Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03661-76

Combined Assessment Program Review of the VA Black Hills Health Care System Fort Meade, South Dakota

January 31, 2012

Washington, DC 20420

Why We Did This Review

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings 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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Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
ED	emergency department
EOC	environment of care
facility	VA Black Hills Health Care System
FY	fiscal year
HF	heart failure
MH	mental health
MRC	Medical Records Committee
OIG	Office of Inspector General
OR	operating room
QM	quality management
UCC	urgent care clinic
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Black Hills Health Care System, Fort Meade, SD

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 October 24, 2011.

Review Results: The review covered seven activities. We made no recommendations in the following activity:

- Medication Management

The facility's reported accomplishment was the establishment of multiple community partnerships to meet the needs of homeless veterans.

Recommendations: We made recommendations in the following six activities:

Quality Management: Ensure Focused Professional Practice Evaluations are initiated, completed, and reported. Require completion of preventative ethics improvement cycles. Require the Special Care Committee to review episodes of resuscitation attempts. Ensure that medical record quality reviews are completed and that the Medical Records Committee provides oversight and coordination. Monitor the copy and paste functions, and address low compliance. Address medical record completion issues and low compliance.

Environment of Care: Ensure that a fire extinguisher is present on the laser supply cart in the surgery suite and that providers credentialed to perform laser surgery have documented laser training.

Colorectal Cancer Screening: Ensure patients receive diagnostic testing within the required timeframe and are notified of positive screening, diagnostic testing, and biopsy results within the required timeframe.

Coordination of Care: Ensure medications ordered at discharge match those listed on patient discharge instructions.

Polytrauma: Ensure that outpatient treatment plans are shared with family members and that this is documented in the medical record.

Moderate Sedation: Ensure that staff assisting with or providing moderate sedation complete annual training and that training is documented in employee records.

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 seven activities:

- COC
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- 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 2010 and FY 2011 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 VA Black Hills Health Care System,*

South Dakota, Report No. 08-02417-200, August 21, 2009). The facility had corrected all findings.

During this review, we also presented crime awareness briefings for 101 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 193 responded. Survey results were shared 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 Accomplishment

Community Partnerships

The facility established community partnerships to meet the needs of homeless veterans. These efforts included a drop-in center in conjunction with the Rapid City homeless coalition; a 60-bed veterans unit at the Cornerstone Rescue Mission in Rapid City; and transitional residences on the Pine Ridge, Standing Rock, and Cheyenne River Indian Reservations.

Results

Review Activities With Recommendations

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, 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.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
X	Focused Professional Practice Evaluations for newly hired licensed independent providers 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.
X	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.
X	There was a medical record 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.
X	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.
X	The facility complied with any additional elements required by local policy.

Focused Professional Practice Evaluations. VHA requires that Focused Professional Practice Evaluations be initiated, completed, and reported to the Executive Committee of the Medical Staff for consideration in making the recommendation on privileges for newly hired licensed independent practitioners.[1] We reviewed the profiles of 10 newly hired licensed independent practitioners and found noncompliance issues in 6 profiles. Three did not have evaluations initiated, two had evaluations initiated but not completed, and one had an evaluation completed but not reported to the committee.

Integrated Ethics Improvement Cycles. VHA requires preventive ethics teams at each facility to use a systematic approach for addressing ethics quality gaps and to perform, at a minimum, two improvement cycles each FY.[2] We found that the facility had not completed any improvement cycles during FY 2011.

Resuscitation Events Review. VHA requires that facilities have a cardiopulmonary resuscitation committee and that the committee review each episode of care where resuscitation was attempted.[3] We found that the Special Care Committee did not review each resuscitation episode in FY 2011.

Medical Record Quality Review. VHA requires facilities to have an MRC that provides oversight of medical record quality reviews.[4] Although some medical record quality reviews had been completed, we found no evidence that the committee provided oversight and coordination.

