Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-03805-20

Combined Assessment Program Summary Report

Evaluation of Inpatient Flow in Veterans Health Administration Facilities

March 7, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office completed a healthcare evaluation of coordination of care in Veterans Health Administration facilities. The purpose of the review was to evaluate selected aspects of the Veterans Health Administration patient flow process over the inpatient continuum (admission through discharge). The objectives were to determine whether clinicians complied with requirements for admission assessments, transfer notes, and discharge documentation and whether facilities had clinical Bed Flow Coordinators to coordinate patient flow activities throughout the facility.

We conducted this review at 24 Veterans Health Administration medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2015 through March 31, 2016.

Although we observed many positive practices, we identified system weaknesses. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensure that:

- Discharge policies encourage physicians to schedule discharges early in the day.
- Policies address overflow patients in temporary bed locations, including priority placement into inpatient beds, standards of care while patients are in temporary bed locations, medication administration, and meal provision.
- When resident physicians complete discharge notes or instructions, supervising physicians co-sign the residents' notes.

Comments

The Under Secretary for Health concurred with the report. (See Appendix A, pages 6–9, for the full text of the comments.) The implementation plans are acceptable, and we will follow up until all actions are completed.

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

Purpose

The VA Office of Inspector General (OIG) completed a healthcare evaluation of coordination of care in Veterans Health Administration (VHA) facilities. The purpose of the review was to evaluate selected aspects of the VHA patient flow process over the inpatient continuum of care (admission through discharge). The objectives were to determine whether clinicians complied with requirements for admission assessments, transfer notes, and discharge documentation and whether facilities had clinical Bed Flow Coordinators to coordinate patient flow activities throughout the facility.

Background

In 2009, OIG reviewed VHA compliance with transfer and discharge documentation requirements and identified system weaknesses in discharge instructions.[1] In 2013, OIG reviewed VHA compliance with documentation requirements related to patients' discharge needs and recommended that:[2]

- Clinicians provide and document discharge instructions for all identified needs.
- Clinicians reassess patients' learning needs prior to providing important instructions, including discharge instructions.
- Clinicians reconcile conflicting needs and instructions before discharging patients.
- Patients receive ordered post-discharge referrals.

Several OIG reports have described problems with the patient flow process in VHA facilities, including admission delays related to problems with patient flow, lack of discharge instructions, and lack of documented resident supervision in discharge and other progress notes.[3,4,5,6,7]

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[1] *OIG CAP Briefing Paper – Combined Assessment Program Review Results, January–June 2009*, August 6, 2009.
[2] *Combined Assessment Program Summary Report – Evaluation of Coordination of Care in Veterans Health Administration Facilities,* Report No. 15-01809-163, March 31, 2015.
[3] *Healthcare Inspection – Emergency Department Concerns, Central Alabama VA Health Care System, Montgomery, Alabama*, Report No. 14-04530-41, January 14, 2016.
[4] *Healthcare Inspection – Inadequate Staffing and Poor Patient Flow in the Emergency Department*, *VA Maryland Health Care System, Baltimore, Maryland*, Report No. 12-03887-319, September 18, 2013.
[5] *Healthcare Inspection – Excessive Length of Stay and Quality of Care Issues in the Emergency Department*, *William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina*, Report No. 12-03038-145, March 26, 2013.
[6] *Healthcare Inspection – Vascular Surgery Resident Supervision, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska,* Report No.14-04037-404, July 9, 2015.
[7] *Healthcare Inspection – Resident Supervision in the Operating Room, Ralph H. Johnson VA Medical Center, Charleston, South Carolina,* Report No. 14-00637-199, June, 23, 2014.

Definitions:

- Temporary Bed Location[8]: A designated place where clinicians may care for a patient awaiting an inpatient bed. Examples of temporary bed locations include the post-anesthesia care unit for intensive care unit overflow patients and the Emergency Department or urgent care center for newly admitted patients. It may also include short-term use of a higher level of care (for example an intensive care unit bed for a telemetry inpatient admission) while awaiting the appropriate location.
- Overflow Patient[9]: A patient who requires inpatient care but whom the facility is unable to accept on the designated unit due to a lack of available beds. An overflow patient may be held in a temporary bed location or temporarily placed in a different level of care. While waiting in the Emergency Department or the urgent care center for an inpatient bed, these patients are often referred to as "boarders" or "holders."
- Resident Supervision[10]: Resident physicians receive health care training by supervising physicians in VHA facilities who document this supervision in the electronic health record. The supervising practitioner's co-signature signifies that the supervising practitioner has reviewed the resident's note, and absent an addendum to the contrary, concurs with the content of the resident's note.

