
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 12-02187-282**

# Combined Assessment Program Review of the VA Boston Healthcare System Boston, Massachusetts

**September 20, 2012**

**Washington, DC 20420**

## Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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# Glossary

| | |
|---|---|
| CAP | Combined Assessment Program |
| COC | coordination of care |
| CRC | colorectal cancer |
| EHR | electronic health record |
| EOC | environment of care |
| facility | VA Boston Healthcare System |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| HF | heart failure |
| MEC | Medical Executive Committee |
| MH | mental health |
| MHTC | mental health treatment continuity |
| OIG | Office of Inspector General |
| PM&R | physical medicine and rehabilitation |
| POCT | point-of-care testing |
| PRC | Peer Review Committee |
| PSB | Professional Standards Board |
| QM | quality management |
| RRTP | residential rehabilitation treatment program |
| SCI | spinal cord injury |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Table of Contents

# Executive Summary: Combined Assessment Program Review of the VA Boston Healthcare System, Boston, MA

**Review Purpose:** The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of July 23, 2012.

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

- Coordination of Care
- Environment of Care
- Medication Management
- Mental Health Treatment Continuity
- Point-of-Care Testing

The facility's reported accomplishments were a facility wide innovative hand hygiene program and an elective residency rotation to improve participation in and knowledge of the quality improvement process.

**Recommendations:** We made recommendations in the following five activities:

*Quality Management:* Notify the Peer Review Committee when corrective actions are completed. Ensure that quarterly Peer Review Committee reports are consistently submitted to the Medical Executive Committee and documented in meeting minutes. Consistently report Focused Professional Practice Evaluation results to the Professional Standards Board.

*Polytrauma:* Ensure that all patients with positive traumatic brain injury screening results are appropriately notified of the results and that staff refer patients for comprehensive evaluations within the required timeframe.

*Moderate Sedation:* Ensure that history and physical examinations are performed within the required timeframe and that pre-sedation assessment documentation includes all required elements.

*Colorectal Cancer Screening:* Notify patients of positive screening test results within the required timeframe, and document notification. Ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

*Nurse Staffing:* Ensure that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

## Comments

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

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

# Objectives and Scope

## Objectives

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

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

## Scope

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

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following 10 activities:

- COC
- CRC Screening
- EOC
- Medication Management
- MHTC
- 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 July 27, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Boston Healthcare System, Boston, Massachusetts,* Report No. 10-02980-50, December 22, 2010). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 88 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 395 responded. We shared survey results with facility managers.

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

# Reported Accomplishments

## Hand Hygiene Champion Program

QM data indicated that hand hygiene compliance was suboptimal. In the past, several factors limited effective intervention, including the inability to efficiently trend hand hygiene compliance and capture workgroup specifics in real-time and a lack of standardized reporting. A cross-functional improvement team of software experts, clinicians, and systems engineers collaborated to create, pilot, and implement a standardized electronic hand hygiene monitoring and reporting tool. The electronic form was modified based on customer feedback and focused on improving entry accuracy and efficiency.

The number of total hand hygiene observations per year increased by 261 percent, and the number of personnel completing observations has increased by a factor of 6. Detailed metrics are now available so that targeted interventions can occur quickly, and site-to-site comparisons are possible. With the assistance of a VA innovation grant, VISN managers will spread the program to all facilities in VISN 1.

## Patient Safety/Quality Improvement Program for Medical Residents

The residency program has created an elective rotation called the Ambulatory Patient Safety and Quality Improvement Rotation. The rotation introduces residents to theoretical and practical concepts of patient safety and quality improvement and provides them with hands on experience in improving the safety and quality of patient care. The program allows clinicians who are intensively involved in patient care to

share their observations and insights concerning safety and quality improvement with facility administrators.

Physician program directors, the facility Patient Safety Manager, and the Director of QM act as mentors. Residents conduct an independent study project, reviewing the care they personally delivered to patients and assessing the outcomes of that care. They also learn how to conduct a root cause analysis and use this structured process to evaluate an error or "close-call" incident.

