Department of
Veterans Affairs

Office of Inspector General

OFFICE OF HEALTHCARE INSPECTIONS

HEALTHCARE INSPECTION

MULTIPLE MANAGEMENT AND PATIENT CARE ISSUES AT THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER OMAHA, NEBRASKA

REPORT NUMBER: 00–00025–111
DATE: SEPTEMBER 5, 2000

Office of Inspector General
Washington DC 20420

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

SEP 5 2000

TO: Director, VA Medical Center (636/00)

SUBJECT: Healthcare Inspection – Multiple Management and Patient Care Issues at the Department of Veterans Affairs Medical Center Omaha, Nebraska (Report 00-00025-111)

1. The Department of Veterans' Affairs (VA) Office of Inspector General (OIG) reviewed multiple allegations from an anonymous complainant pertaining to a wide variety of issues at the Omaha, Nebraska VA Medical Center (VAMC). United States Senators J. Robert Kerrey and Tom Harkin wrote the Inspector General asking for a review of similar complaints that their offices received. The purpose of the review was to determine the validity of the allegations.

2. The complainant provided allegations that he collected from multiple individuals, most of whom are Omaha VAMC patients. Additional individuals contacted the OIG during the course of the inspection. We interviewed VA managers, employees, and 165 patients. We grouped the allegations, many of which had similar themes, into management, clinical care, and administrative categories.

3. While we found many positive aspects about the care and treatment of veterans at the Omaha VAMC, we substantiated allegations pertaining to the overall ineffectiveness of the facility's Post Traumatic Stress Disorder (PTSD) Program. We substantiated allegations concerning excessive delays in patient access to specialty care, and patient distrust and dissatisfaction with the Patient Representative Program. We substantiated allegations of poor patient privacy and medical record confidentiality, privacy and security for female inpatients in acute psychiatry, insufficient handicapped restroom access, and inadequate access to hepatitis "C" follow-up care. In addition, we identified some cases of questionable care, which require further review.

4. We did not substantiate allegations that police abused a patient, or that improper administrative actions were taken against a former social worker. We did not substantiate allegations of employee misconduct, mishandling of patients' mail, or theft of patient property. We also did not substantiate that there was a diversion of deceased patients' corneas to a local laboratory, or that managers misused grant funds to purchase office furniture for a VAMC physician. In addition, we did not substantiate allegations that the Women's Health Coordinator provided patients poor quality care and treatment.

5. We reviewed allegations received from a patient that clinicians did not provide her with sufficient medical care. While we did not substantiate allegations of inadequate care, we identified two lapses in administratively processing requests (i.e., processing one consultation and one request for home health care services). This issue was reported separately in a report titled "Patient Care Issue at VA Medical Center, Omaha, Nebraska," dated August 4, 2000 (Report Number 00-00025-95).

6. We made 16 recommendations for improving overall services by the Omaha VAMC. You concurred with the recommendations and provided detailed implementation plans. We will continue to follow-up on the implementation of the recommendations until all issues have been resolved.

(original signed by Michael L. Staley for:)
ALANSON J. SCHWEITZER
Assistant Inspector General for
Healthcare Inspections

CONTENTS

ABBREVIATIONS AND ACRONYMS

AAA	Abdominal aortic aneurysm
ABA	Architectural Barriers Act
ADA	Americans with Disabilities Act
ADE	Adverse Drug Event
AUSH	Acting Under Secretary for Health
CAP	Combined Assessment Program
DAV	Disabled American Veterans
EGD	Esophagogastroduodenoscopy
FOIA	Freedom of Information Act
FTE	Full-Time Employee
FY	Fiscal Year
GI	Gastrointestinal
HCV	Hepatitis C Virus
ICU	Intensive Care Unit
IT	Incentive Therapy
MH&BSD	Mental Health and Behavioral Sciences Department
MRI	Magnetic Resonance Imaging
MSPB	Merit Systems Protection Board
NO.	Number
NWIHCS	Nebraska-Western Iowa Health Care System
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
PICU	Psychiatric Intensive Care Unit
PLMS	Pathology and Laboratory Medicine Service
PTSD	Post-Traumatic Stress Disorder
UFAS	Uniform Federal Accessibility Standards
VA	Department of Veterans Affairs
VAMC	Department of Veterans Affairs Medical Center
VFW	Veterans of Foreign Wars
VHA	Veterans Health Administration
VISN	Veterans Integrated Services Network
VVA	Vietnam Veterans of America

INTRODUCTION

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) reviewed multiple allegations from an anonymous complainant, pertaining to a wide variety of issues at the Omaha, Nebraska VA Medical Center (VAMC). Many of these allegations centered on services provided by the VAMC's Post-Traumatic Stress Disorder (PTSD) Clinic. The OIG's Office of Healthcare Inspections (OHI) reviewed the issues that focus on clinical matters. United States Senators J. Robert Kerrey and Tom Harkin wrote the Inspector General asking for a review of similar complaints that their offices had received.

Background

Because the allegations involved many areas of medical center operations and services, the OIG performed a Combined Assessment Program (CAP) review of the entire Omaha VAMC during the week of October 25 to 29, 1999. OIG criminal investigators, auditors, and healthcare inspectors collectively focused on the overall quality of care delivered and the effectiveness of management controls. We issued the CAP evaluation report, entitled "Combined Assessment Program Review, Department of Veterans Affairs Medical Center Omaha, Nebraska," on April 3, 2000 (Report Number 00-00025-37).

The Omaha VAMC provides acute medical, surgical and psychiatric care, as well as a variety of outpatient services. It serves as a tertiary care referral center for Veterans Integrated Service Network (VISN) 14. The Omaha VAMC has a dual medical school affiliation, with the University of Nebraska College of Medicine and with Creighton University School of Medicine. Also, the VAMC supports a Vietnam Veterans Outreach Counseling Center in Omaha.

Scope and Methodology

The complainant provided allegations that he had collected from multiple individuals, most of whom are Omaha VAMC patients. Additional individuals contacted the OIG team during the course of the inspection. We thoroughly reviewed the material that we received from the complainant and the two United States Senators. The issues involve management, clinical care, and administrative practices.

We interviewed the complainant by telephone. We met with the VISN 14 Director in Lincoln, Nebraska, the Omaha VAMC Director, and, other VISN and Omaha VAMC managers. During both of our visits to the Omaha VAMC, we reviewed VAMC records

and documents, including administrative files, patients' medical records, quality assurance documents, patient representative correspondence, and VAMC police information. We also reviewed a report of an external evaluation of the VAMC's PTSD Program that was conducted by the Director of the Veterans Health Administration's (VHA) National Center for PTSD.

During the CAP evaluation process, OHI inspectors interviewed VAMC managers and employees, and 165 patients, including 12 PTSD outpatients. We conducted a separate telephone survey of 30 additional randomly selected PTSD Clinic patients. We also interviewed other patients when we required clarification or more information about particular issues. In addition, we interviewed the following:

- Omaha-based representatives of the Vietnam Veterans of America (VVA), the Disabled American Veterans (DAV), the Veterans of Foreign Wars (VFW), and the American Legion
- The Paralyzed Veterans of America representative in Lincoln, Nebraska
- Veterans who work as volunteers for the VAMC's Outreach Group
- An official in the State of Nebraska Department of Veterans Affairs
- The DAV service officer in Lincoln, Nebraska
- VAMC psychiatrists and psychologists
- The Nebraska State representative for the VVA
- A VFW service officer in Council Bluffs, Iowa
- The VAMC Patient Representative
- The VAMC Chief of Mental Health and Behavioral Sciences Department (MH&BSD)
- An accredited service officer for the Veterans of the Vietnam War, Incorporated
- The Director of VHA's National Center for PTSD, located in Menlo Park, California

Two of the allegations concerned potential criminal matters that are not discussed in this report, although we discuss the civil aspects of these cases. Investigators in the OIG Office of Investigations reviewed these two issues.

During the CAP evaluation, employees of VA's Office of Security Service in Washington, D.C. also reviewed allegations made against VAMC police. We also reviewed a specific patient care concern that involves treatment one patient received at the Omaha and the Lincoln VAMCs and at a private facility. We will issue those results in a separate report.

This inspection was conducted in accordance with the Quality Standards for Inspections published by the President’s Council on Integrity and Efficiency.

Conclusions

We found many positive aspects about the care and treatment of veterans at the Omaha VAMC. We also observed many employees, including clinicians, who are dedicated to providing the best care and services possible. We consider the programs that we reviewed to be vital and necessary to the care and well-being of the veterans served by the Omaha VAMC. This includes the VAMC's PTSD Program.

We substantiated allegations pertaining to the overall ineffectiveness of the facility's PTSD Program. We substantiated allegations concerning excessive delays in patient access to specialty care, and patient distrust and dissatisfaction with the Patient Representative Program. We substantiated allegations concerning patient privacy and medical record confidentiality, privacy and security for female inpatients in acute psychiatry, insufficient handicapped restroom access, and inadequate access to Hepatitis “C” follow-up care.

In addition, we substantiated allegations concerning multiple cases of substandard care and treatment. We discussed one complex case in a separate report. We reviewed allegations received from a patient that clinicians did not provide her with adequate medical care. While we did not substantiate allegations of inadequate care, we identified two lapses in administratively processing requests (i.e., processing one consultation and one request for home health care services). This issue was reported separately in a report titled “Patient Care Issue at VA Medical Center, Omaha, Nebraska,” dated August 4, 2000 (Report Number 00-00025-95). A detailed discussion of our review of nine patient care and clinically related issues is described in Appendix B of this report.

We did not substantiate allegations concerning alleged VAMC police abuse of a patient, improper administrative actions against a former social worker, employee misconduct, mishandling of patients' mail, theft of patient property, diversion of deceased patients' corneas to a local laboratory, misused grant funds to purchase office furniture for a VAMC physician, limited times for clinicians to adequately treat patients, or alleged poor quality care and treatment provided by the Women's Health Coordinator.

We made 16 recommendations for improving overall services provided by the Omaha VAMC. We will follow up on the implementation of these recommendations and will be reviewing material we have requested in the report. We also are in the process of inspecting the care and treatment of a specifically identified patient and will report on the results of that work in a separate report.

INSPECTION FINDINGS

A. Substantiated Allegations

The Adequacy of PTSD Clinic Services

We substantiated several patients' allegations regarding the adequacy of, and management over, the medical center's PTSD program. Several patients who receive PTSD treatment at the Omaha VAMC complained about PTSD Clinic services. The patients were upset about the departure of the PTSD Clinic social worker and the departure of a long-time PTSD Clinic psychiatrist. They perceived that managers treated these two employees unfairly and forced them to leave the Omaha VAMC. The patients alleged lack of treatment and follow up by the current PTSD Clinic employees, and the inability to obtain medication refills. They also alleged that the current PTSD Clinic managers are impersonal and that MH&BSD employees are unresponsive to their concerns.

We did not find that managers improperly treated either the PTSD Clinic social worker or the psychiatrist. However, we did substantiate patient concerns regarding the lack of continuity of PTSD care, in part based on the following findings by the VHA National PTSD Director. We concluded that:

- There are an inadequate number of psychiatrists to properly care for or manage PTSD Clinic patients. This adversely affects patients in terms of clinical service availability, medication refill difficulties, etc.

- PTSD Clinic patients, who were followed individually or in group therapy with the former PTSD Clinic clinicians, have in several instances suffered from a lack of continuity of care.

- Patients who were followed by the former PTSD Clinic social worker may not have received appropriate or effective treatment because of the lack of program structure, management, and treatment documentation.

- Individualized PTSD therapy lacked goals and objectives, and there was an over-dependency on certain PTSD Clinic clinicians.

We also determined that there were clinician-patient relationships, involving ***(b)(6)*** and ***(b)(6)***, that appear to have bordered on violations of professional boundaries. These questionable relationships in turn exacerbated the problems in the PTSD Clinic. Various employees including some who work in the PTSD Clinic made the issues known to the Chief of the MH&BSD, as well as the Chief of Staff. However, we could not determine that the senior-level managers acted to address and resolve any real or perceived boundary issues brought to their attention.

