Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-01445-400

Healthcare Inspection

Alleged Short-Stay Rehabilitation Unit Concerns Tuscaloosa VA Medical Center Tuscaloosa, Alabama

July 7, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to an anonymous complaint concerning the Short-Stay Rehabilitation Unit (Valor Center) at the Tuscaloosa VA Medical Center (facility), Tuscaloosa, AL.

We substantiated that the Associate Chief of Staff for Geriatrics and Extended Care Services was the decision maker for admissions to the Valor Center but determined this is not against Veterans Health Administration policy. We did not substantiate that the facility did not have a screening process for prospective Valor Center patients or that patients were inappropriately admitted to the Valor Center; however, we determined that the Valor Center prospective patient screening practices at the time of our site review were not in compliance with the facility's Community Living Center and the Valor Center admission policies. Also, while not an allegation, we determined that pre-admission consults with the facility physiatrist were not documented in patients' electronic medical records.

We substantiated that a portion of the Associate Chief of Staff for Geriatrics and Extended Care Services' performance-based pay was connected to the Valor Center's average daily bed census; however, we determined this was not against Veterans Health Administration policy, and the performance pay incentive did not influence the Associate Chief of Staff's Valor Center admission decisions. We substantiated poor hand-off communication for newly admitted patients.

We did not substantiate that staff who point out potential wrongdoing are intimidated, transferred, harassed, or terminated.

We recommended that the Facility Director ensure that assessments for prospective Valor Center patients screened for admission by the facility physiatrist consultant are documented in the electronic health records, Valor Center screening and admission policies are consistent with Valor Center practices, and all relevant staff are notified of planned patient admissions to the Valor Center to allow staff sufficient time to make appropriate plans for required care and services.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 8–10, for the Directors' Comments.) We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by an anonymous complainant regarding the Short-Stay Rehabilitation Unit (Valor Center) at the Tuscaloosa VA Medical Center (facility), Tuscaloosa, AL.

Background

The facility, part of Veterans Integrated Service Network (VISN) 7, operates a 381-bed teaching hospital. It offers inpatient and outpatient services to a veteran population that includes 12 counties in Western Alabama. The facility provides primary care, mental health, geriatric, and rehabilitation services, including Domiciliary Care for Homeless Veterans and Psychosocial Residential Rehabilitation Treatment Programs, and a 104-bed Community Living Center (CLC). The CLC, part of the Geriatric and Extended Care (GEC) Service Line, includes the 16-bed Valor Center, which opened in 2008.

CLC programs and services assist patients to achieve their highest practicable level of well-being and function. Veterans Health Administration (VHA) Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers*, September 2, 2012, provides the policy and procedures for CLC admission. The handbook states that services offered in CLCs for short-stay (90 days or less) include short-stay rehabilitation, short-stay skilled nursing care, short-stay restorative care, short-stay continuing care, short-stay mental health recovery, short-stay dementia care, hospice, and palliative care. The handbook states that admissions to the CLC must be assessed by a CLC-based admission coordinator, team, or CLC leader with sufficient knowledge about the programs and services offered at the CLC.

Prior to October 2013, the facility's CLC offered patients short-stay rehabilitation services in the Valor Center. Due to low bed census (6.7 patients per day in October 2013) and a desire to improve the continuum of care, the Valor Center expanded its service specialties to include short-stay skilled nursing, short-stay restorative, hospice, and inpatient respite care. The Valor Center average daily census increased (13.2 patients per day in December 2014) after the additional services were included.

Examples of short-stay skilled nursing care include intravenous therapy,[1] care of stages three and four pressure ulcers, complex wound care, and tube feeding. Examples of short-stay restorative care include provision of short-term restorative interventions, such as bowel and bladder training and toileting, restorative dining, and ambulation. Hospice care includes end of life care.

[1] Intravenous therapy is the infusion of liquid substances directly into the vein.

Allegations: On October 28, 2014, the OIG Hotline Division received an anonymous complaint alleging clinical and administrative irregularities at the Valor Center. The complainant alleged that:

- The facility did not have a screening process for patients admitted to the Valor Center.
- Decisions to admit patients to the Valor Center were made by the Associate Chief of Staff for Geriatrics and Extended Care (ACOS-GEC), and patients were admitted inappropriately.
- There was poor hand-off communication when patients were admitted to the Valor Center.
- The ACOS-GEC had a conflict of interest because the ACOS-GEC's performance measures and bonus were associated with Valor Center census.
- Valor Center staff who point out potential wrongdoing were intimidated, transferred, harassed, or terminated.