Copy and Paste Function Monitoring. VHA requires facilities to continuously monitor the copy and paste functions in the electronic medical record and to take appropriate corrective actions as needed.[5] Although the facility monitored the copy and paste functions, results were not presented for discussion at the MRC for the 3rd and 4th quarters of FY 2011, and compliance in the range of 57–80 percent had not been addressed.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] Deputy Under Secretary for Health for Operations and Management, "Integrated Ethics Program Achievement: Goals and Reporting Requirements," memorandum, January 7, 2011.
[3] VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[5] VHA Handbook 1907.01.

Medical Record Completion. Local policy requires providers to meet or exceed 90 percent of medical record coding, documentation, and timeliness requirements. During FY 2011, it was continuously identified in the Clinical Executive Committee that discharge summaries and histories and physicals were not meeting the timeliness standard and that this had not been adequately addressed.

Recommendations

1. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluations are initiated, completed, and reported to the Executive Committee of the Medical Staff for all newly hired licensed independent practitioners.

2. We recommended that processes be strengthened to ensure that at least two preventive ethics improvement cycles are completed each FY.

3. We recommended that processes be strengthened to ensure that the Special Care Committee reviews each episode of care where resuscitation was attempted.

4. We recommended that processes be strengthened to ensure that medical record quality reviews are completed and that the MRC provides oversight and coordination.

5. We recommended that processes be strengthened to ensure that the MRC monitors the copy and paste functions and that corrective actions are taken to address low compliance.

6. We recommended that processes be strengthened to ensure that medical record completion issues are addressed and that corrective actions are taken to address low compliance.

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 and whether the facility's Domiciliary Care for Homeless Veterans and Post-Traumatic Stress Disorder Programs complied with selected MH Residential Rehabilitation Treatment Program requirements.

At the Hot Springs campus, we inspected the medical unit, CLC, dialysis unit, OR, dental clinic, ophthalmology clinic, UCC, and Domiciliary Care for Homeless Veterans and Post-Traumatic Stress Disorder Programs. At the Fort Meade campus, we inspected the intensive care unit, CLC, OR, dental clinic, locked behavioral health unit, medical/surgical unit, polytrauma clinic, and ED. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed 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 EOC
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medications were secured and properly stored, and medication safety practices were in place.
	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
X	Laser safety requirements in the OR were properly addressed, and users received medical laser safety training.
X	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	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.

Laser Safety. Local policy requires that a fire extinguisher be available on the laser supply cart in the surgery suite where laser surgery is performed. We found only one fire extinguisher in the OR; we did not find a fire extinguisher on the laser supply cart.

Local policy requires that all providers who are privileged to perform laser surgery have documentation of laser training. We reviewed six credentialing files and found that

three providers were privileged to perform laser surgery without documentation of laser training.

Recommendation

7. We recommended that processes be strengthened to ensure that a fire extinguisher is present on the laser supply cart in the surgery suite where laser surgery is performed and that all providers credentialed to perform laser surgery have documentation of laser training.

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 VHA's CRC screening.

We reviewed the medical records of 20 patients who had positive CRC screening tests, and we 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.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
X	Patients were notified of the diagnostic test results within the required timeframe.
X	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 or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[6] Four patients' records did not contain documented evidence of timely notification.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[7] Two of the 14 patients who received diagnostic testing did not receive that testing within the required timeframe.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[8] Seven of the 14 patients who received diagnostic testing did not have documented evidence of timely notification in their medical records. Of the seven patients for which there was no documented evidence of timely notification, six received their diagnostic tests in the community through VA fee basis care.

[6] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[7] VHA Directive 2007-004.
[8] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[9] Of the seven patients who had biopsies, two records did not contain documented evidence of timely notification.

Recommendations

8. 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.

9. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

10. We recommended that processes be strengthened to ensure that patients who receive their diagnostic tests at the facility or in the community through VA fee basis care are notified of diagnostic test results within the required timeframe and that clinicians document notification.

11. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[9] VHA Directive 2007-004.

COC

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 24 HF patients' medical records and relevant facility policies, and we interviewed employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
X	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.

