Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03077-122

Combined Assessment Program Review of the Hampton VA Medical Center Hampton, Virginia

March 4, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Hampton VA Medical Center
FY	fiscal year
HF	heart failure
MH	mental health
OIG	Office of Inspector General
POCT	point-of-care testing
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 Hampton VA Medical Center, Hampton, VA

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 24, 2012.

Review Results: The review covered 10 activities. We made no recommendations in the following 6 activities:

- Coordination of Care
- Environment of Care
- Medication Management
- Moderate Sedation
- Point-of-Care Testing
- Quality Management

The facility's reported accomplishment was a peer-led mental health program.

Recommendations: We made recommendations in the following four activities:

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

Colorectal Cancer Screening: Ensure patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe.

Polytrauma: Require that all patients with positive traumatic brain injury screening results receive a comprehensive evaluation as outlined in Veterans Health Administration policy. Ensure interdisciplinary teams develop treatment plans for all polytrauma outpatients who need interdisciplinary care. Maintain minimum staffing levels.

Nurse Staffing: Require the annual staffing plan reassessment process to ensure that all required staff are facility expert panel members.

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:

- Coordination of Care
- 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 September 27, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Hampton VA Medical Center, Hampton, Virginia,* Report No. 11-02718-50 January 11, 2012).

During this review, we presented crime awareness briefings for 275 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 268 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 X Peer-Led MH Program

The facility won a VHA Innovation Award in 2012 for their Veteran X Peer-Led MH Program. Veterans undergoing MH treatment at the facility are offered the opportunity to participate in the peer-led program. **"**Veteran X" is a fictitious veteran who has an abundance of social issues that may include drug abuse, homelessness, poor health, family issues, and economic hardships. The peer-led group identifies "Veteran X's" issues and treatment goals and information on programs and resources available to meet those goals. Group treatment discussions allow safe and objective discussions of "Veteran X's" issues, which often mirror the veterans' own recovery challenges. Veterans participating in the group experience a greater sense of involvement and empowerment in their recovery and the accomplishment of their goals.

Results
Review Activities With Recommendations

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 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.[1] Five 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, six 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.[2] Four of the 10 patients who were on the high risk for suicide list did not receive MH follow-up at the required intervals. Three patients did not receive weekly evaluations during the month following discharge, and another patient did not receive weekly evaluations during days 15–30 from discharge.

[1] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
[2] 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.

Recommendation

1. 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.

2. 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 at least weekly during the first 30 days after discharge and that compliance be monitored.

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 area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
	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.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[3] Ten of the 17 patients who received diagnostic testing did not receive that testing within the required timeframe.

Recommendation

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

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

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 TBI results, 10 EHRs of patients receiving TBI outpatient services, and 6 training records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
X	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.
X	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.

Comprehensive Evaluation. VHA requires that patients with positive TBI screening results at a Level IV site be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[4] A higher level Polytrauma System of Care site must complete the comprehensive evaluation or a Level IV site can develop and submit an alternate plan for review by the VISN and the national Director of Physical Medicine and Rehabilitation for approval of alternate arrangements outside of the directive.

We found that 6 of 10 patients who screened positive for TBI received the comprehensive evaluation at the facility and were not referred to a higher level Polytrauma System of Care site. Additionally, the facility did not have an alternate plan approved by the VISN and the national Director of Physical Medicine and Rehabilitation.

[4] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans,* March 8, 2010.

Outpatient Treatment Planning. VHA requires that polytrauma outpatients who need interdisciplinary care have a specific interdisciplinary treatment plan developed.[5] Eight of the 10 outpatient EHRs did not have treatment plans.

Staffing. VHA requires that minimum polytrauma staffing levels be maintained.[6] The facility did not meet the minimum staffing requirement for a rehabilitation physician, rehabilitation nurse, and physical therapist.

Recommendations

4. We recommended that processes be strengthened to ensure that all patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

5. We recommended that processes be strengthened to ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients who need interdisciplinary care.

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

[5] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[6] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

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 24 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (4E) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
X	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.

Facility Expert Panel Composition. VHA requires that expert panels are comprised of staff knowledgeable about the facility and able to make staffing judgments.[7] The facility's expert panel did not include staff nurses or other nursing staff providing direct patient care.

7. We recommended that the annual staffing plan reassessment process ensure that all required staff are facility expert panel members.

[7] VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

Review Activities Without Recommendations

Coordination of Care

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 22 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's Substance Abuse and Post-Traumatic Stress Disorder RRTPs were in compliance with selected MH RRTP requirements.

