8 |
| • **Medical Care Expenditures** | $128.0 | $212.8 |
| **Total Medical Care Full-Time Employee Equivalents** | 1,048.8 | 1,045.7 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 26,048 | 28,909 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 11,966 | 17,008 |
| o **Community Living Center/Nursing Home Care Unit** | 13,075 | 18,375 |
| **Hospital Discharges** | 0 | 0 |
| **Total Average Daily Census (including all bed types)** | 3,810 | 5,271 |
| **Cumulative Occupancy Rate (in percent)** | 53.6 | 50.3 |
| **Outpatient Visits** | 227,289 | 320,845 |

[11] All data provided by facility management.

# VHA Satisfaction Surveys

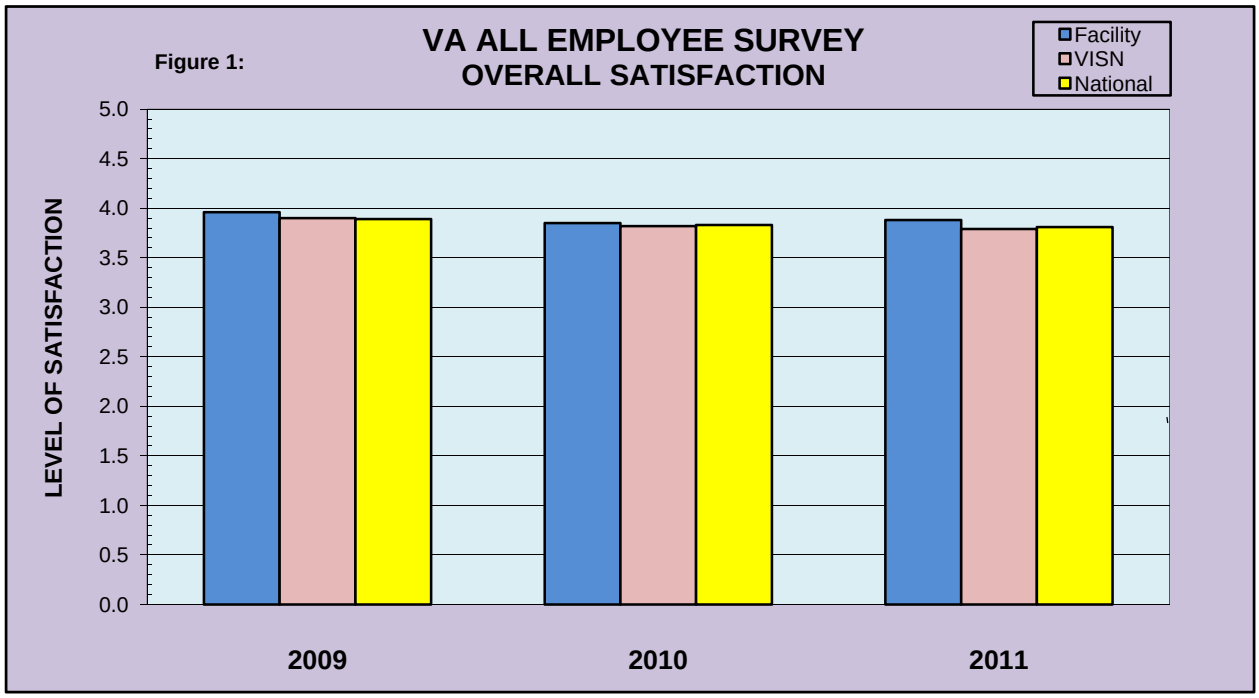
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

**Table 1**

| | Inpatient Scores | | Outpatient Scores | | | |
|---|---|---|---|---|---|---|
| | FY 2011 | FY 2012 | FY 2011 | | FY 2012 | |
| | Inpatient Score Quarters 3–4 | Inpatient Score Quarters 1–2 | Outpatient Score Quarter 3 | Outpatient Score Quarter 4 | Outpatient Score Quarter 1 | Outpatient Score Quarter 2 |
| Facility | 65.6 | 65.1 | 57.9 | 57.6 | 54.1 | 60.8 |
| VISN | 64.8 | 63.6 | 55.3 | 54.3 | 54.7 | 54.1 |
| VHA | 64.1 | 63.9 | 54.2 | 54.5 | 55.0 | 54.7 |

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

**Figure 1:**



# Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[12] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[13]

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Congestive HF | Pneumonia | Heart Attack | Congestive HF | Pneumonia |
| Facility | 16.2 | 12.2 | 14.5 | 21.1 | 30.4 | 25.4 |
| U.S. National | 15.5 | 11.6 | 12.0 | 19.7 | 24.7 | 18.5 |

[12] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

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

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** December 11, 2012

**From:** Director, VA Mid South Healthcare Network (10N9)

**Subject:** **CAP Review of the Huntington VA Medical Center, Huntington, WV**

**To:** Director, Washington, DC, Office of Healthcare Inspections (54DC)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the VA Medical Center Huntington, West Virginia, as well as the action plan developed by the facility.

2. If you have questions or require additional information from the Network, please do not hesitate to contact Joseph Schoeck, Staff Assistant to the Network Director, at 615-695-2205, or me at 615-695-2206.

*(original signed by:)*
John Dandridge, Jr.

**Appendix D**

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** December 11, 2012

**From:** Director, Huntington VA Medical Center (581/00)

**Subject:** **CAP Review of the Huntington VA Medical Center, Huntington, WV**

**To:** Director, VA Mid South Healthcare Network (10N9)

1. On behalf of the VA Medical Center Huntington, West Virginia, I wish to extend my appreciation to the Office of the Inspector General (OIG) Comprehensive Assessment Program (CAP) survey team for their professional review of our organization and its programs.