Discharge Medications. The Joint Commission's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. In 17 records, medications ordered at discharge did not match those listed in patient discharge instructions.

Recommendation

12. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

Polytrauma

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

We reviewed relevant documents, 10 medical records of patients with positive traumatic brain injury results, 10 medical records of patients receiving traumatic brain injury outpatient services, and training records, and we interviewed key staff. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
X	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.

Outpatient Treatment Plans. VHA requires that the treatment plan developed by the interdisciplinary polytrauma team be shared with family members.[10] Of the 10 outpatient records reviewed, 9 did not include documentation that the plan had been shared with the family.

Recommendation

13. We recommended that processes be strengthened to ensure that outpatient treatment plans are shared with family members and that this is documented in the medical record.

[10] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.

Moderate Sedation

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

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

Noncompliant	Areas Reviewed
X	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
	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.

Competency-Based Education/Training. VHA requires that individuals administering, monitoring, and/or supervising moderate sedation have annual competency-based education and training.[11] None of the employee training/competency records reviewed included evidence of education/training in moderate sedation.

Recommendation

14. We recommended that processes be strengthened to ensure that employees assisting with or providing moderate sedation complete annual training related to moderate sedation and that training is clearly documented in employee records.

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

Review Activity Without Recommendations

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 30 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	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 D and E, pages 21–28 for full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[12]		
Type of Organization	Health care system	
Complexity Level	3	
VISN	23	
Community Based Outpatient Clinics	Rapid City, SD Eagle Butte, SD Access Point Faith, SD Access Pont Isabel, SD McLaughlin, SD Mission, SD Pierre, SD Pine Ridge, SD Winner, SD Gordon, NE Scottsbluff, NE Newcastle, WY	
Veteran Population in Catchment Area	30,305	
Type and Number of Total Operating Beds: • **Hospital** • **Psychosocial Residential Rehabilitation Treatment Program**	 48 112	
• **CLC/Nursing Home Care Unit**	104	
• **Other**	29 transitional residence house	
Medical School Affiliation(s)	University of South Dakota Rocky Vista University	
• **Number of Residents**	0	
	Prior FY (2011 through March 2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$150.5	$161
• **Medical Care Expenditures**	$83.9	$161
Total Medical Care Full-Time Employee Equivalents	1,066.1	1,057.3
Workload:		
• **Number of Station Level Unique Patients**	16,955	20,955
• **Inpatient Days of Care:**		
o **Acute Care**	3,713	7,499
o **CLC/Nursing Home Care Unit**	11,666	22,588
Hospital Discharges	1,020	2,126
Total Average Daily Census (all bed types)	164.1	169.6
Cumulative Occupancy Rate (in percent)	62	64
Outpatient Visits	117,174	237,044

