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Office of Inspector General

Office of Healthcare Inspections

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Comprehensive Healthcare Inspection Program Review of the VA Nebraska-Western Iowa Health Care System Omaha, Nebraska

March 26, 2018

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infections
CS	controlled substances
CSC	Controlled Substances Coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
facility	VA Nebraska-Western Iowa Health Care System
FY	fiscal year
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Nebraska-Western Iowa Health Care System (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the Office of Inspector General's (OIG) overall efforts to ensure that our nation's veterans receive high-quality and timely VA health care services. The reviews are performed approximately every 3 years for each facility. OIG selects and evaluates specific areas of focus on a rotating basis each year. OIG's current areas of focus are:

1. Leadership and Organizational Risks
2. Credentialing and Privileging
3. Quality, Safety, and Value
4. Environment of Care
5. Medication Management
6. Mental Health Care
7. Long-Term Care
8. Women's Health
9. High-Risk Processes

This review was conducted during an unannounced visit made during the week of November 13, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the VA Nebraska-Western Iowa Health Care System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. Organizational communication and accountability is carried out through a committee reporting structure, with the Executive Leadership Board having oversight for leadership committees such as the Veteran Experience Council; Quality, Safety, Value Council; Environment of Care Council; Nursing Executive Council; and Executive Committee of Medical Staff Council. The executive leaders are members of the Executive Leadership Board. The Facility Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality of care standards, and perform

organizational management and strategic planning. The Quality, Safety, Value Council, co-chaired by the Facility Director, is responsible for quality, safety, and value functions and for tracking, trending, and monitoring quality of care and patient outcomes.

OIG found that the executive leaders had been working together as a team since September 2016. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted high satisfaction scores that reflected active engagement with employees and patients. OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the (VHA).[1]

The senior leadership team was knowledgeable about selected SAIL metrics likely contributing to the current 5-star rating. In the review of key care processes, OIG issued seven recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director. Of the eight areas of clinical operations reviewed, OIG noted findings in five. These are briefly described below.

Environment of Care. OIG noted a safe environment of care. However, OIG identified deficiencies with staff attendance for environment of care rounds and discussion of high-risk elements in the Infection Prevention Committee minutes.

Medication Management. OIG found general compliance with many of the requirements evaluated, such as monthly and quarterly reports, annual physical security surveys, and program coordinators and inspectors having no conflicts of interest and completing required training. OIG also noted appropriate controlled substances procurement process. However, OIG identified deficiencies with 1-day's reconciliation and return of stock requirement during inspections of patient care areas and 72-hour inventories of the pharmacy.

Long-Term Care. OIG noted general compliance with provision/access to geriatric and medical evaluations, patient education, psychosocial assessment, plan of care development, and interventions implementation when indicated. However, OIG

[1] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" ranking system to designate a facility's performance in individual measures, domains, and overall quality.

identified deficiencies in Geriatric and Evaluation Management program oversight and nurse assessments.

Women's Health. OIG found general compliance with requirements for linking mammogram results to radiology order, scanning mammogram reports, including required components in the report, and performing follow-up mammograms if indicated. However, OIG identified deficiencies in communicating results to patients.

High-Risk Processes Related to Central Line-Associated Bloodstream Infections. OIG noted that the facility tracked healthcare-associated bloodstream infections due to central lines and reported low incidence of infection. However, OIG identified deficiencies with routine discussions and documentation of central line-associated bloodstream infections data, staff education, and the use of a checklist with all the required elements that warranted recommendations for improvement.

Summary

In the review of key care processes, OIG issued seven recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 52–53, and the responses within the body of the report for the full text of the Directors' comments.) OIG will follow up on the planned actions until they are completed.