At the conclusion of the rotation, the residents deliver a teaching seminar to their colleagues on an aspect of patient safety or the results of an investigation.

# Results

## Review Activities With Recommendations

### QM

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

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

| Noncompliant | Areas Reviewed |
|---|---|
| | There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members. |
| | There was evidence that inpatient evaluation data were discussed by senior managers. |
| X | The protected peer review process complied with selected requirements. |
| | Licensed independent practitioners' clinical privileges from other institutions were properly verified. |
| X | FPPEs 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. |

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

Peer Review. VHA requires that the PRC receive written notification upon completion of corrective actions.[1] We reviewed meeting minutes for the period June 2011 through May 2012 and identified three corrective actions that should have been completed. There was no evidence that any of the three corrective actions were reported to the committee. This was a repeat finding from our previous CAP review.

VHA requires that the PRC submit quarterly reports to the MEC.[2] We reviewed MEC meeting minutes for the period June 2011 through May 2012 and found that peer review reports were not submitted for 2 of the 4 quarters.

FPPEs. VHA requires that the results from FPPEs be reported to the PSB for consideration in making recommendations on privileges for newly hired licensed independent practitioners.[3] We reviewed the profiles of 10 newly hired licensed independent practitioners and found that for 6 of the practitioners, results were not reported to the PSB.

## Recommendations

**1.** We recommended that processes be strengthened to ensure that the PRC is notified when corrective actions are completed.

**2.** We recommended that processes be strengthened to ensure that quarterly peer review reports are consistently submitted to the MEC and documented in meeting minutes.

**3.** We recommended that processes be strengthened to ensure that results from FPPEs are consistently reported to the PSB.

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Directive 2010-025.
[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

## Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and COC for patients affected by polytrauma.

We reviewed relevant documents, 10 EHRs of patients with positive traumatic brain injury results, and 10 training records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| X | Providers communicated the results of the traumatic brain injury screening to patients and referred patients for comprehensive evaluations within the required timeframe. |
| | Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy. |
| | Case Managers were appropriately assigned to outpatients and provided frequent, timely communication. |
| | Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements. |
| | Adequate services and staffing were available for the polytrauma care program. |
| | Employees involved in polytrauma care were properly trained. |
| | Case Managers provided frequent, timely communication with hospitalized polytrauma patients. |
| | The interdisciplinary team coordinated inpatient care planning and discharge planning. |
| | Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit. |
| | Polytrauma-Traumatic Brain Injury System of Care facilities provided an appropriate care environment. |
| | The facility complied with any additional elements required by local policy. |

Screening Results. VHA requires that all positive traumatic brain injury screening results be communicated to patients at the time of the screening and that further evaluation be offered.[4] The provider who determined the positive screening result must refer the patient for a comprehensive evaluation within 5 days of the positive screening. Four of the EHRs did not contain evidence that providers informed patients of their positive screening results. In addition, two EHRs did not contain evidence that staff referred the patients for the required evaluations.

[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.

## Recommendation

**4.** We recommended that processes be strengthened to ensure that all patients with positive traumatic brain injury screening results are appropriately notified of the results and that staff refer patients for comprehensive evaluations within the required timeframe.

## 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, 13 EHRs, and 133 training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[5] Three patients' EHRs did not have a history and physical examination documented within 30 days of the procedure, and 11 patients' EHRs did not include all required elements of the pre-sedation assessment, such as a review of substance abuse and the patient's past sedation/anesthesia experience.

### Recommendation

**5.** We recommended that processes be strengthened to ensure that history and physical examinations are performed within 30 days prior to a procedure where moderate sedation will be used and that pre-sedation assessments include all required elements.

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

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

| Noncompliant | Areas Reviewed |
|---|---|
| X | Patients were notified of positive CRC screening test results within the required timeframe. |
| X | Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe. |
| | Patients received a diagnostic test within the required timeframe. |
| | Patients were notified of the diagnostic test results within the required timeframe. |
| | Patients who had biopsies were notified within the required timeframe. |
| | Patients were seen in surgery clinic within the required timeframe. |
| | The facility complied with any additional elements required by local policy. |

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinician's document notification.[6] Six patients' EHRs did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[7] Six patients did not have a documented follow-up plan within the required timeframe.

