Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-02190-281

Combined Assessment Program Review of the Veterans Health Care System of the Ozarks Fayetteville, Arkansas

September 18, 2012

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

CAP	Combined Assessment Program
COC	coordination of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Veterans Health Care System of the Ozarks
FY	fiscal year
HF	heart failure
MH	mental health
OIG	Office of Inspector General
PI	performance improvement
POCT	point-of-care testing
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Veterans Health Care System of the Ozarks, Fayetteville, AR

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of July 30, 2012.

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

- Coordination of Care
- Medication Management
- Mental Health Treatment Continuity
- Point-of-Care Testing
- Quality Management

The facility's reported accomplishment was the MOVE! weight management program for veterans.

Recommendations: We made recommendations in the following five activities:

Environment of Care: Ensure that clean and dirty supplies are stored separately and that patient privacy in the spinal cord injury clinic is maintained.

Polytrauma: Ensure that polytrauma Case Managers are appropriately assigned to polytrauma outpatients and that facility staff working with polytrauma patients receive training in polytrauma care.

Colorectal Cancer Screening: Ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Moderate Sedation: Ensure that pre-sedation assessment documentation includes all required elements.

Nurse Staffing: Complete the steps to develop the staffing methodology for nursing personnel.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following 10 activities:

- COC
- CRC Screening
- EOC
- Medication Management
- MH Treatment Continuity
- Moderate Sedation
- Nurse Staffing
- POCT
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through July 30, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas,* Report No. 11-02085-10, October 26, 2011).

During this review, we presented crime awareness briefings for 124 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 180 responded. We shared survey results with facility managers.

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

Reported Accomplishment

MOVE! Weight Management Program for Veterans

VA Nationwide Teleconferencing System sessions for group discussion were developed to accommodate the needs of veterans participating in the MOVE! program who could not travel to a clinic. The implementation of MOVE! teleconferences have allowed participants to engage in education and discussion with other participants. They have also allowed for an increase in employee efficiency in completing the curriculum in a uniform manner by establishing a consistent timeframe for group classes.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the two medical/surgical units, the intensive care unit, the inpatient MH unit, the emergency department, the SCI clinic, and the dental clinic. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

Noncompliant	Areas Reviewed for MH RRTP (continued)
	Actions were initiated when deficiencies were identified in the residential environment.
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Infection Prevention. The Joint Commission requires that clean and dirty items be stored separately. We found oxygen tanks stored with clean supplies in five of the patient care areas inspected.

Patient Privacy. The Health Insurance Portability and Accountability Act requires the protection of personally identifiable health information. In the SCI clinic, we found computers displaying patient information within view of other patients, families, and/or visitors. We also found a lack of auditory privacy during treatment-related discussions. The facility has ordered privacy screens for the computer monitors.

Recommendations

1. We recommended that processes be strengthened to ensure that clean and dirty supplies are stored separately.

2. We recommended that processes be strengthened to ensure that patient privacy in the SCI clinic is maintained and that compliance is monitored.

Polytrauma

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

We reviewed relevant documents, 10 EHRs of patients with positive TBI results, and 1 training record, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
X	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
X	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Outpatient Case Management. VHA requires that patients with positive TBI results who need interdisciplinary care have a Case Manager assigned.[1] None of the 10 patients with positive TBI results had a polytrauma Case Manager assigned.

Training. The facility expects staff working with polytrauma patients to have training in polytrauma care.[2] Facility staff working with polytrauma patients did not have training in the polytrauma care.

[1] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[2] VHA Handbook 1172.1, *Polytrauma Rehabilitation Procedures*, September 22, 2005.

Recommendations

3. We recommended that processes be strengthened to ensure that polytrauma Case Managers are appropriately assigned to polytrauma outpatients.

4. We recommended that processes be strengthened to ensure that facility staff working with polytrauma patients receive training in polytrauma care.