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

Purpose and Scope

Purpose

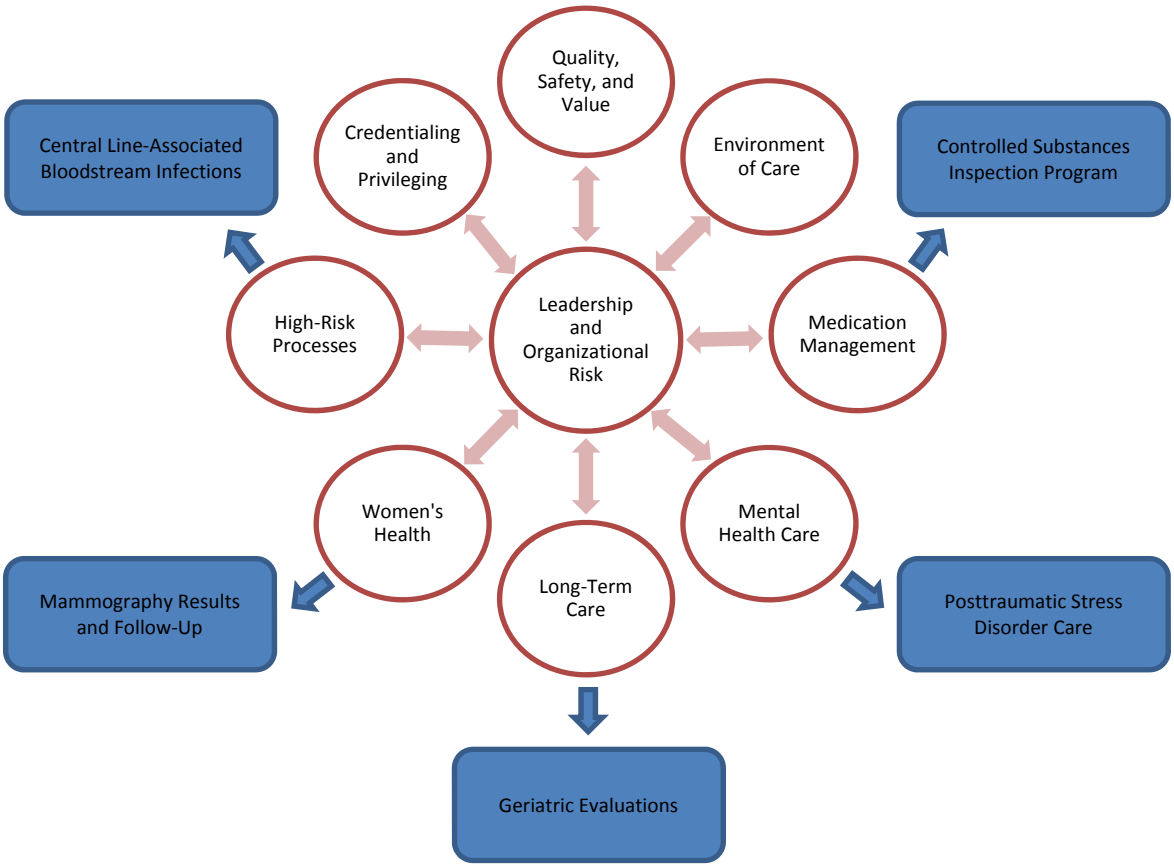
This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the VA Nebraska-Western Iowa Health Care System (facility) inpatient and outpatient settings through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of health care services to veterans and to share findings with facility leaders so that informed decisions can be made to improve care.

Scope

CHIP reviews currently focus on the following nine areas: (1) Leadership and Organizational Risks; (2) Credentialing and Privileging; (3) Quality, Safety, and Value (QSV); (4) Environment of Care (EOC); (5) Medication Management; (6) Mental Health (MH) Care; (7) Long-Term Care; (8) Women's Health; and (9) High-Risk Processes. These were selected because of risks to patients and the organization when care is not performed well. For fiscal year (FY) 2018,[2] the Office of Inspector General (OIG) selected the following specific focus areas—Medication Management: Controlled Substances (CS) Inspection Program; MH Care: Post-Traumatic Stress Disorder (PTSD) Care; Long-Term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-Up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 1).

[2] October 1, 2017 through September 30, 2018.

Figure 1. Fiscal Year 2018[3] Comprehensive Healthcare Inspection Program Review of Health Care Operations and Services



Source: VA OIG.

Additionally, OIG staff provided crime awareness briefings to increase facility employees' understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to OIG.

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[4] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[5] and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

[3] October 1, 2017 through September 30, 2018.
[4] Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.
[5] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.

The review covered operations for March 9, 2015[6] through November 13, 2017, the date when an unannounced week-long site visit commenced. On November 21, 2017, OIG presented crime awareness briefings to 45 of the facility's 2,444 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Recommendations for improvement in this report target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The Facility Director's comments submitted in response to the recommendations in this report appear within each topic area.

