Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00881-203

Combined Assessment Program Review of the New Mexico VA Health Care System Albuquerque, New Mexico

June 19, 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	New Mexico VA Health Care System
FY	fiscal year
HF	heart failure
MH	mental health
MM	medication management
OIG	Office of Inspector General
POCT	point-of-care testing
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

	Page
Executive Summary	i
Objectives and Scope	1
Objectives	1
Scope	1
Reported Accomplishment	2
Results	3
Review Activities With Recommendations	3
Moderate Sedation	3
POCT	5
CRC Screening	7
MH Treatment Continuity	9
COC	10
Nurse Staffing	11
QM	12
Review Activities Without Recommendations	14
EOC	14
MM	15
Polytrauma	16
Comments	17
Appendixes	
A. Facility Profile	18
B. VHA Satisfaction Surveys and Hospital Outcome of Care Measures	19
C. VISN Director Comments	21
D. Facility Director Comments	22
E. OIG Contact and Staff Acknowledgments	30
F. Report Distribution	31

Executive Summary: Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, NM

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 April 2, 2012.

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

- Environment of Care
- Medication Management
- Polytrauma

The facility's reported accomplishment was the initiation of weekly wound rounds in the spinal cord injury unit.

Recommendations: We made recommendations in the following seven activities:

Moderate Sedation: Ensure that pre-sedation assessment documentation includes all required elements, that team members document their participation in pre-procedure timeouts, and that patients are appropriately monitored during sedation.

Point-of-Care Testing: Ensure that all glucose test results are documented in electronic health records (EHRs) and that required actions are taken in response to critical test results.

Colorectal Cancer Screening: Notify patients of positive screening test results and biopsy results within the required timeframe. Develop follow-up plans or document that no follow-up is indicated within the required timeframe. Ensure that patients receive diagnostic testing within the required timeframe and that EHRs contain testing documentation or reasons why testing was not done.

Mental Health Treatment Continuity: Ensure discharged mental health patients receive follow-up within the specified timeframes.

Coordination of Care: Ensure medications listed in discharge instructions match those ordered at discharge.

Nurse Staffing: Monitor the staffing methodology implemented in March.

Quality Management: Ensure that the EHR Committee provides oversight and coordination of EHR reviews and that reviews are analyzed and trended. Include all providers and all required elements in EHR reviews. Monitor the copy and paste functions.

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
- MH Treatment Continuity
- MM
- Moderate Sedation
- Nurse Staffing
- Polytrauma
- POCT
- 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 April 2, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico,* Report No. 10-01435-210, July 27, 2010).

During this review, we presented crime awareness briefings for 361 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 459 responded. We shared survey results with facility managers.

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

Reported Accomplishment

SCI Wound Rounds

The SCI unit treatment team identified inconsistencies in wound measurement, wound care treatment modalities, and documentation related to wound care. An interdisciplinary taskforce developed and implemented a structured process for weekly wound rounds. As a result, there has been a 62 percent decrease in the cost of wound care supplies and medication inventories on the SCI unit. Additionally, patients' ability to verbalize their wound care treatment plans increased from 29 percent in October 2011 to 82 percent in January 2012.

Results
Review Activities With Recommendations

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 15 training/competency records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	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.
X	Timeouts were appropriately conducted.
X	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.[1] We found the following documentation deficiencies in seven of the EHRs:

- None had the time and nature of last oral intake.
- Four lacked a history of any previous adverse experience with sedation.
- Two lacked assessments of tobacco, alcohol, and/or substance use.

Timeouts. VHA requires that relevant team members, including the provider who will perform the procedure, participate in the pre-procedure timeout.[2] Three patients' EHRs did not contain documented evidence of provider participation in the timeout.

[1] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.
[2] VHA Directive 2010-023, *Ensuring Correct Surgery and Invasive Procedures*, May 17, 2010.

