Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03072-48

Combined Assessment Program Review of the VA Central Western Massachusetts Healthcare System Leeds, Massachusetts

December 4, 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
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E-Mail: vaoighotline@va.gov
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Glossary

CAP	Combined Assessment Program
CLC	community living center
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	VA Central Western Massachusetts Healthcare System
FY	fiscal year
MH	mental health
MHTC	mental health treatment continuity
OIG	Office of Inspector General
POCT	point-of-care testing
QM	quality management
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA Central Western Massachusetts Healthcare System, Leeds, MA

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 September 10, 2012.

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

- Colorectal Cancer Screening
- Environment of Care

The facility's reported accomplishments were a systems redesign effort that included more than 80 projects and resulted in time and money saving solutions and an outreach project that brought more than 300 new enrollees into the facility.

Recommendations: We made recommendations in the following five activities:

Quality Management: Complete at least two preventive ethics improvement cycles each fiscal year. Ensure that the electronic health record committee provides consistent oversight and coordination of quality reviews and that quality reviews are completed, analyzed, and trended for all services, including long-term care.

Polytrauma: Ensure that a rehabilitation nurse is available for the polytrauma program.

Medication Management: Ensure all patients in opioid dependence treatment undergo urine drug screenings with the frequency required by local policy.

Mental Health Treatment Continuity: Ensure all discharged mental health patients receive follow-up evaluations at the required intervals, and monitor compliance.

Point-of-Care Testing: Ensure employees who perform glucose point-of-care testing have competency assessed at the required intervals. Complete and document the actions required in response to critical test results. Require Clinical Engineering staff to inspect, approve, and label glucose meters in accordance with local policy.

Comments

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

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- CRC Screening
- EOC
- Medication Management
- MHTC
- 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 September 14, 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 Northampton VA Medical Center, Leeds, Massachusetts, Report No. 11-00029-193, June 13, 2011).

During this review, we presented crime awareness briefings for 68 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 137 responded. We shared survey results with facility managers.

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

Reported Accomplishments

Systems Redesign

The facility continues to foster a culture of improvement with in-service and formal training on data collection and analysis, team building activities, and a variety of Lean methodology tools. Through training, coaching, and facilitation, 35 engaged teams work together on a daily basis towards a common goal of continuous improvement. Teams have completed more than 80 projects, resulting in time and money saving solutions. One example is a dental department project recognized during a Joint Commission survey as a best practice in the storage and use of sterilized instruments. Additionally, a team in urgent care eliminated more than 45 steps in the admissions process, reducing wait times and improving veteran satisfaction. This team went on to make changes to patient flow and the work area, providing a consistently safe environment for patients at risk for elopement.

Outreach

To expand its patient base, the facility Outreach Workgroup plans, implements, and evaluates strategies to aggressively educate, enroll, and retain veterans to increase the number of patients being served. Key strategies include an integrated communications approach using advertising, media relations, face-to-face communication, and special events. These events have included a presence at regional career days; open houses at community based outpatient clinics; and a military appreciation day at the Eastern States Exposition, the largest agricultural exposition and seasonal entertainment venue in New England. The facility is also a lead partner in the Western Massachusetts Stand-Down, which brings together more than 50 community agencies to serve homeless veterans. Facility outreach efforts in FY 2012 brought more than 300 new enrollees into the facility.

Results
Review Activities With Recommendations

QM

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

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

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
	The protected peer review 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.
X	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	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 an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.

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

Integrated Ethics Improvement Cycles. VHA requires preventive ethics teams at each facility to perform, at a minimum, two improvement cycles each FY.[1] We found that the facility did not complete any improvement cycles during FY 2011.

EHR Review. VHA requires facilities to have an EHR committee that provides oversight of EHR quality reviews, which includes analyzing aggregated data at least quarterly.[2] 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 EHR committee provided inconsistent oversight and coordination and did not analyze or trend aggregated data quarterly. Although some EHR quality reviews had been completed (for example, primary care and MH), we found minimal evidence of EHR quality reviews for long-term care.

Recommendations

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

2. We recommended that processes be strengthened to ensure that the EHR committee provides consistent oversight and coordination of EHR quality reviews and that quality reviews are completed, analyzed, and trended for all services, including long-term care.

[1] Deputy Under Secretary for Health for Operations and Management, "Integrated Ethics Program Achievement: Goals and Reporting Requirements," memorandum, January 7, 2011.
[2] 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 coordination of care for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive traumatic brain injury results, 10 EHRs of patients receiving outpatient services, and 10 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 traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
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-Traumatic Brain Injury System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Available Staffing. VHA requires that minimum polytrauma staffing levels be maintained.[3] The facility did not have a rehabilitation nurse available.

