Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03076-161

Combined Assessment Program Review of the James H. Quillen VA Medical Center Mountain Home, Tennessee

July 10, 2009

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 fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of April 13–17, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the James H. Quillen VA Medical Center (the medical center), Mountain Home, TN. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 120 employees. The medical center is part of Veterans Integrated Service Network (VISN) 9.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strength:

- Discharge Coordination and Time-Out Process.

We made recommendations in three of the activities reviewed. For these activities, the medical center needed to assure that:

- Emergency department (ED) space ensures patient privacy, confidentiality, and safety.
- Medical record reviews are conducted in accordance with Veterans Health Administration (VHA) policy.
- All patients at high risk for suicide have documented safety plans.
- The Knoxville community based outpatient clinic (CBOC) is staffed with a full-time Suicide Prevention Coordinator (SPC).

The medical center complied with selected standards in the following four activities:

- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Victoria Coates, Director, Atlanta Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–15, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Introduction

Profile

Organization. The medical center is a tertiary care facility located in Mountain Home, TN, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five CBOCs located in Bristol and Norton, VA, as well as in Morristown, Rogersville, and Knoxville, TN. The medical center is part of VISN 9 and serves a veteran population of about 47,789 throughout northeast Tennessee, southwest Virginia, western North Carolina, and southeast Kentucky.

Programs. The medical center provides medical, surgical, mental health, geriatric, rehabilitation, domiciliary, and community living center (CLC)[1] services. It has 114 acute inpatient hospital beds, 295 domiciliary beds, and 120 CLC beds.

Affiliations and Research. The medical center is affiliated with East Tennessee State University's James H. Quillen College of Medicine and provides training for 89 medical residents and for students in allied health disciplines, such as audiology, laboratory technology, nursing, pharmacy, physician assistant, and radiology. In fiscal year (FY) 2008, the medical center research program had 65 projects and a budget of $1.4 million. Important areas of research included audiology, cardiology, and oncology.

Resources. In FY 2008, medical care expenditures totaled approximately $256 million. The FY 2009 medical care budget is about $233 million. FY 2008 staffing was 1,674 full-time employee equivalents (FTE), including 109 physician and 286 nursing FTE.

Workload. In FY 2008, the medical center treated 47,789 unique patients and provided 30,260 inpatient days in the hospital and 35,739 inpatient days in the CLC. The inpatient workload totaled 5,661 discharges, and the average daily inpatient census was 83. The CLC had an average daily census of 98. Outpatient workload totaled 513,061 visits.

[1] A CLC (formerly called a nursing home care unit) provides a safe and homelike environment to eligible veterans who require a nursing home level of care.

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 fraud and integrity awareness training 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 work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- QM Program.
- SHEP.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and FY 2009 through April 17, 2009, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the James H. Quillen VA Medical Center, Mountain Home, Tennessee,* Report No. 06-02301-210, September 13, 2006). The medical

center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 120 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.

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. Activities in the "Review Activities Without Recommendations" section have no findings requiring corrective actions.

Organizational Strength

Discharge Coordination and Time-Out Process

The medical center received a 2008 Robert W. Carey Performance Excellence Award for achievements in overall organizational performance. Notwithstanding this recognition, the medical center continued to make performance improvement progress through the implementation of a discharge coordination time-out planning process. Early and comprehensive discharge planning and follow-up help ensure a smooth transition for patients from inpatient care to the post-discharge care setting.

The process was launched when nurse discharge planners—called Team Nurses—were hired to improve discharge planning and follow-up. Team Nurses collaborate with the medical team, the patient, and the family to identify and complete the tasks needed to ensure a smooth transition to the post-discharge care setting. A Team Nurse coordinates discharge activities, provides education, and follows up with a post-discharge telephone call to evaluate patient needs and satisfaction.

The next significant step in the discharge planning process occurred when the medical center initiated a discharge time-out process. The concept was modeled after the pre-operative time-out process, which requires confirmation of the correct patient and surgical procedure prior to surgery. The discharge time-out process requires that attending physicians review and verify that discharge notes and orders are accurate and include the correct discharge diagnosis,

follow-up appointments, home care needs, and reconciled[2] medications. The patient cannot be discharged until this review is completed. If needed, a second medication review is completed by a clinical pharmacist to identify duplications, omissions, required prescriptions, medication contraindications, and post-hospital monitoring for high-risk medications.

These processes have contributed to improved inpatient satisfaction scores (from 76 percent in FY 2008 to 86.7 percent in the 1st quarter of FY 2009) and decreased 30-day readmission rates (from 21.9 percent in February 2008 to 18.7 percent in February 2009).

