Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00306-95

Combined Assessment Program Review of the VA Eastern Colorado Health Care System Denver, Colorado

March 19, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EHR	electronic health record
EOC	environment of care
facility	VA Eastern Colorado Health Care System
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of January 13, 2014.

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

- Environment of Care
- Medication Management
- Coordination of Care

The facility's reported accomplishments were Lean Six Sigma implementation and the Telehealth Program.

Recommendations: We made recommendations in the following four activities:

Quality Management: Reassess observation criteria and utilization timely when conversions from observation bed status to acute admissions are over 30 percent. Perform continuing stay reviews on at least 75 percent of patients in acute beds. Ensure the Surgical Work Group meets monthly and includes the Chief of Staff as a member.

Nurse Staffing: Implement the nurse staffing methodology. Ensure that the facility expert panel includes all required members and that all members of the facility and unit-based expert panels receive the required training.

Pressure Ulcer Prevention and Management: Ensure all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged.

Community Living Center Resident Independence and Dignity: Complete and document restorative nursing services according to clinician orders and/or residents' care plans. Provide all care planned/ordered assistive eating devices to residents for use during meals. Ensure there are no unnecessary disruptions during resident meal periods.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–25, for the full text of the Directors' comments.) We consider recommendation 3 closed. We will follow up on the planned actions for the open recommendations 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 quality and the EOC.
- 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2012, FY 2013, and FY 2014 through January 12, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado,* Report No. 09-03040-114, March 24, 2010).

During this review, we presented crime awareness briefings for 239 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 436 responded. We shared summarized 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

Lean Six Sigma Implementation

The facility has improved patients' experiences and quality outcomes by integrating patient-centered Lean Six Sigma implementation with strategic planning. In FY 2013, the facility conducted an Enterprise Wide Value Stream Analysis that identified areas in need of organizational improvement, such as access to care, MH, inpatient flow, and staff and employee engagement. These areas were selected based on metrics from various sources analyzed from the previous year and align with VHA's strategic plan. Using Lean Six Sigma methodology, interdisciplinary teams consisting of frontline staff were chartered to improve both clinical and administrative areas and successfully completed 22 Rapid Process Improvement Workshops. Successes include a reduction in ventilator-associated pneumonia incidents, improved patient flow in the Infusion Center, a decrease in missed appointments, and improved staff satisfaction through engagement.

Telehealth Program

The facility's Telehealth Program has expanded to 24 telehealth clinics, including MH, dermatology, gynecology, pain, post-traumatic stress disorder, and wheelchair seating clinics. Ten of these clinics support other VHA facilities in Sheridan and Cheyenne, WY; Helena, MT; and Grand Junction, CO. The program also provides educational opportunities in dermatology, where residents review images sent from remote locations through a "Store and Forward" program. Currently, more than 11,000 veterans (over 15 percent of the facility's patients) receive care through the Telehealth Program.

Results and 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 met selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated, completed, and reported to the MEC.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
X	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	Twelve months of data reviewed: • For December 2012–November 2013, 50 percent of observation patients were converted to acute admissions, and the facility had not reassessed observation criteria or utilization during that time.
X	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	Twelve months of continuing stay data reviewed: • For all 12 months, less than 75 percent of acute inpatients were reviewed.
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	• The Surgical Work Group only met 4 times over the past 12 months. • The Chief of Staff was not a member of the Surgical Work Group.
	Critical incidents reporting processes were appropriate.	
	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed timely.

2. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of patients in acute beds.

3. We recommended that the Surgical Work Group meet monthly and include the Chief of Staff as a member.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in radiology and acute MH were met.[2]

We inspected the locked MH, medical intensive care, and medical/surgical inpatient units; the emergency and radiology departments; the primary care, specialty care, and dental outpatient clinics; and the CLC. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 30 employee training records (10 radiology employees, 10 acute MH unit employees, 5 Multidisciplinary Safety Inspection Team members, and 5 occasional acute MH unit employees). The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	

NM	Areas Reviewed for Radiology (continued)	Findings
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	
	The facility had policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
	MH EOC inspections were conducted every 6 months.	
	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	

NM	Areas Reviewed for Acute MH (continued)	Findings
	The locked MH unit(s) was/were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 31 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

Coordination of Care

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 32 randomly selected patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on three inpatient units (acute medical/surgical, long-term care, and MH).[5]

We reviewed facility and unit-based expert panel documents and 36 training files, and we conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• Initial implementation had not been completed.
X	The facility expert panel followed the required processes and included the required members.	• The facility expert panel did not include the evening supervisor or direct care staff nurses.
	The unit-based expert panels followed the required processes and included the required members.	
X	Members of the expert panels completed the required training.	• Four of the 18 members of the unit-based expert panels had not completed the required training. • Five of the 18 members of the facility expert panel had not completed the required training.
NA	The 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 VHA or local policy.	