While onsite, OIG did not receive any concerns beyond the scope of the CHIP review. We conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[6] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus.[7] The factors OIG considered in assessing the facility's risks and strengths were:

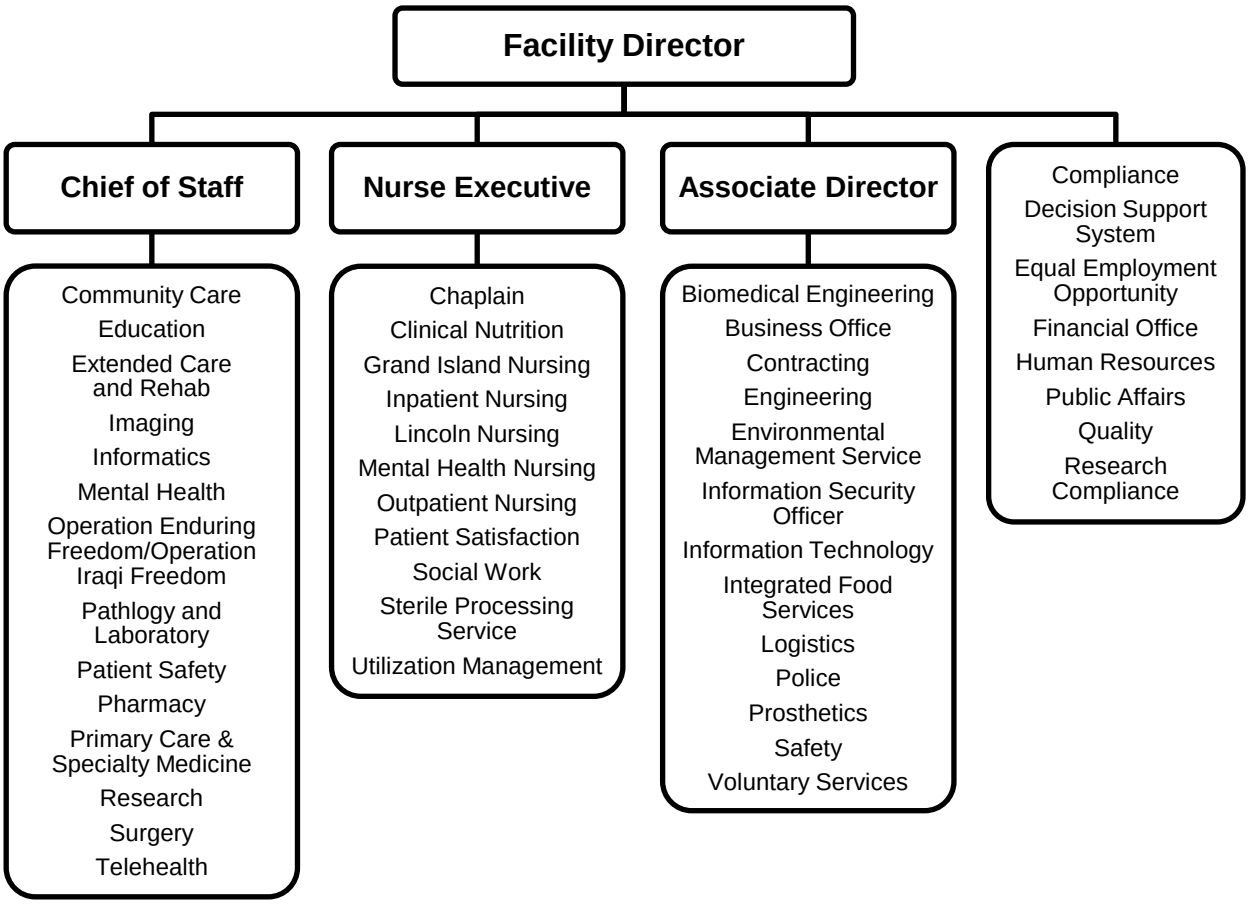
1. Executive leadership stability and engagement
2. Employee satisfaction and patient experience
3. Accreditation/for-cause surveys and oversight inspections
4. Indicators for possible lapses in care
5. VHA performance data

Executive Leadership Stability and Engagement. Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, the leadership organization chart may differ between facilities. Figure 2 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. The Chief of Staff and Nurse Executive are responsible for overseeing patient care and service and program chiefs.

All member of the leadership team are permanently assigned. The Chief of Staff was permanently assigned in September 2016, and the Associate Director served as Interim Associate Director for approximately 6 months before being permanently assigned in December 2016. The executive leaders have been working together since September 2016.

[7] Botwinick, L., Bisognano, M., and Haraden, C., 2006. *Leadership Guide to Patient Safety*. Institute for Healthcare Improvement, Innovation Series white paper. Retrieved February 2, 2017 from http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx.

Figure 2. Facility Organizational Chart



Source: VA Nebraska-Western Iowa Health Care System (received November 13, 2017).