Results

Review Activities With Recommendations

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of the ED, such as clinical services, consultations, inter-facility transfers, staffing, and staff competencies. We interviewed ED physicians, the ED program manager, the transfer coordinator, and other staff. We reviewed policies and other pertinent documents, including competency files and credentialing and privileging (C&P) folders. We also reviewed selected medical records of patients who had mental health (MH) consultations, who were admitted to the medical center, or who were transferred from the ED to other medical facilities.

The ED is located in the main hospital building at the medical center and operates 24 hours per day, 7 days per week, as required for an ED. Emergency services provided are within the medical center's patient care capabilities.

We found some non-compliance with the completion of ED provider C&P forms; however, C&P staff provided acceptable plans for improvement. We found documentation to be appropriate for five patients admitted to the medical center and three MH patients discharged from the ED.

We reviewed the medical records of three patients transferred from the ED during January and February 2009 and found that two did not include all the documentation

[2] Reconciliation compares medications that are prescribed and needed with those taken by a patient in the past. The comparison helps to avoid mistakes and interactions.

required by VHA policy.[3] The medical center had implemented new policies, documentation tools, and a patient transfer monitoring process. We reviewed data provided by the transfer coordinator and found documentation to be in compliance for patients transferred after implementation of these changes. Therefore, we made no recommendation for this finding.

We conducted a tour and found that the area was clean and secure and that equipment was appropriately maintained. However, we identified the following area that needed improvement.

EOC. We found that the number of patients present in the ED exceeded the seven-bed capacity on a regular basis. When capacity was exceeded, patient privacy was not adequate, and confidentiality was not maintained. The Joint Commission (JC) requires that medical centers appropriately manage the environment by providing adequate space to minimize hazards and risks while maintaining patient privacy and confidentiality. Although we found that staff triaged and treated patients without incident even when exceeding capacity, conditions exist that could place patients at risk.

The medical center had taken steps to improve patient flow and streamline discharge processes. In addition, the medical center recently submitted a long-term proposal to expand the ED to provide additional space for the volume of patients treated. However, this will take more than a year to accomplish.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director implements an interim plan, pending completion of construction, to provide adequate ED space to ensure patient privacy, confidentiality, and safety.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center implemented interim measures to manage ED patient flow, including diverting patients when necessary. Additionally, the ED will be expanded to increase bed capacity and workspace. The expansion project is expected to be completed by February 2010. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[3] VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.

Quality Management Program

The purposes of this review were to determine whether: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported QM efforts and appropriately responded to QM results; and (c) the medical center was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. To evaluate QM processes, we interviewed senior managers and reviewed the self-assessment completed by QM staff regarding compliance with QM requirements.

The QM program was in compliance with standards in the following areas: (a) mortality review and analysis; (b) peer review; (c) patient complaints; (d) adverse event disclosure; (e) patient safety related to the use of anticoagulation therapy; (f) medication reconciliation; (g) root cause analysis; (h) utilization management; (i) moderate sedation outcome monitoring; (j) resuscitation and outcomes; and (k) system redesign/patient flow. However, we identified the following area that needed improvement.

Medical Record Reviews. We found that service-level personnel did not conduct medical record reviews regularly at the point of care. In addition, the Medical Records Committee did not receive consistent, regular data from clinical services. VHA policy[4] requires ongoing medical record reviews by staff who document in the record to assess quality, consistency, accuracy, completeness, and authentication.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that medical record reviews be conducted in accordance with VHA policy.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center has developed tracking tools to monitor the completion of point-of-care and medical record reviews. These reviews have been added to the Documentation and Standards Committee agenda as monthly recurring report items. Findings, actions, and recommendations will also be reviewed and/or addressed by the Quality Executive Board. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Suicide Prevention Program

The purpose of this review was to determine whether the medical center had implemented a suicide prevention program that was in compliance with VHA regulations. We assessed whether senior managers had appointed an SPC at the medical center and at the very large Knoxville CBOC. [5] Also, we evaluated whether the SPCs fulfilled all required functions. In addition, we verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags (PRFs),[6] documented safety plans that addressed suicidality,[7] and evidence of collaboration between MH providers and SPCs.

We interviewed the medical center SPC and reviewed pertinent policies. Also, we reviewed the medical records of seven medical center patients and three CBOC patients determined to be at risk for suicide. We found that the suicide prevention program was generally effective. However, we identified the following areas that needed improvement.

