Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-02600-28

Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan

November 8, 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
CPR	cardiopulmonary resuscitation
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	John D. Dingell VA Medical Center
FY	fiscal year
HF	heart failure
MH	mental health
OIG	Office of Inspector General
POCT	point-of-care testing
PR	peer review
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, MI

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of August 6, 2012.

Review Results: The review covered 10 activities. We made no recommendations in the following activities:

- Medication Management
- Mental Health Treatment Continuity
- Nurse Staffing

The facility's reported accomplishment was implementing the "Veteran's Recovery & Resource Workbook" to facilitate mental health patients' recovery and treatment continuity.

Recommendations: We made recommendations in the following seven activities:

Colorectal Cancer Screening: Ensure patients with positive screening test results receive diagnostic testing within the required timeframe. Notify patients of biopsy results within the required timeframe, and document notification.

Point-of-Care Testing: Complete the actions required in response to critical test results. Store test strips and maintain glucometers according to manufacturers' recommendations.

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

Coordination of Care: Ensure staff make and document post-discharge telephone calls in accordance with local policy.

Environment of Care: Provide camera surveillance monitoring on the locked acute mental health unit at all required locations.

Quality Management: Notify the Peer Review Committee when corrective actions are completed, and document notification. Ensure the Medical Records Committee provides oversight and coordination of electronic health record quality reviews, and complete quality reviews for all services. Report aggregated data from resuscitation episodes to the Cardiopulmonary Resuscitation Subcommittee monthly, and document this in the minutes.

Polytrauma: Ensure all required services are available to polytrauma outpatients, and maintain minimum staffing levels.

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 10 activities:

- COC
- CRC Screening
- EOC
- Medication Management
- MH Treatment Continuity
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

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

The review covered facility operations for FY 2011 and FY 2012 through August 9, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan,* Report No. 10-02993-70, January 21, 2011).

During this review, we presented crime awareness briefings for 280 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 188 responded. We shared survey results with facility managers.

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

Reported Accomplishment

"Veteran's Recovery & Resource Workbook"

"The Veteran's Recovery & Resource Workbook" was developed and implemented in May 2012 to facilitate MH patients' recovery and treatment continuity from inpatient to outpatient care. This workbook is given to patients upon admission to the inpatient MH unit to assist them in developing and following their treatment plans in the inpatient and outpatient settings. The implementation of this workbook is part of Project Re-Engineered Discharge (RED), which is redesigning the discharge process from inpatient MH. The changes that have been implemented have resulted in a 2 percent reduction in average length of stay for the facility's top two MH diagnoses—psychosis and alcohol and drug abuse. In addition, there has been a sustained 4.3 percent reduction in the combined readmission rate for these two diagnoses.

Results

Review Activities With Recommendations

CRC Screening

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

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

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinician 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.
	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.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening tests results unless contraindicated.[1] Five of the 13 patients who received diagnostic testing did not receive that testing within the required timeframe.

Biopsy Result Notification. VHA require that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[2] Of the nine patients who had a biopsy, two EHRs did not contain documented evidence of timely notification.

Recommendations

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

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

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

POCT

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

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

Test Results Management. When glucose values are determined to be critical, the facility requires the employee performing the test to repeat the test within 10 minutes and notify the clinician of the results. Of the 10 patients who had critical test results, the repeat testing was not performed timely for 5 patients, and no repeat testing was performed on 1 patient. Additionally, there was no documented evidence of clinician notification for six patients.

Equipment Storage and Maintenance. VHA requires that the facility follow the manufacturers' recommendations for equipment storage and maintenance.[3] In one of the four patient care areas we inspected, test strips were open and sitting out on the counter for easy access. Additionally, glucometers in the four patient care areas we

[3] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

inspected were not maintained in accordance with the manufacturer's recommendations.

Recommendations

3. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

4. We recommended that processes be strengthened to ensure that test strips are stored and glucometers are maintained in accordance with the manufacturers' recommendations.