CRC Screening

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

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Patients were notified of positive CRC screening test results within the required timeframe.
	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[3] Six patients had a biopsy; none of the six EHRs contained documented evidence of timely notification.

Recommendation

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

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

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, nine EHRs, and eight training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[4] Three patients' EHRs did not include all required elements of the history and physical examination, such as a review of substance use or abuse or history of any previous adverse experience with sedation or analgesia.

Recommendation

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

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

Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on one selected acute care unit.

We reviewed relevant documents and interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	The unit-based expert panels followed the required processes.
	The facility expert panel followed the required processes.
	Members of the expert panels completed the required training.
X	The facility completed the required steps to develop a nurse staffing methodology by the deadline.
	The selected unit's actual nursing hours per patient day met or exceeded the target nursing hours per patient day.
	The facility complied with any additional elements required by local policy.

Facility Methodology Deadline. VHA required that the steps to develop the facility's staffing methodology for nursing personnel, which include convening unit-based expert panels, be completed by September 30, 2011.[5] The facility had only the facility level expert panel rather than the required facility and unit-based expert panels.

Recommendation

7. We recommended that the facility complete the steps to develop the staffing methodology for nursing personnel.

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

Review Activities Without Recommendations

COC

The purpose of this review was to determine whether patients with a primary discharge diagnosis of HF received adequate discharge planning and care "hand-off" and timely primary care or cardiology follow-up after discharge that included evaluation and documentation of HF management key components.

We reviewed 21 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Medications in discharge instructions matched those ordered at discharge.
	Discharge instructions addressed medications, diet, and the initial follow-up appointment.
	Initial post-discharge follow-up appointments were scheduled within the providers' recommended timeframes.
	The facility complied with any additional elements required by local policy.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[6] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	The facility complied with any additional elements required by local policy.

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

MH Treatment Continuity

The purpose of this review was to evaluate the facility's compliance with VHA requirements related to MH patients' transition from the inpatient to outpatient setting, including follow-up after discharge.

We interviewed key employees and reviewed relevant documents and the EHRs of 30 patients discharged from acute MH (including 10 patients deemed at high risk for suicide). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 28 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

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

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–24, for the full text of the Directors' comments.) We consider Recommendation 4 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[7]		
Type of Organization	Acute care facility	
Complexity Level	2	
VISN	16	
Community Based Outpatient Clinics	Mt. Vernon, MO Branson, MO Harrison, AR Ozark, AR Fort Smith, AR Jay, OK	
Veteran Population in Catchment Area	129,652	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	73	
• **Community Living Center/Nursing Home Care Unit**	0	
• **Other**	0	
Medical School Affiliation(s)	University of Arkansas for Medical Sciences, Area Health Education Center – Northwest	
• **Number of Residents**	1	
	Current FY (through April 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$258	$251
• **Medical Care Expenditures**	$114	$251
Total Medical Care Full-Time Employee Equivalents	1,206.7	1,197.6
Workload:		
• **Number of Station Level Unique Patients**	47,487	54,149
• **Inpatient Days of Care:**		
o **Acute Care**	11,692	20,861
o **Community Living Center/Nursing Home Care Unit**	0	0
Hospital Discharges	2,553	4,554
Total Average Daily Census (including all bed types)	55	50
Cumulative Occupancy Rate (in percent)	75.3	78.3
Outpatient Visits	308,781	525,246

[7] All data provided by facility management.