2. We have reviewed the findings from the CAP survey conducted August 20 through August 23, 2012. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have already been completed.

Edward H. Seiler
Medical Center Director

# Comments to OIG's Report

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

**OIG Recommendations**

**Recommendation 1.** We recommended that PR analysis summary reports be discussed quarterly at the ECMS and that the discussion be documented in meeting minutes.

Concur

Target date for completion: Corrective action has been completed.

Facility Response: The following action has been taken to bring the facility into compliance. The Quality Manager prepares a quarterly Risk Management report that is presented to the facility Medical Staff Council. The report includes peer review, autopsy, and mortality data. Peer Review data includes the following: Nationally Reported Monitors for peer review including peer review totals, timeliness measures, and final level determinations; Aspects of Care data; Event Source (i.e. how the event were identified for peer review) data; and Services Reviewed data.

The first revised peer review/autopsy/mortality quarterly report was presented to the Medical Staff Council at the August 30, 2012 meeting. The second quarterly report was presented at the November 28, 2012 meeting (minutes from the November meeting are pending).

**Recommendation 2.** We recommended that processes be strengthened to ensure that results from FPPEs are consistently reported to the ECMS.

Concur

Target date for completion: January 31, 2013

Facility Response: The Focused Professional Practice Evaluations (FPPE) that had not previously been reviewed by the Professional Standards Board (PSB) were submitted to the PSB at the September 20, 2012 meeting. The Credentialing/Privileging staff track all FPPE through an Excel spreadsheet. To further strengthen tracking of open FPPE, a grid will be placed on each monthly PSB agenda that lists the provider name, responsible service, and the projected due date so that PSB members can track all open FPPE. The provider name will be removed from the grid once the FPPE has been presented and approved for closure.

**Recommendation 3.** We recommended that the facility develop a local policy mandating a Cardiopulmonary Resuscitation Committee.

Concur

Target date for completion: Corrective action has been completed.

Facility Response: A Medical Center Memorandum was prepared by the Intensive Care Unit (ICU) Nurse Manager and was reviewed by the Quality Manager. The MCM was sent to the October 2012 Medical Staff Council meeting and was approved by the Council.

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

Concur

Target date for completion: March 29, 2013

Facility Response: An ad hoc workgroup was formed to establish a process for completing test result notification to patients within 14 days and to capture the documentation in the patients' electronic medical records. The workgroup is responsible for implementing the process once it has been formalized. Quality Management will continue to monitor compliance through medical record reviews of all (100% review) positive fecal occult blood test (FOBT) screens. Monitoring results will be presented monthly, rather than quarterly, to the Medical Staff Council beginning in December 2012.

**Recommendation 5.** We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: January 30, 2013

Facility Response: Quality Management (QM) will continue to monitor compliance through medical record reviews of all (100%) positive fecal occult blood test (FOBT) screens. Monitoring results will be presented monthly, rather than quarterly, to the Medical Staff Council beginning in December 2012. An ad hoc workgroup will be established to review results of previous QM collected data and to develop a documentation template to capture the physician's plan of care or reason for no follow-up (i.e. patient refusal, follow-up in the community, etc.). The documentation template will be presented to the Medical Records Committee and Medical Staff Council for approval.

**Recommendation 6.** We recommended that processes be strengthened to ensure that smoking occurs in designated areas only.

Concur

Target date for completion: February 4, 2013

Facility Response: Currently the facility documents smoking violations in the Police Desk Journal and, if needed, a Police Report. In conjunction with No Smoking Signs there will be additional signage placed in high risk or problem areas stating: **Non-Designated Smoking Area, NO Smoking, Enforced by VA Police.**

**Recommendation 7.** We recommended that processes be strengthened to ensure that staff are able to locate MSDS for hazardous chemicals used in their areas.

Concur

Target date for completion: March 29, 2013

Facility Response: The facility will develop a desktop icon that will link directly to the MSDS resource material for immediate access for all employees with computer access. Additional resource material will also be available to employees in a paper format for immediate access. All service chiefs will provide their employees with training on how to access the MSDS materials.

**Recommendation 8.** We recommended that the annual staffing plan reassessment process ensures that each unit has a unit-based expert panel and that each panel includes members from all nursing roles.

Concur

Target date for completion: Corrective action has been completed.

1. Facility Response: Expert panels were established in each one of our patient care areas (units).
2. All disciplines are involved as member of our expert panels.

**Recommendation 9.** We recommended that the annual staffing plan reassessment process ensures that all required staff are facility expert panel members.

Concur

Target date for completion: December 31, 2012

Facility Response: All disciplines are involved as member of our expert panels. (Registered Nurses, Licensed Practical Nurses, Health care technicians and Nursing Assistants) Nurse practitioners and Certified Registered Nurse Anesthetists (CRNAs)

are included in specific areas such Medical Service, Surgical Service, OR and Mental Health.

**Recommendation 10.** We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: March 29, 2013

Facility Response: Quality Management will review the documentation templates for non-operating room areas where sedation is given (i.e. Cardiology and Imaging) to ensure documentation elements for pre-sedation are present as required. Templates will be revised as needed should any missing elements be identified. A sample of five (5) records from each area will be monitored monthly for compliance, with a target of 90% or greater, until compliance has been reached for three (3) consecutive months.

# OIG Contact and Staff Acknowledgments

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