Additionally, a considerable number of PTSD Program patients are dissatisfied with the treatment that they receive at the Omaha VAMC. We reached this conclusion after interviewing PTSD Clinic patients who contacted a service organization and/or the OIG, and 30 other randomly selected PTSD patients.

Until late fiscal year (FY) 1999, the PTSD Clinic Team did not appear to have been a cohesive or adequately staffed treatment team. PTSD Clinic employees did not apparently consistently work collaboratively to operate and improve the PTSD Program. Patients and employees told inspectors that this had been a long-standing problem with the PTSD Clinic, although recent staffing changes may be correcting this situation. For example, the current PTSD Clinic Clinical Director had not been given adequate authority that she needed to address issues and concerns about the PTSD Clinic, but the Director recently gave her that authority (provided as a result of the VHA National PTSD Director's recommendations). The PTSD Clinic Director and the Chief of the MH&BSD are implementing the National PTSD Director's recommendations, which should improve the quality and management of the PTSD program. (Appendix A contains a copy of the National PTSD Director's report).

Several PTSD Clinic patients, some of whom have become so frustrated that they have discontinued seeking services at the Omaha VAMC, cited examples of unacceptable difficulties they encountered in attempting to obtain medication refills. This problem was in part due to the lack of psychiatrist coverage even during regular workdays. The Chief of the MH&BSD and the Patient Representative both confirmed that this was a problem to OHI inspectors. While this problem may diminish over time with increased psychiatrist coverage, some PTSD Clinic patients have been poorly served by the VAMC.

It does not appear that the Chief of the MH&BSD and the Chief of Staff properly ensured that PTSD Clinic patients were appropriately and consistently cared for. Neither does it appear that those managers were sufficiently responsive to increasing complaints and tensions about and within the PTSD Clinic. Because of the managers' apparent indecisive actions, problems escalated to the point that patients went to outside entities to complain. We recommended that the Medical Center Director address this issue.

The recent actions and changes including implementation of the National PTSD Director's recommendations to the VAMC may begin to resolve system problems in the VAMC's PTSD Program, but more time is needed to see the effect of those actions. At a later date, managers should request a follow-up review by the National PTSD office to ensure, from both a clinical and managerial perspective, that the VAMC's PTSD Program is more effectively staffed, supported, and managed; and that the program's patients are receiving the most effective treatment possible.

We made recommendations regarding follow up of the previous external PTSD evaluation, as well as individual and group therapy availability, additional PTSD clinicians, re-education regarding employee-patient boundary issues, psychiatric medication refills, assigning PTSD Clinic patients to providers, and team building activities for PTSD employees.

Excessive Delays in Patient Access to Specialty Care

We substantiated the allegation that there were excessive delays for patients to obtain appointments in various specialty clinics. The CAP evaluation that is discussed in a separate report[1] found that patients experienced excessive delays in obtaining appointments in primary care, gastrointestinal (GI), (including access to hepatitis C virus [HCV] treatment), cardiology, pain management, and radiological studies. The CAP report also describes delays in patients obtaining prescriptions. The CAP report discusses these issues, and also discusses capital improvement plans that are intended to alleviate the untimely services to patients.

VAMC managers need to reduce scheduling delays for specialty care clinics, which may require adjusted or increased clinic staffing patterns or revised clinic schedules or operating protocols.

Patients Distrusted and Dissatisfied with the Patient Representative Program

We substantiated multiple patients' allegations regarding the effectiveness of the VAMC's Patient Representative Program. OHI inspectors received numerous complaints regarding the Omaha VAMC's Patient Representative Program. Complainants told inspectors that most patients do not consider the Patient Representative to be their liaison or advocate.

VHA requires each medical care facility to have a Patient Representative Program.[2] This program is intended to provide patients with a liaison (Patient Representative) to assist them in obtaining medical care and in solving any problems they may encounter at the medical care facility. Feedback from patient representatives enables managers to obtain timely knowledge about patients' concerns and to adjust services when appropriate. The Patient Representative's name and picture should be posted in all patient care areas to ensure that patients are made aware of this valuable resource.

PTSD Clinic patients, whom we interviewed, reported negative experiences with the Patient Representative. They told us that they no longer discussed their concerns with the Patient Representative because they believe that she does not advocate for the patients. VVA representatives also reported negative experiences.

[1]VAOIG report entitled "Combined Assessment Program Review, Department of Veterans Affairs Medical Center Omaha, Nebraska" (report 00-00025-37 dated April 3, 2000).
[2] VA Manual "Patient Representative Program" (M-2, Part I, Chapter 37 dated February 15, 1994).

We concluded that the Patient Representative Program needs improvement. In October 1999, the Medical Center Director formed an advisory board to assess the Patient Representative Program and to recommend changes as appropriate. OHI supports this effort. We suggest that advisory board members contact other VA medical facilities that have strong Patient Representative Programs for guidance. One such resource is the successful Patient Representative Program at the Lexington, Kentucky VAMC. We made several recommendations to improve the VAMC's Patient Representative Program.

Patient Privacy and Medical Record Confidentiality

We substantiated an allegation that patients had uncontrolled access to medical records. Several patients complained that clinical managers improperly allowed patients to carry their own unsecured medical records from one clinic to another.

Patients' medical records are confidential documents. VHA policy[3] requires that patient records privacy be preserved, and that the information they contain will not be accessible to or discussed with unauthorized persons. VA patients generally have the right to obtain medical information from their own records by requesting the information through proper channels (such as a request under the Freedom of Information Act (FOIA) to the VAMC Release of Information Office). Adherence to prescribed FOIA procedures ensures the medical records' integrity and accuracy, as well as the privacy of patients' personal information.

During our inspection, we asked clinic personnel, how they transport patients' medical records between clinics when patients have more than one appointment. The clerks told OHI inspectors that they secure the medical records in locked bags and the patients carry them to their next clinic appointment. Nevertheless, an OHI inspector observed one patient carrying his own medical record. The record was not properly secured in a locked bag. Because several patients made this allegation and because we observed a patient carrying an unsecured medical record, we concluded that VAMC managers should revisit their medical record transportation practices to ensure that there is not a systemic problem in conforming with VHA policy on the confidentiality of medical records.

We also reviewed an allegation of improper patient access to other patients' medical records. An April 1998 Administrative Board of Investigation found that incentive therapy (IT) patients had improper access to patients' medical record information, including PTSD patients. The Board found that PTSD Clinic employees had IT patients file confidential patient information into medical records. The Board recommended that managers stop this practice.

The Chief of the MH&BSD told OHI inspectors that IT patients continue to provide services in the PTSD Clinic, as well as in other mental health clinics. IT assignments include sorting patient encounter forms by clinic, and sorting medical records by the

[3] VA Manual "Patient Records" (M-1 Part I, Chapter 5 dated June 1985).

clinic provider. Therefore, while IT patients no longer directly filed confidential patient information into medical records, they continued to have access to other patients' medical records, clinic appointment schedules, and provider names.

The Chief of the MH&BSD revised applicable VAMC policy to require that IT patients sign confidentiality statements when they first begin an IT assignment. Managers also told OHI inspectors that each IT patient is trained on confidentiality requirements. Occupational therapy employees closely supervise IT patients during their work assignments, and arrange IT assignments in consultation and with the approval of employees in those areas. Managers also told OHI inspectors that IT patients are never permitted access to the VAMC computer system or to personal computers in the VAMC. The Board recommended that to ensure security of computer information, all computer terminals should have password access. Managers told OHI inspectors that since the revised procedures and confidentiality statements were initiated in 1998, there have been no breaches of security of patient-related information.

We concluded that at one time this allegation was correct, but that VAMC managers implemented appropriate actions to correct the problem.

We reviewed an allegation that the required PTSD Clinic check-in procedures violated patient confidentiality. Several PTSD outpatients complained that they were required to write their names, last four digits of their Social Security numbers, and time of arrival at the clinic on a sheet of paper that is attached to a clipboard, located on the PTSD Clinic reception counter. The patients told us that the PTSD Clinic was the only clinic that required this procedure. They alleged that this sign-in process violated their privacy. Complainants provided OHI inspectors a typed list that included PTSD Clinic patient names and last four digits of their Social Security numbers, to support the allegation that this information is publicly available, and therefore violates patient privacy.

The Chief of MH&BSD told inspectors that the purpose of the sign-in procedure is to improve security. The sign-in procedure lets employees know which patients have arrived in the Clinic. Clinic employees believed that the procedure was especially helpful for after-hour and weekend clinics when there was no receptionist at the PTSD Clinic desk.

Inspectors visited the PTSD Clinic and observed the sign-in sheet. The sheet was attached to a clipboard that was located on an open counter and accessible to anyone in the area. The cover sheet was not placed over the actual sign-in sheet as required.

We concluded that if clinic managers want to continue using the sign-in procedure, an employee must supervise the sign-in sheets at all times to ensure that they are always covered and out of public view. However, because of the patients' sensitivity to public disclosure of even part of their Social Security numbers, the Director should consider discontinuing the practice of requiring patients to write those numbers on sign-in sheets.

Lack of Privacy and Security for Female Psychiatric Inpatients

We substantiated concerns regarding the privacy and security of female inpatients in acute psychiatry units. OHI inspectors toured the inpatient psychiatric wards and the Psychiatric Intensive Care Unit (PICU). All of the wards and the PICU have designated male and female bathrooms. The PICU bathrooms do not have locks, which could compromise patient privacy. However, door locks could represent a security and patient safety issue because of the high-risk patients involved.

While we did not observe actual female patient security incidents, female patients complained that they feel uncomfortable as inpatients on psychiatry units. Some female patients told us that they did not feel safe wearing their pajamas and robes in the ward day rooms that are occupied by mostly male patients. Because of this discomfort, they tend to remain isolated in their rooms. This is especially true for female patients who suffer from PTSD and/or past sexual trauma experiences.

OHI has found in other facility inspections that female patient privacy and security on VAMC psychiatry wards are not problems isolated to the Omaha VAMC; rather, they are concerns in many VHA facilities. Nevertheless, Omaha VAMC clinicians should be sensitive to this issue and make every effort to provide a safe therapeutic environment for female patients. The Director should ensure that the Women's Health Coordinator and appropriate clinicians establish a formal process that ensures that future female patients are admitted to the most appropriate facilities, especially when the admissions are to sensitive areas such as acute psychiatry units.

Insufficient Handicapped Restroom Access

We substantiated an allegation that the VAMC had insufficient handicapped restroom access. A complainant alleged that the VAMC had an inadequate number of handicapped accessible public restrooms. Senator Kerrey raised this same concern to the VAMC in 1997. The Medical Center Director appointed a committee to address this issue. VAMC committee members recommended several actions that were implemented, to improve handicapped access to public restrooms, such as additional signage.

In general, VAMCs, as Federal facilities, are covered by guidelines in Uniform Federal Accessibility Standards (UFAS) in accordance with the Architectural Barriers Act (ABA). Americans with Disability Act (ADA) requirements which are in some ways more comprehensive than those in the UFAS, are not imposed on VA facilities, although VA facilities usually comply with the ADA. Regarding public restrooms, the ABA/UFAS and ADA requirements are nearly identical. Both of these standards require that hospitals have at least 10 percent of patient bedrooms and bathrooms, and all public and common-use areas, including public restrooms, designed and constructed to accommodate handicapped persons.

In buildings that were constructed prior to passage of the governing guidelines, managers must ensure that people in wheelchairs can reasonably access *a* public restroom, but not every public restroom necessarily has to be renovated or relocated in order to allow 100-percent handicapped access. Nevertheless, VA managers are expected to make every effort to maximize handicapped access to all restrooms.

The VAMC's Persons with Disabilities Committee Chairperson told OHI inspectors that the medical center has male and female restrooms on each floor that generally meet the intent of ADA. However, he acknowledged that there are some restrooms that would need minor modifications to put them in full compliance. Facility managers have approved construction plans that should partially improve availability of handicapped accessible restrooms in the VAMC, although the current renovation plan does not include adding handicapped accessible restrooms to the South Clinic area.