We inspected the community living center; the SCI, medical, surgical, inpatient MH, Substance Abuse and Post-Traumatic Stress Disorder RRTP, and intensive care units; the emergency department; and the dialysis, dental, and primary care outpatient 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 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.

Noncompliant	Areas Reviewed for MH RRTP (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.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[8] 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.

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

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, 7 EHRs, and 52 training/competency records, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

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

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

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

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.
	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.
	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
	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.

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 21–28, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[9]		
Type of Organization	Clinical referral medical facility	
Complexity Level	2	
VISN	6	
Community Based Outpatient Clinics	Virginia Beach, VA Albemarle Primary Outpatient Clinic, Elizabeth City, NC	
Veteran Population in Catchment Area	238,476	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	461	
• **Community Living Center/Nursing Home Care Unit**	122	
• **Other**	339	
Medical School Affiliation(s)	Eastern Virginia Medical School	
• **Number of Residents**	47.5	
	Current FY (through June 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$250.5	$250
• **Medical Care Expenditures**	$181	$180
Total Medical Care Full-Time Employee Equivalents	1,603.1	1,596.9
Workload:		
• **Number of Station Level Unique Patients**	37,188	40,291
• **Inpatient Days of Care:**		
o **Acute Care**	21,670	32,462
o **Community Living Center/Nursing Home Care Unit**	19,599	29,118
Hospital Discharges	2,263	2,223
Total Average Daily Census (including all bed types)	306	331
Cumulative Occupancy Rate (in percent)	66.8	83.9
Outpatient Visits	333,069	437,640

[9] All data provided by facility management.

VHA Satisfaction Surveys

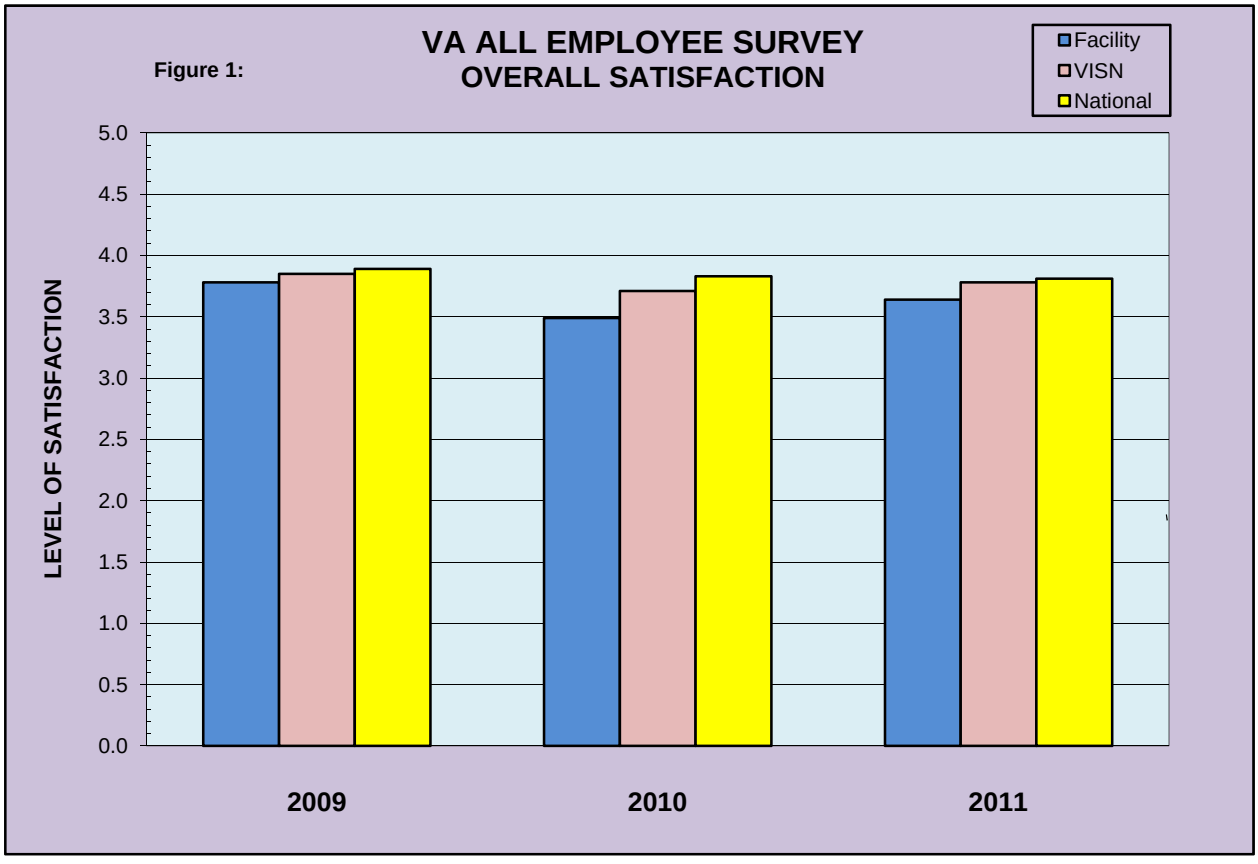
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

