Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-00886-204

Combined Assessment Program Review of the VA Nebraska-Western Iowa Health Care System Omaha, Nebraska

June 22, 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
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	VA Nebraska-Western Iowa Health Care System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HF	heart failure
MEC	Medical Executive Committee
MH	mental health
NWI	Nebraska-Western Iowa
OIG	Office of Inspector General
POCT	point-of-care testing
PUMA	Physician Utilization Management Advisor
QM	quality management
RRTP	residential rehabilitation treatment program
SA	substance abuse
SCI	spinal cord injury
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA Nebraska-Western Iowa Health Care System, Omaha, NE

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 30, 2012.

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

- Medication Management
- Mental Health Treatment Continuity
- Point-of-Care Testing
- Polytrauma

The facility's reported accomplishments were the medical malpractice tort claim system redesign process and the initiation of multidisciplinary bedside rounds to improve patient understanding of the plan of care.

Recommendations: We made recommendations in the following six activities:

Quality Management: Report Focused Professional Practice Evaluation results to the Medical Executive Committee. Require mental health Physician Utilization Management Advisors to complete required activities. Record ethics consultation activities in electronic health records.

Environment of Care: Develop written procedures for contraband detection, and conduct and document monthly Psychosocial Residential Rehabilitation Treatment Program inspections. Ensure the Substance Abuse Residential Rehabilitation Treatment Program's access points are secured, alarmed, and monitored.

Coordination of Care: Ensure medications ordered at discharge match those listed on discharge instructions, and schedule follow-up appointments within providers' requested timeframes.

Colorectal Cancer Screening: Notify patients of positive screening and diagnostic test results within the required timeframe. Require clinicians to either develop follow-up plans or document that no follow-up is indicated.

Moderate Sedation: Include all required elements in pre-sedation assessment documentation. Ensure that intra- and post- procedure assessments are documented.

Nurse Staffing: Ensure that all facility and unit-based expert panel members receive required training.

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:

- Coordination of Care
- CRC Screening
- EOC
- Medication Management
- MH Treatment Continuity
- 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 May 3, 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 VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska,* Report No. 09-03743-189, July 12, 2010).

During this review, we presented crime awareness briefings for 106 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 411 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

Medical Malpractice Tort Claims

The medical malpractice tort claim process was improved through a systems redesign project. The process was separated into four responsibility areas: (1) Director, (2) Chief of Staff, (3) risk management teams, and (4) general counsel. Between October 2010 and October 2011, by streamlining processes and ensuring timely communication, the process for initial notification of a claim was reduced from 45.6 days to 6.2 days.

Nurse/Physician Rounding and the Use of Hospitalists

A nurse/physician rounding team was initiated in May 2011 with the goal of improving patients' perception of discharge readiness. In late 2011, hospitalists joined the team and are now the consistent contact for patients, families, nursing staff, and other medical staff. Daily rounds include all medicine groups that provide inpatient care. During the bedside sessions, patients and families are encouraged to participate and to provide input into care. Through improved communication and documentation, patients, families, and caregivers have a better understanding of the care and discharge plan.

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.
	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 UM reviews met requirements and participated in daily interdisciplinary discussions.
X	If cases were referred to a PUMA for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
X	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
	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.

FPPEs. VHA requires that the results from FPPEs be reported to the MEC for consideration in making the recommendation on privileges for newly hired licensed independent practitioners.[1] We reviewed the profiles of 10 newly hired licensed independent practitioners. The FPPE was not yet completed for one practitioner. None of the remaining nine practitioners' results were reported to the MEC.

UM. VHA requires facility PUMAs to collaborate with facility UM and medical staff to provide medical recommendations on UM cases that did not meet acute inpatient care criteria.[2] We found that MH PUMAs did not collaborate to provide medical recommendations on cases that did not meet criteria.

Integrated Ethics. VHA requires final summary notes for ethics consultations pertaining to active clinical cases to be entered into the EHR.[3] For four of the five cases we reviewed, the EHRs did not contain evidence of the consultation.

Recommendations

1. We recommended that processes be strengthened to ensure that results from FPPEs are consistently reported to the MEC.

2. We recommended that processes be strengthened to ensure that MH PUMAs collaborate with UM and medical staff to provide medical recommendations on cases that did not meet criteria.

3. We recommended that processes be strengthened to ensure that ethics consultation activities are recorded in EHRs.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Directive 2010-021, *Utilization Management Program*, May 14, 2010.
[3] VHA Handbook 1004.06, *Integrated Ethics*, June 16, 2009.

