Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03666-79

Combined Assessment Program Review of the Cincinnati VA Medical Center Cincinnati, Ohio

February 13, 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.

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Glossary

CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
EOC	environment of care
facility	Cincinnati VA Medical Center
FY	fiscal year
MH	mental health
MM	medication management
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Cincinnati VA Medical Center, Cincinnati, OH

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 November 14, 2011.

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

- Colorectal Cancer Screening
- Coordination of Care
- Medication Management
- Psychosocial Rehabilitation and Recovery Centers

The facility's reported accomplishments were the mental health computer skills program, receipt of consecutive Gold Cornerstone Awards, and the inpatient mental health unit's Veterans Resource Book.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure that Focused Professional Practice Evaluations are initiated and completed and that results are reported to the Executive Committee of the Medical Staff. Ensure the Health Record Integrity Review Committee meets with the frequency required by local policy and provides oversight and coordination of medical record reviews, including monitoring the copy and paste functions.

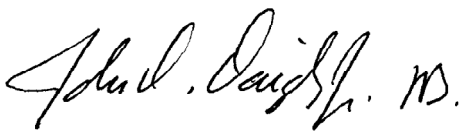
Moderate Sedation: Ensure all required staff receive moderate sedation training. Require that complete histories and physicals are completed for all moderate sedation patients and that pre-sedation assessment documentation includes all required elements.

Polytrauma: Ensure minimum polytrauma staffing levels are maintained. Meet Veterans Health Administration polytrauma training requirements.

Environment of Care: Ensure that the community living center electronic patient tracking system is checked every 24 hours, that daily checks are documented, and that compliance is monitored.

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 eight activities:

- Coordination of Care
- CRC Screening
- EOC
- MM
- Moderate Sedation
- Polytrauma
- PRRCs
- 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 November 18, 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 Cincinnati VA Medical Center, Cincinnati, Ohio,* Report No. 09-03532-112, March 19, 2010). The facility had corrected all findings from our previous review. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 125 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 356 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 Accomplishments

Computer Skills Program

The facility's MH Treatment, Recovery, and Activity Center developed and implemented a computer literacy curriculum for veterans with severe mental illness. Since the program's inception, MH staff have taught 115 veterans skills in word processing, e-mail, online web searching, and social networking. In addition, veterans enroll in My Health*e*Vet, allowing them to contact their provider via e-mail and order prescriptions without coming to the facility. Veterans who complete the curriculum and pass a final examination are given a refurbished computer, which is donated by the Veterans of Foreign Wars, at a graduation ceremony attended by family and friends. Eighty-two percent of the veterans who completed the program's exit survey indicated that the computer has helped them in their daily life.

Gold Cornerstone Award

In FY 2011, the facility received its fourth Gold Cornerstone Award for the quality of its root cause analysis work, for process improvements in the Supply and Processing Department to improve lighting and cleanliness, and for the use of Code Blue (cardiopulmonary resuscitation alert) simulation in procedural areas.

Veterans Resource Book

Inpatient MH unit staff developed an electronic Veterans Resource Book to provide education and a tool for patients to identify resources and desired treatment outcomes. Nurses serve as coaches to help veterans achieve the outcomes they identified in the resource book. In 2009, VHA's Nursing Service recognized the Veterans Resource Book with a national Nursing Innovation Award, and other VA facilities and private

hospitals continue to recognize the book's contribution to evidence-based, recovery-oriented treatment. Additionally, facility staff have presented book-related poster displays and sessions at national conferences.

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.
	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.
	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.
	The facility complied with any additional elements required by local policy.

Focused Professional Practice Evaluations. VHA requires that Focused Professional Practice Evaluations be initiated and completed and that results be 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 that for 6 of the practitioners, Focused Professional Practice Evaluations had not been initiated.

Health Record Review. VHA requires facilities to conduct health record reviews and to report results of those reviews at least quarterly to the facility health record review committee.[2] Local policy requires the committee to meet at least twice per quarter to review medical record monitors, including copy and paste function use. We found that the committee did not meet twice per quarter during the past year and that 5 of 14 services had not submitted medical record reviews as required. Additionally, although monitors of copy and paste function use had been analyzed by Health Information Management Service staff, and the results had been sent to applicable services via e-mail, the committee did not review copy and paste function data.

Recommendations

1. We recommended that processes be strengthened to ensure that Focused Professional Practice Evaluations are initiated and completed and that results are reported to the Executive Committee of the Medical Staff.