OHI inspectors found that access to a male handicapped restroom on the third floor of the medical center was impeded by the location of a waste can. The Chairman of the Persons with Disabilities Committee told OHI inspectors that he was aware of this condition and he agreed that the position of the waste can could limit accessibility for handicapped patients. He said that he has moved the waste can away from the door several times, but someone always puts it back in such a way that it partially obstructs the area near the door.

We concluded that handicapped access to public bathrooms was limited in some areas. However, construction plans have been approved to improve accessibility. The Director should continuously monitor handicapped access to all facility services, including public restrooms, and he should ensure that identified deficiencies are promptly resolved.

Inadequate Access to Hepatitis “C” Follow-Up Treatment

We substantiated an allegation that patients access to testing and treatment for HCV is limited because of backlogged specialty care availability. During our inspection, a patient told OHI inspectors that he knew of another patient who had requested follow up for hepatitis, but physicians did not refer the patient to the GI Clinic. The patient (who did have HCV) eventually did obtain testing and treatment with medication prior to our inspection. Nonetheless, our subsequent review of the VAMC's program for patients who have HCV disclosed that program improvements are needed.

VHA's Under Secretary for Health (USH) published policy on standards for evaluation and testing for HCV in June 1998.[4] The policy outlines HCV background, infection, its growth as a national problem, transmission of the virus, and antibody development. The USH letter directed that "…all patients will be evaluated with respect to risk factors…" for HCV. Clinicians are required to record this assessment in patients' medical records. Based on risk factors, clinicians should proceed with antibody testing

[4] Under Secretary for Health Information Letter "Hepatitis C: Standards for Provider Evaluation and Testing" (number IL 10-98-013 dated June 11, 1998). According to VHA's Acute Care Strategic Health Care Group, this policy remains valid although modifications to it are in process.

in accordance with an algorithm included in the policy letter. According to the VHA Chief Consultant for the Acute Care Strategic Health Care Group, each patient seeking care in a VHA facility is to be screened for HCV risk factors. VHA Headquarters managers advised VISNs of this mandate in 1998.

At the Omaha VAMC, primary care providers are required to screen patients for the HCV. Primary care providers are to refer seropositive patients to a GI Fellows Clinic or to a relatively new Hepatitis C Clinic, which is managed by a hepatologist. As mentioned earlier, one patient's pharmacy computer profile shows that he is currently receiving pharmaceutical treatment for his HCV condition. Also, GI clinicians told OHI inspectors that drugs for the treatment of HCV, such as Rebetron™, are available in the VAMC pharmacy when it is needed.

While a process now exists at the Omaha VAMC for screening and treatment of HCV, there are delays in obtaining specialty care for HCV. At the time of our visit, delays in HCV outpatient care included 4-month waits for patients to obtain appointments in the GI Fellows Clinic, and up to a 6-week wait for the Hepatitis C Clinic. These backlogs will only worsen as more patients become knowledgeable about, and seek screening and/or treatment for HCV. Also, according to the HCV case manager, the facility has yet to begin doing a "look back" process into VAMC computer files, e.g., laboratory test data, to locate and then proactively contact those patients who have already been found to be seropositive. That process was not yet in place, so there was a possibility that patients who needed HCV follow-up and treatment may not receive the necessary care.

The VISN plans to establish a performance measure in 2001, that will require treatment of all patients who are positive for HCV, and for whom treatment is medically appropriate and desired. VAMC clinical managers told OHI inspectors that primary care physicians and physician extenders will be continually reminded about the importance of HCV screening, and that a database will be developed to account for persons who are screened and treated at the VAMC. The VISN is also making public service efforts to alert veterans on the need for screening.

The VAMC's outreach and education efforts regarding HCV screening continued to need full implementation. The Director should order clinicians to complete a look-back process to identify all HCV-positive patients, after which they should be offered appropriate follow up and treatment as indicated.

Multiple Cases of Substandard Care and Treatment

We substantiated allegations of substandard care and treatment that was provided to several patients. Of nine cases that we reviewed, we substantiated clinical care and treatment concerns in seven cases. The substantiated concerns encompassed treatment in medicine, surgery, and psychiatry. We did not, however, find systemic issues or any patterns of problems or errors on the part of individual clinicians.

We discussed one complex case in a separate report. We reviewed allegations received from a patient that clinicians did not provide her with adequate medical care. While we did not substantiate allegations of inadequate care, we identified two lapses in administratively processing requests (i.e., processing one consultation and one request for home health care services). The Medical Center concurred with our recommendations regarding this clinical issue and provided acceptable implementation plans. The issue was reported separately in a report titled Patient Care Issue at VA Medical Center, Omaha, Nebraska, Report Number 00-00025-95, dated August 4, 2000.

We concluded that additional peer review is needed for one of the other cases that we reviewed. We also concluded that VAMC pain management services are inadequate and need improvement, including better monitoring of narcotics prescriptions issued for pain control purposes. A detailed discussion of our review of nine patient care and clinically related issues is presented in Appendix B of this report.

B. Unsubstantiated Allegations

VAMC Police Reportedly Abused a Patient

We did not substantiate an allegation that VA police officers abused or mistreated a patient. This allegation resulted from an incident wherein an outpatient became angry and combative after a physician assistant refused to comply with his request for a prescription for narcotic pain suppressants. The physician assistant became fearful when the patient swung his cane in a threatening manner. When the patient left the area, employees summoned VAMC police officers.

A short while later police officers located the patient in another area of the medical center. When the police officers approached him, the patient was reportedly brandishing his cane and was still in a highly agitated state. The patient refused to comply with the officers' repeated instructions to drop the cane and instead raised the cane as if to strike one of the officers. When the patient, with a raised cane in his hand, stepped toward one of the officers, the officer discharged his "pepper spray" at the patient. The patient's aggression continued and a struggle ensued between the officers and the patient. A third police officer arrived on the scene. The police officers successfully handcuffed and arrested the patient, at which time the patient ceased to be combative. The patient was provided immediate medical care to treat the effects of the pepper spray and to assess his complaint of a sore ankle.

Statements by several VAMC employee witnesses corroborated these events.

In addition, we did not substantiate an allegation that VAMC police were overly aggressive or acted improperly towards patients. VA Headquarters Office of Security and Law Enforcement officials reviewed the VAMC Police Section during the week of October 25, 1999. They concluded that VAMC police training and police actions in the management of patient-related matters were in accordance with VA policy.

The United States Attorney’s Office declined Federal criminal prosecution of the veteran patient on assault charges and instead suggested that local authorities could pursue the matter.

The Omaha City Attorney's Office has accepted this case for criminal prosecution. On November 8, 1999, an arrest warrant was issued for the patient; and on November 11, 1999, the patient surrendered to and was arrested by Omaha Police. The patient was charged and prosecutive action is pending.

Administrative Actions Taken Against a Former Social Worker

We did not substantiate an allegation that VAMC managers improperly took administrative actions against a VAMC social worker who is no longer employed at the medical center. This allegation referred to administrative actions that managers took against a former social worker who personally became involved in a matter between a patient and the VAMC Police. When VAMC police officers attempted to arrest a disorderly patient (described in the previous section), a ***(b)(6)*** social worker intervened while the officers were struggling with the patient. The social worker allegedly failed to obey one officer's instructions to back away and demanded that the officers release the patient. The employee allegedly grabbed one officer's arm during the incident.

Approximately 1 week after the incident occurred, VAMC officials conducted an administrative investigation, which included a recorded interview with the employee. The employee denied that police officers told her to back away or that she touched either of the police officers during the incident. However, several VAMC employee witnesses corroborated both of these events.

After VAMC managers imposed disciplinary action, the employee, through counsel, filed an appeal with the Merit Systems Protection Board (MSPB). The MSPB dismissed the case after both parties reached a mutually acceptable settlement agreement that was also accepted by the administrative law judge.

The employee was not the source of this complaint. Based on our review of all of the facts, including that the employee was provided due process, was represented by counsel, and that MSPB dismissed the appeal, we concluded that the allegation is unsubstantiated. The employee is no longer employed by the Omaha VAMC.

Employee Conduct

We did not substantiate an allegation that VAMC employees acted improperly towards patients. The complainants alleged that employees in several areas of the medical center were often rude and unprofessional. Several patients complained about VAMC police conduct, e.g., that they were too aggressive.

We addressed this allegation during the CAP evaluation process, which is reported in a separate report.[5] We did not observe this type of behavior by any employees during our inspection. However, we take seriously the number of complaints about inappropriate employee behaviors that we heard from complainants. We believe that managers should promptly address any instance in which employees are found to be rude or unprofessional. Because of the number of patients who complained about this matter, we concluded that VAMC managers should establish a customer service-training program for all employees, including clinicians, managers and police officers.

[5] VAOIG report, ibid.

Mishandling of Patients' Mail

We did not substantiate an allegation that VAMC managers mishandled patients' mail. A complainant alleged that he had mailed letters to Omaha VAMC managers and other employees but that they had not received the letters. He asserted that this occurred because medical center managers intercept the mail.

The Omaha VAMC Director denied that any manager had intercepted any employees' mail. We made several attempts to contact the complainant to obtain more details but the complainant did not provide any specifics. Therefore, we were not able to more definitively address this issue.

Theft of Patient Property

VAMC managers addressed this allegation before our review and took appropriate actions. Therefore, we did not substantiate this allegation. A complainant alleged that theft of patients' personal property was a recurring problem which managers had not addressed. The complainant told us that approximately 2 years previously, he accompanied a patient to the Omaha VAMC for an urgent admission. After admission, the patient gave his personal belongings, including clothing, shoes, keys, and a wallet, to a VAMC employee for storage. The patient subsequently died and when the complainant asked for the patient's personal belongings he was told that the items could not be located. The complainant alleges that he reported this apparent theft to the Medical Center Director who reportedly told him that this type of loss "had been happening and was worse lately."

Following the complaint to the Medical Center Director, managers and VAMC police officers reviewed the process for storing and retrieving patients' personal belongings. They concluded that the reason that patients' belongings frequently could not be located was that the medical center did not have a policy assigning responsibility for securing, maintaining, and retrieving patients' belongings. They concluded that there was not a theft problem.

Medical center managers have since instituted a policy (VAMC Memorandum No. 95-04) for obtaining and storing patients' personal belongings. Patients' belongings are now logged on a standardized inventory sheet when the patient is admitted. Patients are required to sign the inventory sheet to certify the accuracy of the inventory both when the belongings are sent to storage and when they are retrieved at the time of discharge. Since implementation of this April 1998 policy, the problem of missing personal items has been alleviated.

Diversion of Deceased Patients' Corneas to a Local Laboratory

We did not substantiate an allegation by an Omaha veterans' service organization that deceased patients' corneas were inappropriately sent to a local laboratory.

VHA Directive 10-95-74, dated July 28, 1995, provides human organ transplant policy but the directive does not contain policy for harvesting organs or corneas. The VHA Transplant Coordinator is drafting a national policy for harvesting organs. A primary concern of this policy is protecting patient privacy. Also, VHA Handbook 1004.1 articulates the requirements for consent forms for any medical or surgical procedure, which would include harvesting corneas. Omaha VAMC Memorandum No. 257, *Donation of Remains or Organs of Deceased Persons*, requires hospital employees to notify the Lions Eye Bank of Nebraska regarding a potential cornea donor. Eye Bank employees obtain the families' consents for cornea donations.

To address this issue, we interviewed the Director of the Lions Eye Bank in Omaha. The Director told us that the Eye Bank does not obtain corneas from the Omaha VAMC.

We interviewed the Omaha VAMC's operating room coordinator, the Medical Technologist Supervisor, and the Chief of Pathology and Laboratory Medicine (PLMS). VAMC employees asserted that medical center clinicians do not harvest corneas, because VA patients are not generally considered to be good cornea donor candidates due to their age. In addition, VAMC employees said that there is only about a 4-hour window after death in which corneas can be harvested, after which they begin to deteriorate. All organ harvesting in Omaha is done by the Nebraska Organ Retrieval System.