VHA Satisfaction Surveys

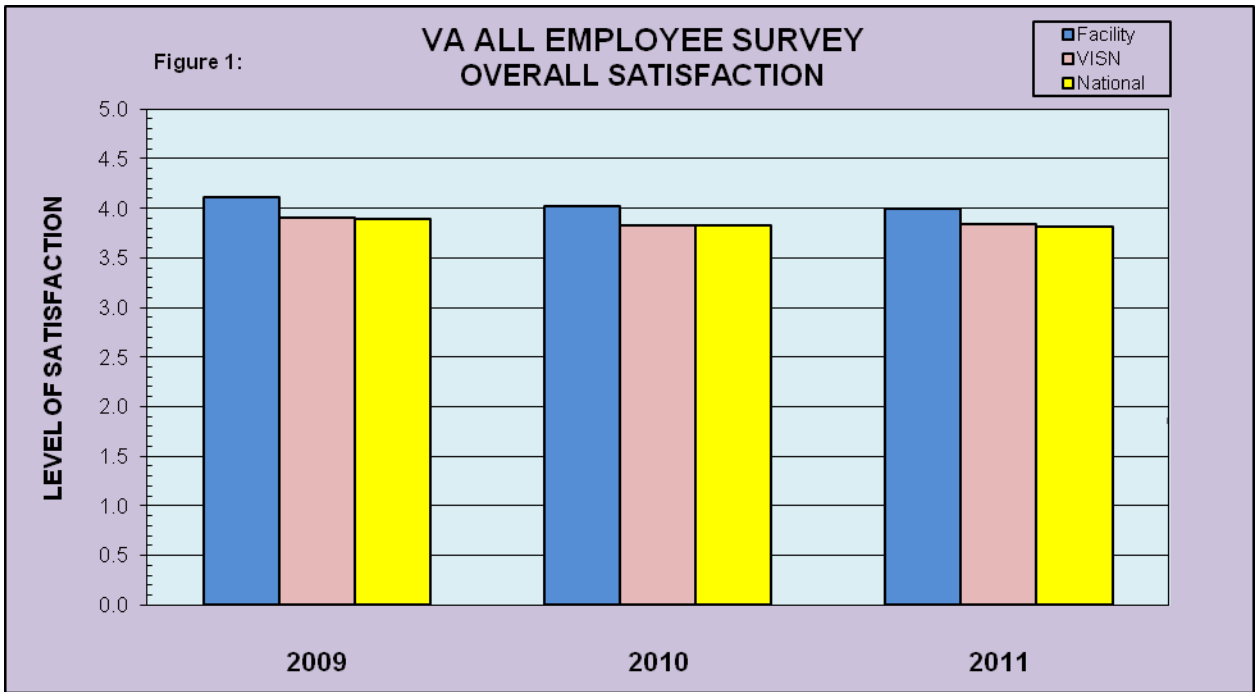
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	68.1	70.9	62.2	61.7	60.7	64.8
VISN	65.9	64.1	52.8	50.7	52.3	50.9
VHA	64.1	63.9	54.2	54.5	55.0	54.7

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[8] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[9]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	17.1	10.2	16.9	**	26.5	19.1
U.S. National	15.5	11.6	12.0	19.7	24.7	18.5

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[8] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[9] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 5, 2012

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Veterans Health Care System of the Ozarks, Fayetteville, AR**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Director, Management Review Service (VHA 10AR MRS)

1. The South Central VA Health Care Network has reviewed and concurs with the draft report of the Combined Assessment Program Review submitted for the Veterans Health Care System of the Ozarks, Fayetteville, AR.

2. If you have questions regarding the information submitted, please contact Reba Moore, VISN 16 Accreditation Specialist, at 601-206-7022.

(original signed by:)
Rica Lewis-Payton, MHA, FACHE
Director, South Central VA Health Care Network (10N16)

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 4, 2012

From: Director, Veterans Health Care System of the Ozarks (564/00)

Subject: **CAP Review of the Veterans Health Care System of the Ozarks, Fayetteville, AR**

To: Director, South Central VA Health Care Network (10N16)

1. Attached is the Veterans Health Care System of the Ozarks response to the July CAP Draft Report.

2. VHSO concurs with the Combined Assessment Program review findings and recommendations.

3. For further concerns or questions please contact Loretta J. Allen, Chief, Quality and Performance. Phone: 479-587-5858.

(original signed by:)
MARK A. ENDERLE, MD
Director, Veterans Health Care System of the Ozarks (564/00)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that clean and dirty supplies are stored separately.