2. We recommended that processes be strengthened to ensure that the Health Record Integrity Review Committee meets with the frequency required by local policy and provides oversight and coordination of medical record reviews, including monitoring the copy and paste functions.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

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, 12 medical records, and 19 training records, and we interviewed key individuals. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	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.

Staff Training. VHA requires that non-physician clinical staff in each area where moderate sedation is performed complete appropriate training.[3] We reviewed the training records of 19 staff and found that 5 had not completed moderate sedation training.

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.[4] One medical record did not contain documentation of a history and physical examination, and two medical records did not contain information regarding illicit drug use.

Recommendations

3. We recommended that processes be strengthened to ensure that all required staff receive moderate sedation training.

4. We recommended that processes be strengthened to ensure that complete histories and physicals are completed for all moderate sedation patients and that pre-sedation assessment documentation includes all required elements.

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

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, 17 medical records of patients with positive traumatic brain injury results, and 9 employee training records, and we interviewed key staff. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings 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.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
X	Adequate services and staffing were available for the polytrauma care program.
X	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.

Staffing. VHA requires that minimum polytrauma staffing levels be maintained.[5] The facility did not meet the minimum staffing requirement because there was no certified rehabilitation RN on staff. The facility had a nurse practitioner functioning in this role who did not have the required rehabilitation certification.

Training. VHA requires staff working with polytrauma patients to have training in age-appropriate interventions, assistive technology, pain management, and other areas.[6] None of the training records reviewed contained evidence of all required training.

[5] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.
[6] VHA Directive 1172.1, *Polytrauma Rehabilitation Procedures*, September 22, 2005.

Recommendations

5. We recommended that minimum polytrauma staffing levels be maintained.

6. We recommended that VHA polytrauma training requirements be met.

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 Program and the Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Programs complied with selected MH Residential Rehabilitation Treatment Program requirements.

We inspected inpatient units (medical, surgical, locked MH, surgical intensive care, and one CLC), the emergency department, the operating room suite, and the primary care, dental, polytrauma, and spinal cord injury clinics. We also inspected the Domiciliary Care for Homeless Veterans unit and the Substance Abuse and the Post-Traumatic Stress Disorder units. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed for EOC
	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	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.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	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.

Environmental Safety. VHA and local policy require a basic check of electronic patient tracking systems in high-risk areas every 24 hours at a minimum to ensure proper functioning and minimize risk.[7] The facility did not implement daily checks in the CLC

[7] VHA Directive 2010-052, *Management of Wandering and Missing Patients,* December 3, 2010.

until October 2011. Additionally, documentation of the daily checks was missing for 10 of the 45 days we reviewed.

Recommendation

7. We recommended that processes be strengthened to ensure that the electronic patient tracking system in the CLC is checked every 24 hours, that the daily checks are documented, and that compliance is monitored.

Review Activities Without Recommendations

Coordination of Care

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

We reviewed 29 heart failure patients' medical records and relevant facility policies, and we interviewed 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.

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 table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Patients were notified of positive 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.
	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.

MM

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 details the areas reviewed. 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.

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	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 19–22 for the full text of the Directors' comments.) We consider Recommendations 3 and 6 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[8]		
Type of Organization	Tertiary care medical center	
Complexity Level	1b	
VISN	10	
Community Based Outpatient Clinics	Clermont County, OH Hamilton County, OH Dearborn County, IN Florence, KY Bellevue, KY Georgetown, OH (outreach clinic)	
Veteran Population in Catchment Area	128,841	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	230	
• **CLC/Nursing Home Care Unit**	64	
Medical School Affiliation(s)	University of Cincinnati	
• **Number of Residents**	110	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$328.2	$298.2
• **Medical Care Expenditures**	$328.2	$298.2
Total Medical Care Full-Time Employee Equivalents	2,006	1,962
Workload:		
• **Number of Station Level Unique Patients**	40,108	38,656
• **Inpatient Days of Care:**		
o **Acute Care**	29,523	31,145
o **CLC/Nursing Home Care Unit**	18,860	20,139
Hospital Discharges	5,639	6,156
Total Average Daily Census (including all bed types)	163	153
Cumulative Occupancy Rate (in percent)	79.1	73.3
Outpatient Visits	506,276	495,907