Moderate Sedation

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

We reviewed relevant documents, 12 EHRs, and 20 training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[4] Eight patients' EHRs did not include all required elements of the history and physical examination, such as a review of tobacco use.

Recommendation

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

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

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' EHRs and relevant documents and interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Post-Discharge Telephone Calls. Local policy requires that staff call patients within 48 hours following an inpatient stay and document this post-discharge telephone call in the EHR. Fourteen EHRs did not include documentation of a post-discharge telephone call.

Recommendation

6. We recommended that processes be strengthened to ensure that staff make and document post-discharge telephone calls in accordance with local policy.

EOC

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

We inspected the medical, surgery, intensive care, step-down, and locked acute MH units; two CLC units; the dental clinic; and the emergency department. Additionally, we reviewed relevant documents and training records, and we interviewed key 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 General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
X	The facility complied with any additional elements required by VHA or local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.

	Areas Reviewed for MH RRTP (continued)
	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.

MH General Safety. VHA requires that locked acute MH units have camera surveillance monitoring at the sally port entrance and in the hallways outside of seclusion rooms.[5] The locked acute MH unit did not have camera surveillance monitoring of these locations.

Recommendation

7. We recommended that the locked acute MH unit have camera surveillance monitoring at all required locations.

[5] VA National Center for Patient Safety, "Mental Health Environment of Care Checklist," March 1, 2012.

QM

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

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

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
X	The protected PR process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a CPR 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 an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	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.

Noncompliant	Areas Reviewed (continued)
	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.

PR. VHA requires that the PR Committee receive written notification upon completion of corrective actions.[6] We reviewed meeting minutes for the period October 2011–January 2012 and identified 17 corrective actions that were completed. There was no evidence that 16 of these completed corrective actions were reported to the committee.

EHR Review. VHA requires facilities to have an EHR Committee that provides oversight of EHR quality reviews.[7] The reviews must include a representative sample of charts from each service or program to ensure that appropriate documentation is occurring. We found that the Medical Records Committee provided inconsistent oversight and coordination. Although some EHR quality reviews had been completed (for example, Social Work and Nursing Services), we found minimal evidence of EHR quality reviews for Surgical Service.

Aggregate Resuscitation Data. Local policy requires that the information from resuscitation episodes be analyzed for trends and the results reported to the CPR Subcommittee monthly. We did not find evidence that aggregated data was reported to the CPR Subcommittee monthly from December 2011 through May 2012.

Recommendations

8. We recommended that processes be strengthened to ensure that the PR Committee is consistently notified when corrective actions are completed and that this notification is documented in the meeting minutes.

9. We recommended that processes be strengthened to ensure that the Medical Records Committee provides oversight and coordination of EHR quality reviews and that EHR quality reviews are consistently completed for all services, including Surgical Service.

10. We recommended that processes be strengthened to ensure that aggregated data from resuscitation episodes is reported to the CPR Subcommittee monthly and documented in the meeting minutes.

[6] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[7] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

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 EHRs of patients with positive TBI results, 10 EHRs of patients admitted to the polytrauma outpatient clinic, and 6 training records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
X	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-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Available Services and Staffing. VHA requires that specific services are available for polytrauma patients and that minimum staffing levels are maintained.[8] The facility did not have rehabilitative nursing services available. In addition, the facility did not meet the minimum staffing requirement for the physical, occupational, and speech therapists.

Recommendation

11. We recommended that all required services be available to polytrauma outpatients and that minimum staffing levels be maintained.

[8] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[9] therapy with methadone and buprenorphine and handling of methadone.

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

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

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

MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	After discharge from a MH hospitalization, patients received outpatient MH follow-up in accordance with VHA policy.
	Follow-up MH appointments were made prior to hospital discharge.
	Outpatient MH services were offered at least one evening per week.
	Attempts to contact patients who failed to appear for scheduled MH appointments were initiated and documented.
	The facility complied with any additional elements required by local policy.