Recommendation

3. We recommended that a rehabilitation nurse be available for the polytrauma program.

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

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically opioid agonist[4] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving buprenorphine for evidence of compliance with program requirements. We also reviewed 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
	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.
X	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.

Urine Drug Screening. VHA requires that patients in opioid dependence treatment be monitored through periodic urine drug screening.[5] Local policy requires that all patients in opioid dependence treatment undergo urine drug screening monthly. Additionally, patients in the induction phase are subject to urine drug screening weekly during the 1st month of treatment. For the 10-month period October 2011–July 2012, we found that nine patients did not undergo urine drug screening with the frequency required by local policy.

Recommendation

4. We recommended that processes be strengthened to ensure that all patients in opioid dependence treatment undergo urine drug screenings with the frequency required by local policy.

[4] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.
[5] VA/DoD, "Clinical Practice Guideline for Management of Substance Use Disorders (SUD)," August 2009.

MHTC

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 25 patients discharged from acute MH (including 5 patients deemed at high risk for suicide). The area marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	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.

Outpatient Follow-Up. VHA requires that all patients discharged from inpatient MH receive outpatient follow-up from a MH provider within 7 days of discharge and that if this contact is by telephone, an in-person or telemental health evaluation must occur within 14 days of discharge.[6] Seven of the 20 patients who were not on the high risk for suicide list did not receive outpatient MH follow-up within 7 days of discharge. Additionally, two patients were contacted by telephone within 7 days of discharge but did not have an in-person or telemental health evaluation within 14 days.

Follow-Up for High Risk for Suicide Patients. VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list be evaluated at least weekly during the first 30 days after discharge.[7] VHA also requires that facilities have an established process to ensure that providers follow up on missed appointments for high-risk patients.[8] Although appointments were scheduled before discharge, two of the five discharged patients who were on the high risk for suicide list did not receive the required MH follow-up during the first 2 weeks after discharge. Although the facility established a process immediately prior to our visit, they did not have a process in place during the review timeframe to ensure that providers followed up on missed high-risk patient appointments.

[6] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
[7] Principal Deputy Under Secretary for Health and Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[8] VHA Handbook 1160.01.

Recommendations

5. We recommended that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up evaluations at the required intervals and that compliance be monitored.

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, 16 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.
X	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.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
X	The facility complied with any additional elements required by local policy.

Competency Assessment. VHA requires the facility to complete and document competency assessments for all employees who perform glucose POCT.[9] The College of American Pathologists requires that after successful initial training and competency assessment, employees must have competency reassessed in 6 months. All employees who perform glucose POCT must then have competency assessed annually. Five employee training records did not have documented evidence of annual competency assessment.

Test Results Management. When glucose values are determined to be critical, the facility requires the employee performing the test to document specific elements, including the test result, date, time, and name of the provider notified of the result. Eight

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

of the 10 EHRs of patients who had critical test results lacked documentation of one or more of the required elements.

Local Policy Requirements. Local policy requires that medical equipment[10] be inspected and approved for use before being placed into service. We inspected five glucose meters on four inpatient care units. None of the meters had labels indicating they had been approved for use by Clinical Engineering staff.

Recommendations

7. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have their competency assessed at the required intervals.

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

9. We recommended that processes be strengthened to ensure that Clinical Engineering staff inspect, approve, and label glucose meters in accordance with local policy.

[10] Glucose meters are used for physiological monitoring of patients. Local policy defines medical equipment as equipment used for the diagnosis, therapy, or physiological monitoring of a patient.

Review Activities Without 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 12 patients who had positive CRC screening tests and 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.

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 acute MH, chronic MH, post-traumatic stress disorder, and CLC units. We also inspected the urgent care, primary care, physical medicine and rehabilitation, SCI, dental, and specialty clinics. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or SCI 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 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.

Noncompliant	Areas Reviewed for MH Residential Rehabilitation Treatment Program (continued)
	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.

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 17–22, for the full text of the Directors' comments.) We consider Recommendation 1 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[11]		
Type of Organization	Medical center	
Complexity Level	3	
VISN	1	
Community Based Outpatient Clinics	Springfield, MA Greenfield, MA Pittsfield, MA Worcester, MA Fitchburg, MA	
Veteran Population in Catchment Area	108,753	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	81	
• **CLC/Nursing Home Care Unit**	32	
• **Other**	16 Domiciliary	
Medical School Affiliation(s)	Tufts University School of Medicine – Baystate Medical Center University of Massachusetts	
• **Number of Residents**	1	
	Current FY (through June 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$71.7	$63.0
• **Medical Care Expenditures**	$56.5	$62.5
Total Medical Care Full-Time Employee Equivalents	731.43	627.14
Workload:		
• **Number of Station Level Unique Patients**	22,262	15,514
• **Inpatient Days of Care:**		
o **Acute Care**	1,820	2,275
o **CLC/Nursing Home Care Unit**	8,037	14,924
Hospital Discharges	706	947
Total Average Daily Census (including all bed types)	102	120.7
Cumulative Occupancy Rate (in percent)	79	83
Outpatient Visits	234,784	202,679

[11] All data provided by facility management.