Scope and Methodology

We performed this review in conjunction with 24 Combined Assessment Program reviews conducted from October 1, 2015 through March 31, 2016. The facilities we visited were a stratified random sample of all VHA facilities and represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks. OIG generated an individual Combined Assessment Program report for each facility. For this report, we summarized the data collected from the individual facility Combined Assessment Program reviews.

We reviewed facility policies and interviewed applicable managers and employees. Additionally, we reviewed 834 patients' electronic health records. We focused our review on patients with acute care inpatient stays of at least 3 days from July 1, 2014 through June 30, 2015. We used 90 percent as our expectation for compliance. The patient samples within each facility were not probability samples, and thus do not

[8] VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013. This directive was rescinded and replaced by VHA Directive 1101.05(1), *Emergency Medicine*, September 2, 2016 (amended October 27, 2016). Both directives have the same or similar language regarding temporary bed locations.

[9] VHA Directive 1009. This directive was rescinded and replaced by VHA Directive 1101.05(1), *Emergency Medicine*, September 2, 2016 (amended October 27, 2016). Both directives have the same or similar language regarding overflow patients.

[10] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

represent the entire patient population of that facility. Therefore, the patient results presented in this report are not generalizable to the entire VHA.

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

Inspection Results

We identified several strong patient flow practices, including that most facilities had committees that monitored patient flow and addressed identified problems or opportunities for improvement. In addition, most facilities had appointed a Bed Flow Coordinator with a clinical background to coordinate inpatient admissions and bed assignments. Clinicians documented patients received a copy of the discharge instructions and understood the instructions. However, we identified system weaknesses.

Issue 1: Policy Requirements

VHA requires all facilities to have a policy that addresses patient discharge and encourages physicians to schedule discharges early in the day.[11] All facilities had policies that addressed patient discharge from the facility. However, 37.5 percent of the policies did not encourage physicians to schedule discharges early in the day.

VHA also requires facilities to have a policy that addresses overflow patients in temporary bed locations.[12] We found that 25 percent of facilities did not have a policy that addresses overflow patients in temporary bed locations. Such policies need to include at least the following elements.

- Priority placement for inpatient beds given to patients in temporary bed locations
- Upholding standards of care while patients are in temporary bed locations
- Medication administration
- Meal provision

We found that 11.1 percent of facilities' policies did not include all four elements.

We recommended that facility managers revise discharge policies to include encouraging physicians to schedule discharges early in the day. Additionally, facility managers need to develop or revise policies addressing overflow patients in temporary bed locations and include priority placement for inpatient beds given to patients in temporary bed locations, upholding standard of care while patients are in temporary bed locations, medication administration, and meal provision.

[11] VHA Directive 1009. This directive was rescinded and replaced by VHA Directive 1101.05(1). Both directives have the same or similar language regarding discharging patients.
[12] VHA Directive 1009. This directive was rescinded and replaced by VHA Directive 1101.05(1). Both directives have the same or similar language regarding overflow patients in temporary bed locations.

Issue 2: Resident Supervision Documentation

VHA requires that when resident physicians complete discharge notes or instructions, a supervising physician co-sign the resident's note.[13] We found that when resident physicians completed discharge notes or instructions, the supervising physician did not co-sign 12.1 percent of the residents' notes or instructions.

We recommended that when resident physicians complete discharge notes or instructions, supervising physicians co-sign the residents' notes.

Conclusions

We observed many positive practices during our review, including that most facilities had committees that monitored patient flow and addressed identified problems or opportunities for improvement, most facilities had appointed clinical Bed Flow Coordinators, and clinicians documented providing patients with a copy of the discharge instructions the patients understood. However, we identified system weaknesses in discharge policy content, nonexistent or incomplete policies addressing overflow patients in temporary bed locations, and documentation of resident supervision for discharge notes or instructions.

Recommendations

1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that facilities revise discharge policies to include encouraging physicians to schedule discharges early in the day.

2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that facilities develop or revise policies addressing overflow patients in temporary bed locations and include priority placement for inpatient beds given to patients in temporary bed locations, upholding standard of care while patients are in temporary bed locations, medication administration, and meal provision.

3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when resident physicians complete discharge notes or instructions, supervising physicians co-sign the residents' notes.

[13] VHA Handbook 1400.01.

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: September 29, 2016

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Combined Assessment Program (CAP) Summary Report – Evaluation of Inpatient Flow in Veterans Health Administration Facilities (Project No. 2016-03805-HI-0680) (VAIQ 7724805)

To: Assistant Inspector General for Healthcare Inspections (54)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review and comment on the draft report, Evaluation of Inpatient Flow in Veterans Health Administration Facilities. The Veterans Health Administration (VHA) is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the Department of Veterans Affairs (VA) health care system. VHA is using the input from VA's Office of Inspector General, and other advisory groups to identify root causes and to develop critical actions. As VHA implements corrective measures, we will ensure our actions are meeting the intent of the recommendations. VHA is dedicated to sustained improvement in the high risk areas.