Nurse Staffing

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

We reviewed relevant documents and training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (A3N) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. See Appendixes C and D, pages 21–27, for the full text of the Directors' comments. We will follow up on the planned actions until they are completed.

Facility Profile[10]		
Type of Organization	Medical center with primary, secondary, and tertiary care	
Complexity Level	1b	
VISN	11	
Community Based Outpatient Clinics	Pontiac, MI Yale, MI	
Veteran Population in Catchment Area	242,809	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	240	
• **CLC/Nursing Home Care Unit**	109	
Medical School Affiliation(s)	Wayne State University School of Medicine	
• **Number of Residents**	85.45 Full-time employee equivalents	
	Current FY (through June 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$338.1	$323.6
• **Medical Care Expenditures**	$217.7	$312.3
Total Medical Care Full-Time Employee Equivalents	1,994	1,854
Workload:		
• **Number of Station Level Unique Patients**	38,693	43,926
• **Inpatient Days of Care:**		
o **Acute Care**	18,362	27,583
o **CLC/Nursing Home Care Unit**	17,950	24,746
Hospital Discharges	3,793	4,559
Total Average Daily Census (including all bed types)	171.8	181
Cumulative Occupancy Rate (in percent)	50.6	59.5
Outpatient Visits	308,865	445,281

[10] All data provided by facility management.

VHA Satisfaction Surveys

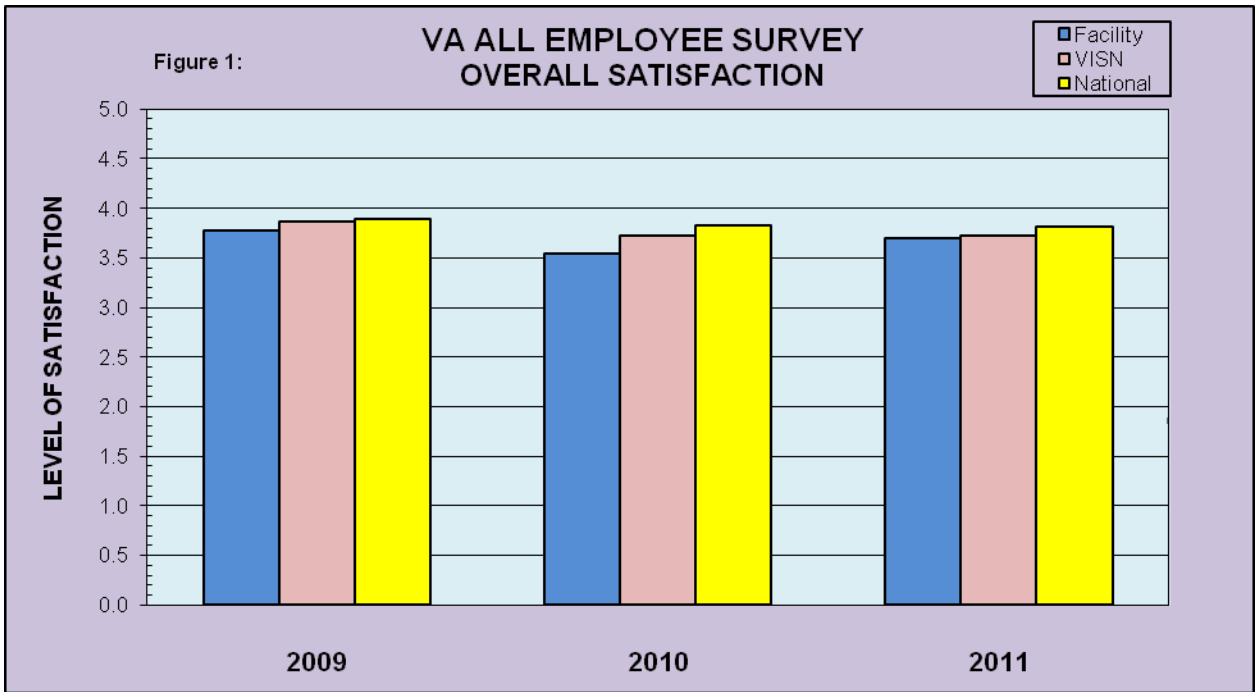
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	53.3	52.8	53.6	49.5	40.4	49.2
VISN	65.2	65.9	55.0	58.3	53.0	56.7
VHA	64.1	63.9	54.2	54.5	55.0	54.7