Intra-Procedure Monitoring. VHA requires that vital signs be documented at 5-minute intervals during the procedure.[3] Six patients' EHRs did not contain documented evidence of vital signs taken at 5-minute intervals.

Recommendations

1. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

2. We recommended that processes be strengthened to ensure that relevant team members document their participation in the pre-procedure timeout.

3. We recommended that processes be strengthened to ensure that patients are appropriately monitored during moderate sedation.

[3] VHA Directive 2006-023.

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, 12 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 areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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.
X	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
X	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.

Test Results Management. VHA requires that all verified test results be available in patient EHRs.[4] Six patients' glucose test results were not documented in the EHRs.

When glucose values are determined to be critical, the facility requires the employee performing the test to repeat the test with a new finger stick, notify the responsible clinician within 30 minutes, and document notification in the Nursing Critical Value Notification Note. Of the 10 patients who had critical test results, 7 EHRs had deficiencies. Four EHRs did not contain evidence of a repeat glucose test, two EHRs did not contain evidence of clinician notification, and five EHRs did not contain a Nursing Critical Value Notification Note.

[4] VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.

Recommendations

4. We recommended that processes be strengthened to ensure that all glucose test results are documented in EHRs.

5. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests, and we 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.
X	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
X	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 clinicians document notification.[5] Three patients' EHRs did not contain documented evidence of timely patient notification, and five patients' EHRs did not contain any documented evidence of patient 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.[6] Three patients' EHRs did not have a documented follow-up plan within the required timeframe, and two patients' EHRs did not have any documented evidence of a follow-up plan.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[7] One patient preferred a date outside the 60-day timeframe. Seven of the remaining 19 patients' EHRs did not have any documented evidence of required diagnostic testing, patients' refusal of diagnostic testing, or contraindication to diagnostic testing. Additionally, six of the 12 patients who received diagnostic testing did not receive that testing within the required timeframe.

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

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[8] Of the eight patients who had a biopsy, two EHRs did not contain documented evidence of timely notification, and three EHRs did not contain any documented evidence of patient notification.

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 either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

8. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe and that EHRs contain documentation of testing or reasons why testing was not done.

9. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

[8] VHA Directive 2007-004.

MH Treatment Continuity

The purpose of this review was to evaluate the facility's MH patients' transition from the inpatient to outpatient setting. Specifically, we evaluated compliance with selected requirements from VHA Handbook 1160.01 and VHA's performance metrics.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Outpatient Follow-Up. VHA requires that all patients discharged from inpatient MH receive outpatient follow-up from a MH provider within 7 days of discharge and that if this contact is by telephone, an in-person or telemental health evaluation must occur within 14 days of discharge.[9] Seven patients did not receive outpatient MH follow-up within 7 days of discharge. Additionally, one patient was contacted by telephone within 7 days of discharge but did not have an in-person or telemental health evaluation within 14 days.

Recommendation

10. We recommended that processes be strengthened to ensure that all discharged MH patients receive follow-up within the specified timeframes and that compliance is monitored.

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

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 22 HF patients' EHRs and relevant documents and 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	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.

Discharge Medications. The Joint Commission's National Patient Safety Goals require the safe use of medications and stress the importance of maintaining and communicating accurate patient medication information. In four EHRs, medications listed in patient discharge instructions did not match those ordered at discharge.

Recommendation

11. We recommended that processes be strengthened to ensure that medications listed in patient discharge instructions match those ordered at discharge.

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 interviewed key employees. 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.
	Members of the expert panels completed the required training.
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Facility Methodology Deadline. VHA required that the steps to develop the facility's staffing methodology for nursing personnel, which include convening unit-based expert panels, be completed by September 30, 2011.[10] The facility did not convene unit-based expert panels until March 28, 2012.

Recommendation

12. We recommended that nursing managers monitor the staffing methodology that was implemented in March.

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

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.
	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
X	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.
X	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

EHR Committee Oversight. VHA requires facilities to have an EHR Committee that provides oversight of EHR quality reviews, which includes analyzing aggregated data.[11] We found that the EHR Committee provided inconsistent oversight and coordination and did not analyze or trend aggregated data.