The Medical Center Director established procedures for medical staff to follow for donation of deceased persons' organs. The PLMS had controls to prevent tampering with a body. From our discussion with clinicians who were familiar with results of autopsies performed at the Omaha VAMC, no evidence of illegal cornea harvesting existed. For example, the Chief of PLMS, in performing an autopsy, will record the condition of each body part including the eyes. In addition, area morticians who have received VAMC patients' remains have not expressed any concerns to PLMS employees regarding illegal removal of patient's eyes or corneas.

The person(s) making this allegation did not provide us enough specific information or details to allow us to more definitively review this issue.

Misused Grant Funds to Purchase Office Furniture for a VAMC Physician

We did not substantiate an allegation that managers used $3,500 in grant funds to purchase a credenza and desk for the Chief of the MH&BSD.

We reviewed FY 1996 through 1999 purchase orders for the MH&BSD's PTSD and Substance Abuse Programs. We also toured the department and we reviewed transactions for the medical center's fund control point for furniture purchases. We did not find any evidence that a credenza or desk had been purchased for the Chief of the MH&BSD. We concluded that VA grant funds were not used to improperly purchase furniture for the Chief of the MH&BSD.

Limited Times for Clinicians to Adequately Treat Patients

We did not substantiate an allegation that managers allowed inadequate time for clinicians to provide treatment to patients. Issues involving patients' satisfaction with clinical services, staff availability, etc., are addressed in the CAP report.[6] CAP employee surveys and patient interviews did not confirm this allegation.

Poor Quality Care and Treatment Provided by the Women's Health Coordinator

We did not substantiate an allegation that when a patient complained to the Women's Health Coordinator, that she had chest pain, the coordinator ignored her concerns. The pain was later diagnosed as a breast mass.

An OHI inspector interviewed the Women's Health Coordinator, and reviewed the patient's medical records, including annual gynecology exams, biopsy reports, and radiology tests. Medical record documentation shows that on July 17, 1997, during a routine mammogram, the 40-year-old patient was found to have a lump in her right breast. A July 31, 1997 fine needle aspiration, followed by a biopsy were both interpreted by pathologists as benign.

We did not find any documentation or evidence that the Women's Health Coordinator ignored the patient's complaint of pain in her chest. Also, the complainant did not provide inspectors with any private practitioner medical information regarding her conditions. Therefore, we were unable to pursue this issue further.

[6] Ibid.

RECOMMENDATIONS AND COMMENTS

Recommendation 1: The Medical Center Director should provide OIG with evidentiary documentation that the VHA National PTSD Program Director's recommendations are implemented.

Acting Medical Center Director's Comments:

Concur. Continual progress on all the recommendations received from Mr. Gusman has been followed. The Chief, Mental Health & Behavioral Sciences (MH&BS) generally meets weekly with the PTSD Program Director to discuss policy and program issues. All the recommendations in Mr. Gusman's report have been implemented. Staff development is a continuing process including work with Mr. Gusman on a formal curriculum for staff education. Another recommendation that continues to evolve is the incorporation of the PTSD team into the overall Mental Health Clinic, both administratively and functionally. A formal relationship has been established with the Vet Center and there will be an open house in October 2000 to introduce the program to various community resources and to begin to establish more formal relationships with them. Documentation of the action plan, policy, procedures and other documents that have been developed are available for review, if desired.

Status: In Process Target Date: November 30, 2000

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. The OIG will close this recommendation once we complete a review of the final VAMC documentation (after November 30, 2000) and determine that the VAMC managers' actions demonstrate full implementation of the VHA National PTSD Program Director's recommendations.

Recommendation 2: Ensure that affiliated medical institutions provide consistent attending physician coverage of the PTSD Clinic and other associated mental health areas to improve continuity of care.

Acting Medical Center Director's Comments:

Concur. One of the concerns of physicians on staff in Psychiatry at the Omaha VAMC was the limitation placed by the VA regulations with their special pay contracts. Physicians had to sign a contract for a one-year period of time, and if they left the facility prior to the one-year period, they had to repay the entire amount of the special pay. A contract was negotiated with both universities to provide physicians to cover the areas in the VA Mental Health programs where a need existed. The new contract allows flexibility on the part of the affiliates to provide physician coverage when and if

the need arises. It also affords more flexibility to the affiliates to recruit physicians for the Mental Health programs at the VA.

Status: In Process Target Date: Ongoing

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan met the intent of the recommendation. The new contract for psychiatrists from the affiliated medical institutions should improve physician availability to and coverage in the PTSD Clinic. While the Acting Medical Center Director's response indicates that VAMC managers consider this recommendation closed because of the revised contracting procedures with the affiliated medical institutions, we plan to follow-up and require copies of the actual attending psychiatrist duty times over a 6-month period. We will follow-up on the recommendation to determine whether the new contracting procedures actually improve psychiatrist coverage and increase continuity of care for patients in the PTSD Clinic.

Recommendation 3: Provide training to re-educate patient/provider VAMC clinical managers on the identification and management of interpersonal patient/provider relationship boundary issues that may arise.

Acting Medical Center Director's Comments:

Concur. Current and new staff members have viewed and discussed the videotape, "Uncertain Borders I: Boundary Issues in Psychotherapy." This video was produced by Cavalcade Productions. Several experts in the trauma field are interviewed about boundary issues.

Status: Closed Target Date: N/A

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. Based on the training conducted about boundary issues in psychotherapy that have taken place, we consider the recommendation implemented and therefore closed.

Recommendation 4: Initiate an effective consultation process to ensure timely consultations between Urgent Care clinicians and psychiatrists for PTSD patients who need psychiatric medication refills.

Acting Medical Center Director's Comments:

Concur. One psychiatrist who started as a Fee for Service provider in August 1999 went abroad on extended leave from November 18, 1999 until January 18, 2000. Another psychiatrist started as a Fee for Service provider on April 7, 2000. The PTSD

Clinic currently has 0.50 FTEE psychiatrist coverage which meets the recommendations from Fred Gusman, VHA National PTSD Program Director.

Status: In Process Target Date: Ongoing

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan met the intent of the recommendation. The Quality Officer is in the process of providing us with a copy of the scheduled physician/psychiatrist coverage as it exists at the time of the Acting Medical Center Director's comments. As stated in our comments to recommendation 2 above, we will be reviewing psychiatrist coverage for the PTSD Clinic coverage over the next 6 months during our follow-up process.

Recommendation 5: Institute a comprehensive customer service-training program for employees, including all managers, clinicians, and VAMC police officers.

Acting Medical Center Director's Comments:

Concur. There is currently a Customer Service Team for all VA sites in Nebraska. This team has developed training that is being provided to all staff members. There is currently a two-part program of mandatory training (Everyone Is My Customer) for all staff. The first part includes a video on customer service and the second part focuses on service recovery. This training is further emphasized through the service level patient advocate training, placing the first responsibility for customer service at the department level.

Status: In Process Target Date: Ongoing

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. We will consider the recommendation unimplemented pending our review of information after a 6-month period that shows completion of the planned training of all existing employees, as well as a plan for the training of new employees hired in the future (e.g., during their new employee orientation training, etc.).

Recommendation 6: Initiate procedures to reduce the delays experienced by patients for specialty clinic appointments.

Acting Medical Center Director's Comments:

Concur. We have established a task force to address waits and delays at both primary care and specialty care clinic sites. This coordinated group will also address referrals both from within the Omaha facility and between care sites in the Nebraska-Western Iowa Health Care System (NWIHCS). Pilot projects are currently addressing

orthopedic, vascular surgery, and cardiology specialty clinics and primary care clinics. Projects include 1) reduction of principal care by specialty clinic providers with return of patients to their primary provider to increase availability of patient care visit slots for new patient consultations, 2) establishment of referral guidelines to reduce unnecessary referrals from generalist physicians for conditions that can be readily handled, and 3) establishment and communication of clear long-term care plans for use of primary physician and mid-level providers to utilize such that there should be a reduction of reliance on specialty clinic physicians for care. We are also utilizing case managers to assist in referral from primary care to specialty care clinics to help with timeliness of visits and follow-up of patients. As examples, vascular surgery clinic has enacted electronic referral of patient consults from general medicine clinics permitting timely review of patient records and timing of the consultation. We have also integrated our patient care database as of April 1, 2000 between all care sites in NWIHCS with improved transfer of patient data and reports. In orthopedics, we have reduced waiting time for a new patient appointment to 3 days as of July 3, 2000.

Status: In Process Target Date: Ongoing

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. In our follow-up process, we will obtain a list of next available specialty clinic appointment dates as of September 30, 2000 and determine if specialty care appointment access continues to improve. Upon our determination that improvement has taken place, we will consider the recommendation fully implemented.

Recommendation 7: Evaluate the Patient Representative Program and initiate procedures to improve overall effectiveness and patient awareness.

Acting Medical Center Director's Comments:

Concur. The evaluation has been completed. An addition to the program has been designed and is in the process of implementation. Staff members from all designated departments are being trained to be service level patient advocates. The training will be completed at the Omaha Division on August 16, 2000. Approximately 50 employees are scheduled for that training. These individuals will assist veterans who have concerns specific to one department. Complaints which are multi-faceted or which involve several departments will be coordinated through the facility Patient Advocate. These individuals are trained to utilize the Patient Advocate VISTA Package to document the meetings with the veterans and the follow-up provided to address the issue(s). The name of the facility Patient Advocate and the telephone number for contact are posted in all Departments throughout the facility.

Status: In Process Target Date: October 31, 2000

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. We will consider the recommendation implemented upon documentation that the training is completed and that the restructured Patient Advocacy Program is fully completed.

Recommendation 8: Revise medical record transport procedures to ensure patient confidentiality.

Acting Medical Center Director's Comments:

Concur. Several years ago, at least 200 locking bags were purchased for use in the clinics when it was necessary for a patient to report to more than one clinic location on the same day. The records were to be placed in these locking bags, and the patient could then transport their own records to the next clinic location. I concur that there appears to be a lack of compliance on the part of the clinic staff in the utilization of these bags. [The Acting Medical Center Director] discussed this issue with the Acting Manager in Ambulatory Care. She also agreed that there needs to be better compliance with this process, and sent a message to all clinic staff to reinforce the importance of following this procedure. Continual monitoring to assure that this process is followed is planned.

Status: Closed Target Date: N/A

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. Employee compliance with the requirement of using the locking bags will depend on responsible VAMC managers. We consider the recommendation implemented and therefore it is closed.

Recommendation 9: Initiate procedures to ensure that the PTSD Clinic sign-in sheets are not left unattended; and discontinue the requirement for partial Social Security numbers on sign-in sheets.

Acting Medical Center Director's Comments:

Concur. The sign-in sheet was revised and the requirement for the partial social security number of the veteran was eliminated. Sign-in sheets are covered with a plain piece of paper and are not left unattended.

Status: Closed Target Date: N/A

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. Based on the actions taken, we consider the recommendation implemented and therefore it is closed.

Recommendation 10: Initiate guidelines to ensure that clinicians consider privacy and safety issues when assessing female patients for psychiatry admissions. Some female patients may need to be admitted to other VAMC or private facilities.

Acting Medical Center Director's Comments:

Concur. We will review, in conjunction with Female Veterans Health Coordinator, current PICU operations that support female veteran privacy and security needs. We will request the Female Veterans Health Coordinator to formally report to the Hospital Director any feasible enhancements in operations that would support psychiatric female veteran safety/privacy needs. We will include in this review an identification of community inpatient standards of care and availability of alternative resources for female veterans with PTSD or sexual trauma. We will develop an informational sheet for our psychiatric female veterans being admitted to acute psychiatry to encourage them to openly discuss any comfort issues related to unit setting with clinical team and review for them the measures taken to assure their safety and privacy. A VISN policy will soon be signed which outlines procedures related to the special needs of the female veteran patient. All sites will be in compliance with that policy.