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

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[11] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[12]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	16.1	9.9	14.0	20.6	26.3	19.6
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

[11] 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.

[12] 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: October 19, 2012

From: Director, Veterans In Partnership (10N11)

Subject: **CAP Review of the John D. Dingell VA Medical Center, Detroit, MI**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (VHA 10AR MRS)

1. Per your request, attached is the response to the draft CAP report for Detroit, VAMC.

2. If you have any questions, please contact Kelley Sermak at 734-222-4302.

Michael S. Finegan

Attachment

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 12, 2012

From: Director, John D. Dingell VA Medical Center (553/00)

Subject: **CAP Review of the John D. Dingell VA Medical Center, Detroit, MI**

To: Director, Veterans In Partnership (10N11)

1. I would like to express my gratitude to the Office of Inspector General (OIG) CAP Team for the comprehensive and thorough review.

2. I have reviewed each recommendation in the draft report for the John D. Dingell VA Medical Center, Detroit, MI, and concur with the findings and recommendations. Action plans for each finding have been developed and implemented.

3. Thank you again for your assistance during this visit.

Pamela Reeves MD

Pamela J. Reeves, MD, Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that 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: Completed on October 12, 2012

1. Two additional full-time providers have been added to the clinic to assist with the increased patient load. The two full-time providers replaced existing part-time contract providers.

2. A restructure of patient triage and priority has been initiated, creating a high priority scheduling field for positive Fecal Occult Blood Test (FOBT) patients and symptomatic patients.

3. Additional overbooking slots have been added to the providers grids (two a day) designated for positive FOBT patients and additional add ons.

4. The FOBT education process in primary care is being actively addressed so patients understand the importance of the test, and the impact of a positive result (improving the no show rate).

Recommendation 2. 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: Completed on October 12, 2012

1. The addition of two full time providers has assisted in continuity of patient care and improved result notification.

2. The test results notification policy dictates the timeframe of result notification.

3. Patients are now notified by a letter, face-to-face follow up appointment, or a follow up phone call which is documented by the provider and reported within required timeframes.

Recommendation 3. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

Concur

Target date for completion: December 31, 2012

1. Personnel performing point of care glucose testing have been instructed to follow the SOP for reporting critical test results.

2. A Critical Results Template has been developed to standardize documentation of critical point of care testing results reported to providers.

3. Training of personnel in the use of the Critical Results Reporting Template will take place during the Nursing Competency Fair, October 30 and 31, 2012.

4. Implementation of the Critical Results Reporting Template will provide us with a standardized system for reporting critical test results at the point of care and improve our ability to track compliance.

5. Quality indicators have been developed to:
   (a) Monitor and track compliance of repeat testing of critical results by personnel performing testing.
   (b) Monitor and track compliance of provider notification of critical lab test results performed at the point of care.

6. Non compliance will be reported to the unit Clinical Nurse Manager/Supervisor for corrective action.

Recommendation 4. We recommended that processes be strengthened to ensure that test strips are stored and glucometers are maintained in accordance with the manufacturers' recommendations.

Concur

Target date for completion: December 31, 2012

1. Pertinent staff members have been instructed to adhere to the SOP for whole blood glucose monitoring to ensure that test strips are stored according to the manufacturer's recommendations.