Safety Plan Documentation. VHA regulations[8] require that all medical records of patients at high risk for suicide contain a documented safety plan. We reviewed the medical records of 10 patients deemed at high risk for suicide and found that 9 (90 percent) of the records did not contain documented safety plans.

Knoxville CBOC SPC. VHA regulations also require that very large CBOCs designate a full-time SPC committed to suicide prevention activities. At the time of our visit, the Knoxville CBOC did not have a full-time SPC. Managers told us that they had recently hired a suicide prevention case manager who provided CBOC coverage in conjunction with the medical center SPC. They told us that they would designate one of these individuals as the Knoxville SPC until a full-time SPC is hired.

[5] Very large CBOCs are defined as clinics with more than 10,000 unique patients enrolled. The Knoxville CBOC serves more than 11,100 unique veterans and requires a separate SPC.
[6] A Category II PRF is an alert mechanism that is displayed prominently in medical records.
[7] A safety plan provides a predetermined list of potential coping strategies as well as a list of individuals or agencies that a patient can contact for help when dealing with suicidal issues and crises.
[8] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires documented safety plans for all patients at high risk for suicide.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center is implementing a process to ensure that patients identified as high risk for suicide have documented safety plans and scheduled MH follow-up. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director assigns a full-time SPC to the Knoxville CBOC.

The VISN and Medical Center Directors agreed with the finding and recommendation. The medical center has assigned an interim full-time SPC to the Knoxville CBOC and expects to have a permanent SPC in place by the end of July 2009. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed a total of 36 randomly selected inpatient medical records for the 2nd quarter of FY 2009. We found timely responses for all 12 of the inpatient consultations we reviewed, and in all cases, nursing assessments had been completed within the required timeframes. For all 12 patients who transferred between units, we found consistent and timely patient assessments by receiving unit nursing staff. Also, for the 12 discharged patients, we found that all the medical records contained documentation that patients received and understood written discharge instructions. We made no recommendations.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and JC standards.

We inspected the medical/surgical, locked MH, specialty care, progressive care, intensive care, and CLC units. The medical center maintained a generally clean and safe environment. We found that infection control staff monitored exposures and reported data to clinicians for implementation of quality improvements. Safety guidelines were met, and risk assessments were in compliance with VHA and other standards. Managers on the locked MH unit complied with safety regulations, and staff were trained to identify environmental hazards. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether the medical center had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes on the medical/surgical, intensive care, locked MH, CLC, and domiciliary units. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers to identify patients prior to medication administration. We found that reconciliation of controlled substances discrepancies at the unit level was adequate. We also found that documentation of PRN (as needed) pain medication effectiveness was generally in compliance with local policy. We made no recommendations.

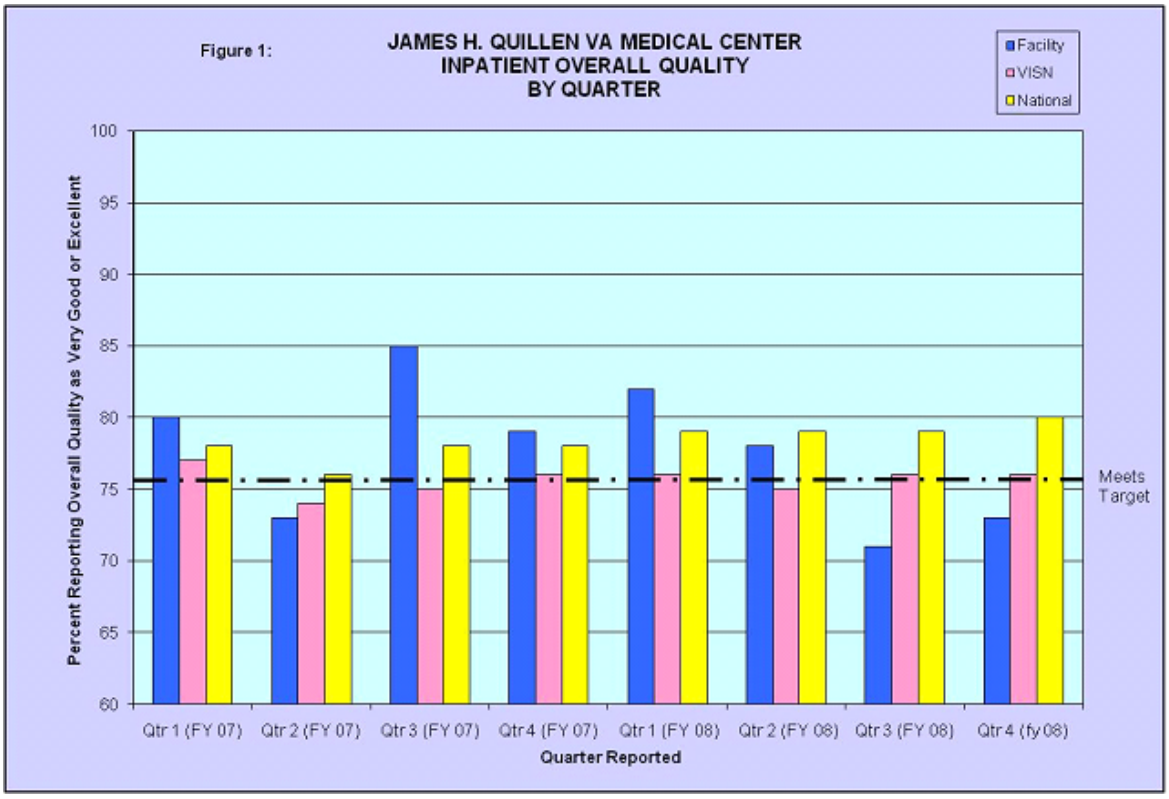
Survey of Healthcare Experiences of Patients