2. The recommendations in this report apply to GAO high risk areas 1 and 4. VHA's actions will serve to address ambiguous policies, inconsistent processes, and inadequate training for VA staff.

3. If you have any questions, please email [redacted], M.D., Director, Management Review Service at [redacted].

4. I have reviewed the draft report, and provide the attached action plan to address the report's three recommendations.

David J. Shulkin, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Combined Assessment Program
Summary Report – Evaluation of Inpatient Flow in VHA Facilities

Date of Draft Report: July 29, 2016

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that facilities revise discharge policies to include encouraging physicians to schedule discharges early in the day.

VHA Comments: Concur

VHA Response: A DUSHOM memo will be issued to direct the VISNs and/or to update discharge policies to reflect the need for early/smoothed patient discharge.

In addition, the Office of Systems Redesign and Improvement will sponsor training via Systems Redesign/Improvement Collaborative and other educational events including calls to educate medical centers about the importance of early/smoothed patient discharge(s) in optimizing inpatient flow utilizing the Integrated Flow Management Tool (IFMT) that integrates inpatient flow data derived from VHA flow informatics applications.

At completion of this action, VHA will provide OIG with the following documentation:

1. Copies of the education information disseminated to encourage early/smoothed discharge;

2. The DUSHOM memo issued to the VISNs and/or facilities instructing them to update discharge policies to reflect the need for early/smoothed patient discharge.

	Status:	Target Completion Date:
	In Process	March 17, 2017

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that facilities develop or revise policies addressing overflow patients in temporary bed locations and include priority placement for inpatient beds given to patients in temporary bed locations, upholding standard of care while patients are in temporary bed locations, medication administration, and meal provision.

VHA Comments: Concur

VHA Response: The Office of the DUSHOM will work collaboratively with the Office of Patient Care Services to draft and distribute a DUSHOM memorandum to ensure that there are VISN and/or facility policies that provide consistent, safe, patient centric care to patients in temporary inpatient beds.

At completion of this action, VHA will provide OIG with the memorandum from the DUSHOM.

Status:	Target Completion Date:
In Process	March 17, 2017

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that when resident physicians complete discharge notes or instructions, supervising physicians co-sign the residents' notes.

VHA Comments: Concur in principle

VHA Response: VHA agrees with the OIG that co-signature of resident notes is a core supervisory responsibility for attending physicians. The co-signature responsibility is established in national policy and enforced through a robust oversight process. The first line of oversight occurs at the facility where monitoring of resident supervision is a health record review process, and a quality management activity. Documentation of supervision must be entered into the health record by the supervising practitioner or reflected within the resident progress note. The health record must reflect the involvement of the supervising practitioner. The health record is reviewed for the types of allowable documentation. In the Inpatient Setting; the supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from an inpatient service of the medical facility is appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen; discharge instructions and orders may include physical activity, medications, diet, functional status, and follow-up plans, including coordination with the patient's primary care team. Evidence of this involvement must be documented by the supervising practitioner's countersignature of the discharge note and discharge summary. The Resident Supervision Handbook states "monitoring of resident supervision is a health record review process, and a quality management activity." Facility policy determines who is responsible for tracking resident supervision requirements and reporting, no less than quarterly, to the appropriate medical staff committee. The Handbook also states that

"monitoring of resident supervision is a shared responsibility of national, VISN, and local facility leaders."

We appreciate the IG's finding that 88 percent of the records they reviewed across 21 facilities complied with the policy requirement for attending co-signature. VHA's compliance standard is 90 percent on this policy requirement. VHA's Office of the Deputy Under Secretary for Health for Policy and Services (DUSH-PS) will convene an interdisciplinary workgroup to assess national compliance with co-signature on resident generated discharge notes, opportunities for improvement on the current three lines of oversight. Membership of the workgroup will include, at minimum, representatives from the Office of Health Information, Office of Academic Affairs, Office of Quality Safety Value, Office of the Deputy Under Secretary for Health's offices for Clinical Operations, Veterans Integrated Service Network, and facilities.

At completion of this action, VHA will provide OIG with:

1. A report from the workgroup that has been approved by the DUSH-PS;
2. Action plan for recommendations, if any, made by the workgroup;

Status:	Target Completion Date:
In Process	March 17, 2017

OIG Contact and Staff Acknowledgments

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