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	57.1	53.4	41.4	38.2	46.9	43.8
VISN	62.5	59.5	51.8	48.8	49.7	49.7
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.[10] 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.[11]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	**	11.0	11.5	**	24.8	18.1
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

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

[10] 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. 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.

[11] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 9, 2013

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **CAP Review of the Hampton VA Medical Center, Hampton, VA**

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

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

1. The Mid-Atlantic Health Care Network submits the following responses to recommendations on the Draft report resulting from the Office of Inspector General visit to the Hampton VA Medical Center dated December 10, 2012. We concur with the findings and have initiated processes to prevent any future occurrences.

2. Thank you for providing me the opportunity to review the document and respond.

3. If you have any questions and/or concerns, please feel free to contact Lisa Shear, VISN 6, QMO at 919-956-5541.

(original signed by:)
DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 9, 2013

From: Director, Hampton VA Medical Center (590/00)

Subject: **CAP Review of the Hampton VA Medical Center, Hampton, VA**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. I have reviewed the draft report and concur with the recommendations. The findings outlined in the OIG report reflect a thorough evaluation.

2. We have implemented processes to ensure that variations in the processes are resolved.

(original signed by:)
MICHAEL H. DUNFEE, MHA

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 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: **February 28, 2013**

Facility Response: The following actions are currently in place for following up with all veterans identified as Non High Risk post discharge from the inpatient Mental Health unit. Under new T-21 guidance, effective for fiscal year 2013, immediately prior to discharge from an inpatient Mental Health unit, all Non High Risk veterans are required to be scheduled to attend a face to face appointment or to be contacted telephonically or via Telemental Health Services within seven (7) days of their discharge from the inpatient mental health unit. A Social Worker contacts the veteran one to two days post discharge to remind them of their upcoming scheduled follow-up appointment.

Any veteran that is a no-show for a scheduled appointment receives a follow up phone call within twenty-four (24) hours of the no show appointment. If contact is successful, the veteran is assessed for current risk and encouraged to report to the next group and/or is offered a rescheduled appointment. If the veteran is unable to be reached on the first phone call, two additional attempts to contact the veteran are initiated and the status of ability to contact the veteran is documented in the medical record. The provider enters a historical "No Show" note in the veteran's medical record.

At the time of our survey, our compliance rate for ensuring that all veterans discharged from inpatient mental health receive a follow up within seven days of their discharge was 40%. As of September 2012, our compliance rate has increased to 93%. Actions put in place to maintain our current compliance include:

- All patients are contacted telephonically by a Social Worker one to two days post discharge to remind them of their upcoming appointment
- Any patient that is a no show for their appointment will be contacted telephonically and rescheduled within seven days post discharge in a follow up group; these actions along with attempts to contact the patient are documented in a progress note in the medical record

A Mental Health spreadsheet has been developed to track the compliance with follow up appointments of all veterans discharged from inpatient mental health and who are non high risk for suicide. Starting with the month of November 2012, monthly medical

record reviews are being performed and are being reported to the Mental Health Executive Council for leadership oversight.

Recommendation 2. 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 at least weekly during the first 30 days after discharge and that compliance be monitored.

Concur

Target date for completion: **February 28, 2013**

Facility Response: Category II High Risk Suicide Flags are utilized as a means of enhancing patient safety and ensuring that providers can incorporate the patient's risk status into their treatment decisions. As of September 30, 2012, there were 21 veterans flagged with Category II High Risk Suicide Flags. The following actions are currently in place for following up with all veterans with a Category II High Risk Suicide Flags post discharge from the inpatient Mental Health unit. Immediately prior to discharge from an inpatient Mental Health unit, all patients with a newly placed Cat II High Risk for Suicide are scheduled for four (4) weekly appointments. All patients are also scheduled to attend a weekly Tuesday morning Risk Management Group, unless contraindicated by their primary Mental Health treatment provider.