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 SA and Psychosocial RRTPs were in compliance with selected MH RRTP requirements.

We inspected the intensive care, acute psychiatric, cardiac telemetry, and medical-surgical inpatient units. We also inspected the dental, polytrauma, SCI primary care, and outpatient primary care clinics; the emergency department; the community living center; and the SA and Psychosocial RRTP units. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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 outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
X	There was a policy that addressed safe medication management, contraband detection, and inspections.
X	MH RRTP inspections were conducted, included all required elements, and were documented.

Noncompliant	Areas Reviewed for MH RRTP (continued)
	Actions were initiated when deficiencies were identified in the residential environment.
X	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.

MH RRTP Policy. VHA requires that MH RRTP managers develop written procedures for detecting contraband brought onto the unit.[4] We determined that the SA and Psychosocial RRTP units did not have written procedures for contraband detection in public areas.

MH RRTP Inspections. VHA requires facilities to conduct and document monthly MH RRTP self-inspections that include safety, security, and privacy.[5] Additionally, random and regular public area contraband inspections must be conducted. On the Psychosocial RRTP unit, we found that monthly self-inspections did not consistently include all required elements and that public area contraband inspections were not performed.

MH RRTP General Safety. VHA requires that all MH RRTP access points are secured with keyless entry, alarms, and closed-circuit television monitoring.[6] MH RRTP staff may open the main entrance to the MH RRTP unit during normal business hours as long as the main access point is monitored to ensure that only authorized patients, staff, and visitors enter the unit. On the SA RRTP unit, we found that none of the unit's six entrance/egress access points were secured, alarmed, or monitored during the day.

Recommendations

4. We recommended that MH RRTP managers develop written procedures for contraband detection in public areas.

5. We recommended that processes be strengthened to ensure that documentation of monthly Psychosocial RRTP unit self-inspections includes all required elements and that public area contraband inspections are conducted and documented.

6. We recommended that processes be strengthened to ensure that the SA RRTP's access points are secured, alarmed, and monitored during the day.

[4] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[5] VHA Handbook 1162.02.
[6] VHA Handbook 1162.02.

Coordination of Care

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 23 HF patients' EHRs and relevant documents and interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings 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.
X	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 six EHRs, medications ordered at discharge did not match those listed in patients' discharge instructions.

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[7] Although provider discharge instructions requested specific follow-up appointment timeframes, six EHRs did not have appointments scheduled within the timeframes requested.

Recommendations

7. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patients' discharge instructions.

8. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

[7] VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 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 20 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.
X	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.[8] Seven 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.[9] Five EHRs did not have a documented follow-up plan within the required timeframe.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinician's document notification.[10] Four of the 14 patients who received diagnostic testing did not have documented evidence of timely notification in their EHRs.

[8] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[9] VHA Directive 2007-004.
[10] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Recommendations

9. 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.

10. 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.

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

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 57 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.
	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.[11] VHA also requires that providers reassess the patient immediately before the procedure starts and document the time and nature of the last oral intake. Ten EHRs did not include all required elements of the history and physical examination, such as history of substance use or abuse, airway assessment, and previous anesthesia. Additionally, three EHRs did not contain evidence of reassessment immediately before the procedure started, and none of the EHRs contained documentation of the time and nature of the last oral intake.

Intra- and Post-Procedure Monitoring. VHA requires that assessments, including vital signs, level of consciousness, and pain level, during and after a procedure involving moderate sedation are documented appropriately.[12] Two EHRs did not contain any documentation of patient status intra- and/or post-procedure.

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

Recommendations

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

13. We recommended that processes be strengthened to ensure that patients undergoing moderate sedation are appropriately assessed intra- and post-procedure and that assessments are documented in EHRs.

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. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (7E) 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.[13] There was no documentation that any of the facility and unit-based expert panel members had completed the required training.

Recommendation

14. 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 and that the training is documented.

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

Review Activities Without Recommendations

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[14] 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 and interviewed key employees. 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 who 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.

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

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 29 patients discharged from acute MH (including 9 patients deemed at high risk for suicide). 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, 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 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.