[12] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Fully implement a comprehensive QM plan that includes a process to track program requirements.	Leadership governance structure was redesigned. Policies are in place to identify responsibility and accountability for program requirements.	N
2. Collect, trend, analyze, and report data in a clear and meaningful manner for all required QM program areas.	Leadership councils and reporting committees report data and analyze, trend, and track it through action. Action logs are in place. Council dashboards are in place and are reviewed at meetings.	N
COC		
3. Require staff to complete inpatient consults in accordance with VISN policy.	Inpatient consult status is reviewed weekly by leaders at the morning facility meeting, and corrective actions are identified. The Clinic Profile Management/Consult Committee has been in place since January 2010.	N
4. Require staff to complete intra-facility transfer documentation as specified by local policy.	All transfers are reviewed for appropriate documentation requirements, consents, signature, and hand-off communication.	N
5. Require staff to consistently complete discharge documentation as specified by VHA policy.	Medical record completion is reviewed by the Health Information Management Service. Deficiencies are sent to service line leaders and the Chief of Staff with plans of correction required. All medical record performance is reported and acted on by the Clinical Executive Committee.	N
Suicide Prevention Program		
6. Require staff to finalize the suicide prevention program policy and define roles and responsibilities.	The suicide prevention policy is completed and includes definition of roles.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
7. Require staff to document timely safety plans that meet all VHA policies for all patients determined to be at high risk for suicide and to document collaboration between MH providers and the Suicide Prevention Coordinator.	The August record review of high risk for suicide patients was completed by the Organizational Improvement Department.	N
Medication Management		
8. Require that nurses consistently document the effectiveness of all pain medications within the required timeframe of local policy.	Pain medication effectiveness is audited and reported weekly by inpatient unit and to leadership with results graphed and reported at Nursing Management Council.	N
EOC		
9. Ensure that all required staff receive training on the environmental hazards that represent a threat to suicidal patients.	Annual education was developed and implemented post OIG CAP. Tracking is done by the MH department.	N
10. Require staff to update the local hand hygiene policy, monitor compliance, and provide feedback to health care workers.	Weekly hand hygiene secret shopper results are reported at Tuesday morning facility meetings with action plans required for those areas with deficiencies. This is reported through the Infection Control Committee, Clinical Executive Council, and Nursing Management Council.	N
11. Require staff to implement a written plan for the annual evaluation of Legionnaire's Disease prevention for each campus and specify prevention strategies.	Annual evaluations of Legionnaire's Disease prevention are completed and reported through the Infection Control Committee.	N
Emergency/Urgent Care Operations		
12. Require that ED and UCC staff complete inter-facility transfer documentation, as required by VHA and local policy.	Transfers are reviewed for appropriate documentation requirements, consents, signature, and hand-off, communication.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
13. Require staff to develop ED and UCC policies for the dispositions of patients whose care needs exceed the facility's capabilities, as required by VHA.	A diversion policy was developed and implemented.	N
14. Require UCC staff to provide written discharge instructions to all patients discharged from the UCC to home and to document that patients understood the instructions, as required by The Joint Commission.	Discharge template notes were created. Discharge documentation is reviewed by the Continual Readiness Subcommittee, and discharge instructions are completed. We are now in the process of reviewing the quality of the instructions and ensuring the instructions are pertinent to the UCC and/or ED visit. This is reported daily through the morning facility meeting by the UCC and ED.	N
Contracted/Agency Registered Nurses		
15. Require staff to validate that contracted/agency registered nurses have completed mandatory training and the unit-specific competency checklist.	Standardized competencies were developed and implemented post OIG CAP.	N