Status: In Process Target Date: October 31, 2000

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. During our follow-up process, we will review the Coordinator's report to the Acting Medical Center Director, once it is approved, as well as the forthcoming VISN policy after it is finalized and approved. Following our determination that female veteran patients' privacy and safety in inpatient psychiatry units is satisfactorily improved, we will close the recommendation.

Recommendation 11: Provide OIG with documents that demonstrate a process for continued VAMC assurance that handicapped access issues to public restrooms are appropriately addressed.

Acting Medical Center Director's Comments:

Concur. Facilities have the inclusion of handicapped restrooms as a high priority in all renovations. The Major Ward Project, which is a renovation of the inpatient area, will be 100 percent handicapped accessible and exceeds the ADA requirement of 10 percent. In addition, the new clinic areas are being constructed with the Minor

Construction Program are all built with handicapped accessible restrooms. Upon completion of the current, approved projects, there will be three new, handicapped accessible restrooms that either have been or are in the process of being built.

There is a correction to the draft report. In the South Clinic, there is not a renovation project to redesign the restrooms to make them handicapped accessible. With the new construction, two handicapped restrooms have been built approximately 50 feet away. We currently meet the 10 percent ADA requirement for handicapped accessible restrooms.

Status: In Process Target Date: Ongoing

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. During our review of this matter (discussed on pages 9 and 10), the OHI inspector understood that remodeling of the South Clinic area was one of those areas being remodeled that would include improved handicapped restroom access. However, the Acting Medical Center Director's response states that the South Clinic itself will not have a handicapped-accessible restroom, but that such restrooms will exist approximately 50 feet from that Clinic. We have revised wording in paragraph two on page 10. The recommendation will remain in an unimplemented status until we review additional information from the VAMC that demonstrates how it will be in compliance with ADA requirements for the South Clinic area (e.g., placement of signage, etc.), as well as documentation of an ongoing process to assure accessibility is maintained.

Recommendation 12: Require clinicians to complete a look-back process to ensure that patients who have previously tested positive for HCV are notified and offered appropriate follow-up care.

Acting Medical Center Director's Comments:

Concur. We will initiate a five-year look back to identify all veterans who have tested positive for Hepatitis "C" at the Omaha VA. The names will be cross-checked with the veterans already being followed for their Hepatitis "C" status according to our registry. For those not currently on the registry, we will initiate a chart review to verify whether or not follow-up has been completed. If there is no evidence of follow-up, we will initiate a contact with the patient for follow-up treatment.

Currently, the Clinical Lab sends all positive Hepatitis "C" results to the PA and Nurse Coordinator in the Gastroenterology Section. They put the patient's information in their Hepatitis "C" patient data bank. A form letter is then sent to the patient. The letter informs the patient that the blood test for Hepatitis "C" was positive. The letter also instructs the patient to call the Gastroenterology Section PA or Nurse Coordinator. Patients who respond are evaluated to see if they are candidates for therapy. If

treatment is indicated, they are followed in the Gastroenterology Clinic. Hepatitis "C" patients who abuse alcohol need to remain sober for six months before they can be considered for treatment. If Hepatitis "C" patients have persistent problems with alcohol addiction or are not candidates for treatment due to some other reason, the Gastroenterology service notifies their primary care provider and makes appropriate recommendations for follow-up.

Status: In Process Target Date: Ongoing

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. We will follow up with the VAMC on the results of the look back process and determine after that time if the recommendation can be considered implemented.

Recommendation 13: Regarding case 4 in Appendix B: Obtain a peer review by non-Omaha VAMC clinicians, and provide those review results to OHI for evaluation.

Acting Medical Center Director's Response:

Concur. A peer review will be completed upon receipt of the patient specific information from the Office of Inspector General. Several cases were reviewed during the inspection and we cannot identify the specific veteran from the summary provided in the Draft report.

Status: In Process Target Date: October 31, 2000

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan met the intent of the recommendation. We have provided the identity of all of the patients included in the cases in Appendix B. We will review the results of the peer reviews and determine after that time whether the recommendation can be closed.

Recommendation 14: Require the Pharmacy and Therapeutics Agents Review Committee to report the adverse drug reaction discussed in case 4 of Appendix B to the Food and Drug Administration as required by VHA policy, and ensure that the Committee's peer reviews are more rigorous and address all aspects of possible adverse drug reactions.

Acting Medical Center Director's Comments:

Concur. We have reviewed the clinical information available for Case 4 (Appendix B of OIG report). While this is a complicated case, we have proceeded with the reporting of

the patient's clinical events and the potential interaction of medications to the Food and Drug Administration.

We are also in process of evaluating our current reporting mechanisms for adverse drug events (ADE) and interactions, our local and national reporting mechanisms of these ADE's, and our education process for our staff on potential problems with medications and their interactions. We have also initiated direct electronic physician order entry for prescriptions to ensure adequate documentation of medication administration and proper ordering.

Our Pharmacy and Therapeutics committee has been charged with review of their procedures for adverse drug reactions. We will reassess our progress in reporting within 6 months and compare this time period and its reports to a similar time period in FY 1999 for comparison to assure that our reporting mechanism is improving.

Status: In Process Target Date: Ongoing

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. We will review the results of the Pharmacy and Therapeutics Committee's review after 6 months and determine at that time if the recommendation can be considered implemented.

Recommendation 15: Establish monitors and focus employee efforts on reducing delays in obtaining Pain Management Clinic appointments and ensuring the appropriateness of narcotic prescriptions for pain control.

Acting Medical Center Director's Comments:

Concur. We have developed a comprehensive plan for acute and chronic pain management in VISN 14 that has enhanced and expanded our capability for care. This plan, "Acute and Chronic Pain Management Program: VISN 14, has been submitted to the VISN leadership for consideration. This program will establish us as a center of excellence in pain management, ensure continuity of care for pain-related patients, and optimize clinically appropriate, cost-effective care delivery.

In the short-term, we have added a Nurse Practitioner (as of January 2000) as a contract provider of pain management care in addition to our physician staff in the Omaha Pain Management Service. This has increased our capacity for new and follow-up patient care visits. Waiting time for a new patient to be seen by the pain management service is now at 3 weeks. We expect this waiting time to drop as we expand our capacity.

To assist other physicians with pain management evaluation and care, we have also developed projects to assess pain perception and control of pain in our surgical

intensive care unit, admitting area, and oncology clinic for routine pain severity assessment, provision of patient education, and establishment of an adequate plan of care. We will continue development of clinically useful pain control algorithms for use by our physicians.

Status: In Process Target Date: Ongoing

Inspector General Comments:

The Acting Medical Center Director's response and implementation plan are responsive to the recommendation. We established a target date of December 31, 2000 to allow time for the VISN to review and approve the submitted pain management plan, to obtain pain management clinic appointment availability data, and to review the forthcoming pain control algorithms now under development. Upon our review of actions and information that both are to improve pain management clinic availability and assure appropriateness of narcotics prescribed for pain control, we will determine if the recommendation can then be considered implemented.

Recommendation 16: The Director, Veterans Integrated Service Network (VISN), in conjunction with the Medical Center Director, evaluate the COS' and Chief of the MH&BSD's management and oversight activities of the PTSD Program to determine if administrative action is indicated.

Director, Veterans Integrated Service Network Comments:

Concur. The Chief of Staff retired as of June 30, 2000. An Acting Chief of Staff is currently filling the position during our transition to permanent medical staff leadership.

The [Medical Center] Director met individually with the Chief of MH&BSD following the OIG inspection. An action plan was put into place for immediate implementation. The medical staff leader for the PTSD program left ***(b)(6)*** and a new leader was named. This individual was charged with implementation of all the recommendations from Mr. Gusman's report as well as addressing further issues related to the PTSD Program. The response to Recommendation 1, indicates the progress made on that action plan.

Status: Closed Target Date: N/A

Inspector General Comments:

The VISN Director's comments met the intent of the recommendation. As stated earlier in our comments to the Medical Center Director's response to recommendation 1, we will monitor the actions taken to improve the effectiveness of the PTSD Program, including VAMC managers' actions to improve the quality of services to patients.

NATIONAL CENTER FOR PTSD REPORT

DEPARTMENT OF VETERANS AFFAIRS
PALO ALTO HEALTH CARE SYSTEM
3801 MIRANDA AVENUE
PALO ALTO, CALIFORNIA 94304
August 16, 1999

In Reply Refer To:

John Phillips, Director
VA Medical Center
4101 Woolworth Avenue
Omaha, NE 68105-1873

Dear Mr. Phillips:

Enclosed is the report of my site visit to your facility that took place in July 1999. Thank you for your hospitality and openness during my visit; I appreciated the opportunity to review your PTSD services and have included some recommendations in the report. These recommendations mirror what was discussed with your administrative leadership on the final day of my visit.

As mentioned during my meetings, the recommended changes will require various interventions ranging from program redesign and integration to continuing education for staff, and as we agreed, I will continue to provide consultation and mentoring as needed. As I shared with you and your staff, my recent seven-month relationship with the Clarksburg, West Virginia VA Medical Center staff was a success and we were able to implement the necessary changes because I was in direct communication with the VISN and facility directors and worked under their authority. A similar circumstance will be most effective as I work with you and your leadership staff.

Should you or your executive leadership team have any questions or need additional information with regard to the report, please contact me at the number listed below. I look forward to continuing to work with you and your staff as you implement the changes included in the report and those that I discussed in person. Again, I appreciate your efforts and support during my visit.

Sincerely,

(original signed by:)
FRED D. GUSMAN, MSW
Director, National Center for PTSD
(650) 493-5000 x27314

NATIONAL CENTER FOR PTSD REPORT

PTSD SITE VISIT AND CONSULTATION
Omaha VA Medical Center, Nebraska
July 12-14, 1999

Purpose of Visit

At the request of Dr. Matoole, Chief of Staff and in response to concerns of the facility Director in part based on veteran-generated congressional inquiries regarding services for veterans with post-traumatic stress disorder (PTSD), Mr. Fred Gusman visited the PTSD Clinical Team (PCT) at the Omaha VA Medical Center. The reason for the request was based on the desire of the Chief of Staff and the facility Director to have outside expert consultation to assess the clinical efficacy and the administrative organization for PTSD service delivery. Additionally, facility administration expressed concern regarding the veteran community's longstanding division with regard to their support for PTSD services as well as professional division within the PCT about the types of treatment offered and the service delivery processes.

Mr. Gusman met with the Medical Center senior administrative staff, the Chief of Mental Health and Behavioral Sciences Department, all PCT administrative support staff and PCT clinicians with the exception of one clinician who initiated an interviewe by telephone, and veterans currently enrolled in treatment with the PCT. Mr. Gusman also had a telephone interview with the Vet Center Team Leader. In conjunction with these meetings, Mr. Gusman reviewed Mental Health Council minutes for the past three years, Mental Health and PCT standard operating procedures, PCT program policies, curriculum vitas and training records of PCT professional staff, case load data, veterans' demographic data, and medical records of forty veterans currently receiving PTSD treatment.

Findings

Initially, facility administration perceived problems with PCT staff members' abilities and clinical service delivery to be those of personnel and philosophical differences. The problem was found to be much greater; after reviewing data and records and conducting interviews, it became evident that this was a systemic problem that had grown over time. The following are examples that contributed to the current situation:

- Existing operational policies and procedures are limited in scope and depth. Additionally, adherence to existing policies is minimal.
- No outcome measurement system is in place to determine treatment efficacy.