Polytrauma

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

We reviewed relevant documents, 10 EHRs of patients with positive traumatic brain injury results, 10 EHRs of patients who received outpatient polytrauma services, and 8 staff training records. We also 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 findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 21–27, for the full text of the Directors' comments.) We consider Recommendation 6 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[15]		
Type of Organization	Tertiary medical center	
Complexity Level	1C	
VISN	23	
Community Based Outpatient Clinics	Bellevue, NE, Holdrege, NE Norfolk, NE North Platte, NE Lincoln, NE Grand Island, NE O'Neill, NE (contract clinic)	
Veteran Population in Catchment Area	161,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	142	
• **Community Living Center/Nursing Home Care Unit**	76	
• **Other**	N/A	
Medical School Affiliations	University of Nebraska Medical Center Creighton University School of Medicine	
• **Number of Residents**	125	
	Current FY (through January 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$362.7	$363.3
• **Medical Care Expenditures**	$200.7	$362.1
Total Medical Care Full-Time Employee Equivalents	1,837	1,858
Workload:		
• **Number of Station Level Unique Patients**	36,901	54,942
• **Inpatient Days of Care:**		
o **Acute Care**	6,719	20,056
o **Community Living Center/Nursing Home Care Unit**	4,895	16,588
Hospital Discharges	1,380	5,294
Total Average Daily Census (including all bed types)	75	69.8
Cumulative Occupancy Rate (in percent)	59	59.9
Outpatient Visits	177,887	510,361

[15] All data provided by facility management.

VHA Satisfaction Surveys

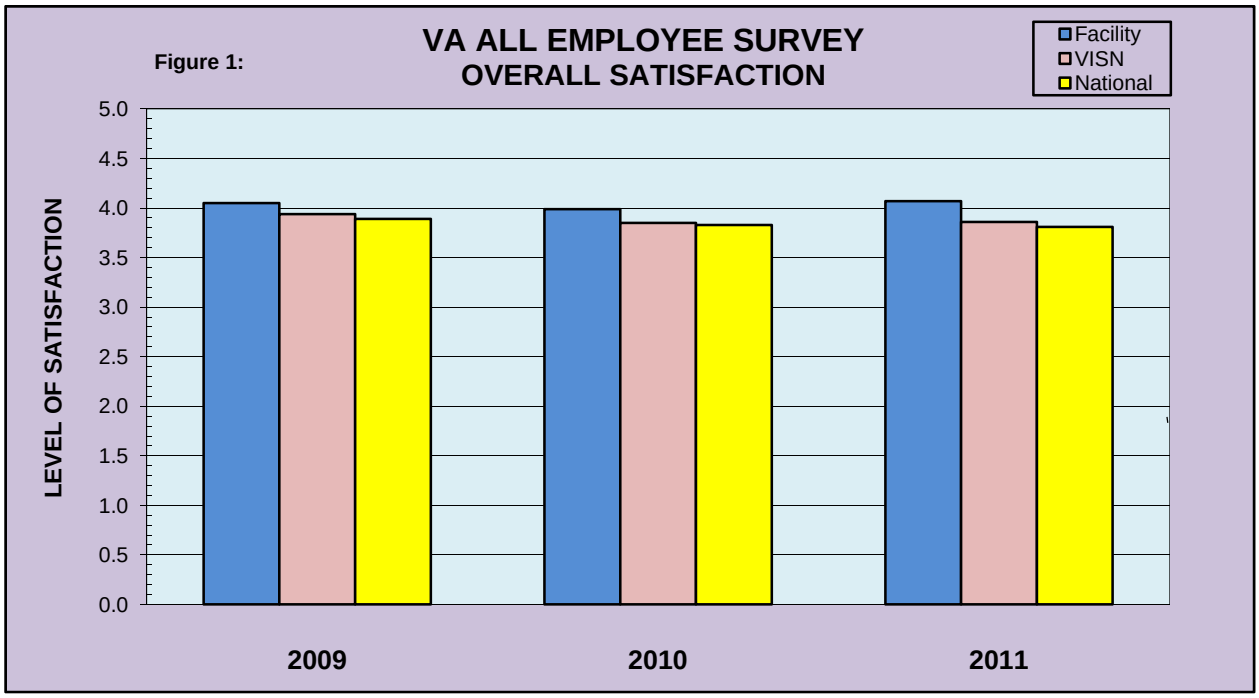
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2011.

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	73.0	64.3	59.4	58.9	54.2	55.3
VISN	67.2	66.5	61.2	58.1	60.4	58.8
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.[16] 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.[17]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	16.8	12.1	11.2	23.3	26.5	20.6
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[16] 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.

[17] 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: June 1, 2012

From: Director, VA Midwest Health Care Network (10N23)

Subject: **CAP Review of the VA Nebraska-Western Iowa Health Care System, Omaha, NE**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

Thank you for the opportunity to review and provide comments in regard to the Combined Assessment Program review of VA Nebraska-Western Iowa Healthcare System conducted April 30–May 3, 2012.