VHA Satisfaction Surveys

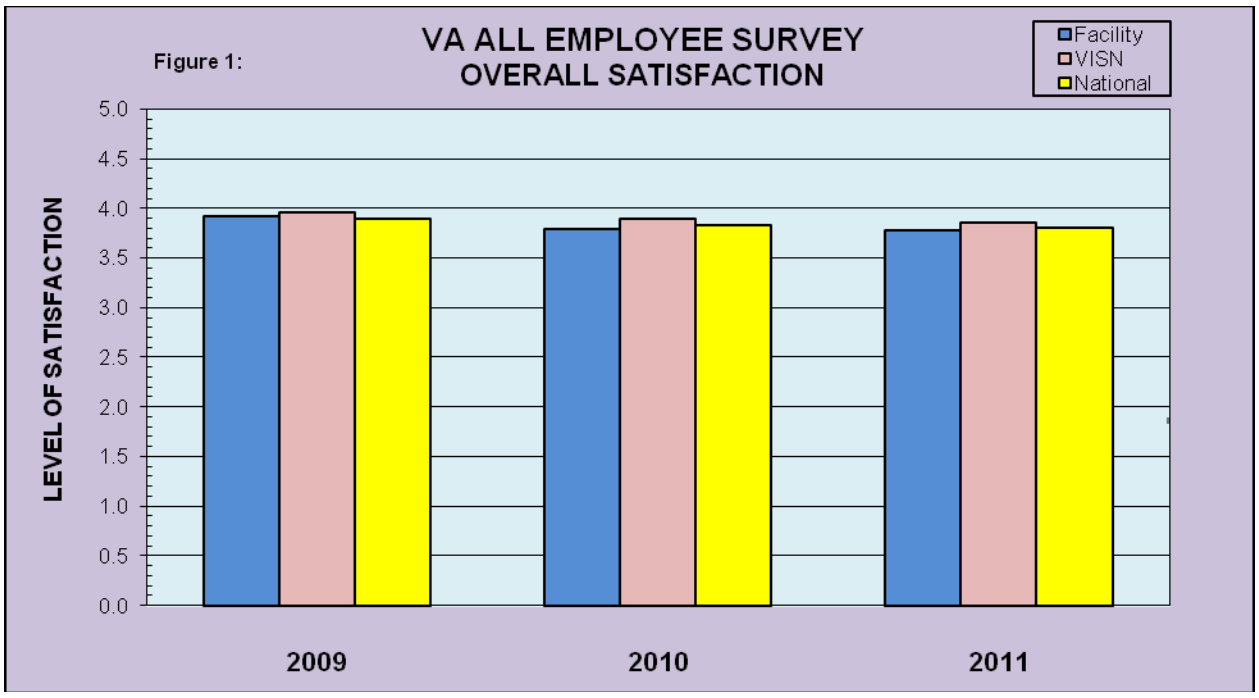
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	*	*	68.2	54.1	55.7	59.4
VISN	67.4	65.7	62.8	60.5	60.8	59.9
VHA	64.1	63.9	54.2	54.5	55.0	54.7

* A score is not reported because there were fewer than 30 cases.

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.



Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 8, 2012

From: Director, VA New England Healthcare System (10N1)

Subject: **CAP Review of the VA Central Western Massachusetts Healthcare System, Leeds, MA**

To: Director, Bedford Office of Healthcare Inspections (54BN)

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

I have reviewed and concur with the action plans regarding the Draft Report, Combined Assessment Review, VA Central Western Massachusetts Healthcare System.

Sincerely,

For Michael F. Mayo-Smith
Network Director, New England Healthcare System

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 5, 2012

From: Director, VA Central Western Massachusetts Healthcare System (631/00)

Subject: **CAP Review of the VA Central Western Massachusetts Healthcare System, Leeds, MA**

To: Director, VA New England Healthcare System (10N1)

We concur with the recommendations and have already imitated corrective actions.

If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (413) 582-3000.

Sincerely,

(original signed by:)
Roger Johnson
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 at least two preventive ethics improvement cycles are completed each FY.

Concur

Target date for completion: Completed.

Response: At the time of inspection, the facility did not supply the necessary documents demonstrating completion of the Preventive Ethics cycles in FY12. These had been completed and uploaded to the VISN and Facility Integrated Ethics Share-Point site on September 10th, 2012. A copy of the October 2012 Integrated Ethics Council minutes with PE storyboards for FY12 which support the completion of the two preventative ethics cycles were forwarded to the OIG following the CAP. Two Preventive Ethics improvement cycles were also completed in FY11. The minutes of the July 2011 Integrated Ethics Council meeting noting completion of the FY11 preventive ethics cycles and copies of these storyboards were also forwarded to the OIG.