Concur

Target date for completion: November 1, 2012

Used oxygen tanks will be moved out of all clean supply rooms. The terminal cleaning checklist will be amended to include that oxygen tanks used in a patient room will be cleaned with soap and water as part of terminal cleaning. Compliance will be monitored weekly during EOC rounds and reported to the Environment of Care team (EOC) and Administrative Executive Board (AEB) monthly.

Recommendation 2. We recommended that processes be strengthened to ensure that patient privacy in the SCI clinic is maintained and that compliance is monitored.

Concur

Target date for completion: November 30, 2012

Auditory privacy—Staff were instructed at staff meeting on 8-22-12 to ensure there were no other patients in the area when discussing healthcare issues. This training will be repeated at the staff meeting on 9-26-12. The area is controlled and only patients/visitors with the need to know or who have business in the clinic area have access. Auditory privacy will be monitored through EOC rounds in Primary Care Clinics. The element has been added to the EOC checklist. The results will be sent to the Environment of Care Committee (EOC) and the Administrative Executive Board (AEB) monthly.

Privacy screens were placed on the computers in the SCI Clinic on 8-3-12. Privacy screens on the computers will be monitored through EOC rounds in the Primary Care clinic. The element has been added to the EOC checklist for PC. The results will be sent to Environment of Care (EOC) and the Administrative Executive Board (AEB) monthly.

Recommendation 3. We recommended that processes be strengthened to ensure that polytrauma Case Managers are appropriately assigned to polytrauma outpatients.

Concur

Target date for completion: November 30, 2012

An outpatient case manager was assigned on 8-13-12 for all polytrauma Veterans with positive TBI screening. One hundred percent of Veterans with positive TBI screening that require follow-up services will be monitored for compliance. This will be reported to the Quality Improvement Team (QIT) monthly.

Recommendation 4. We recommended that processes be strengthened to ensure that facility staff working with polytrauma patients receive training in polytrauma care.

Concur

Target date for completion: August 27, 2012

The Polytrauma Case Manager, who is the only staff member identified as needing this training, received the following training: Per VHA Handbook 1172.1, Polytrauma Rehabilitation Procedures, September 22, 2005.

Mild TBI Web Based Case Study: Use, Administration and Interpretation of the MACE VA 10176

Mild TBI Web Based Case Study: Screening & Diagnosis

VA's Poly trauma System of care: TBI Care for the 21st Century

Polytrauma Pain Web Course

VHI: Traumatic Brain Injury Independent Study

Recommendation 5. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: December 31, 2012

Endoscopists will forward pathology reports with recommendations to the primary care teams for patient notification and follow-up.

Approximately 300 colonoscopies are completed each month; therefore, to ensure a 10 percent sample size, 40 randomly selected records will be reviewed monthly to verify compliance. The target rate which designates compliance is 95 percent.

Recommendation 6. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: November 30, 2012

A note titled “Pulmonary Consult with Pre Bronch Anesthesia Assessment” was updated to include all required pre-sedation assessment documentation. All bronchoscopies will be reviewed monthly until 3 consecutive months demonstrate 90 percent compliance. This will be reported to the Quality Improvement Team (QIT) monthly.

Recommendation 7. We recommended that the facility complete the steps to develop the staffing methodology for nursing personnel.

Concur

Target date for completion: October 17, 2012

Per the recommendation, The Staffing Methodology program has been restructured with the addition of Unit Based Panels including the requisite membership as outlined in the VHA Directive.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Cathleen King, MHA, CRRN, Project Leader Rose Griggs, MSW, LCSW, Team Leader Gayle Karamanos, MS, PA-C Trina Rollins, MS, PA-C Larry Ross, MS Misti Kincaid, BS, Management and Program Analyst James Werner, Special Agent In Charge, Office of Investigations

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Director, Veterans Health Care System of the Ozarks (564/00)

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