Scope and Methodology

The period of our review was December 2014 through February 2015. We conducted a site visit from January 12–15, 2015, and interviewed the facility Director, Chief of Staff, ACOS-GEC, Associate Chief Nurse for GEC, Associate Chief Nurse for Medicine, Chief of Quality Management, the facility physiatrist, and other medical providers with knowledge about the processes. In addition, we interviewed the patient safety representative, admissions coordinator, program support assistant for GEC, the Valor Center Nurse Manager, Valor Center registered nurses, licensed practical nurses, nurse aides, social workers, a physical therapist, an occupational therapist, a dietician, and the Resident Assessment Instrument/Minimum Data Set Coordinator.

We reviewed VHA and local admission screening process policies, pay for performance standards, Valor Center length of stay data, Valor Center re-hospitalization rates for fiscal year (FY) 2014, Valor Center occupancy data, Valor Center staffing methodology, InterQual® Criteria[2] Admissions Screening, systems redesign reports, Joint Commission survey reports, and training records.

We also reviewed the electronic health records (EHR) of the patients specifically referred to us by the anonymous complainant and all patients who were admitted to the Valor Unit at the time of our onsite review.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[2] InterQual® Criteria provides a guide to evaluate a patient's severity of illness, comorbidities and complications, as well as the intensity of services being delivered to determine the clinical appropriateness and level of care of patient care services.

Inspection Results

Issue 1: Valor Center Admission Screening Process

We did not substantiate that the facility did not have a screening process for patients admitted to the Valor Center. However, the screening process at the time of our review was not consistent with the facility's local CLC and Valor Center admission policies.

At the time of our site visit, prospective Valor Center patient information was obtained by an admissions registered nurse and an admissions program support staff. Once all required information was available, the ACOS-GEC reviewed the material and determined whether or not the patient was appropriate for admission. During our EHR reviews, we noted a consistent process of documenting prospective patients' information for admission. For conditions that required moderate to extensive physical rehabilitation, we confirmed through interviews that the ACOS-GEC consulted with the facility physiatrist; however, the consultation process was informal and not documented in patients' EHRs.

Although the screening practice did not violate VHA policy, it did not reflect the facility's CLC and Valor Center policies. The facility's CLC screening policy, dated September 20, 2013, stated that the ACOS-GEC will be the approving official for all admissions; however, the policy also stated that the following staff have input into screening and coordination of patients for admission: Patient Flow Coordinator, Associate Chief Nurse for GEC, Unit Manager, and a CLC social worker. The facility's Valor Center policy, dated September 23, 2013, stated that the screening of referrals was to be done by a screening committee consisting of the unit manager, social worker, and a therapist.

Prior to December 2013, staff were involved in the prospective patient screening process consistent with the CLC and Valor Center policies discussed above. Sometime after November 2013, the ACOS-GEC assumed the screening role, and a process improvement workgroup designed a different workflow aimed at speeding the admission decision process by removing the screening committee portion of the workflow. During our site visit, staff voiced that there was better communication concerning the date, arrival time, and care needs of patients prior to admission when they were part of the admission screening team. Their participation in the admission screening process also provided staff with an opportunity to clarify any issues regarding care needs prior to a patient's arrival. Staff reported that at times patients presented for admission to the Valor Center, and staff were not aware of their planned admission. The staff interviewed believed the new process was a vulnerability but denied it had resulted in patient harm.

Issue 2: Valor Center Admissions

We substantiated that the ACOS-GEC decided who was admitted to the Valor Center; however, we did not substantiate the implied inappropriateness of the allegation.

Further, we did not substantiate that patients were admitted inappropriately to the Valor Center.

VHA Handbook 1142.02 states that admissions to the CLC must be assessed by a CLC-based admission coordinator, team, or CLC leader with sufficient knowledge about the programs and services offered at the CLC. We considered the ACOS-GEC to be a CLC leader with sufficient knowledge about the Valor Center programs and services.