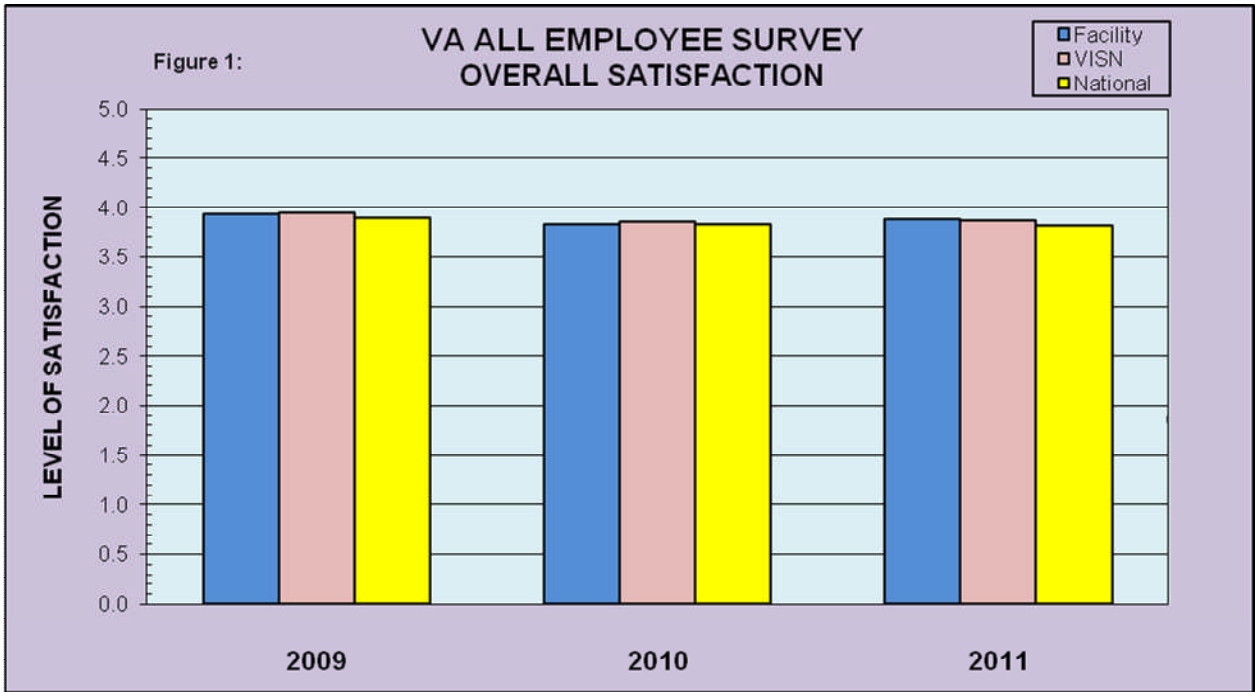
VHA Satisfaction Surveys

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 satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	76.1	56.5	72.0	66.8	60.6	63.7
VISN	67.7	57.2	67.2	61.2	58.1	60.4
VHA	64.1	54.4	63.9	55.9	55.3	54.2

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.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[13] 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, 2007, and June 30, 2010.[14]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	**	8.8	13.1	**	25.0	16.3
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[13] 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.

[14] 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: January 17, 2012

From: Network Director, VISN 23 (10N23)

Subject: **CAP Review of the VA Black Hills Health Care System, Fort Meade, SD**

To: Director, Seattle Office of Healthcare Inspections (54SE)

Director, Management Review Service (VHA 10A4A4 Management Review)

Attached please find our response to the Combined Assessment Program review of VA Black Hills Health Care System conducted October 24–28, 2011.

If you have any questions, you may contact the Director at VA Black Hills Health Care System at (605) 347-2511 Extension 7170.

Janet P. Murphy, MBA

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 9, 2012

From: Director, VA Black Hills HCS (568/00)

Subject: **CAP Review of the VA Black Hills Health Care System, Fort Meade, SD**

To: Director, VISN 23 (10N23)

Attached please find our response to the Combined Assessment Program review of VA Black Hills Health Care System conducted October 24–28, 2011.

If you have any questions, you may contact the Director at VA Black Hills Health Care System at (605) 347-2511 Extension 7170.

Stephen R. DiStasio, FACHE
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 processes be strengthened to ensure that Focused Professional Practice Evaluations are initiated, completed, and reported to the Executive Committee of the Medical Staff for all newly hired licensed independent practitioners.

Concur

Target Date for Completion: June 30, 2012

The Medical Staff Office developed a local spreadsheet downloaded from PRIV PLUS. This spreadsheet tracks the status and completion of all pending FPPE (Focused Professional Practice Evaluation). This "status report" is provided monthly to the Chief of Staff, Service Chiefs and discussed monthly at the Executive Committee of the Medical Staff (ECMS). If it is determined that further data is needed during the focused review period, the FPPE are given up to a six month extension. If sufficient data is gathered and analyzed before the end of the six month extension, the FPPE monitor on the tracking sheet will be closed. If the FPPE is not completed, the case will re-appear on the spread sheet 60 days prior to the end of the six month extension period. This tracking mechanism will ensure that the ECMS has the completed FPPE data for review for newly hired independent practitioners or for justification of new privileges.

Completion data will be compiled quarterly and presented to the COS and Service Chiefs and ECOS, beginning in March 2012. The measure of success is that the FPPE is completed and reviewed within 60 days of appointment or extended if more time is needed for the focused review.

Recommendation 2. We recommended that processes be strengthened to ensure that at least two preventive ethics improvement cycles are completed each FY.