EHR Review. VHA requires facilities to conduct EHR reviews that include a representative sample of charts from each service or program and specific elements and to monitor the copy and paste functions.[12] Although some EHR quality reviews had been completed, we found no evidence of EHR quality reviews for physicians. Additionally, we found that the reviews did not include all of the required elements, such as unsigned/un-cosigned progress notes. Further, the facility did not monitor the copy and paste functions in the EHR.

Recommendations

13. We recommended that processes be strengthened to ensure that the EHR Committee provides consistent oversight and coordination of EHR quality reviews and that EHR quality reviews are analyzed and trended.

14. We recommended that processes be strengthened to ensure that EHR reviews include all providers and all required elements and that the copy and paste functions are monitored.

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

Review Activities Without Recommendations

EOC

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

We inspected six inpatient units (SCI, two medical, one intensive care, one locked inpatient MH, and the community living center), the emergency department, the Substance Abuse and Post-Traumatic Stress Disorder RRTPs, ambulatory surgery, and six outpatient clinics (polytrauma, dental, SCI, co-occurring disorders, primary care, and women's health). Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or SCI outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.

	Areas Reviewed for MH RRTP
	There was a policy that addressed safe MM, 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.

MM

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[13] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving 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.
	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.

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

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, 20 EHRs of patients with positive traumatic brain injury results, and 8 training records, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	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.

Comments

The VISN and Facility Directors agreed with the CAP review finds and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 21–29, for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

Facility Profile[14]		
Type of Organization	Tertiary referral medical center	
Complexity Level	1	
VISN	18	
Community Based Outpatient Clinics	Artesia, NM Farmington, NM Gallup, NM Raton, NM Santa Fe, NM Silver City, NM	
Veteran Population in Catchment Area	339,917	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	310 (158 Acute, 26 SCI/disorder, 90 RRTP)	
• **Community Living Center/Nursing Home Care Unit**	36	
• **Other**	0	
Medical School Affiliation	University of New Mexico School of Medicine	
• **Number of Residents**	435	
	Current FY (through January 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$379.6	$391.0
• **Medical Care Expenditures**	$280.2	$388.1
Total Medical Care Full-Time Employee Equivalents	2,319	2,272
Workload:		
• **Number of Station Level Unique Patients**	39,226	57,072
• **Inpatient Days of Care:**		
o **Acute Care**	14,001	41,636
o **Community Living Center/Nursing Home Care Unit**	2,642	7,976
Hospital Discharges	2,034	6,622
Total Average Daily Census (including all bed types)	222.7	222.1
Cumulative Occupancy Rate (in percent)	76.6	76.6
Outpatient Visits	214,057	651,881

[14] All data provided by facility management.