Any veteran that is a no-show for a scheduled appointment receives a follow up phone call the same business day of the scheduled appointment; if contact is successful, the veteran is assessed for current risk and encouraged to report to the next group and/or is offered a rescheduled appointment. If the veteran is unable to be reached on the first phone call, two additional attempts to contact the veteran are initiated and the status of ability to contact the veteran is documented in the medical record. The provider enters a historical "No Show" note in the veteran's medical record. If a veteran is not able to be reached by phone, a call will be made to the listed emergency contact to try to validate the veteran's safety. If the emergency contact is unable to be reached and there is reason to believe the veteran is not safe, a police wellbeing check is requested either by the Suicide Prevention Coordinator or their primary Mental Health provider to validate their safety. If a veteran is able to be contacted and is deemed to be safe, a post card and or a letter is sent to them encouraging them to make contact the Mental Health clinic to schedule a follow up appointment.

If the veteran lives in a rural area and has transportation difficulties which limit their access to onsite care, they can be offered the opportunity to be contacted telephonically by a mental health provider to reassess the veteran and update their Safety Plan, if indicated.

A Mental Health spreadsheet has been developed to track the compliance with follow up appointments of all veterans identified with a Category II High Risk Suicide Flag. Starting with the month of November 2012, monthly medical record reviews are being performed and are being reported to the Mental Health Executive Council for leadership oversight.

Recommendation 3. 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: **April 30, 2013**

Facility Response: Our processes to ensure all veterans with a positive FOBT are offered diagnostic testing within the sixty (60) day timeframe have been defined as follows:

- The Provider that ordered the Fecal Occult Blood Test (FOBT) screening submits an endoscopy consult to Surgical Services for a positive FOBT result no later than fourteen (14) calendar days from the date of the positive test result.
- All submitted endoscopy consults are reviewed by the Surgery Physician Assistant (PA) to identify those veterans with a positive FOBT with a diagnostic colonoscopy indicated.
- The Surgery PA assigns the veteran to the Hampton PA Surgery Clinic. The scheduler in the surgery clinic contacts the veteran and schedules an appointment for the veteran with the Surgery PA.
- At the time of the appointment, the Surgery PA schedules the veteran for a colonoscopy in the first available appointment to meet the mandated timeline for performing the diagnostic test within 60 calendar days of the positive FOBT. If the veteran's desire is to have the colonoscopy scheduled more that 60 calendar days after the positive screening, this is documented by the provider in the veteran's medical record and the colonoscopy is scheduled within fourteen (14) calendar days of the veteran's requested date.
- A new Colorectal Cancer (CRC) Standard Operating Procedure (SOP) has been developed to accurately reflect our current processes as described above.
- Our CRC tracking spreadsheet has been revised to include all the tracking requirements and specified timelines for completing each as defined in our SOP.

We were not consistently meeting the requirement for offering all patients with a positive Fecal Occult Blood Test (FOBT) diagnostic testing; a colonoscopy within the 60-day time frame. We have reviewed and modified the notification and scheduling processes of our Colorectal Cancer (CRC) program. In addition, we have a Colorectal Surgeon and a Gastroenterologist during 2012. To ensure our veterans are receiving diagnostic testing for positive FOBTs within the required timeframe, consults for positive FOBT are currently being funneled to the new Gastroenterologist via the GI consult route.

The current Colorectal Cancer (CRC) tracking spreadsheet has been revised to include tracking of all the required CRC program elements and the timelines for their completion. Updating and maintaining the CRC spreadsheet assigned as a collaborative responsibility to Primary Care and Surgery Services. The spreadsheet is located on our facility shared internet T drive to facilitate easy accessibility by both clinics. Monthly audits are being performed to validate compliance with the sixty calendar day timeline for performing indicated diagnostic testing for positive FOBT

screening. Results of the monthly audits are reported quarterly to the Operating Room/Invasive Procedure Committee and the Clinical Champions Working Group for leadership oversight.

Recommendation 4. We recommended that processes be strengthened to ensure that all patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Concur

Target date for completion: **April 30, 2013**

Facility Response: Appointments for a second level Traumatic Brain Injury (TBI) evaluation are currently being scheduled within the required thirty (30) days of a positive first level screening.

A Nurse Practitioner that has completed the required TBI training modules via the Talent Management System (TMS) for Polytrauma staff is currently assigned to complete and document the second level assessments. As of October 1, 2012, a Physiatrist from Rehabilitation Medicine Service has been temporarily assigned to the Polytrauma Support Clinic Team (PSCT) for oversight of the program, to co-sign the second level assessments performed by the Nurse Practitioner and to provide consultation to the PSCT.