Recommendations

4. We recommended that the nurse staffing methodology be implemented.

5. We recommended that the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

6. 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.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 16 EHRs of patients with pressure ulcers (4 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 2 patients with pressure ulcers at the time of our onsite visit), and 7 employee training records. Additionally, we inspected two patient rooms. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
X	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	• Two of the applicable five EHRs did not contain evidence of wound care follow-up plans at discharge or of patient receipt of dressing supplies prior to discharge.

NM	Areas Reviewed (continued)	Findings
	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	
	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

7. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed six EHRs of residents (three residents receiving restorative nursing services and three residents not receiving restorative nursing services but candidates for services). We also observed one resident during two meal periods, reviewed five employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	• In all three applicable EHRs, there was insufficient documentation that facility staff completed restorative nursing services according to clinician orders and/or residents' care plans.
	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from physical therapy, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	
	Areas Reviewed for Assistive Eating Devices and Dining Service	
X	Care planned/ordered assistive eating devices were provided to residents at meal times.	• Four of the six assistive eating devices care planned/ordered were not provided.

NM	Areas Reviewed for Assistive Eating Devices and Dining Service (continued)	Findings
X	Required activities were performed during resident meal periods.	• There were unnecessary disruptions during resident meal periods such as a lack of eating utensils, a delay in food preparation, and floor mopping around residents.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

8. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

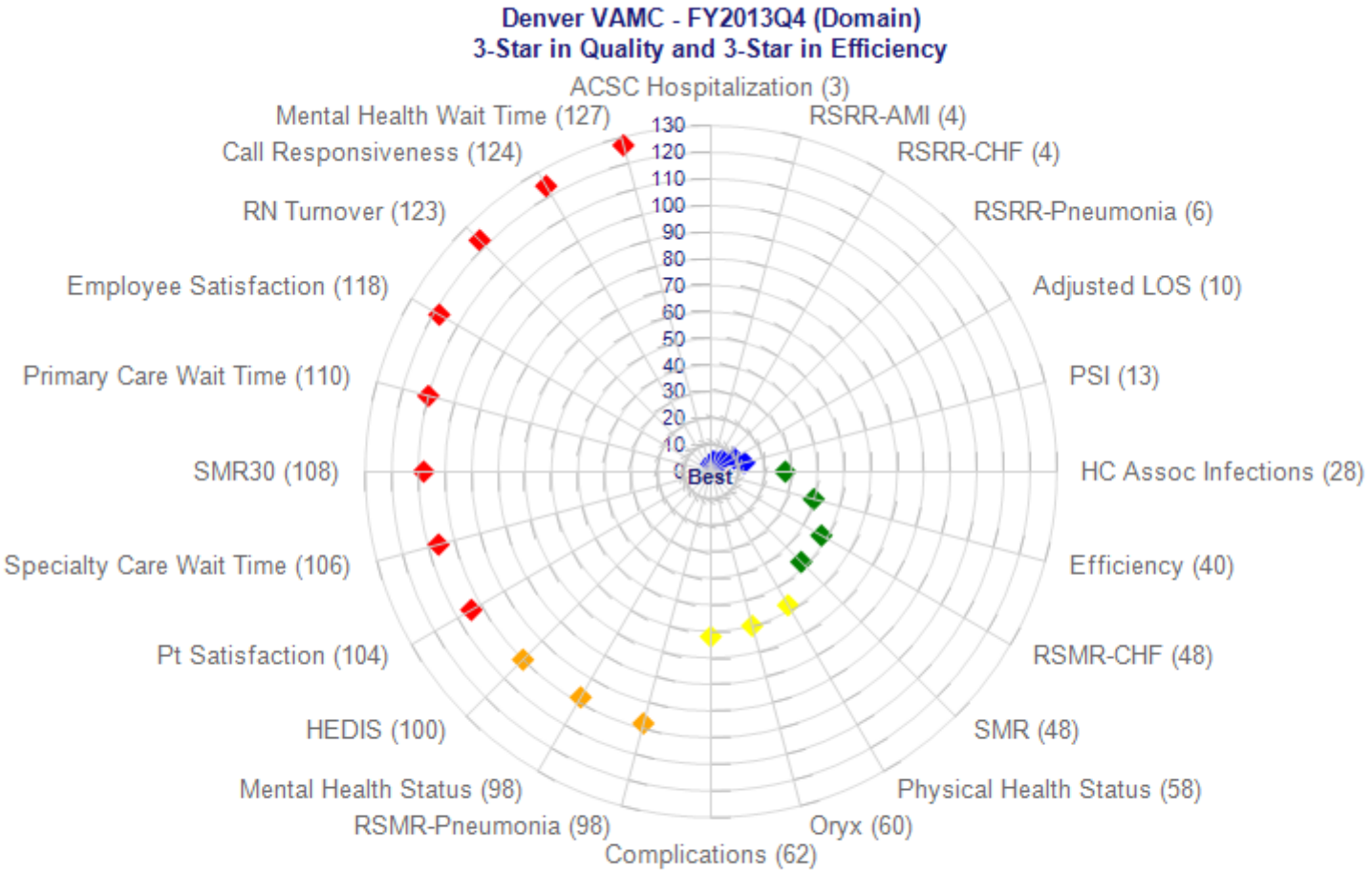
9. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