Concur

Target Date for Completion: September 30, 2012

The Integrated Ethics Chair (Facility Director) and Acting Preventative Ethics Coordinator are responsible for this improvement. To ensure the facility performs two improvement cycles, the Preventative Ethics Committee has initiated an improvement process titled "Impaired Driver." This cycle will be completed by January 31, 2012. Upon completion of the initial cycle, the second ethics improvement process will be selected by the Preventative Ethics Committee. The Preventative Ethics Coordinator will report bi-monthly to the Integrated Ethics Council regarding the status of the

improvement cycles. The minutes to Integrated Ethics Council will be reviewed to ensure bi-monthly reporting, until two PE improvement cycles are completed.

Recommendation 3. We recommended that processes be strengthened to ensure that the Special Care Committee reviews each episode of care where resuscitation was attempted.

Concur

Target Date for Completion: June 30, 2012

This action is the responsibility of the ACOS/Primary Care and the ICU Director. In November 2011, the Special Care Committee changed its process and each resuscitation event from Q4 FY11 was reviewed according to recommended criteria. Bimonthly Committee review of resuscitation events will continue. Minutes will be forwarded to Organizational Improvement and the Clinical Executive Council. Minutes will be monitored until three consecutive sets of minutes reflect this improved process.

Recommendation 4. We recommended that processes be strengthened to ensure that medical record quality reviews are completed and that the MRC provides oversight and coordination.

Concur

Target Date for Completion: June 30, 2012

In December, 2011 the Medical Record Committee (MRC) was provided five months of aggregate results of the ongoing quality reviews. These findings are being analyzed to prioritize documentation deficiencies. The MRC will assign corrective actions to responsible Service Chiefs and follow that corrective action through to completion. Minutes to MRC will be reviewed for six months to ensure processes for quality review and corrective actions are effective. MRC Minutes are forwarded to Clinical Executive Council for oversight.

Recommendation 5. We recommended that processes be strengthened to ensure that the MRC monitors the copy and paste functions and that corrective actions are taken to address low compliance.

Concur

Target Date for Completion: September 30, 2012

Copy and Paste reviews for FY11 Quarter 3 and 4 were reviewed by the MRC at the December meeting. Analysis of Copy/Paste reviews will be conducted on a quarterly basis by MRC and forwarded to service chiefs for corrective action. MRC will ensure effectiveness of corrective action with ongoing monitoring and feedback. Education regarding Copy/Paste will be provided by HIMS staff upon request. The MRC will inform the Clinical Executive Committee if corrective actions are ineffective. Minutes of

MRC will be reviewed until three consecutive reporting quarters reflect compliance with this action.

Recommendation 6. We recommended that processes be strengthened to ensure that medical record completion issues are addressed and that corrective actions are taken to address low compliance.

Concur

Target Date for Completion: June 30, 2012

Medical Center Policy will be strengthened to define corrective actions to be taken in response to delinquent medical records. The MRC will review medical record completion reports on a monthly basis and forward analysis of the reports to the Clinical Executive Committee (CEC) and Service Chiefs. Clinical Executive Committee will provide direction and oversight, as needed, to Service Chiefs regarding medical record delinquency. Minutes of MRC and CEC will be reviewed until three consecutive reporting months reflect compliance with this action

Recommendation 7. We recommended that processes be strengthened to ensure that a fire extinguisher is present on the laser cart in the surgery suite where laser surgery is performed and that all providers credentialed to perform laser surgery have documentation of laser training.

Concur

Target Date for Completion: February 1, 2012

A 5 pound CO2 extinguisher has been ordered to be mounted on the laser cart within 30 days. In the interim, a 10 pound CO2 extinguisher has been co-located with the laser cart and travels with the cart to all locations. Competency and SOP's have been revised to reflect the location and use of the CO2 extinguisher during laser surgery.

The providers who were lacking the laser training completed the training per an online TMS course. Certificates are maintained by the Laser Safety Coordinator. This yearly training requirement and new hires will be monitored by the Laser Safety Coordinator through the TMS system.