VHA Satisfaction Surveys

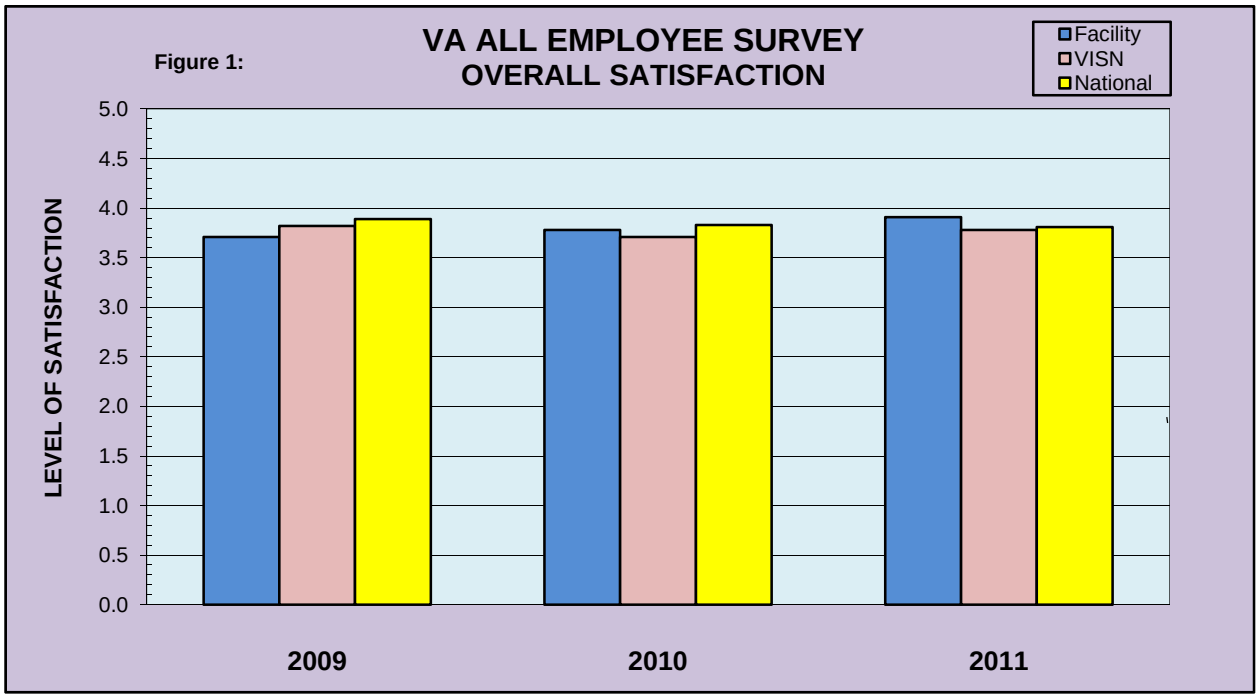
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	64.6	61.7	49.0	58.1	56.3	58.8
VISN	64.6	63.8	52.5	52.0	51.0	53.7
VHA	63.9	64.1	55.9	55.3	54.2	54.5

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.[15] 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, 2007, and June 30, 2010.[16]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	13.1	14.1	11.6	20.2	23.6	17.8
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[15] 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.

[16] 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: May 29, 2012

From: Director, VA Southwest Health Care Network (10N18)

Subject: **CAP Review of the New Mexico VA Health Care System, Albuquerque, NM**

To: Director, San Diego Office of Healthcare Inspections (54SD)

Director, Management Review Service (VHA 10A4A4 Management Review)

I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(original signed by:)
Susan P. Bowers

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 29, 2012

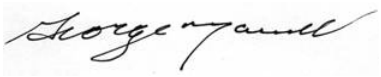
From: Director, New Mexico VA Health Care System (501/00)

Subject: **CAP Review of the New Mexico VA Health Care System, Albuquerque, NM**

To: Director, VA Southwest Health Care Network (10N18)

1. Enclosed are the responses to the recommendations in the draft Office of Inspector General's report of our Combined Assessment Program review.

2. If you have any questions or wish to discuss the report, please contact me at (505) 265-1711, extension 2889.



George Marnell

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 pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: September 30, 2012

All Services providing moderate sedation (Interventional Radiology, Pulmonary, Pain, Gastrointestinal (GI), Cardiology, and Surgery Non-Operating Room) will be responsible for monitoring five (5) patients per month to assure all pre-sedation assessment elements are fully documented. Results will be compiled, analyzed and follow-up plans will be sent to the Anesthesia Service Chief and reported monthly to the Clinical Executive Board.

Recommendation 2. We recommended that processes be strengthened to ensure that relevant team members document their participation in the pre-procedure timeout.

Concur

Target date for completion: September 30, 2012

All Services providing moderate sedation (Interventional Radiology, Pulmonary, Pain, Gastrointestinal (GI), Cardiology, and Surgery Non-Operating Room) will be responsible for monitoring five (5) patients per month to assure all pre-procedure timeouts are fully documented and relevant team members will be identified. Results will be compiled, analyzed and follow-up plans will be sent to the Anesthesia Service Chief and reported monthly to the Clinical Executive Board.