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- Given that a "private practitioner" model is in place, program evaluation and review are not systematically employed.
- Clinical assessment, treatment planning, case assignment, and case termination are not currently structured or coordinated.
- PTSD related continuing education seems not to be expected or supported.
- Position descriptions are outdated and lack specificity with regard to PTSD service delivery and training.
- Direct supervision by the PCT Program Director is unwelcome and disregarded.
- Supervision by Mental Health and Behavioral Sciences is minimal.
- PCT is not effectively incorporated into the overall Mental Health Service.
- Relationships with Vet Center and other community resources are informal at best as evidenced by the lack of documented memoranda of understanding.
- The PCT has no University involvement to support clinical and educational activities that would advance the knowledge and skill of staff members as well as enhance the provision of care for their veterans.
- The facility did not follow the implementation plan as outlined in the original application to establish a PCT with resource allocation from Central Office in which they agreed to address several of the aforementioned issues.

Recommendations:

- Develop operational policies and procedures with appropriate scope and depth that are implemented, evaluated, and revised on a consistent and continuing basis.
- Establish a comprehensive outcome measurement system to determine treatment efficacy.
- Establish a cohesive group practice specialty clinic with a clear mission and vision that is supported and monitored by facility administration and PCT leadership and staff.
- Develop and implement an integrated process for clinical assessment, treatment planning, case assignment, and appropriate termination and/or referral.
- Implement guidelines and procedures for PTSD related continuing education.
- Revise existing position descriptions for PCT staff that are specific with regard to PTSD service delivery and training, clearly delineating job expectations and lines of supervision.
- Based on the revised position descriptions mentioned above, facility administration must empower and support the PCT Program Director's supervisory role and efforts.
- Supervision by Mental Health and Behavioral Sciences must be intensified and expanded with regard to PCT administration and service delivery.
- Administratively and functionally incorporate the PCT into the overall Mental Health Service thereby improving the referral process to and from the PCT.

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- Establish formal relationships with Vet Center and other community resources with documented memoranda of understanding in order to broaden the resource base available to veterans and to ensure provision of comprehensive care.
- Establish a formal relationship with the University to support clinical and educational activities that will advance the knowledge and skill of staff members as well as enhance the provision of care for their veterans.
- Facility administration should review, revise, implement, and evaluate the plan as outlined in the original application to establish the PCT as well as address the aforementioned recommendations.

Concluding Remarks

In reviewing this program, it became evident that the staff is very concerned about the veterans and their needs for mental health services. The veterans recognize that staff members are clearly divided with regard to the types and delivery processes for mental health service provision. This dilemma has occurred because of the ambiguity regarding program structure, process, review, and revision, professional roles and supervision, and clients' treatment responsibilities.

With regard to program structure and process, Mr. Gusman was unable to identify a clear program structure or review process for this specialty clinic wherein decisions are made regarding which client's are appropriate for treatment, which professionals should provide what types of care, and how veterans are terminated from treatment or referred to non-specialty care. The absence of structure and program evaluation are evident via the lack of administrative documentation as well as limited documented treatment planning, absence of or minimal charting with regard to identifying and reviewing goals and objectives, and progress notes failing to reflect a clear treatment course.

Ambiguity regarding the roles of individual disciplines and how these disciplines will interact as a cohesive team has been longstanding. The position descriptions for PCT personnel lack specificity regarding duties, knowledge factors, and supervisory controls. The absence of clear role definition supports the individual private practice model in effect and undermines any attempts at supervision or implementation of structure. For example, a client assigned to one therapist who for some reason was dissatisfied with the treatment would complain to another provider. That other provider would take this client into his or her caseload without discussion with the initial therapist or with the team as a whole. Additionally, no evidence was found of documentation regarding veterans' complaints (e.g., reports of contact or incident reports). Also, clients referred by the Vet Center for medication would be recruited for adjunctive therapy without notifying Vet Center personnel. Due to the aforementioned difficulties with program organization and staff roles, a non-therapeutic dependency has developed among clients, leading to

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unrealistic expectations of the treatment process and ambiguous treatment goals on the part of the veterans and the providers.

Despite perceptions of PCT staff regarding their own expertise in the field, training and continuing education has been minimal at best. The National Center for PTSD is charged with acting as an educational resource for PTSD treatment programs throughout the country. In this vein, the National Center will provide any support or mentoring with regard to the recommendations included in this report. Should the facility administration choose to access the National Center for PTSD as a resource, please contact Fred Gusman, MSW, Director, Education and Clinical Laboratory Division.

(Original signed by:)
FRED D. GUSMAN, MSW

CLINICAL CASE REVIEWS

This appendix discusses the results of our reviews of nine patient care cases and associated clinical issues. Cases 1 through 8 pertain to specific patient care concerns that complainants brought to our attention. Case 9 is a matter that inspectors identified in the course of our inspection. These cases comprise the substantiated allegation discussed on page 11.

Case 1: A patient in the Gastro-Intestinal (GI) Laboratory area was clutching his chest to indicate he was trying to obtain help but employees ignored him and he subsequently died.

We did not substantiate the concerns in this case.

(b)(6) wrote their concerns about the care and attention that VAMC clinicians afforded to this patient while he was waiting for services in the GI Laboratory area. ***(b)(6)*** provided the names of two people who allegedly knew of or observed the situation at the time of the patient's cardiac arrest and subsequent death. We interviewed one of the individuals, but after several attempts we were not able to reach the other individual.

This patient was an 85-year-old male who had a history of abdominal aortic aneurysm (AAA), hypertension and a renal cyst. He was admitted to the VAMC on April 10,1998, for persistent epigastric abdominal pain. He continued to have mild to moderate abdominal pain throughout his hospitalization. Clinicians administered Demerol® to the patient to alleviate his pain.

The patient's physician consulted vascular surgery because he was concerned that the patient may have mesenteric ischemia related to the AAA. The patient initially refused to consider surgery for the AAA, but as his abdominal pain persisted and appeared to worsen, he agreed to undergo an abdominal angiogram.

The angiogram revealed a partial occlusion of the inferior mesenteric artery, but the mesentery had good collateral circulation. Since the angiogram did not support a diagnosis of mesenteric ischemia, the patient's physicians obtained a gastroenterology consultation in order to obtain an esophagogastroduodenoscopy (EGD).

On April 14,1999, 4 days after the angiogram, the patient was taken, on a stretcher, to the GI Laboratory. While waiting for clinicians to perform the EGD, the patient developed ventricular fibrillation. Cardio-pulmonary resuscitation efforts were unsuccessful.

We interviewed the physician assistant (PA) who worked in the GI Clinic. The PA told inspectors that she was aware that the patient had abdominal pain and recalled that he was the next patient to be called into the GI Laboratory. The PA recalled that she passed by the patient while he was lying on the stretcher in the hallway outside of the GI Clinic, and that he had not asked for any assistance. However, she also recalled that as she passed by the patient a second time, her assistant informed her that the patient had passed out. She found that the patient was hypotensive and unresponsive, and she initiated resuscitative procedures.

An OHI inspector reviewed a Report of Special Incident Involving a Beneficiary (VA Form 10-2633) that ***(b)(3)***. We concluded that there was no reasonable way that clinicians could have prevented the patient's cardiac arrest and subsequent death. We were unable to verify that clinicians neglected or ignored the patient, or that they may have called a code sooner. Therefore, we did not substantiate the allegation.

We interviewed the patient's niece whom the complainant told us could corroborate his allegation. The niece told OHI inspectors that 2 weeks after her uncle died, a ***(b)(6)*** visited her and told her that the patient "…did not die the way the hospital led her to believe…" and suggested that she obtain a copy of the patient's medical records. She recalled that the ***(b)(6)*** told her that the patient had asked for help while lying on the stretcher, but that no one tried to help him. The niece obtained a copy of the patient's medical records and in turn provided them to ***(b)(6)***. She was not at the VAMC at the time of the patient's death, nor was she able to provide any specific information that would contradict what VAMC employees told us.

Case 2: A patient was prematurely discharged from inpatient psychiatric care and subsequently committed suicide.

We did not substantiate this allegation.

This 47-year-old male who had chronic, paranoid schizophrenia, was admitted to the Psychiatric Intensive Care Unit on January 7, 1998. The patient's mother and nephew transported him to the hospital because he was not sleeping, he was agitated, he had auditory hallucinations, and he was not complying with his medication regimen. A January 7, 1998 medical record note states that the patient admitted that he heard voices that others did not hear. He also acknowledged feelings of paranoia and persecution related to his race and mental disorder, and that he had a pre-occupation with suicidal thoughts. However, he asserted that he did not have a plan for suicide at that time, even though he had a history of eight or nine past suicide attempts.

The patient's hospital course was uneventful. Physicians treated him with medications, including Zyprexa®, Tylenol®, and Ativan®. On January 8, the patient denied that he had suicidal or homicidal ideations. Physicians discharged him on January 9, 1998, in satisfactory condition. Clinicians arranged for a January 12, 1998 Mental Hygiene Clinic follow-up appointment for the patient.

At his January 12 outpatient psychotherapy appointment, the examining psychiatrist noted that the patient had negative thought content for suicidal or homicidal ideations but that he did have auditory hallucinations and paranoid delusions. The outpatient psychiatrist considered that the patient had been "…less than optimally treated for mental disorder…" as he had difficulty allowing physicians to manage his care and was non-compliant with treatment. The physician continued the patient's Ativan® and planned further psychotherapy with reality testing to manage the patient's paranoid delusions. The physician planned to see the patient biweekly. The physician's electronic progress note states that the patient was not a danger to himself, was not acting impulsively or making threats of harming himself or others, and was considered appropriate for outpatient management.

On January 14, 1998, someone notified VAMC officials that on January 13, 1998, the patient had jumped off a building to his death. Suicide is considered an adverse event and therefore clinicians performed a psychological autopsy as required by the VHA Patient Safety Program.[7]

The psychological autopsy report states that ***(b)(3)*** . During the 2-day hospital stay, physicians started the patient on a new medication regime and he appeared to return to his usual mental status. He had a long history of paranoid schizophrenia, which previously had been treated with Clozaril®. However, physicians had discontinued that medication because of its possible side effects, and prescribed resperidone, which he did well on until he developed a side effect and stopped taking it on his own.

Reviewers concluded that ***(b)(3)*** . ***(b)(3)*** .

[7] VA Handbook "Patient Safety Improvement" (Handbook 1051/1 Appendix D dated January 13, 1998).

The psychological autopsy team ***(b)(3)*** ***(b)(3)*** ***(b)(3)***.

We concluded that ***(b)(3)***. This patient was extremely ill and because of his non-compliance with treatment, his condition was very volatile, and his suicide was not preventable.

Case 3: A patient alleged that: *(i) a psychologist inappropriately altered a progress note in her medical record; (ii) she was unable to obtain psychiatric medication refills; and, (iii) she experienced an excessive delay in being seen by the PTSD Clinic social worker for a scheduled appointment.*

We partially substantiated the concerns in this case.

We interviewed this patient and reviewed her medical records. The patient asserted that in 1998, she attended an all-female PTSD therapy group but dropped out because she was not comfortable with the group method of therapy She told us that she preferred the individual sessions that she had with the previous full-time PTSD Clinic social worker. She also complained that since the full-time PTSD Clinic psychiatrist's late-1999 departure, she had not been able to obtain timely refills of her psychiatric medications. On December 6, 1999, the patient had an appointment with a social worker but the social worker was late and the patient left without being seen. Before she left the clinic she asked the PTSD Clinic receptionist about obtaining refills of her psychiatric medications. The receptionist reportedly told her that she had to go through the primary care Walk-In Clinic to obtain the refills. However, the primary care physician refused to refill her medications. She allegedly left the VAMC, saw a private physician who gave her the prescriptions, and purchased the medications at a private pharmacy.

The patient alleged that the PTSD Clinic psychologist inappropriately altered a December 17, 1998 progress note to make it appear that she had left the female PTSD therapy group because she was delusional. Our review of the patient's medical record did not find any indication that the December 17, 1998 note had been altered.

However, a December 19, 1998 note documenting the patient's treatment team's assessment of her condition states, in part, that "…(there is a) possibility that the patient is experiencing delusional processes and meets diagnostic criteria for delusional disorder, persecutory type, (this) was considered and will need to be ruled out." Because our medical record review did not disclose evidence of alteration of this patient's December 17, 1998 progress note, we did not substantiate the allegation of an improper progress note alteration.