Recommendation 8. 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: June 30, 2012

A multidisciplinary rapid cycle improvement team has been established to improve the process of positive test result notification. The goal of this team will be to review and

update as necessary the Medical Center Policy COS-74 – Ordering and Reporting Test Results. The team will insure that the policy is implemented in all areas of the Medical Center regardless of location or level of care. The Team will establish a monitoring process to evaluate compliance with all components of the policy, with special emphasis on positive CRC Screening results.

Recommendation 9. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target Date for Completion: June 30, 2012

A multidisciplinary rapid cycle improvement team has been established to improve the process of further diagnostic testing for positive CRC Screening. The goal of this team will be to review and update as necessary the Medical Center Policy COS-74 – Ordering and Reporting Test Results. The team will insure that the policy is implemented in all areas of the Medical Center regardless of location or level of care. The Team will establish a monitoring process to evaluate compliance with all components of the policy, with special emphasis on further diagnostic testing for positive CRC screening tests within specified time frames.

Recommendation 10. We recommended that processes be strengthened to ensure that patients who receive their diagnostic tests at the facility or in the community through VA fee basis care are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target Date for Completion: June 30, 2012

A multidisciplinary rapid cycle improvement team has been established to improve the process of patient notification in cases of fee basis or community testing. The goal of this team will be to review and update as necessary the Medical Center Policy COS-74 – Ordering and Reporting Test Results. The team will insure that the policy is implemented in all areas of the Medical Center regardless of location or level of care. The Team will establish a monitoring process to evaluate compliance with all components of the policy, with special emphasis on patient notification in cases of fee basis or community diagnostic tests relating to CRC.

Recommendation 11. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target Date for Completion: June 30, 2012

A multidisciplinary rapid cycle improvement team has been established to improve the process of patient notification of biopsy results. The goal of this team will be to review and update as necessary the Medical Center Policy COS-74 – Ordering and Reporting Test Results. The team will insure that the policy is implemented in all areas of the Medical Center regardless of location or level of care. The Team will establish a monitoring process to evaluate compliance with all components of the policy, with special emphasis on patient notification of biopsy results relating to CRC.

Recommendation 12. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patient discharge instructions.

Concur

Target Date for Completion: June 30, 2012

The Medication Reconciliation Committee is responsible for implementation and monitoring of this corrective action. A pharmacist will reconcile the inpatient and admission medication orders with the medication ordered by the provider upon discharge. This will insure that the discharge medication portion of the discharge instructions matches the discharge medications ordered by the physician. This process has been implemented. The first report of compliance will be presented to the Medication Reconciliation Committee on March 19, 2012. The measure used to monitor compliance is: # discharge medication lists matching discharge orders/# of discharged veterans. Target is three consecutive months of 90% compliance or better.

Recommendation 13. We recommended that processes be strengthened to ensure that outpatient treatment plans are shared with family members and that this is documented in the medical record.

Concur

Target Date for Completion: June 30, 2012

Responsibility is assigned to the Poly Trauma/TBI Coordinator. The Poly Trauma Team will adopt a treatment plan format containing the required elements found in VHA Handbook 1172.04. The treatment plan will facilitate the process and documentation of family involvement/communication required in Directive. A monthly audit will be performed with a measure of shared treatment plans/total treatment plans developed. Exclusions include those cases in which the veteran declines to include his family and/or cases in which there is no family available. Target performance is three consecutive months of 95% compliance of those cases which meet the sample definition.

Recommendation 14. We recommended that processes be strengthened to ensure that employees assisting with or providing moderate sedation complete annual training related to moderate sedation and that training is clearly documented in employee records.

Concur

Completed

The Nurse Manager, Operating Room has combined the TMS education record with the Competency Validation tool to strengthen the training/competency processes for Moderate Sedation. All competencies/training records are up to date and are monitored by the Nurse Manager, Operating Room.

OIG Contact and Staff Acknowledgments

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