Compliance is monitored monthly to validate that second level assessments are being completed within the required thirty days from the date of a positive screening. The first chart audits will be performed during the month of December 2012. The results of each monthly audit are reported to the Mental Health Executive Council for leadership oversight.

Recommendation 5. We recommended that processes be strengthened to ensure that interdisciplinary teams develop treatment plans for all polytrauma outpatients who need interdisciplinary care.

Concur

Target date for completion: **April 30, 2013**

Facility Response: For the veterans that meet the Veteran Health Administrations (VHA) Individualized Rehabilitation and Community Reintegration (IRCR) Care Plan criteria, the National IRCR Care Plan template is completed. For the veterans that do not meet the criteria to require the utilization of the Veteran Health Administrations (VHA) Rehabilitation and Community Reintegration Care Plan National Template, our facility has developed a Polytrauma/Interdisciplinary Team (IDT) Note and Treatment Plan template. The template includes the following elements:

- Brief history
- Current medical problems, conditions and medications
- Whether the veteran is to be referred to a Primary Care Physician

- Comprehensive assessments by a Physiatrist, Psychologist, Nurse Practitioner/Case Manager, Occupational Therapist, Social Work/Case Manager, Physical Therapist and Speech-Language Pathologist
- Interdisciplinary Team Discussion and Review
- Interdisciplinary Team Goals that are measurable and obtainable for improving the physical, cognitive and vocational function of the veteran to maximize their independence and reintegration into the community
- Veteran and family education and/or skills to maximize independence
- Vocational Rehabilitation
- The date to review/evaluate the veterans plan of care

The Polytrauma/Interdisciplinary Team (IDT) Note and Treatment Plan template is completed by the IDT within thirty (30) days of a veteran's referral for a positive screening. Treatment plan updates are completed and documented at least every six months or more often if clinically indicated. All Interdisciplinary Team (IDT) Members actively contribute their specialized expertise by participating in goal setting, treatment planning, and development and approval of the interdisciplinary treatment plan. Compliance for completion of individual goals and treatment plans within the 30 day required timeframe is monitored on a monthly basis utilizing a tracking spreadsheet and medical record audits. The first medical record audits will be performed for the month of December 2012. The results of each monthly audit are reported to the Mental Health Executive Council for leadership oversight.

Recommendation 6. We recommended that minimum polytrauma staffing levels be maintained.

Concur

Target date for completion: **June 30, 2013**

Facility Response: At the time of the survey, our Polytrauma Support Clinic Team (PSCT) consisted of the following staffing; a nurse practitioner, social worker, clinical psychologist, neuropsychologist, speech-language pathologist, and an occupational therapist. A .5 Physiatrist and a .5 Physical Therapist position had not been assigned to the PSCT. Effective October 1, 2012, a Physiatrist from Rehabilitation Medicine Service has been detailed to the PSCT for oversight of the Traumatic BrainInjury evaluations by the Nurse Practioner and for performing consultations. We are actively recruiting for the .5 Physiatrist position, which is a difficult to fill position. As of October 15, 2012, two contract Physical Therapists have been hired and are currently providing services to the veterans enrolled to the PSCT.

In order to address any potential future needs for interventions by a Rehabilitation Nurse, as of February 1, 2013, the Hampton Polytrauma Team is actively beginning the process for the hiring of a .5 Rehabilitation Nurse. The projected timeline to have the Rehabilitation Nurse in place is May 2013.

Recommendation 7. We recommended that the annual staffing plan reassessment process ensure that all required staff are facility expert panel members.

Concur

Target date for completion: **February 28, 2013**

Facility Response: As of November 7, 2012, the Nursing Service Facility Based Expert Panel membership has been revised to include unit nursing staff, unit Nurse Managers, a Nursing Officer of the Day (NOD) representative, Associate Chiefs for Nursing Services (ACNS) and a Nursing Services representative that functions as a liaison with the Fiscal department for long range staffing planning and budget projections. Each nursing staff representative assigned to the facility Expert Panel was selected based on their in-depth knowledge of evidence based factors impacting nurse staffing needs at the point of care and to identify individualized staffing needs within specific clinical settings. These members collectively function in an advisory capacity to the Associate Director for Patient Care Services (ADPCS) by making recommendations regarding safe and effective nurse staffing levels at various points of care and overseeing the outcome analysis and modifications to staffing recommendations. The ADPCS reviews and evaluates the nursing staffing plan at least annually for executive leadership oversight.

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