Recommendation 3. We recommended that processes be strengthened to ensure that patients are appropriately monitored during moderate sedation.

Concur

Target date for completion: September 30, 2012

All Services providing moderate sedation (Interventional Radiology, Pulmonary, Pain, Gastrointestinal (GI), Cardiology, and Surgery Non-Operating Room) will be responsible for monitoring five (5) patients per month to assure all vital signs are monitored per policy. The provider giving medications will not be responsible for any other aspect of the procedure other than monitoring the patient. Audit results will be compiled,

analyzed and follow-up plans will be sent to the Anesthesia Service Chief and reported monthly to the Clinical Executive Board.

Recommendation 4. We recommended that processes be strengthened to ensure that all glucose test results are documented in EHRs.

Concur

Target date for completion: July 30, 2012

The Associate Chief, Nursing Services (ACNS) will ensure the increase in inpatient, outpatient and subspecialty nursing staff's awareness of MCM 11-64, Reporting of Critical Lab Results, and the responsibilities of nursing personnel in Point of Care Testing documentation of critical laboratory results. A comprehensive education plan will be developed for all areas using glucometers. Monthly audits will be conducted and data will be analyzed and trended to ensure glucometer documentation is adequately accomplished. The goal is to increase compliance in documentation to 80 percent by July 2012.

Recommendation 5. We recommended that processes be strengthened to ensure that staff complete the actions required in response to critical test results.

Concur

Target date for completion: July 30, 2012

The ACNS will ensure that the in-patient, out-patient, and sub-specialty nursing staff's awareness of MCM 11-64, Reporting of Critical Lab Results, and the responsibilities of nursing personnel in Point of Care Testing (POCT) documentation of critical laboratory results. A comprehensive education plan on appropriate reporting and documentation of critical lab results will be developed and rolled out to all areas using glucometers (inpatient and outpatient registered nurses, nursing assistances and health techs). This educational plan will be aligned with the facility's current policy regarding POCT. Monthly audits will be conducted and data will be analyzed and trended to ensure staff complete the actions required in response to critical test results.

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: June 30, 2012

The Ambulatory Care Population Health Coordinator, with the help of Informatics Service registries, will run reports showing: whether the FIT kits were returned or not, what the result was, whether a consult has been submitted to GI, and where the consult is within the GI Service. The Population Health Coordinator will be responsible for

communicating to the patient, PCP, and GI Service as needed and for coordinating the entire screening process. Reports to be run by Population Health Coordinator will be created by June 4, 2012, tested and implemented by June 11, 2012.

New patient letter templates will be completed and implemented by June 11, 2012. The Population Health Coordinator will be responsible for sending patient letters which identify the following: FIT+, FIT-, FIT not yet received, and annual FIT reminders with kits. The Population Health Coordinator will ensure consults to GI are generated and follow any FIT+ result.

The Population Health Coordinator will document the status of patient notification in CPRS and assure that the PCP is notified of the positive CRC screening.

All aspects of our new registry report-based program should be fully implemented by the end of June 2012.

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

Concur

Target date for completion: June 30, 2012

As above, we are actively implementing a registry report-based program, coordinated by the Population Health Coordinator, which will identify the CRC screening status of all patients. This report will be updated daily and the specific PCP/teamlet will be notified with inaction for FIT+ patients being noted by the following day's report. Appropriate response to the PCP notification by the Population Health Coordinator may be: documentation that consult to GI has been generated or documentation that no follow-up is required.

Recommendation 8. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe and that EHRs contain documentation of testing or reasons why testing was not done.

Concur

Target date for completion: In 6–12 months (depending on timing of recruitment of needed personnel), for increasing colonoscopy capacity with the target of providing the procedure as a diagnostic test within the required time frame.