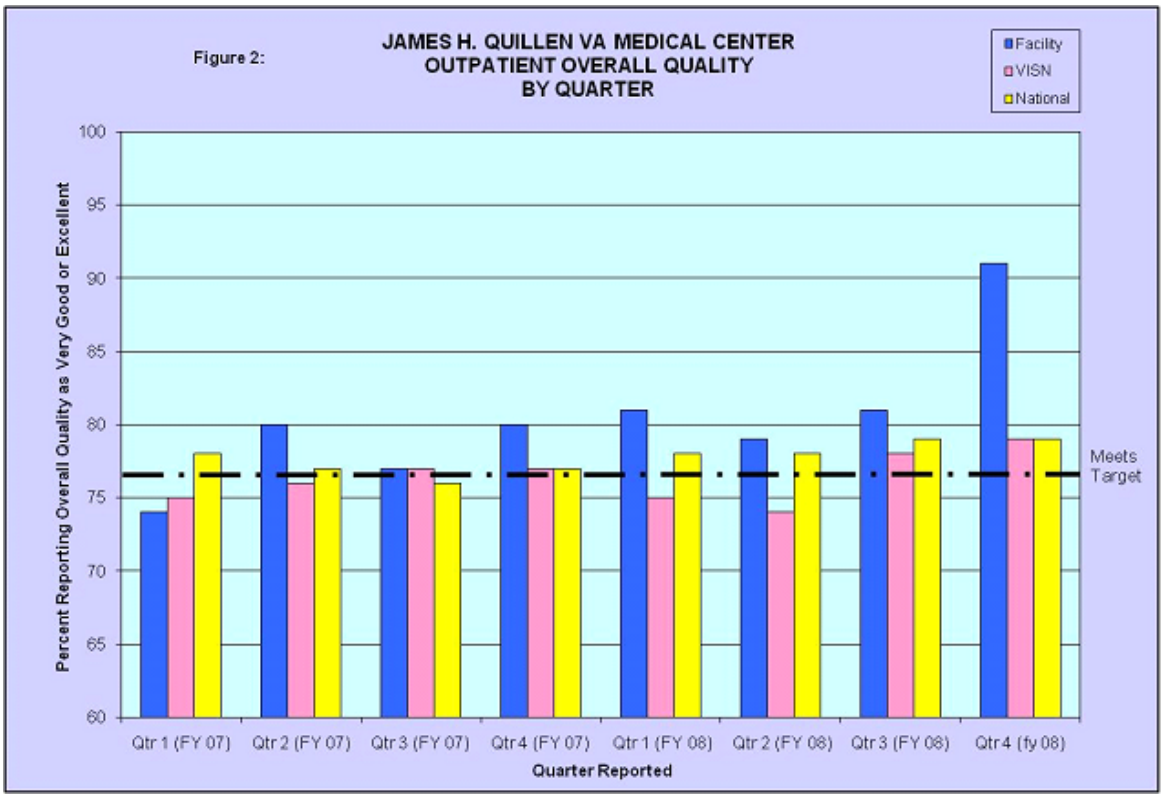
The purpose of this review was to assess the extent that the medical center used SHEP data to improve patient care, treatment, and services. The SHEP is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as "very good" or

"excellent." Medical centers are expected to address areas in which they are underperforming.