We concur with the action plans regarding the recommendations identified in this report.

(original signed by:)
Janet P. Murphy, MBA

Appendix D

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 1, 2012

From: Director, VA Nebraska-Western Iowa Health Care System (636/00)

Subject: **CAP Review of the VA Nebraska-Western Iowa Health Care System, Omaha, NE**

To: Director, VA Midwest Health Care Network

This is to acknowledge the receipt and review of the findings and recommendations of the Office of Inspector General Combined Assessment Program review. Nebraska-Western Iowa Health Care System concurs with the findings and recommendations. Corrective action plans have been developed or implemented for all recommendations.

Our appreciation is extended to the OIG CAP team. The team was consultative, professional and provided constructive feedback to our staff. We appreciate the thorough review and the opportunity to further improve the quality of care we provide to our veterans.

(original signed by:)
Marci Mylan, Ph.D.
Director

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 results from FPPEs are consistently reported to the MEC.

Concur

Target date for completion: September 30, 2012

NWI concurs that the FPPE process be strengthened to ensure that results from FPPEs are consistently reported to the MEC. Beginning in April, all FPPEs are reported to the MEC as a standard item for the committee. The discussion and recommendations of the committee are documented in the committee minutes.

Recommendation 2. We recommended that processes be strengthened to ensure that MH PUMAs collaborate with UM and medical staff to provide medical recommendations on cases that did not meet criteria.

Concur

Target date for completion: July 31, 2012

NWI concurs that the process related to Mental Health PUMAs be strengthened. On a daily basis the UM Manager will follow-up with responses and facilitate communication with the medical and MH teams when there are treatment concerns, as well as with the PUMA staff if an agreeable plan of care is not able to be developed. In the absence of the UM Manager, a back-up manager will be fulfilling these responsibilities to ensure that daily follow-up is occurring. An additional MH PUMA has been educated on the role/responsibilities of the PUMA and will work in conjunction with the lead PUMA for consistent MH PUMA coverage. Daily monitoring of all PUMA responses will be reported to the Executive team with the monthly National Utilization Management Integration report. All cases referred to the MH PUMA will be addressed by either the lead Mental Health PUMA or the secondary Mental Health PUMA. This report will begin in June 2012.

Recommendation 3. We recommended that processes be strengthened to ensure that ethics consultation activities are recorded in EHRs.

Concur

Target date for completion: July 1, 2012

NWI concurs that the ethics consultation activities should be recorded in the EHRs. Effective immediately, all ethics consultants assigned to an active clinical case will make an entry into EC Web and into the patient medical record on a weekly basis and/or as updates occur until the consult is completed. This note will be entered into the "Patient Ethics Consult Note." Upon completion of the patient ethics consult, the assigned consultant will enter a complete discussion of the ethics consult into the medical record within one week of completing the consult. If the ethics consultant is unable to enter the complete discussion within one week, the Ethics Consultative (EC) Coordinator will make the entry from data and information available through EC Web. The EC Coordinator will audit all active clinical case records to ensure that each ethics consultant is documenting as required. The results of the audits will be reported to the Integrated Ethics Committee beginning with the June 2012 meeting. All ethics consultations will be documented in the medical record.

Recommendation 4. We recommended that MH RRTP managers develop written procedures for contraband detection in public areas.

Concur

Target date for completion: June 30, 2012

NWI concurs that the RRTP units have a written procedure for contraband detection in public areas. The RRTP managers will develop a uniform Standing Operating Procedure related to contraband detection in public areas.

Recommendation 5. We recommended that processes be strengthened to ensure that documentation of monthly Psychosocial RRTP unit self-inspections includes all required elements and that public area contraband inspections are conducted and documented.

Concur

Target date for completion: September 30, 2012

NWI concurs that the process regarding monthly Psychosocial RRTP unit self-inspections be strengthened. Based upon the VHA Handbook and the unit's Standard Operating Procedure for monthly inspections, a checklist will be developed that includes all required elements and addresses public area contraband inspections. The unit will complete these inspections on a monthly basis and will report the results to the Mental Health Leadership Committee.

Recommendation 6. We recommended that processes be strengthened to ensure that the SA RRTP's access points are secured, alarmed, and monitored during the day.

Concur

Target date for completion: Completed May 7, 2012

NWI agrees that all SARRTP access points should be secured, alarmed and monitored during the day. All doors on the SARRTP unit are now secured and alarmed 24/7. CCTV cameras are in all hallways on the unit and monitored 24/7 by the SARRTP staff. We consider this recommendation closed.