[8] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Report peer review data to the Medical Executive Committee.	Peer review data is presented and embedded into Clinical Executive Committee meeting minutes quarterly.	N
2. Implement a comprehensive respiratory protection program.	Quarterly and annual fit testing are tracked quarterly through a manual system.	N
EOC		
3. Address identified MH and infection control training deficiencies.	MH inpatient unit staff and the MH EOC rounds members completed the required infection prevention training.	N
4. Properly maintain negative air pressure room logs, and educate staff on their responsibilities.	Training is completed during orientation and as needed. Negative air pressure checks are documented on the crash cart log and maintained in each service area.	N
MM		
5. Ensure that assessment and documentation of pain medication effectiveness is timely and that compliance with local policy is monitored.	Pain medication effectiveness is reported monthly at the Quality and Performance Committee meetings, and data is imbedded into the minutes.	N
Contracted/Agency RNs		
6. Ensure that monthly evaluations are completed and that clinical competencies are demonstrated and documented for all contracted/agency RNs.	Agency RN competencies and monthly evaluations, if they worked that month, are in their folders.	N

VHA Satisfaction Surveys

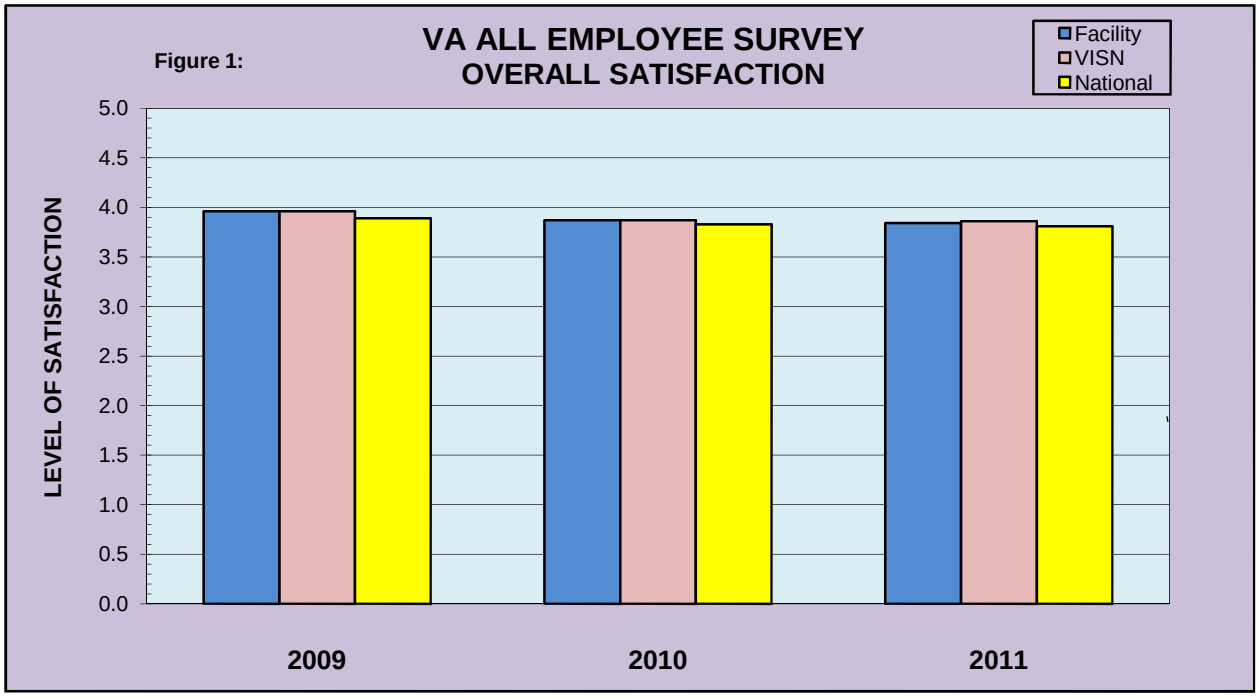
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall 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	57.7	57.1	65.0	60.6	64.8	60.5
VISN	60.8	58.1	61.5	59.3	58.2	56.0
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.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[9] 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.[10]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	14.6	10.5	12.2	21.9	28.1	17.9
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[9] 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 heart failure 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.

[10] 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 25, 2011

From: Director, VISN 10 VA Healthcare System of Ohio (10N10)

Subject: **CAP Review of the Cincinnati VA Medical Center, Cincinnati, OH**

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

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

1. I have reviewed the recommendations and concur with responses and action plans submitted by the Cincinnati VA Medical Center.