### Recommendations

**6.** We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

**7.** We recommended that processes be strengthened to ensure that responsible clinicians develop follow-up plans or document that no follow-up is indicated within the required timeframe.

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

## 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 17 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (progressive care unit) 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. |
| | The facility expert panel followed the required processes. |
| X | 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. |

Expert Panel Member Training. VHA requires that all members of the facility and unit-based expert panels complete chapter 1 of the Staffing Methodology National Training.[8] We reviewed the training files of the facility panel members and the progressive care unit panel members and found that 8 of the 17 members had not completed the required training.

### Recommendation

**8.** We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

[8] VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.

# Review Activities Without Recommendations

## COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 28 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 domiciliary and Substance Abuse RRTP were in compliance with selected MH RRTP requirements.

At the West Roxbury campus, we inspected one medical unit, the surgical/polytrauma unit, the medical intensive care unit, the SCI unit, the emergency department, and the PM&R and SCI clinics. At the Brockton campus, we inspected one behavioral health unit; the SCI/long-term care unit; the Women's Integrated Treatment and Recovery Program; the domiciliary; and the urgent care, dental, and PM&R clinics. At the Jamaica Plain campus, we inspected the Substance Abuse RRTP and the urgent care, dental, and PM&R 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. |

| Noncompliant | Areas Reviewed for MH RRTP |
|---|---|
| | There was a policy that addressed safe medication management, contraband detection, and inspections. |
| | MH RRTP inspections were conducted, included all required elements, and were documented. |
| | Actions were initiated when deficiencies were identified in the residential environment. |
| | Access points had keyless entry and closed circuit television monitoring. |
| | 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[9] therapy with methadone and buprenorphine and handling of methadone.

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

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

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

## MHTC

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

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

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

## 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, 14 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. |

# 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 21–26, for the full text of the Directors' comments.) We consider Recommendations 1, 2, 3, and 6 closed. We will follow up on the planned actions for the open recommendations until they are completed.

| **Facility Profile[10]** | | |
|---|---|---|
| **Type of Organization** | Tertiary care health care system | |
| **Complexity Level** | 1a | |
| **VISN** | 1 | |
| **Community Based Outpatient Clinics** | Quincy, MA<br>Framingham, MA<br>Boston, MA (Causeway St.)<br>Lowell, MA | |
| **Veteran Population in Catchment Area** | 65,580 | |
| **Type and Number of Total Operating Beds:**<br>• **Hospital, including Psychosocial RRTP** | 507 | |
| • **Community Living Center/Nursing Home Care Unit** | 120 | |
| • **Other** | 0 | |
| **Medical School Affiliation(s)** | Harvard University<br>Boston University | |
| • **Number of Residents** | 1,259 | |
| | **Current FY (through April 2012)** | **Prior FY (2011)** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $637 | $697 |
| • **Medical Care Expenditures** | $355 | $633 |
| **Total Medical Care Full-Time Employee Equivalents** | 2,474.77 | 2,509.48 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 53,544 | 65,580 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 9,097 | 8,746 |
| o **Community Living Center/Nursing Home Care Unit** | 3,839 | 3,987 |
| **Hospital Discharges** | 1,067 | 1,008 |
| **Total Average Daily Census (including all bed types)** | 431.19 | 424.41 |
| **Cumulative Occupancy Rate (in percent)** | 66.96 | 67.69 |
| **Outpatient Visits** | 398,900 | 735,730 |

[10] All data provided by facility management.

