Department of Veterans Affairs

Office of Inspector General

Healthcare Inspection

Follow-Up Review of the Quality of Care at the James A. Haley VA Medical Center Tampa, Florida

Report No. 05-00641-166 **July 12, 2006**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The purpose of this inspection was to evaluate whether recommended actions described in our 2005 report on quality of care at the James A. Haley VA Medical Center (JAHVAMC), Tampa, Florida, have been implemented. We sought to determine whether consultations requested for patients with traumatic brain injury (TBI) are completed promptly by attending physicians; providers receive medical records when patients are transferred from other facilities; and transferred TBI patients are admitted initially to an acute medical or surgical ward.

We conducted focused chart reviews for patients who were on active military duty at the time of TBI and who were currently hospitalized or recently discharged from inpatient rehabilitation. We also interviewed Physical Medicine and Rehabilitation Service and Radiology Service staff members.

The 21 patients described in this report had been admitted between November 2005–May 2006. Eleven of the 21 sustained injuries in motor vehicle accidents. The nine patients from Iraq were injured by improvised explosive devices, other explosions, or mortar fire. Ten patients had been transferred from military hospitals and each of these had medical records from the transferring facilities readily accessible. For the 12 patients currently hospitalized, 7 had images from military facilities loaded into the JAHVAMC Radiology Service imaging system or available on compact discs at the nursing unit.

Requests for consultations generated prompt responses from consultants. In the case of consultations completed by resident physicians, however, it was unclear from the record whether an attending ever interacted with the patient in person. Several consultations were completed by an Orthopedics physician assistant (PA), with variable evidence of attending involvement. This inspection found that the Scope of Practice for this PA does not include consultation services. Sixteen of the 21 patients in this review were admitted initially to acute medical or surgical wards; the five patients admitted directly to the PM&R ward came directly from home or were more than a year removed from their injury.

We concluded that major improvements have been made in the availability of medical records from military hospitals, but radiology images are inconsistently available. Comprehensive consultations are provided for TBI inpatients, and the involvement of attending physicians is well documented. However, it was unclear whether attending physicians consistently visited patients. In the case of an orthopedics physician assistant, consultations were performed even though this function is not in the approved Scope of Practice.

We recommended that physician assistants engage only in clinical activities specified in their Scope of Practice; consultations in the care of TBI patients be completed with the direct, hands-on involvement of attending physicians; and efforts continue to optimize the transfer of clinical information, especially Radiology data, when patients are received from other facilities.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N8)

SUBJECT: Healthcare Inspection – Follow-Up Review of the Quality of Care at the James A. Haley VA Medical Center (JAHVAMC), Tampa, Florida

Purpose

The purpose of this inspection was to evaluate whether recommended actions described in the report *Healthcare Inspection, Review of Quality of Care, Department of Veterans Affairs, James A. Haley Medical Center, Tampa, FL*, No. 05-00614-149, June 1, 2005, have been implemented.

Objectives

This inspection focused on two recommendations from the 2005 report that management officials should ensure that:

- Consultations are timely and of the highest quality.
- Patients transferred to Veterans Health Administration facilities are transferred with all available and relevant medical records.

Specific objectives for this inspection included:

A. To determine if consultations requested by providers caring for patients with traumatic brain injury (TBI) are completed promptly by attending physicians.

B. To determine whether James A. Haley VA Medical Center (JAHVAMC) providers have ready access to the complete medical records from the hospitalizations of TBI patients transferred from other facilities.

C. Although not one of the report's recommendations, JAHVAMC responded to the report by indicating that all TBI patients transferred from other facilities would subsequently be admitted initially to an acute medical or surgical ward. The current inspection therefore also determined whether this practice is in evidence in the case of recently admitted patients.

Background

In December 2004 the Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections was requested by the Secretary of Veterans Affairs to review the care of an active duty marine who was seriously wounded in Iraq, treated initially in Department of Defense (DoD) facilities, and transferred for rehabilitative care to JAHVAMC Tampa, Florida, where he died 3 weeks later.

The report[1] found "the intensity and comprehensiveness of his rehabilitative care to be high. However, we noted deficiencies with respect to other specific aspects of care." In particular, an evaluation by an Infectious Diseases fellow "was the only documented visit [by] any Infectious Diseases Section physician until after the patient had a cardiopulmonary arrest on October 19. Furthermore, we found that …the Infectious Diseases Section response lacked depth…and did not provide more than a general outline of how to proceed with the evaluation and management of this most complex patient."

The 2005 review also found that "copies of the patient's entire NNMC [National Naval Medical Center] medical records were never sent to the JAHVAMC." In addition, "Naval medical authorities asserted that a compact disc [CD] containing all of the patient's radiological studies had been sent to the JAHVAMC, while JAHVAMC staff denied receipt or even knowledge of this CD." Finally, "While an NNMC progress note sent to the JAHVAMC refers to having a 'low threshold for [performing a] cisternal tap should fever recur,' NNMC [cerebrospinal fluid] results were not provided to JAHVAMC staff."