On December 8, 1999, we brought this patient's concerns to the attention of the Chief of the MH&BSD. The Chief acknowledged that there continued to be a lack of psychiatrist coverage for the PTSD Clinic and that this physician shortage was adversely affecting patients who need medication refills. He said that primary care providers could call him or other psychiatrists for telephone consultation, and he maintained that this patient's primary care provider should have been able to reach a psychiatrist to obtain the proper consultation. The Patient Representative also told OHI inspectors that she had been aware of this problem for some time, but to her knowledge, no remedy was in sight until more psychiatrists are available to PTSD Clinic patients.

OHI inspectors received a copy of a December 8, 1999 note that the PTSD Clinic social worker wrote to the patient, in which she apologized for running late on the day of the patient's appointment (December 6, 1999). The social worker urged the patient to return to the PTSD Clinic and continue her follow up. This note confirmed that the patient was not promptly seen for a scheduled appointment. However, while the delay was unfortunate, such delays may occur due to emergencies.

Because of the situation experienced by this patient, confirmed by the Chief of the MH&BSD, we also substantiated that the patient did not receive needed psychiatric medication refills. We concluded that the current procedure for PTSD Clinic patients to obtain medication refills puts an unnecessary burden on the patients. Medical center managers need to assess this issue and take immediate action to ensure that PTSD Clinic patients receive timely medication refills.

Case 4: A patient allegedly received questionable or poor care during his hospitalization which ultimately resulted in his death.

We substantiated the concerns in this case.

A complainant alleged that a 78-year-old male patient received inadequate or poor care, which led to his February 15, 1998 respiratory arrest and death. We interviewed the complainant and reviewed the patient's medical records.

The complainant alleged that the patient lost excessive weight during his hospitalization. She told an OHI inspector that she visited the patient on February 14, 1998, and he appeared to be fine, but that he died suddenly the next day.

This patient had multisystem illnesses (i.e., ischemic heart disease, carotid artery disease, peripheral vascular disease, history of deep venous thrombosis, chronic obstructive pulmonary disease, left inguinal hernia repair, history of hypercholesterolemia, recurrent bronchitis, history of pneumonia, history of dementia, and a history of stroke). He presented to the Omaha VAMC on January 16, 1998, due to mental status changes.

Physicians thoroughly examined the patient but could not identify an acute neurologic cause of these mental status changes. There were no new lesions on computerized-tomography scans, and other laboratory tests did not provide any clues to the patient's change in mental activity.

However, we found that the patient did have a condition that could explain his change in mental activity. He had acute bronchitis and a history of chronic recurrent bronchitis. Bronchitis or pneumonia in the elderly readily cause mental status changes. Physicians appropriately prescribed Unasyn® (ampicillin sodium/sulbactam sodium) for the bronchitis. The patient's physician also ordered a Magnetic Resonance Imaging (MRI) test (also an appropriate clinical action, to rule out stroke, etc., even if there was an already available explanation for the mental status changes).

On January 19, 1998, to sedate the patient for his MRI, the patient's physician ordered a relatively small dose of Xanax® (alprazolam) (0.5 mg). This, too, was appropriate because the patient had no known drug allergies or sensitivities, and he had, in fact received a dose of Xanax® the day before, for agitation, without apparent ill effect. This time, however, he experienced a respiratory arrest.

He became suddenly unresponsive with decreased respirations, developed acute respiratory distress and became hypoxic. Physicians transferred him to the Intensive Care Unit (ICU) where physicians found that the patient experienced a myocardial infarction.

Of note about this respiratory arrest is that:

- It occurred 15 minutes after the Xanax® was given.

- The patient appeared to respond, i.e., come out of his arrest, after physicians administered Romazicon® (flumazenil), a benzodiazepine antagonist or benzodiazepine reversing agent.

- The arrest was purely respiratory, i.e., it did not appear to have a cardiac component.

- The arrest was so brief that the patient only had to be intubated for a very short time period.

The medical record describes an extensive discussion among physicians as to what caused the arrest, with most of the focus on the patient's peri-arrest, non-Q wave, myocardial infarction. However, OHI concluded that, this infarction almost certainly occurred after the respiratory arrest, as there were apparently no pre-arrest cardiac symptoms. Also, the possibility of an event such as pulmonary embolus (for which no evidence was found) was considered. Curiously, no clinician explicitly placed a benzodiazepine reaction in their differential diagnosis nor even discussed this possibility. This may have been because it is virtually unheard of to have a respiratory arrest from an *orally* administered benzodiazepine, in the absence of other sedatives such as alcohol or opiates. Regardless, physicians did not overtly consider the possibility, despite one or two clinical notes which vaguely allude to the proximity between the Xanax® dose and the arrest.

We concluded that Omaha VAMC clinicians did not appear to be overly concerned about the possibility of a benzodiazepine-induced arrest because post-arrest, they prescribed Ativan® (lorazepam) for anxiety and restlessness. Ativan® is another benzodiazepine that is very similar to Xanax®. By this time, the patient's bronchitis had been treated for several days with intravenous Unasyn®, at which point the bronchitis may have been largely cured, or at the least, substantially under control.

The patient spent 12 days in the ICU. Physicians later transferred him to an acute medical ward for further monitoring and resolution of his cardiac status. Physicians deemed the patient to be incompetent to care for himself even though the patient's family felt that his mental status was improving. Psychiatry was consulted to see the patient, and the consulting psychiatrist reiterated that he was incompetent to care for himself and should be placed in a nursing home. The main issue for the medical center at this point was to find the patient an available and suitable nursing home bed.

Nursing home placement proved to be very difficult. At this stage of his hospitalization, when the patient received the Ativan®, even in very small doses, e.g., 0.5 or 1.0 mg, he had excessive somnolence. This is noted in numerous notes, but generally with each note being written by a different nurse or doctor.

On February 4, a neurologist discontinued the Ativan® and ordered Risperdal® (respiridone). Once on the Risperdal®, the patient's mental status substantially improved.

On that same day, a physician noted that the treatment team spoke with the neurologist, and that the team wanted to "improve (the patient's) night (and) day disorientation and avoid snowing (the) patient during the day with Ativan®."

It appears to be clear at this point that the Ativan® *alone*, or another benzodiazepine drug *alone*, would indeed heavily sedate this patient, although these drugs were not thought by clinicians to be of any harm to him. Numerous practitioners noted this sedative effect from Ativan® on this patient. However, over subsequent days in the ICU, no clinician seemed to think that the heavy sedative effect was excessive or unmanageable. Apparently no one truly integrated all of the clinical notes and findings in this regard. Nevertheless, on February 5, a geriatric evaluation recommended that mood-altering drugs be discontinued. At this point, the patient was on the acute medicine ward.

The patient then developed another respiratory infection -- this time pneumonia. The patient again became agitated, just as he was upon admission several weeks earlier. A physician examined the patient and then prescribed a single dose of Ativan®. On February 15 at 1:00 a.m., the patient developed labored respiration and nurses called a physician. At 1:30 a.m., the physician ordered chest x-rays, an electrocardiogram, and blood tests. A physician later wrote on the same date that "…last night, patient found by nurse in respiratory distress after having taken Ativan®." Also on the same date, shortly prior to the time of his arrest, a physician ordered that someone "…*alert pharmacy of … reaction(s) (twice by) 'Benzo's x 2' (two kinds of benzodiazepines)*."

The patient developed a cardio pulmonary arrest at 9:50 a.m. on February 15, according to a code sheet. Clinicians discontinued resuscitative efforts at 9:59 a.m., at which point the patient was pronounced dead. Physicians called the complainant, whom OHI inspectors interviewed. Later, the patient's legal next of kin declined an autopsy.

We concluded that in this patient's case the *combination* of a respiratory infection and a benzodiazepine was apparently the cause of his death. Neither one would have been lethal individually, because the respiratory infection alone in this patient just caused mental status changes, cough, shortness of breath, etc., and benzodiazepines alone in this patient caused excessive sedation. In combination, however, the two apparently caused this patient's death.

The other major possibility in this case is that the combination of a benzodiazepine *plus* Unasyn® may have led to a serious drug reaction. Our research thus far, however, has not produced any indication of a Unasyn®-benzodiazepine interaction.

In summary, we believe that the patient had either a serious drug interaction, although not well if at all described in the medical record, or possibly a serious physiologic reaction to a respiratory infection-benzodiazepine combination. Only by combining these elements together did the lethal reaction occur.

The medical record contained information that should have caused a more exhaustive Pharmacy and Therapeutics Committee review, but we found that the Committee's review was cursory. A physician completed a Cardiac Resuscitation-Evaluation Sheet (on VA Form 10-0114j) on February 15, 1998. The attending physician initiated a death review on this patient, documented on a February 22, 1998 Report of Special Incident Involving a Beneficiary (VA Form 10-2633). However, the Chief of Staff did not request a peer review of this case, even though the death review noted that the death was unexpected. A peer review should have been performed on this case. In addition, the events in the case should be reported to the Food and Drug Administration as an adverse drug reaction. We also concluded that an outside peer review of this case is needed.

After the patient's first respiratory arrest, clinicians should *not* have missed or avoided noting the clinical reasoning (in the first code sheet) about the possibility that the Xanax® may have caused or may have been related to the first respiratory arrest. Had they not failed to do this, it is possible that the second arrest may have been prevented.

We did not substantiate unreasonable weight loss, as the patient weighed 140 pounds upon admission and lost only 6 pounds during the hospitalization in spite of the seriousness of his illness.

Case 5: A patient allegedly received substandard care and treatment follow-up for allergies, panic attacks, and thrombophlebitis. The patient also had difficulty understanding clinicians' use of the English language, complained about lack of privacy, and was not afforded female pajamas.

We did not substantiate the concerns in this case regarding substandard care and treatment follow-up for allergies, panic attacks, and thrombophlebitis, or regarding the availability of female pajamas. We did substantiate this patient's concerns about use of the English language and female privacy.

This patient was a 48-year-old female who had a history of PTSD, panic attacks, and thrombophlebitis. The patient was first seen in the VAMC in January 1988. Since that time she has had 716 scheduled treatment encounters documented in the medical center computer system, 57 of which the patient cancelled. The patient did not keep 40 other appointments; and 45 were cancelled by clinic personnel. The patient was seen numerous times by the former PTSD Clinic social worker.

The complainant alleged that the patient was only being seen by the General Medicine Clinic every 6 months.

VAMC managers had already received and reviewed the complaints about this patient's care.

We interviewed the patient on December 9, 1999. She described her experiences at the VAMC 12 years previously and the subsequent difficulty over the ensuing years with her allergies and viral infections. She was not satisfied with the VAMC's allergists or the PTSD Clinic psychologist, although she said that her allergies are now under control. She liked the former PTSD Clinic social worker, and asserted that she was improving psychologically until the social worker left. She also complained about physician rotations in primary care, the lack of follow-up regarding abnormal test results, and people "with personality" in the PTSD Clinic.

An OHI inspector reviewed the patient's medical records and associated quality management documents. We concur with the results of the medical center's review that concluded that ***(b)(3)***. The medical record shows that the patient has been followed on a regular basis in the Coumadin, Allergy, and General Medical Clinics.

The medical record also shows minimal documentation of treatment and treatment planning by the former PTSD Clinic social worker. The social worker did not apparently develop any consistent treatment goals for this patient. Treatment plan and progress note documentation was minimal. PTSD treatment is discussed in detail on page 4.

We did not confirm that this patient received substandard care and follow-up for her allergies or thrombosis. However, because the former PTSD Clinic social worker's documentation was inadequate, we could not evaluate the quality of care that she received for her PTSD and panic attacks.

Concerning the issues of clinicians' use of the English language; the lack of female privacy on inpatient psychiatry units, and the unavailability of female pajamas; we found that English was not every clinician's first language and therefore the patient may have had difficulty understanding some clinicians. The inpatient psychiatry units did not have rooms specifically reserved and designed for female patients, so privacy is an issue. We could not confirm that pajamas were not specifically available to this patient, but we recommend that managers ensure that such materials are consistently available for female patients.