We reviewed two groups of patients. The first group consisted of four Valor Center patients who were described to us by the complainant. We were able to review the EHRs of three of the patients (Patients A, B, and C). We did not have enough information to identify the fourth patient. Our review of the EHRs revealed that appropriate prescreening was done and that those patients entered the Valor Center with medical conditions that were consistent with services the unit could provide. All three patients had complex medical issues that were stable and amenable to rehabilitation.

Patients A and B had had recent strokes and were at moderate to severe levels of dysfunction. Both were readmitted to the hospital shortly after admission to the Valor Center. We note that the readmission rates of stroke patients are proportional to the severity of the stroke.[3] Patient C had acute gastrointestinal bleeding while in the Valor Center that required immediate hospital evaluation, but we determined the patient had no signs or symptoms of bleeding on admission.

The second group of patients we reviewed consisted of all 15 patients who were admitted to the Valor Center during our site visit. We reviewed this group's EHRs and determined that all required screening and rehabilitation assessment documents were entered in the EHR timely, and all the patients were appropriately screened prior to admission. We also reviewed the patients' clinical status, vital signs, laboratory values, and any applicable rehabilitation assessments that were completed by the transferring facility prior to the patient's acceptance. We determined all 15 patients had conditions that were appropriate for admission to the Valor Center.

During our site visit, a patient was transferred to another VA hospital for acute inpatient admission within 12 hours of arriving to the Valor Center due to anemia and hypotension. In review of the case, we interviewed the ACOS-GEC, who accepted the patient for admission, and reviewed the patient's preadmission and facility EHRs. We determined that information given to facility staff by the transferring hospital conveyed the patient was clinically stable with no indication of any issues that would have precluded the admission to Valor Center.

[3] Andersen HE, Schultz-Larsen K, Can Readmission After Stroke be Prevented? Results of a Randomized Clinical Study: a Post Discharge Follow-up Service For Stroke Survivors. *Stroke.* 2000 May;31(5):1038–45.

Issue 3: Hand-Off Communication

We substantiated that, prior to our site visit, there was poor hand-off communication for newly admitted patients. After the ACOS-GEC accepted a patient for admission to the Valor Center, an admission program support staff was tasked to send notice via a "group email" to Valor Center staff. The email notification was to ensure that medications were prepared, patient specific equipment was available, and specialized staff training could occur prior to the patient's arrival. However, for unknown reasons, several key staff were removed or dropped from the Valor Center staff group email. Prior to our site visit, facility leadership ensured the staff names were added to the planned admissions group email notice.

Issue 4: Conflict of Interest

We substantiated the allegation that one of the ACOS-GEC's pay for performance measures was directly connected to the average daily bed census in the Valor Center. However, we did not substantiate that the performance measure created a conflict of interest. We found no evidence that performance pay was factored into decisions to admit patients, and our review of 18 patients found that all of the patients admitted to the Valor Center were appropriate for admission.

Issue 5: Retaliation

We did not substantiate the allegation that staff who point out potential wrongdoing are intimidated, transferred, harassed, or terminated.

We interviewed current Valor Center staff and facility staff who transferred out of Valor Center within the past year. All staff who had transferred out of the Valor Center told us their transfers were voluntary and/or that they had requested the transfer. Of the 14 staff interviewed, 4 expressed concerns of retaliation. These allegations were general in nature such as staff had heard of retaliation within the VA system. Although two of the four staff told us they had personally experienced retaliation, we were unable to determine the details of their experiences because they declined to further elaborate. However, all staff interviewed stated they would not hesitate to voice their concerns to leadership if their concern involved patient safety.

Conclusions

The Valor Center underwent significant changes in 2013 when, due to low census and a desire to increase continuum of care services, facility leadership expanded its service specialties to include short-stay skilled nursing, short-stay restorative, hospice, and inpatient respite care. In addition, during that time, the Valor Center prospective patient screening and admission processes changed. As a result, the average daily census increased.

While the prospective patient screening process was not consistent with the existing facility policies, we did not substantiate that the facility did not have an admission screening process for patients admitted to the Valor Center. We substantiated that the

ACOS-GEC was the sole decision maker for admissions to the Valor Center, but determined this practice is not in violation of VHA policy. We also substantiated that there was poor hand-off communication for newly admitted patients.