In response to the 2005 review, the JAHVAMC director wrote that "the Chief of Staff directed that all consults requested on multiple trauma patients must be initially responded to by the Chiefs of Clinical Services, i.e. Medicine, Surgery, Neurology, etc. The attending may be accompanied by their resident or fellow; however, the service member will be initially evaluated by and closely followed by the attending."

Scope and Methodology

This inspection consisted of a focused chart review to address the current care of TBI patients at JAHVAMC. Patient records were selected based on the following criteria:

A. Active military duty at the time of TBI.

B. TBI occurred in 2005–2006.

C. Discharged in 2006 or currently hospitalized.

[1] *Healthcare Inspection, Review of Quality of Care, Department of Veterans Affairs, James A. Haley Medical Center, Tampa, FL,* No. 05-00614-149, June 1, 2005.

Medical records for these patients were reviewed in reverse chronological order until the target number of 20 was reached. This review included records for each of the 12 patients hospitalized on May 16, 2006, and for the most recent 9 patients of the 40 patients discharged in 2006[2]. Radiology records were also reviewed. In addition, Physical Medicine and Rehabilitation (PM&R) Service and Radiology Service staff members were interviewed to clarify the extent of medical records transfer from other facilities.

Examined medical records were scrutinized for the presence of requests for consultations from medical/surgical specialists (including Psychiatry and Neurology). The urgency of each request was noted, along with the time from consultation request to completion. The appropriateness of consultant findings and recommendations and degree of attending physician involvement were also assessed.

This examination also assessed whether complete medical records from transferring facilities were readily available to JAHVAMC providers. Finally, evidence from the medical record was sought to determine whether these patients were admitted initially to an acute medical or surgical ward.

The inspection was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Findings

The following table summarizes patient characteristics. All of these patients were on active duty at the time of injury, which occurred between May 2003–April 2006; all but one of the injuries occurred in 2005 or 2006. These patients were admitted to the JAHVAMC between November 23, 2005–May 15, 2006.

The age and gender of the patients in the sample were very similar to the patients reported in a recent OIG review of OIF/OEF TBI patients.[3] As in the prior review, the majority of these active duty patients sustained their injuries in motor vehicle accidents (MVA). However, all of the injuries sustained in Iraq were due to improvised explosive devices (IED), other explosions, or mortar fire. They came from civilian hospitals, various Federal medical centers (MC), and direct from home.

[2] Eight rather than 9 patients discharged in 2006 were evaluated because 1 of the 12 patients hospitalized at the time of the review suffered TBI before 2005.

[3] *Healthcare Inspection – Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation,* Report publication pending.

Patient Characteristics	
Number	21
Female	2
Age, Mean (Range)	27 (19–41)
Branch of Service	
Army	10
Marine Corps	5
Nat Guard (Army)	2
Navy	1
Air Force	1
Coast Guard	1
Reserves (Army)	1
TBI Location	
U.S.	10
Iraq	9
Djibouti	1
Pakistan	1
TBI Cause	
MVA	11
IED	5
Mortar or Explosion	4
Surfing	1
Admission Source	
Civilian Hospital	7
National Naval MC	4
Walter Reed Army MC	3
Brooke Army MC	2
Tripler Army MC	1
Miami VAMC	1
Direct from Home	3

A. Transfer of Medical Records

All of the patients transferred from military and VA hospitals had medical records from the transferring facilities readily accessible through the recently-deployed VistaWeb enhancement of the computerized patient record system (CPRS). Available records included basic laboratory and radiology data from Walter Reed (WRAMC), Brooke (BAMC), and Tripler Army Medical Centers; National Naval Medical Center (NNMC); and Landstuhl Regional Medical Center in Germany. Complete medical records were not routinely requested or received, but one JAHVAMC staff physician had direct computer

access to the medical records systems at WRAMC and NNMC, and JAHVAMC staff reported that plans were underway to gain access to records at BAMC.

For the 12 patients currently hospitalized, 3 had images from military facilities previously loaded into the JAHVAMC Radiology Service filmless Picture Archiving and Communication System (PACS) and 4 had imaging compact discs (CDs) attached to their paper medical record at the nursing unit. None of the three patients transferred from non-Federal hospitals had radiology images available. Any imaging data from outside facilities that accompanies the patients being transferred to JAHVAMC requires multiple steps before being loaded into the JAHVAMC PACS.

B. Consultations

Consultations from PM&R Service physicians generated prompt responses from consultants. There was no indication of negative clinical impact or prolonged hospitalization resulting from delays in completing consultations. In the case of consultations completed by resident physicians, there was uniform evidence of attending involvement. In some of those cases, however, it was unclear from the record whether an attending physician ever interacted with the patient in person. This expectation was explicitly stated in the JAHVAMC response to the 2005 review.

Several consultations were completed by an Orthopedics physician assistant (PA), with variable evidence of attending involvement. Our inspection found that the Scope of Practice for this PA does not include consultation services.