10. We recommended that processes be strengthened to ensure that there are no unnecessary disruptions during resident meal periods.

Facility Profile (Denver/554) FY 2014 through January 2014[a]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions (September 2013)	$569.1
Number of:	
• **Unique Patients**	53,625
• **Outpatient Visits**	252,858
• **Unique Employees**[b]	2,200
Type and Number of Operating Beds (December 2013):	
• **Hospital**	129
• **CLC**	100
• **MH**	59
Average Daily Census (December 2013):	
• **Hospital**	103
• **CLC**	72
• **MH**	44
Number of Community Based Outpatient Clinics	8
Location(s)/Station Number(s)	Aurora/554GB Lakewood/554GC Pueblo/554GD Colorado Springs/554GE Alamosa/554GF La Junta/554GG Lamar/554GH Burlington/554GI
VISN Number	19

[a] All data is for FY 2014 through January 2014 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

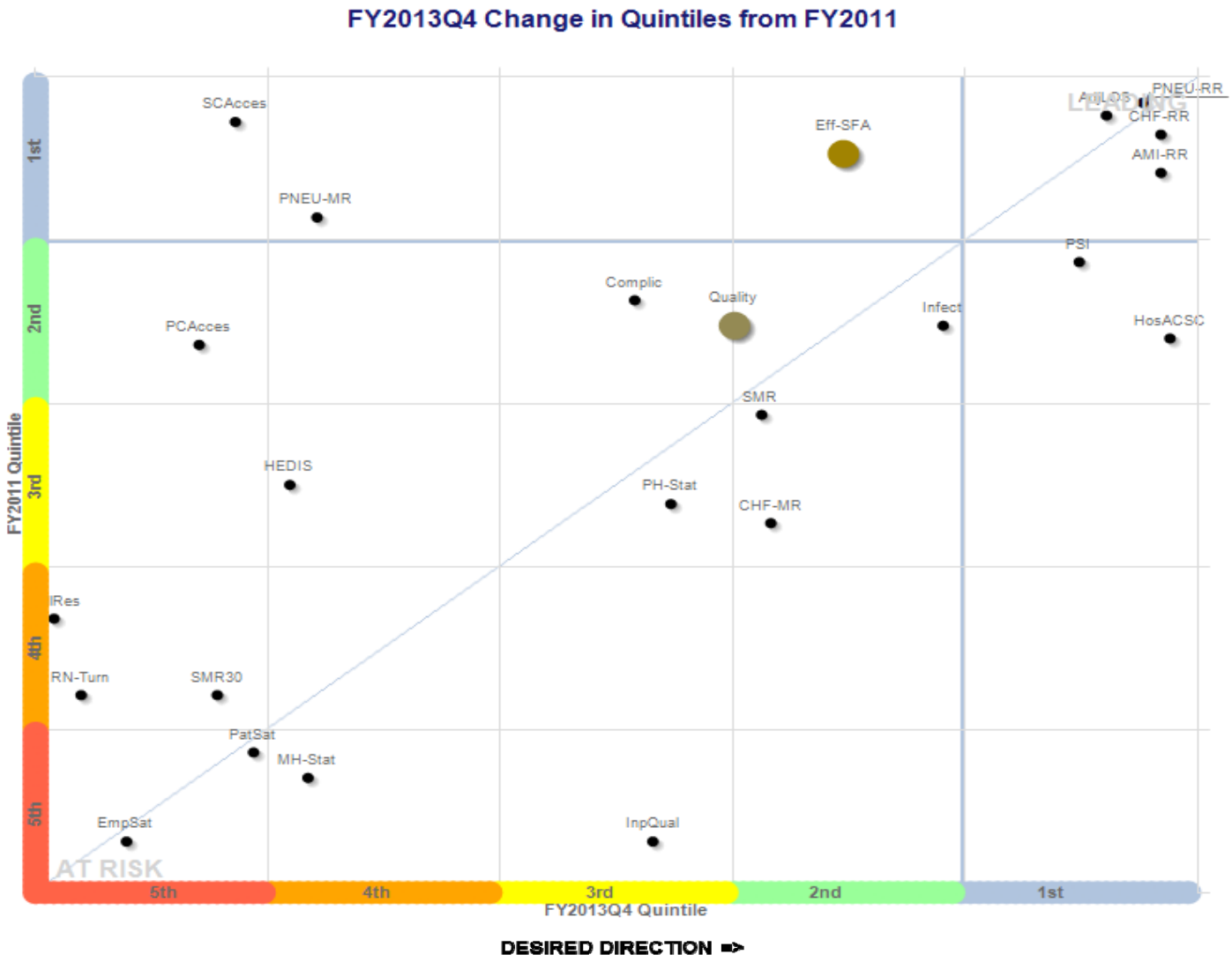
Strategic Analytics for Improvement and Learning (SAIL)[c]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[c] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Status	MH status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value
PSI	Patient safety indicator	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 24, 2014

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the VA Eastern Colorado Health Care System, Denver, CO**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. We are submitting written comments in response to the Combined Assessment Program Review completed January 13–17, 2014, at the VA Eastern Colorado Health Care System at Denver, Colorado.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. Network 19 concurs with the report.

3. If you have any questions regarding this response, please contact Ms. Susan Curtis, VISN 19 HSS at (303) 639-6995.

(original signed by:)
Ralph T. Gigliotti, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 21, 2014

From: Director, VA Eastern Colorado Health Care System (554/00)

Subject: **CAP Review of the VA Eastern Colorado Health Care System, Denver, CO**

To: Director, Rocky Mountain Network (10N19)