We substantiated that the facility uses a performance-based pay system directly connected to the average daily bed census in the Valor Center; however, we found no evidence that performance pay was factored into decisions to admit patients. We determined the patients whose cases we reviewed met the criteria for admission to the Valor Center.

We did not substantiate the allegation that staff who point out potential wrongdoing are intimidated, transferred, harassed, or terminated. Although 4 of 14 staff expressed some concerns of retaliation, the concerns were either general in nature or the staff chose to not share specific information with us. However, all staff interviewed stated they would not hesitate to voice their concerns to leadership if their concern involved patient safety.

Recommendations

1. We recommended that the Facility Director ensure that the assessments for patients screened for admission by the facility physiatrist consultant are documented in the electronic health records.

2. We recommended that the Facility Director ensure Valor Center screening and admission policies are consistent with Valor Center practices.

3. We recommended that the Facility Director ensure that all relevant staff are notified of planned Valor Center admissions to allow staff sufficient time to make appropriate plans for required care and services.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: April 29, 2015

From: Director, VA Southeast Network (VISN 7)

Subj: Healthcare Inspection—Alleged Short-Stay Rehabilitation Unit Concerns Tuscaloosa VA Medical Center, Tuscaloosa, Alabama

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. In reference to Healthcare Inspection - Alleged Short-Stay Rehabilitation Unit Concerns, Tuscaloosa VA Medical Center, Tuscaloosa, Alabama, VISN 7 submits the attached documents.

2. I concur with the corrective actions taken by the Tuscaloosa VA Medical Center.

3. I appreciate the opportunity for this review as a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information, please contact John F. Merkle, Director, and Tuscaloosa VA Medical Center at (205) 554-2000 ext. 2201.

Thomas C. Smith III, FACHE

Attachment

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 28, 2015

From: Acting Director, Tuscaloosa VA Medical Center (679/00)

Subj: Healthcare Inspection—Alleged Short-Stay Rehabilitation Unit Concerns, Tuscaloosa VA Medical Center, Tuscaloosa, Alabama

To: Director, VA Southeast Network (10N7)

1. I concur with the recommendations presented in the Alleged Short-Stay Rehabilitation Unit Concerns, Tuscaloosa VA Medical Center, Tuscaloosa, Alabama.

2. Attached are the facility actions taken as a result of these findings.

3. Thank you for these opportunities for improvement. The OIG Team conducted the audit in a very professional, comprehensive, and impartial manner. The Tuscaloosa VAMC staff have already initiated corrective actions on all recommendations to enhance the quality of care and services provided to our Veterans.

4. If you have any additional questions or need for further information, please contact me at (205) 554-2000 ext. 2201.

(original signed by:)

John F. Merkle, FACHE
Director, Tuscaloosa VA Medical Center (679/00)

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 the Facility Director ensure that the assessments for patients screened for admission by the facility physiatrist consultant are documented in the electronic health records.

Concur

Target date for completion: Done 04/17/2015

Facility response: The physiatrist consultant was instructed to document patient screening information for Valor admissions in the electronic health records on April 17, 2015. Instructions were provided via phone contact and email.

Recommendation 2. We recommended that the Facility Director ensure Valor Center screening and admission policies are consistent with Valor Center practices.

Concur

Target date for completion: 06/01/2015

Facility response: The facility will rescind center memorandum GEC-19, Admission, Transfer and Discharge of Patients in the Valor Center for Rehabilitation Program Unit and revise center memorandum GEC-11, Community Living Center (CLC) Admission Process to reflect current practice. Education will be provided regarding policy changes as evidence by signature.

Recommendation 3. We recommended that the Facility Director ensure that all relevant staff are notified of planned Valor Center admissions to allow staff sufficient time to make appropriate plans for required care and services.

Concur

Target date for completion: 4/17/2015

Facility response: Names of missing staff were added to the planned admissions group email notice prior to 01/ 2015 OIG inspection. Additionally, the Admission Coordinator now contacts the Valor Center charge nurse via phone to enhance the communication process.

Appendix C

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Laura Snow, LCSW, MHCL, Team Leader Stephanie Hensel, RN, JD Sherrian Pater, RN Thomas Wong, DO

Appendix D

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