# VHA Satisfaction Surveys

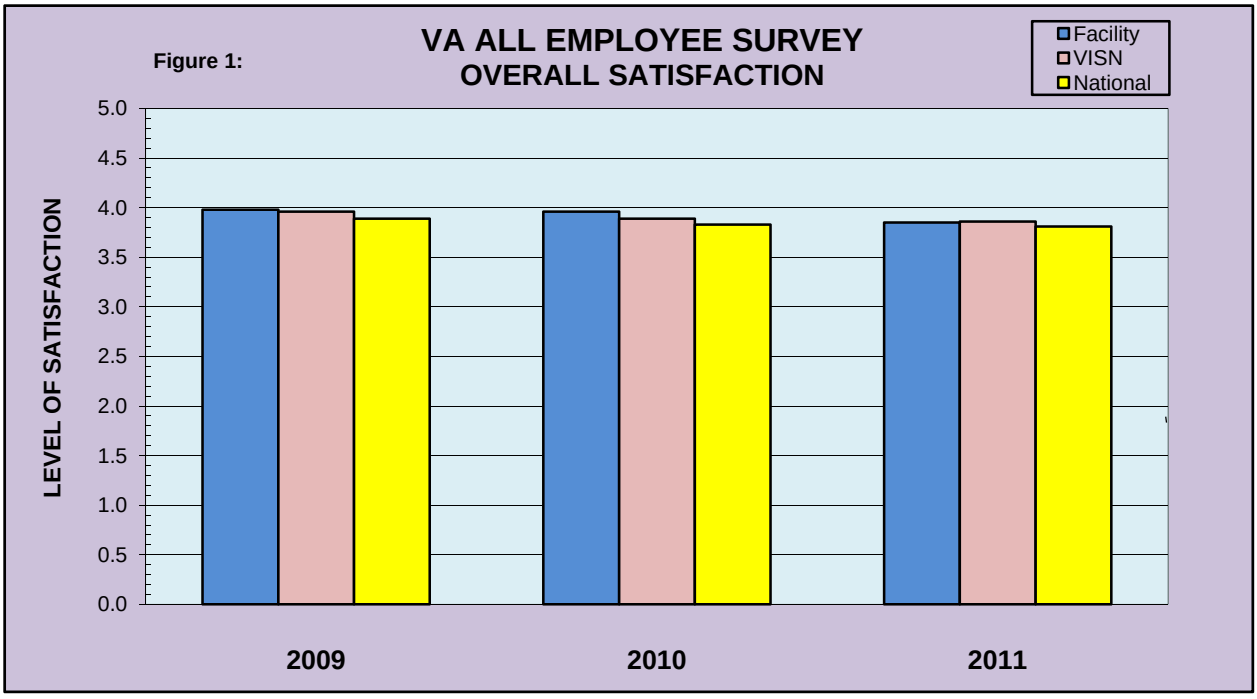
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

**Table 1**

| | Inpatient Scores | | Outpatient Scores | | | |
|---|---|---|---|---|---|---|
| | FY 2011 | FY 2012 | FY 2011 | | FY 2012 | |
| | Inpatient Score Quarters 3–4 | Inpatient Score Quarters 1–2 | Outpatient Score Quarter 3 | Outpatient Score Quarter 4 | Outpatient Score Quarter 1 | Outpatient Score Quarter 2 |
| Facility | 69.4 | 67.2 | 63.0 | 62.4 | 64.0 | 59.9 |
| VISN | 67.4 | 65.7 | 62.8 | 60.5 | 60.8 | 59.9 |
| VHA | 64.1 | 63.9 | 54.2 | 54.5 | 55.0 | 54.7 |

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

**Figure 1:**



# Hospital Outcome of Care Measures

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

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Congestive HF | Pneumonia | Heart Attack | Congestive HF | Pneumonia |
| Facility | 14.4 | 9.4 | 9.4 | 20.4 | 26.1 | 20.5 |
| U.S. National | 15.5 | 11.6 | 12.0 | 19.7 | 24.7 | 18.5 |

[11] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

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

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** September 6, 2012

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

**Subject:** **CAP Review of the VA Boston Healthcare System, Boston, MA**

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

Director, Management Review Service (VHA 10AR MRS)

I concur with the recommendations from VA Boston HCS regarding the OIG CAP Review and approve of the corrective action plans.

Sincerely,

*(original signed by Glen B. Gechlik, MD, for:)*
Michael Mayo-Smith, MD, MPH
Network Director

**Appendix D**

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** September 6, 2012

**From:** Director, VA Boston Healthcare System (523A4/00)

**Subject:** **CAP Review of the VA Boston Healthcare System, Boston, MA**

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

I have read and concur with the recommendations from the OIG CAP Review and approve of the corrective action plans.