Recommendation 7. We recommended that processes be strengthened to ensure that medications ordered at discharge match those listed on patients' discharge instructions.

Concur

Target date for completion: September 30, 2012

NWI concurs that the process related to discharge medications and instructions be strengthened. An interdisciplinary group comprised of pharmacy and providers will meet to implement the ability to import the discharge pharmacy list into the discharge summary. Education for providers will be developed and on-going. The interdisciplinary group will begin to audit the process once the ability to import and education has been completed. Results will be reported to the Quality Board beginning July, 2012.

Recommendation 8. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

Concur

Target date for completion: July 30, 2012

NWI concurs that the process related to follow-up appointments for the CHF patient be strengthened. A discharge order set will be implemented that will provide for timely follow-up appointments. In addition, there will be the addition of reserved outpatient clinic appointments specifically for the CHF follow-up appointments. Audits of CHF follow-up appointments will be done to ensure that appropriate and timely follow-up was completed. Audit results will be reported to the CHF work-group for review and discussion. Audit results will also be reported to the Quality Board.

Recommendation 9. 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: September 30, 2012

NWI concurs that the process of notifying patients of their positive CRC screening results be strengthened. Within fourteen days, the ordering provider will be alerted electronically by lab of a positive screening result through a CPRS alert. The ordering providers, within fourteen days, will also document they received notification and the

patient has been notified of the results. Audits of patients with a positive screen will conducted monthly with results discussed at the Non-OR Invasive Committee and to the Quality Board. All patients will be notified of their positive CRC screening results.

Recommendation 10. 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: September 30, 2012

NWI concurs that the process regarding CRC follow-up plans or follow-up not indicated be strengthened. Appropriate patient follow-up will be ordered and documented into the electronic medical record by the primary provider after receiving a CPRS alert generated by pathology. Monthly audits of patients will be conducted and results discussed at the Non-Operating Room Invasive Committee and Quality Board. All patients will have documentation addressing a follow-up plan or documentation indicating no documentation is required.

Recommendation 11. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: September 30, 2012

NWI concurs that the process regarding patient notification of CRC diagnostic test results and provider documentation of patient notification be strengthened. The GI lab will enter a clinical note into the electronic medical record stating that the patient has received both verbal and written results following the colonoscopy. If biopsies are taken, the patient will also receive a letter from the GI provider as soon as results are known and this letter is also entered into the electronic medical record. Monthly audits of patients will be conducted and results discussed at the Non-Operating Room Invasive Committee and Quality Board. All patients will receive notification of diagnostic test results within the required time frame and clinicians will document this patient notification.

Recommendation 12. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: July 6, 2012

NWI concurs that the pre-sedation assessment documentation should include all the required elements. Each department that performs moderate sedation will receive a

copy of the VHA Directive and the departments will complete a gap analysis related to their current documentation and required elements for pre-sedation assessments. The Chief of Anesthesiology and Nursing Surgical Director will meet with each department to confirm that all required elements are addressed in their documentation. A random audit of departments will be done with the target goal of 100% completion of all required elements. Monthly audits will begin in June with results reported to the Non-OR Invasive Committee.

Recommendation 13. We recommended that processes be strengthened to ensure that patients undergoing moderate sedation are appropriately assessed intra- and post-procedure and that assessments are documented in EHRs.

Concur

Target date for completion: July 6, 2012

NWI concurs that the intra- and post-procedure assessments documentation should include all the required elements. Each department that performs moderate sedation will received a copy of the VHA Directive and the departments will complete a gap analysis related to their current documentation and required elements for intra- and post-procedure assessments. The Chief of Anesthesiology and Nursing Surgical Director will meet with each department to confirm that all required elements are addressed in their documentation. A random audit of departments will be done with the target goal of 100% completion of all required elements. Monthly audits will begin in June with results reported to the Non-Operating Room Invasive Committee.

Recommendation 14. 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 and that the training is documented.

Concur

Target date for completion: July 1, 2012

NWI concurs that all members of the facility and unit-based expert panels receive the required training and the training should be documented. With this year's reassessment of NWI's staffing methodology, all team members, unit and expert panels will be required to complete a locally developed training package through the Talent Management System (TMS). TMS will track training completion. Managers of the units will audit completion with a target of 90% compliance. Results will be reported to the Nursing Management Council.

OIG Contact and Staff Acknowledgments

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