If the procedure has already been completed (at non-VA facility), that information must be documented, including outcome of testing or reasons why the testing was not done (i.e., could not be successfully performed). The GI clinic personnel will follow-up on the status of all GI consults for diagnostic colonoscopy and arrange for appropriate scheduling and follow-through at the NMVAHCS or fee-basis site. GI clinic personnel

will also conduct monthly audits of open consults to "close the loop," assuring that EHRs contain documentation of testing, results of testing, or reasons why testing was not done.

In terms of providing colonoscopy, we have been working on a long-term enhancement of our capacity through the building of both physical facility (done) and nursing staff (in process). A recovery area dedicated to GI endoscopy patients is now built. We are currently building our nursing manpower to open the recovery function post-colonoscopy and expect to make this service available by late summer 2012.

All diagnostic colonoscopies performed at NMVAHCS are documented in CPRS as a procedure report once the test is performed. If the colonoscopy was not done (i.e., could not be successfully performed due to difficulty in achieving adequate conscious sedation, an inadequate prep or a technical issue), the circumstances are documented in CPRS with the alternative plan included such as rescheduling the procedure after a more thorough prep or scheduling the procedure with general anesthesia.

In addition we are reinforcing our current following practice:

- All gastroenterology consults will be reviewed as soon as they are received by assigned gastroenterology staff within the required timeframe.
- Positive CRC screening tests will be identified and sorted out promptly upon arrival in GI and scheduled within the required timeframe. The gastroenterology staff who reviews the consults will be required to document in CPRS that the consult was received and addressed within the required timeframe.
- An assigned GI attending will monitor this process to ensure that all the required steps are completed and documented in timely manner.
- The GI nurse manager will follow up on all CRC positive screening test consults to ensure that all procedures ordered by the GI staff are scheduled within the required timeframe. The GI nurse manager will be responsible for keeping track of all these consults to ensure they are all addressed and completed in a timely manner.

Recommendation 9. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: July 31, 2012

We have had a notification process in place whereby patients are notified of the biopsy results by phone or by letter. We have documented this notification by inserting a note in CPRS describing the pathology findings and the recommended schedule for future surveillance. We are improving our documentation to include the additional clarification that the patient has been notified (by phone or by letter). We expect this educational effort to be completed by July, 2012.

Currently, the Gastroenterology Service has an established practice to address this matter. All gastroenterology results are reviewed as soon as they are received by GI staff and addressed in a timely manner. Based on the clinical judgment of the GI staff reviewing the results, additional consults are generated to appropriate follow-up service, including the PCP.

Recommendation 10. We recommended that processes be strengthened to ensure that all discharged MH patients receive follow-up within the specified timeframes and that compliance is monitored.

Concur

Target date for completion: July 31, 2012

- Implement a process that ensures 75 percent or greater of patients discharged from the acute inpatient have a follow-up post discharge appointment within 7 days.

- Implement solutions to decrease patient no-show rates for post-discharge appointments from the acute inpatient unit.
    -- Implement an enhanced discharge plan that includes intensive patient education on post discharge appointments; validation of patient's primary and secondary contact information; and concurrence on patient's plan for adherence to appointed times.
    -- Implement patient introductions to follow-up appointment staff to increase patient compliance and ownership of follow-up appointment times. Warm introductions have shown to increase compliance rates for post discharge appointments.
    -- Develop and implement internal audit controls to measure and validate effectiveness of the process.

Recommendation 11. We recommended that processes be strengthened to ensure that medications listed in patient discharge instructions match those ordered at discharge.