1. We are submitting written comments in response to the Combined Assessment Program Review completed January 13–17, 2014, at the VA Eastern Colorado Health Care System (ECHCS) at Denver, Colorado.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. ECHCS concurs with the report.

3. If you have any questions regarding this response, please contact Mr. Keith Harmon at (303) 398-7469.

(original signed by:)
Lynette A. Roff

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 when conversions from observation bed status to acute admissions are over 30 percent, observation criteria and utilization are reassessed timely.

Concur

Target date for completion: August 31, 2014

Facility response: All observation patients will be assessed daily for appropriate bed status based on current utilization management (UM) criteria. Providers/care teams will be notified of identified issues. On an on-going basis data on reasons for conversions to admission status will be collected and action plans developed/implemented to decrease conversions based on this data.

ECHCS will perform monthly monitoring over the next 6 months. This will be reported to the Performance Improvement Board and will be reflected in the monthly minutes.

Recommendation 2. We recommended that processes be strengthened to ensure that continuing stay reviews are performed on at least 75 percent of patients in acute beds.

Concur

Target date for completion: July 31, 2014

Facility response: Utilization reviews for continued stays will be performed on at least 75 percent of patients in acute beds according to the National UM performance measure. UM reviewers and inpatient care coordinators daily primary goal will be completion of UM reviews. Secondary goals will include support of discharge planning functions after UM reviews are completed and as needed.

UM will perform weekly audits over the next 5 months to ensure compliance. This will be reported to the Performance Improvement Board and will be reflected in the monthly minutes.

Recommendation 3. We recommended that the Surgical Work Group meet monthly and include the Chief of Staff as a member.