2. Glucometers in need of physical maintenance have been repaired and/or replaced. To ensure ongoing compliance and maintenance, review of the monitors and storage process will be added to the monthly nursing rounds checklist as well as the EOC monitor/checklist.

3. Instructions on cleaning and maintenance of glucometers will be presented to personnel during the Nursing Competency Fair on October 30 and 31, 2012.

4. Survey of glucometer testing sites monthly to track compliance with the SOP for storage of strips used for patient testing, and report findings to the to the Clinical Nurse Managers/Supervisors.

5. New Accessory Boxes have been ordered to replace the ones currently in use that are in need of repair and maintenance.

Recommendation 5. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: October 12, 2012

The pre-sedation template has been modified to include all required elements. This template has been implemented as a standard pre-sedation template (includes all history & physical components). This has been implemented in all of our moderate sedation areas, including; Endoscopy, Bronchoscopy suite, Cardiac Cath Lab, in the ED, and at the bedside during non-anesthesia moderate sedation procedures.

Recommendation 6. We recommended that processes be strengthened to ensure that staff make and document post-discharge telephone calls in accordance with local policy.

Concur

Target date for completion: October 12, 2012

The telephone call center has been tasked with completing all post discharge follow up phone calls within 2 days. The VISN target for this measure is 50%; Detroit is currently performing well over that target at 85% – 97% for the past 12 months. Also patients discharged with a primary diagnosis of heart failure are being referred to the heart failure service line for management (if diagnosis is severe, or a patient has had multiple admissions for the same diagnosis). The telephone call center is documenting the follow up phone call as an encounter, thus the call and documentation do occur.

Recommendation 7. We recommended that the locked acute MH unit have camera surveillance at all required locations.

Concur

Target date for completion: November 30, 2012

A new camera system for the B2 North acute inpatient MH unit has been ordered, received and is currently in the process of being installed.

Recommendation 8. We recommended that processes be strengthened to ensure that the PR Committee is consistently notified when corrective actions are completed and that this notification is documented in the meeting minutes.

Concur

Target date for completion: Completed on October 10, 2012

The process developed in response to the OIG finding is as follows:

During the Peer Review Committee (PRC) meeting, time is set aside to review the open systems issues and those that have been closed since the last meeting to ensure the feedback loop is complete to the members of the PRC. The minute's format has been adjusted to document these discussions.

Recommendation 9. We recommended that processes be strengthened to ensure that the Medical Records Committee provides oversight and coordination of EHR quality reviews and that EHR quality reviews are consistently completed for all services, including Surgical Service.

Concur

Target date for completion: Completed on October 1, 2012

The Medical Record Review Specialist/VERA Coordinator met with the Acting Chief of Surgical Service to review VA Central Office Health Record Review Practice Brief # 7 which provides detailed guidelines for the health record review process, sample size requirements, report submission dates and action plan requirements for indicators that do not meet a 95% threshold. The Health Information Management Committee will review all services to ensure that EHR quality reviews are consistently completed according to policy.

Recommendation 10. We recommended that processes be strengthened to ensure that aggregated data from resuscitation episodes is reported to the CPR Subcommittee monthly and documented in the meeting minutes.

Concur

Target date for completion: Completed on October 12, 2012

Aggregate data and unit/department specific data are reported to the CPR committee. Quality Management has developed a new database for tracking code occurrences. This is recorded in the minutes and embedded as an attachment.

Recommendation 11. We recommended that all required services be available to polytrauma outpatients and that minimum staffing levels be maintained.

Concur

Target date for completion: January 1, 2013

We are recruiting a 0.5 FTE for Physical Therapy (PT) and Speech Language Pathology positions from current staff. A request to the Position Management Committee (PMC) to recruit for a 0.5 FTE Occupational Therapist (OT) and Rehabilitative Nurse will be submitted per recommendation. Currently we are using nursing from PACT for the Polytrauma/TBI Clinic and current OT/PT staff, as needed, to meet the therapy needs of the Polytrauma/TBI Veteran.

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