Concur

Target date for completion: September 1, 2012

Our medication reconciliation committee is working on adjusting the template for discharge instructions to accurately reflect medications that have been started or stopped while inpatient (the specific fields for New Medications and Discontinued Medications will be forced and randomly audited for accuracy); and the process itself is being changed so that the inpatient providers will reconcile the medication lists, cancelling discontinued medications from the outpatient active lists, and adding new medications to the outpatient lists PRIOR to completing the Discharge Instructions/Medication Reconciliation note. This will be implemented over the next 6–9 months with education for attending staff and residents, and as with all of the improvements made in the medication reconciliation committee will have an associated

monthly audit, with reports to patient safety from the service chiefs, which is our current practice. The discharge pharmacists will be also be educated to assist when a discrepancy is found between the discharge medications and the active outpatient list and contact the appropriate inpatient provider for correction. The goal is to resolve a potential discrepancy before the patient leaves the pharmacy.

Recommendation 12. We recommended that nursing managers monitor the staffing methodology that was implemented in March.

Concur

Target date for completion: June 30, 2012

The facility expert review panel is reviewing Unit Based Panel Members (UBPM) recommendations for Nursing Hours Per Patient Day (NHPPD) and FTEE projections. Once approved, each nurse manager will facilitate processes in each clinical area for the daily use of the shift staffing tool. Calculations for NHPPD and nursing care hours are completed for each shift and made available to all nursing personnel. The NHPPD and nursing care hours data is used by off-tour nursing supervisors to facilitate the efficient use and allocation of nursing personnel.

Nurse Managers are expected to use the unit staffing calculators daily that are maintained on the common access drive: Z://Shared/Staffing Methodology/Unit, NHPPD Tracker Folder. At the end of the month staffing sheets for each day are archived by month to facilitate retrospective and prospective review of staffing trends. The staffing calculators are accessible to all nursing personnel to review NHPPD and Nursing Care Hours requirement for each unit.

The nurse managers will provide staffing metrics on a quarterly basis to the Associate Director of Patient Care Services through the facility Expert Review Panel for staffing methodology that compares required v. actual nursing staff available and targeted v. actual nursing care hours delivered for each inpatient area. Ongoing review will facilitate more efficient use of nursing resources across the organization. Availability of the staffing data will facilitate more efficient use of float staff personnel and the cross utilization of nursing personnel to augment turbulence and other unanticipated factors that impact nursing care delivery.

Recommendation 13. We recommended that processes be strengthened to ensure that the EHR Committee provides consistent oversight and coordination of EHR quality reviews and that EHR quality reviews are analyzed and trended.

Concur

Target date for completion: July 31, 2012

The Health Information Management Specialist (HIMS) will conduct monthly, service-specific, Electronic Medical Record (EMR) quality reviews. The data obtained from the EMR reviews will be analyzed, trended and reported monthly to the Medical

Records Committee (MRC). This comprehensive review will include appropriate recommendations for corrective actions should negative trends occur. The Joint Commission's chart audit review criteria will be utilized when performing service-specific, EMR, quality reviews:

The total number of reviews required are as follows:

* For a population size of fewer than 30 cases, sample 100 percent of available cases
* For a population size of 30 to 100 cases, sample 30 cases
* For a population size of 100 to 500 cases, sample 50 cases
* For a population size greater than 500 cases, sample 70 cases

Recommendation 14. We recommended that processes be strengthened to ensure that EHR reviews include all providers and all required elements and that the copy and paste functions are monitored.

Concur

Target date for completion: July 31, 2012

The Chief of Health Information Management (HIM) will ensure EMR reviews include all applicable providers and required elements. Additionally the Chief of HIM will ensure copy and paste functions are monitored, data is analyzed, trended and reported monthly to the MRC. This comprehensive review will include appropriate recommendations for corrective actions should negative trends occur. The Joint Commission's chart audit review criteria will be utilized when performing service-specific, EMR, quality reviews:

The total number of reviews required are as follows:

* For a population size of fewer than 30 cases, sample 100 percent of available cases
* For a population size of 30 to 100 cases, sample 30 cases
* For a population size of 100 to 500 cases, sample 50 cases
* For a population size greater than 500 cases, sample 70 cases

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