2. If you have questions or require additional information, please contact Jane Johnson, VISN 10 Deputy Quality Management Officer at (513) 247-4631.

/s/
Jack G. Hetrick, FACHE
Director, VA Healthcare System of Ohio (10N10)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 25, 2012

From: Director, Cincinnati VA Medical Center (539/00)

Subject: **CAP Review of the Cincinnati VA Medical Center, Cincinnati, OH**

To: Director, VA Healthcare System of Ohio (10N10)

1. Attached please find the VHACIN responses and relevant action plan for the 7 recommendations from the Office of the Inspector General Combined Assessment Program Review conducted November 14–18, 2011.

2. We appreciate the professionalism demonstrated by the OIG CAP Team and the consultative attitude demonstrated during the review process.

3. If you have any questions regarding this report, please contact Lisa Sporing, Cincinnati VA Medical Center Accreditation Specialist, at 513-861-3100, extension 5249.

/s/
LINDA D. SMITH, FACHE

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 and completed and that results are reported to the Executive Committee of the Medical Staff.

Concur

Target date for completion: December 19, 2011

Response: The Focused Professional Practice Evaluation process has been amended to include additional Clinical Executive Board oversight, with service chiefs maintaining Focused Professional Practice Evaluation files. Services chiefs will be reminded through Clinical Executive Board when a Practitioner is to be reviewed. The process now includes guidance to new applicants related to the Focused Professional Practice Evaluation process and privileging.

Recommendation 2. We recommended that processes be strengthened to ensure that the Health Record Integrity Review Committee meets with the frequency required by local policy and provides oversight and coordination of medical record reviews, including monitoring the copy and paste functions.

Concur

Target date for completion: April 2, 2012

Response: The Health Records Integrity Committee is under a new chair and co-chair as of December 14, 2011. The chair and co-chair will maintain a reporting grid to ensure discussion and documentation of critical information, including copy and paste functions. The Clinical Executive Board will maintain oversight to ensure the appropriate frequency of Health Records Integrity Committee meetings.

Recommendation 3. We recommended that processes be strengthened to ensure that all required staff receive moderate sedation training.

Concur

Target date for completion: December 7, 2011

Response: Moderate sedation training was completed by all required staff on December 7, 2011. Nurse managers will maintain oversight of required training to ensure timely completion.

Recommendation 4. We recommended that processes be strengthened to ensure that complete histories and physicals are completed for all moderate sedation patients and that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: May 25, 2012

Response: The history and physical remains part of the pre-procedure checklist. The history and physical template was modified to contain an assessment of illicit drug use. A random chart review will be completed for a three month time period to evaluate the completion of the pre-procedure checklist, including the history and physical/illicit drug use. Individuals will be educated if criteria are not met.

Recommendation 5. We recommended that minimum polytrauma staffing levels be maintained.

Concur

Target date for completion: July 1, 2012

Response: The polytrauma rehabilitation nurse practitioner has completed training to ensure her competency to serve this population. She will complete formal certification training in June 2012 to become a certified rehabilitation nurse.

Recommendation 6. We recommended that VHA polytrauma training requirements be met.

Concur

Target date for completion: January 13, 2012

Response: Polytrauma staff have completed required training as of January 13, 2012.

Recommendation 7. We recommended that processes be strengthened to ensure that the electronic patient tracking system in the CLC is checked every 24 hours, that the daily checks are documented, and that compliance is monitored.

Concur

Target date for completion: April 30, 2012

Response: The Quality Management nurse or designee will ensure compliance with daily checks of the patient tracking system and completion of documentation with just-in-time training for any needed re-education.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720
Contributors	Randall Snow, JD, Project Leader Kathy Gudgell, RN, JD, Team Leader Josephine Andrion, MHA, RN Bruce Barnes Lisa Barnes, MSW Myra Conway, RN Katharine Foster, RN Donna Giroux, RN Natalie Sadow-Colón, MBA, Program Support Assistant Todd Springer, Special Agent, Office of Investigations Gavin McClaren, Special Agent, Office of Investigations

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Healthcare System of Ohio (10N10)
Director, Cincinnati VA Medical Center (539/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Sherrod Brown, Rob Portman
U.S. House of Representatives: Steve Chabot

This report is available at http://www.va.gov/oig/publications/default.asp.