Recommendation 2. We recommended that processes be strengthened to ensure that the EHR committee provides consistent oversight and coordination of EHR quality reviews and that quality reviews are completed, analyzed, and trended for all services, including long-term care.

Concur

Target date for completion: December 31, 2012.

Response: The Medical Records Committee currently provides oversight and coordination to a number of quality reviews. These include but are not limited to reports related to "copy and paste" in the medical record, timeliness of history and physical exams, unsigned orders and progress notes and coding accuracy. These reviews have now been expanded to include long term care as appropriate. The Medical Records Chairperson and Health Information Manager will meet with clinical service line managers to determine which quality reviews are currently being completed at the service line level and to ensure that mechanisms are in place for results of these reviews to be analyzed, trended and reported.

Recommendation 3. We recommended that a rehabilitation nurse be available for the polytrauma program.

Concur

Target date for completion: December 31, 2012

Response: The recruitment of a rehabilitation nurse will be addressed at the November 13, 2012 Resource Management Committee meeting. The responsibility of this position will include nursing support for the polytrauma program.

Recommendation 4. We recommended that processes be strengthened to ensure that all patients in opioid dependence treatment undergo urine drug screenings with the frequency required by local policy.

Concur

Target date for completion: December 31, 2012

Response: A multi-disciplinary and inter-departmental action team has been charged to explore the best options for UDS collection, including centralizing this function in the lab. Centralization of UDS collection will allow for closer monitoring of policy compliance, decreased waits and delays for patients (and therefore improved adherence to treatment mandates), and quite possibly improved patient privacy and confidentiality.

Recommendation 5. We recommended that that processes be strengthened to ensure that all discharged MH patients who are not on the high risk for suicide list receive follow-up within the specified timeframes and that compliance be monitored.

Concur

Target date for completion: December 31, 2012

Response: A tracking mechanism has been developed and is being utilized to monitor follow-up contacts with all discharged MH patients. This tracker will improve compliance and decrease the risk of missing patients to follow up due to cancelation of appointments and no shows. A standard operating procedure outlining the specific steps is also under development with a plan for completion by December 31, 2012.

Recommendation 6. We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up evaluations at the required intervals and that compliance be monitored.

Concur

Target date for completion: December 31, 2012

Response: A tracking mechanism has been developed and is being utilized to monitor compliance. Responsibility for monitoring of follow-up evaluations has been assigned to the Suicide Prevention Coordinator, who will also provide follow-up evaluations whenever necessary. Mental Health Service Line management is developing a Standard Operating Procedure that will delineate responsibility for scheduling and completion of follow-up evaluations with all discharged MH patients on the high risk for suicide list.

Recommendation 7. We recommended that processes be strengthened to ensure that employees who perform glucose POCT have their competency assessed at the required intervals.

Concur

Target date for completion: November 16, 2012

Response: A spreadsheet has been developed to facilitate the tracking of annual proficiency testing by the POCT Coordinator. This includes all POCT users, their work location, date of initial training, and the date when next annual proficiency testing is due. In addition to notifying the employee of the annual training requirement, processes have been strengthened to include the concurrent notification of the employee's supervisor. Supervisors have been notified that staff failure to complete annual training will result in deactivation of the employee access to point of care glucose testing. Access will not be restored until the employee completes re-training with the POCT Coordinator.

Recommendation 8. We recommended that processes be strengthened to ensure that staff complete and document the actions required in response to critical test results.

Concur

Target date for completion: November 16, 2012

Response: A progress note template was developed which requires documentation of the result, date, time and name of the provider notified (as per policy) and any actions taken in response to the critical finger stick glucose test results. The template was approved by the Forms Sub-Committee of the Medical Records Committee, and was initiated in CPRS on November 2nd, 2012. All staff are in the process of being notified of of the new template and instructions for completion. Formal monitoring of all critical fingerstick glucose results will begin December 1, 2012 to ensure that staff document actions required per policy.

Recommendation 9. We recommended that processes be strengthened to ensure that Clinical Engineering staff inspect, approve, and label glucose meters in accordance with local policy.

Concur

Target date for completion: November 30, 2012

Response: At a meeting on October 31st, 2012 with Logistics, Clinical Engineering, POCT Coordinator and Quality Management, processes were developed to ensure that Clinical Engineering staff inspect, approve and label glucose meters in accordance with local policy. This process includes existing meters, new meters, and meters returned from the vendor following repair. This process is currently being implemented for all meters located at the main campus of the facility. Arrangements are being made for inspecting and labeling meters at the Community Based Outpatient Clinics.

OIG Contact and Staff Acknowledgments

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