Concur

Target date for completion: January 31, 2014

Facility response: Meetings are now scheduled monthly as of January and Chief of Staff is a permanent attendee for the Surgical Work Group.

Recommendation 4. We recommended that nurse staffing methodology be implemented.

Concur

Target date for completion: June 30, 2014

Facility response: Based on staffing methodology review, Nursing Service will present their recommendation for staffing to the ECHCS Director by February 28, 2014. Decisions to allocate resources to each unit based on the medical center's projected budget and in consideration of the justification for the requested full-time employee equivalent will be made subsequent to this presentation. Nurse Managers will be trained to monitor the actual nursing hours per patient day versus the target nursing hours per patient day, analyze the variances, and make recommendations for action.

Nursing Service will implement Nurse Staffing methodology within the next 4 months and develop an ongoing monitoring program to assure continuous compliance. This will be reported to the Governing Board and will be reflected in the monthly minutes.

Recommendation 5. We recommended that the annual staffing plan reassessment process ensures that the facility expert panel includes all required members.

Concur

Target date for completion: April 30, 2014

Facility response: Existing expert panel members will be given the opportunity to continue as members for FY15. Additional expert panel members will be added to insure the inclusion of all required members per directive. All current and future expert panel members will be apprised of the responsibilities involved in participating as a member of the facility expert panel.

Nursing Service will ensure additional members have been added within 2 months. This will be reported to the Governing Board and will be reflected in the minutes.

Recommendation 6. We recommended that all members of the facility and unit-based expert panels receive the required training prior to the next annual staffing plan reassessment.

Concur

Target date for completion: December 30, 2014

Facility response: Current unit-based expert panel members will be assigned to complete the required training by May 30, 2014. All new unit-based expert panel

members at the time of the October 2014 staffing plan reassessment will be assigned to complete the required training by December 30, 2014.

Nursing Service will ensure that all expert panel members have completed the training prescribed.

Recommendation 7. We recommended that processes be strengthened to ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that compliance be monitored.

Concur

Target date for completion: May 30, 2014

Facility response: Medicine service at orientation receives the newly developed Wound Care Treatment fact sheet. Pressure ulcer orders now have an added notification "patient has a pressure ulcer, please notify wound care prior to discharge or place discharge wound care orders." The Wound Care Consult recommendations are incorporated into the discharge plan for supplies and follow up appointment. The patient's medicine team co-signs the wound care consult.

Wound Care Team will perform random patient record audits monthly for the next 3 months to ensure compliance and will be reflected in the Wound Care Committee minutes. This will also be reported to the Clinical Executive Board in April.

Recommendation 8. We recommended that processes be strengthened to ensure that staff complete and document restorative nursing services according to clinician orders and/or residents' care plans and that compliance be monitored.

Concur

Target date for completion: June 30, 2014

Facility response: Restorative orders and care plans are being reviewed with restorative staff. Restorative nursing documentation and care plans have been updated and documentation of treatment plans is being updated daily.

Compliance audits will be maintained at 90% compliance for the next 4 months and then will be conducted randomly.

Recommendation 9. We recommended that processes be strengthened to ensure that all care planned/ordered assistive eating devices are provided to residents for use during meals.

Concur

Target date for completion: April 30, 2014

Facility response: Nutrition and Food Service (N&FS) will review all ordered assistive devices in collaboration with the Restorative Registered Nurse to ensure availability. Current ordered assistive devices are available to CLC residents. CLC are now monitoring for adequate stock of adaptive cups and knives.

N&FS will maintain a tracking sheet of patients who are planned/ordered assistive eating devices and establish a par level to ensure an appropriate amount is available for this patient population. Inventory results will be tracked daily and reported quarterly. Par levels will be adjusted as needed.

Recommendation 10. We recommended that processes be strengthened to ensure that there are no unnecessary disruptions during resident meal periods.

Concur

Target date for completion: May 30, 2014

Facility response: The dining room will be off limits to housekeeping staff during meal times while patients are present, unless absolutely necessary. Housekeeping Supervisors will monitor for compliance daily. Utensils will be made available to residents at all meal times. Staff will monitor CLC cart to ensure silverware is washed and ready for each meal maintaining 90% compliance. Food preparation and meal schedules will be reviewed with staff to ensure timely meal preparation to meet 95% compliance.

Compliance audits will be performed during the next 3 months to ensure 95% compliance and then random PRN observations.

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Endnotes

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