The medical center's SHEP performance in relation to national and VISN performance is shown in the graphs below and on the next page. The medical center met or exceeded the established target for overall quality for inpatients (shown in Figure 1) during 5 of the last 8 quarters and for outpatients (shown in Figure 2) during 7 of the last 8 quarters.

Figure 1:





The medical center's Service Excellence Committee analyzed and reported SHEP results. The committee initiated improvement actions, including the "Keeping the Promise" campaign, which focuses on veterans' needs; the "Everyday Heroes" program, which focuses on staff recognition; and inpatient satisfaction rounds, which are conducted by multiple services that provide direct patient care. Since the medical center had already taken appropriate actions, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 18, 2009

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **Combined Assessment Program Review of the James H. Quillen VA Medical Center, Mountain Home, Tennessee**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (10B5)

1. I concur with the findings and recommendations of this Office of Inspector General Combined Assessment Program Review of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, as well as the action plan developed by the facility.

2. If you have any questions or need additional information from the Network, please do not hesitate to contact Pamela Kelly, Staff Assistant to the Network Director, at 615-695-2205 or me at 615-695-2206.

(original signed by
Danny F. Foster for:)
John Dandridge, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 17, 2009

From: Director, James H. Quillen VA Medical Center (621/00)

Subject: **Combined Assessment Program Review of the James H. Quillen VA Medical Center, Mountain Home, Tennessee**

To: Director, VA Mid South Healthcare Network (10N9)

1. On behalf of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, I concur with the findings and recommendations of this Office of Inspector General report. We had already been actively working to improve or enhance several of these areas and welcome the "fresh eyes" perspective provided by this report.

2. Included herein is an outline of improvement actions taken, in progress, or planned in response to these findings. We believe these changes will further enhance key systems and processes at our medical center.

(original signed by:)
Charlene S. Ehret, FACHE

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director implements an interim plan, pending completion of construction, to provide adequate ED space to ensure patient privacy, confidentiality, and safety.

Concur

An interdisciplinary team was immediately chartered to develop an interim plan to provide adequate emergency room space to ensure patient privacy, confidentiality, and safety. The medical center has implemented measures to include:

- Revision of their ED surge plan.
- Medical center is placed on diversion status upon reaching seven patients treated in the ED with notification to the Chief of Staff.
- Improvement of emergency room through-put by sending patients not requiring monitoring to an emergency clinic.
- Emergency room patient flow algorithm was revised to reduce the need for non-medically urgent mental health patients to enter the acute ED area.
- Non-emergent patients are being redirected away from the emergency room to their primary care clinic provider or surrogate with the emergency room physician assistant being relocated in the primary care clinic.

These interim measures are being monitored to ensure patient privacy, confidentiality, and safety are maintained.

The emergency room structural/physical workspace will be revised to increase capacity for the emergency area to 11 monitored beds, a dedicated mental health evaluation area, and expansion of the urgent care clinic area. This is projected to be completed by February 2010. The long-term plan includes construction of a 2,000 square foot addition to the emergency room.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that medical record reviews be conducted in accordance with VHA policy.

Concur

Tracking tools have been developed to monitor the completion of on-going point of care and medical record reviews. The medical record tracking tool includes timelines of progress notes and order signatures. New format for ongoing point of care reviews implemented June 1, 2009. Point of care and medical record reviews were added to the Documentation & Standards Committee agenda template as monthly recurring report items. Findings, action, and recommendations will also be reviewed and/or addressed by the Quality Executive Board.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires documented safety plans for all patients at high risk for suicide.

Concur

All of the Veterans identified as high-risk for suicide have been provided the opportunity to complete a safety plan as soon as they are determined to be clinically stable to participate in the development of a safety plan. The exception to this are patients that are initially hospitalized in the community and decline to receive mental health follow-up at this facility or have been recently discharged from the community and mental health follow-up at this facility is pending.

The Suicide Prevention Coordinators and case managers monitor the high-risk patient listing daily to ensure that each Veteran has a completed safety plan, is provided the opportunity to complete a safety plan, and is scheduled for mental health follow-up. The safety plan and subsequent follow-up appointments are documented in the CPRS electronic record. A standardized template is provided to ensure content consistency.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director assigns a full-time SPC to the Knoxville CBOC.

Concur

An interim full-time Suicide Prevention Coordinator was immediately assigned to the Knoxville CBOC. The medical center posted a full-time SPC position for the Knoxville CBOC which closes on June 18th and is expected to be filled as a permanent position by July 31, 2009.

OIG Contact and Staff Acknowledgments

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