*(original signed by:)*
Michael M. Lawson
Medical Center Director
VA Boston Health Care System

# 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 the PRC is notified when corrective actions are completed.

Concur

Target date for completion: Completed

The following corrective actions were taken:

- Modifications were made to the letter templates that are sent to providers and service chiefs from the Peer Review Committee so that findings require a submission of an action plan within a defined deadline.
- An InfoPath form was created to track Peer Review cases, including the field: date Peer Review Committee was notified of corrective actions. For tracking purposes, the Peer Review Committee agenda was modified to include action plans and completed corrective actions as standing topics for discussion to be documented in the minutes.

**Recommendation 2.** We recommended that processes be strengthened to ensure that quarterly peer review reports are consistently submitted to the MEC and documented in meeting minutes.

Concur

Target date for completion: Completed

The following corrective actions were taken:

- Peer Review was added as a topic to the Medical Executive Committee Agenda, to be reported on quarterly. Discussion of submitted reports will be documented in the minutes.

**Recommendation 3.** We recommended that processes be strengthened to ensure that results from FPPEs are consistently reported to the PSB.

Concur

Target date for completion: Completed

The following actions were taken to ensure that results from FPPEs are consistently reported to the PSB:

- Improved the PSB tracking spreadsheet by including a column for the date the FPPE results were reported to the PSB.
- Provided additional, on-going teaching regarding the details of the FPPE process to the clinical services such that they will complete the FPPEs correctly and on time.
- Implemented an additional quality control measure involving a second level review that will assure all FPPEs are completed and reported to the PSB. This includes maintaining a running list of providers whose FPPE has remained open and reporting this in the PSB minutes.

**Recommendation 4.** We recommended that processes be strengthened to ensure that all patients with positive traumatic brain injury screening results are appropriately notified of the results and that staff refer patients for comprehensive evaluations within the required timeframe.

Concur

Target date for completion: October 31, 2012

The following corrective actions will be taken:

- The clinical reminder will be modified to automatically generate a consult if there is a patient screen positive for TBI.
- Training materials will be developed and appropriate providers will receive education on proper procedures.

**Recommendation 5.** We recommended that processes be strengthened to ensure that history and physical examinations are performed within 30 days prior to a procedure where moderate sedation will be used and that pre-sedation assessments include all required elements.

Concur

Target date for completion: Completed

The following corrective actions were taken:

- All documents used for Moderate Sedation MD assessments have the additional prompt: “H&P has been completed within 30 days” and requests the provider insert the date of the note they are referencing.

**Recommendation 6.** We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: Completed

The following corrective actions were taken:

- All Primary Care staff were educated on policies and procedures to notify patients of CRC test results within 14 days.
- A standardized progress note was implemented by Primary Care to document patient CRC test result notification at the time of a face-to-face visit or telephone encounter. This note summarizes the discussion, treatment plan, and follow-up.
- Primary Care developed and implemented a standardized procedure for staff to review findings with Patients using My Healthy Vet.
- Primary Care created a letter to notify patients of FOBT [fecal occult blood test] results and trained their teams on the process.

**Recommendation 7.** We recommended that processes be strengthened to ensure that responsible clinicians develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: Completed

The following corrective actions were taken:

- All Primary Care staff members were educated on policies and procedures to develop follow-up plans or document that no follow up is indicated for positive CRC screening tests.
- A standardized progress note was implemented by Primary Care to document patient CRC test result notification at the time of a face-to-face visit or telephone encounter including follow up plans.

**Recommendation 8.** We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: October 31, 2012

The following corrective actions will be taken:

- An E-mail to all nurse mangers was sent to assign training in TMS [Talent Management System] for those staff participating on unit expert panels.
- "Staffing Methodology for VHA Nursing Personnel" was assigned to appropriate staffing TMS. This will be tracked via TMS.

# OIG Contact and Staff Acknowledgments

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|---|---|
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