Case 6: A patient was dissatisfied with his PTSD Clinic therapist and allegedly experienced continuity of care problems, and therefore his PTSD symptoms worsened.

We substantiated the concerns in this case.

In June 1999, this patient and members of his family wrote numerous letters to VAMC managers and congressional representatives complaining about the lack of follow-up by the PTSD Clinic and about their anger over the departure of the former PTSD Clinic social worker (discussed on page 14). The patient stated that he was satisfied with a PTSD Clinic psychologist's treatment, but he complained that appointment availability with an Omaha VAMC psychologist were too limited (the psychologist has since left the VAMC). The patient's wife wrote that she was not able to deal with the patient's symptoms of nightmares, and episodes of anger at home. She also wrote complaints about the attitudes of the PTSD Clinic employees towards the patient, and poor customer service.

In response to the patient's June 1999 complaint letters, the Chief of the MH&BSD sent a June 10, 1999 letter to the patient. He offered to meet with the patient and his family to discuss options for continued care if they were dissatisfied with the current PTSD Clinic clinician. The patient declined the offer.

OHI inspectors reviewed the patient's medical record and associated correspondence. In June 1999, a psychologist wrote in the patient's medical record that the patient continued to have nightmares, flashbacks, irritability, depression, sleep disturbance, and avoidance symptoms. In July 1999, the patient told this psychologist that he was afraid to go to his (the psychologist's) office because he feared "…mistreatment by the police here because of an incident, which occurred with another PTSD veteran." Since the psychologist was leaving his employment at the VAMC at the end of July 1999, he arranged for another practitioner to see the patient. On August 31, 1999, the patient saw a new part-time PTSD Clinic psychiatrist, at which time he asked for and received medication changes.

Following the August 31 appointment, the patient was to return in 2 weeks. Progress notes indicate that he agreed with the psychiatrist's treatment plans and medication changes. The patient was scheduled to see the same psychiatrist on September 14, 1999, but he cancelled that appointment. He also did not keep his rescheduled appointment on September 21. Then, the PTSD Clinic cancelled an appointment for October 26 because the psychiatrist was on extended leave.

On November 4, 1999, the PTSD social worker received a telephone call from the patient's wife, stating that he was transferring to the Lincoln VAMC for psychiatric services. He was therefore discharged from the Omaha PTSD Program.

The social worker did not discuss why the patient was changing facilities. According to the VAMC Quality Officer, the patient is seeing a Lincoln VAMC psychiatrist who changed his medications.

We recognize that in June 1999, the patient declined the Chief of the MH&BSD's offer to meet with him personally. The patient therefore did not completely afford the VAMC a chance to remedy his concerns about his PTSD Clinic treatment. However, there was significant psychiatrist and other staff turnover in the PTSD Clinic in 1999. The patient's ability to establish rapport and trust with a PTSD therapist was hindered. While the patient cancelled two appointments, he did experience disruptions to his continuity of care because of staff turnover and his distrust in some practitioners. These factors combined would likely cause the patient to decompensate in his mental status. Therefore, we concluded that the patient's allegations were substantiated.

Case 7: A patient received inadequate PTSD therapy, experienced rude employee treatment, and had problems obtaining a compensation and pension examination.

We did not substantiate the concerns in this case.

On June 30, 1999, this female patient who had PTSD symptoms wrote to Senator Kerrey. In her letter, she requested an investigation into the health care procedures and mental health services provided to her at the VAMC. The patient also stated that she felt her physical and emotional well being had worsened since she began treatment at the VAMC. She alleged that because she was unable to obtain appointments in the PTSD Clinic she decided to move out of state.

The last notation made on the patient's Omaha VAMC medical record pertained to a June 6, 1999 PTSD Clinic appointment. An OHI inspector asked the Patient Representative to contact the patient to follow-up on her quality of care concerns. The Patient Representative was unsuccessful because she did not have a telephone number for the patient. However, OHI inspectors were able to obtain the patient's telephone number and spoke with her twice, on December 14, 1999, and on January 4, 2000.

The patient asserted that the former PTSD Clinic social worker was the only therapist who understood her. She began weeping when the OHI inspector asked her to describe what type of care and service she had received from the Omaha VAMC psychiatrist. She said that she was made to feel like a burden, and alleged that at one point, the psychiatrist told her that she was irritating to him. She also stated that the PTSD Clinic receptionist made her wait 30 to 40 minutes for her appointments with the former social worker. She did not recall the last time that she had been seen in the PTSD Clinic.

She said that "I just remember that my stomach would burn and I would get sick when I had to go there. Things got so bad that I moved to Jackson, Mississippi. They do you wrong there (Omaha VAMC). They stick up for each other, not for the veterans." The patient became extremely upset when she talked about her Omaha VAMC experiences. The patient told OHI inspectors that she currently receives her medications from the Jackson, Mississippi VAMC.

We subsequently telephoned Jackson VAMC managers and found that the patient had completed compensation and pension examinations. Also, she was seen October 12, 1999, in the Primary Care Mental Hygiene Clinic and had a January 10, 2000 appointment in the Jackson VAMC's Outpatient Trauma Recovery Program. Therefore, we did not recommend further actions for this patient at this time. Although we acknowledge this patient's dissatisfaction with the Omaha VAMC and its mental health providers, we were unable to substantiate that she received inappropriate PTSD care.

Case 8: A patient received substandard care and service at the VAMC in March 1999, and was harassed by VAMC police.

We did not substantiate the allegation.

The complainant alleged that she brought her 47-year-old husband to the Omaha VAMC, on March 23, 1999, because he had stopped taking his medications and was confused. She alleged that the patient had to wait more than 5 hours before a physician would agree to admit him. The complainant further alleged that after the former PTSD Clinic psychiatrist left in the fall of 1999, the patient never received notification concerning follow-up care by the PTSD Clinic.

This patient's medical record shows that he had been seeing the former PTSD Clinic psychiatrist on an outpatient basis for more than 3 years. He was seen in the ER on March 23, 1999, because he had stopped taking his medications, and he was confused and delusional. The patient told the ER physician that others could read his thoughts and that he could read others' thoughts as well. He also informed the physician that he possessed special abilities to influence people, such as to make them happy or upset. The patient admitted to having strong homicidal thoughts toward one of the physicians and one of his neighbors.

The medical record further reflects that this patient became irritable in the ER, when the physician mentioned that he needed to be hospitalized. The physician determined that the patient needed hospitalization because the patient was overtly psychotic. Also, the patient had a history of committing violence towards others including his family. The patient's wife told the physician that she did not feel safe with the patient, and that he had a history of possessing guns.

Once the patient was told that he would be admitted, he became upset and stated that he would fight medical center employees if he was admitted. VAMC employees initiated an emergency police certificate, which allows police to hold the patient until he is further evaluated over a period of up to 36 hours. The patient was subsequently admitted to the PICU. He was discharged on March 30, 1999.

The patient also complained that he was in the admitting area for more than 5 hours on March 23, 1999. The medical record reflects the following sequence of events:

- Arrival in the Admissions Office (Urgent Care) - 5:00 p.m.
- Triaged - 5:10 p.m.
- Nursing and Physician Examinations - not timed
- Laboratory tests - 5:40 p.m. to 7:00 p.m.
- Radiology Scan - 7:51 p.m.
- Discharged to PICU - 9:25 p.m.
- PICU admission intake note - 10:05 p.m.
- Physicians orders written - 10:25 p.m.
- Medication administered - 11:10 p.m.
- Nursing co-signed physician orders - 11:50 p.m.
- Medication administered -12:00 midnight

The medical record does not contain any evidence that the patient spent excessive time in Urgent Care, considering the time involved in ordering and waiting for laboratory test and x-ray results and getting an emergency police certificate. The patient was in Urgent Care for about 4½ hours but during that time he received numerous laboratory tests and x-rays. We did not find evidence of any improper actions or unusual treatment delays by Urgent Care clinicians.

Case 9: Patients needing pain control or management should be referred to appropriate pain management specialists.

We included this case as the result of our findings during the inspection.

The patient is a 50-year-old male who has a history of PTSD, polysubstance abuse, antisocial personality, and chronic neck pain from multiple motor vehicle accidents. On May 10, 1999, this patient reported to the Urgent Care Clinic and requested a renewal of his pain medication (Oxycodone®, 20 milligrams twice a day, and Tylenol® Number 3, every 5 hours as needed).

The patient was taking these medications to alleviate the chronic pain associated with osteoarthritis stemming from a motor vehicle accident in 1992, with exacerbations from similar accidents in 1996, 1997, and again in January 2000.

The patient's medical record shows that this patient's PTSD Clinic psychiatrist had been providing him with narcotics prescriptions, to help alleviate pain, for a lengthy period of time. An OHI clinical pharmacist reviewed the appropriateness of the timing and quantities of these narcotic prescriptions. We did not find any irregularities in the prescriptions issued to the patient. However, we remain concerned that a physician who was not skilled in pain management was prescribing narcotics for this patient for a prolonged period of time. This matter apparently was brought to the attention of clinical managers prior to our inspection, and the Chief of the MH&BSD had already discussed this practice with the psychiatrist.

We reviewed automated VAMC pharmacy records of all of the narcotics prescribed by VAMC psychiatrists (not fee-basis or resident) in FYs 1998 and 1999. Table B1 shows the results of that review.

TABLE B1
NARCOTICS ISSUED BY VAMC STAFF PSYCHIATRISTS
FYs 1998 and 1999

Staff Psychia-trist Identifier No.	Designated Time Assigned to Work in the VAMC	Staff Psychiatrists' Narcotic Prescriptions Issued, FY1998	No. Patients To Whom Narcotics Prescribed FY 1998	Staff Psychiatrists' Narcotic Prescriptions Issued, FY1999	No. Patients To Whom Narcotics Prescribed FY 1999
1	7/8 Time	1	1	2	2
2	4/8 Time*	9	7	4	3
3	5/8 Time	3	3	21	8
4	7/8 Time	0	n/a	3	3
5	3/8 Time	0	n/a	0	0
6	6/8 Time	11	8	29	16
7	5/8 Time#	0	n/a	0	0
8	8/8 Time	388	49	575	77
9	3/8 Time	8	3	4	2
Totals		**420**	**71**	**638**	**111**

**Was 5/8 until 7/1/98.* *# - Started with VAMC on 7/12/99*

There are several observations noted for the prescriptions during FYs 1998 and 1999:

- Psychiatrists wrote 52-percent more narcotics prescriptions in FY 1999 than in FY 1998.

- There was a 56-percent increase in the number of patients to whom narcotics were prescribed.

- There was a 266-percent increase in the number of narcotic prescriptions issued by psychiatrists who were employed more than half-time but less than full-time.

- There was a nearly 53-percent decrease in the number of narcotic prescriptions issued by psychiatrists who were employed half-time or less.

We did not determine whether ***(b)(6)*** overall patient caseload increased during FY 1999. Also, it should be noted that ***(b)(6)*** was acting as a primary care provider. He informed OHI inspectors that he is also an internist. We are not commenting on whether this particular ***(b)(6)*** narcotics prescriptions were clinically appropriate or not. However, the volume of his prescriptions, their rationale, and the number of patients to whom he prescribed narcotics, warranted review. We concluded that better review and monitoring of narcotics prescribing practices is needed.

On January 10, 2000, the Chief of Staff told OHI inspectors that they tried to assign PTSD Clinic patients who needed pain management to primary care. Habitual drug-using patients were to be seen in the Substance Abuse Unit. The Chief of Staff said that the volume of Pain Clinic referrals overwhelmed existing services. Additional physicians and physician-extenders will begin assisting with pain management. He also said that VAMC clinicians may refer some patients to affiliated university facilities or other VAMCs when appropriate. In the meantime, the Pain Clinic was backlogged 2 months or longer. Therefore, we concluded that Pain Management Services for veterans at the Omaha VAMC were inadequate.

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