C. Initial Care on Admission to JAHVAMC

Sixteen of the 21 patients in this review were admitted initially to acute medical or surgical wards under the care of Internal Medicine or General Surgery attending physicians. After a brief period of observation (typically less than 48 hours), the patients were transferred to the PM&R ward. The five patients admitted directly to the PM&R ward came directly from home or were more than a year removed from their injury.

Conclusions

In the period since the review published June 1, 2005, major improvements have been made in the availability of medical records from DoD hospitals, but radiology images are inconsistently available to JAHVAMC radiologists.

Comprehensive and prompt consultations are provided for TBI inpatients, and the involvement of attending physicians is well documented. However, when consultations were completed by resident physicians or physician assistants, it is unclear whether attending physicians conducted patient interviews and physical examinations. In the case

of an orthopedics physician assistant, consultations were not in the approved Scope of Practice.

Recommendations

We recommend that the VISN Director ensure that the JAHVAMC Director ensures:

1. Physician Assistants engage only in clinical activities specified in an approved Scope of Practice.

2. Documentation demonstrates that attending physicians interview and examine TBI patients in response to consultation requests.

3. Efforts continue to optimize the transfer of clinical information, including Radiology data, when patients are received from other facilities.

VISN and JAHVAMC Director Comments

The VISN Director and JAHVAMC Director concurred with the results of this inspection and have taken actions to implement the recommendations in this report (See Appendixes A and B, pages 7–11, for VISN and JAHVAMC Director comments).

Assistant Inspector General of Healthcare Inspections Comments

The VISN and JAHVAMC Directors agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 27, 2006

From: VISN Director

Subject: **Follow-Up Review of the Quality of Care at the James A. Haley VA Medical Center, Tampa, Florida**

To: Office of Inspector General

Thank you for the opportunity to review the draft report of the Follow-Up Review of the Quality of Care at the James A. Haley VA Medical Center, Tampa, Florida.

We have reviewed the draft report and concur with the findings and recommendations. We have also reviewed the response and plan of action by the medical center and agree with their course of action.

Please contact Karen Maudlin (727) 319-1063 if you have any questions.

(original signed by)

George H. Gray, Jr.

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

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

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the JAHVAMC Director ensures Physician Assistants engage only in clinical activities specified in an approved Scope of Practice.

Concur **Target Completion Date:** Implemented

The Acting Chief of Staff issued a memorandum on June 9, 2006 noting that mid level-providers are not authorized to perform consultations unless specifically authorized to do so in their scope of practice. The memorandum also notes that if a mid-level provider's scope of practice authorizes consultation, the supervising attending must personally meet and examine the patient and write an independent note or addendum. (Attachment 1 [not included here]) A meeting was held on June 19, 2006 with all clinical service chiefs to discuss this requirement. Quality Management will conduct a 100% chart review on consultations of all TBI patients for three months, and all deficiencies will be promptly addressed.

Recommendation 2. We recommend that the VISN Director ensure that the JAHVAMC Director ensures documentation demonstrates that attending physicians interview and examine TBI patients in response to consultation requests.

Concur **Target Completion Date:** Implemented

Per Hospital Policy Memorandum and VA Resident Supervision Guidelines for inpatient consultations, a supervising practitioner is responsible for the clinical consultations from each specialty service. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents. Any of the four defined types of documentation (progress note, addendum, co-signature, resident progress note) are acceptable. However, while we are in compliance with these policies for documenting supervision, this documentation does not necessarily confirm that the attending or supervising practitioner had hands-on involvement, i.e., interviewed and examined the patient.

Therefore, the Acting Chief of Staff has mandated that each attending note or addendum clearly state that the patient was seen or examined by the attending. A memorandum notifying all medical and dental staff has been generated to that effect. (Attachment 2 [not included here]) Quality Management will conduct a 100% chart review on consultations of all TBI patients for three months, and all deficiencies will be promptly addressed.

Recommendation 3. We recommend that the VISN Director ensure that the JAHVAMC Director ensures efforts continue to optimize the transfer of clinical information, including Radiology data, when patients are received from other facilities.

Concur **Target Completion Date:** Ongoing

We receive radiographs on compact discs from Walter Reed, Brooke, and National Naval Medical Center. In urgent or emergency situations, the images can be viewed by the providers and radiologists on a regular computer utilizing the image viewer software on the disc. Once the images are delivered to the PACS administrator, they are uploaded as a priority into the PACS system.

We are able to access electronic medical record information from DOD; however, we have no control or influence in the functioning of non-military facilities. When a patient is a state-side injury and will be transferred from a private non-military hospital, we have encouraged, and will continue to encourage, transfer of all records, including radiographs.

Appendix B

JAHVAMC Director Comments

Department of Veterans Affairs **Memorandum**

Date:

From: JAHVAMC Director

Subject: **Follow-Up Review of the Quality of Care at the James A. Haley VA Medical Center, Tampa, Florida**

To: Office of Inspector General

James A. Haley VA Medical Center is in agreement with the above response from VISN 8.

Appendix C

OIG Contact

OIG Contact	Jerome E. Herbers, Jr., M.D. Associate Director, Medical Assessment & Consultation (202) 565-8121

Appendix D

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