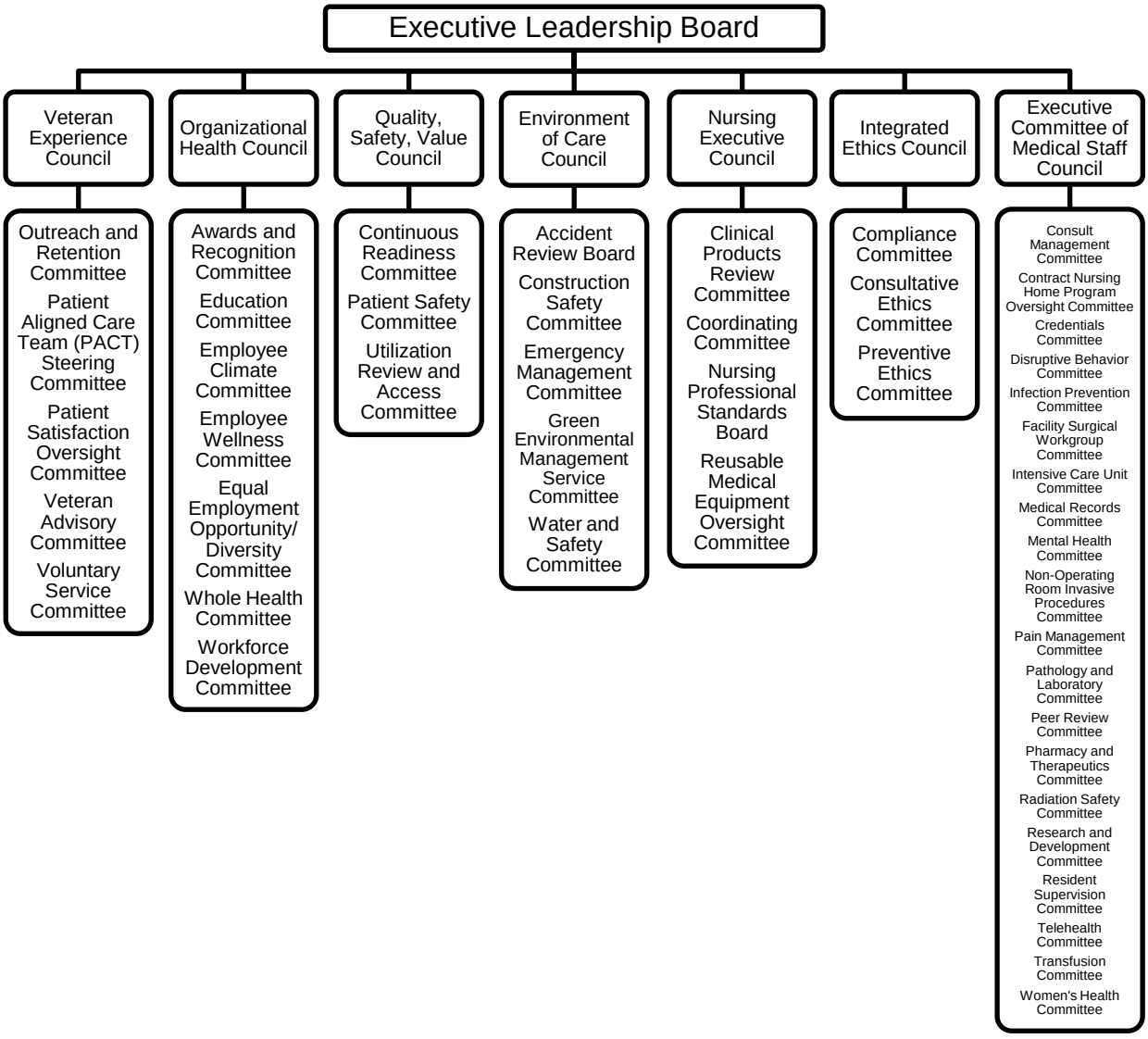
To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, Nurse Executive, and Associate Director regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. Organizational communication and accountability is carried out through a committee reporting structure with the Executive Leadership Board having oversight for leadership councils such as the Veteran Experience Council; Quality, Safety, Value Council; Environment of Care Council; Nursing Executive Council; and Executive Committee of Medical Staff Council. The executive leaders are members of the Executive Leadership Board. The Facility Director serves as the Chairperson with the

authority and responsibility to establish policy, maintain quality of care standards, and perform organizational management and strategic planning. The Quality, Safety, Value Council, co-chaired by the Facility Director, is responsible for QSV functions: tracking, trending, and monitoring quality of care and patient outcomes. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: VA Nebraska-Western Iowa Health Care System (received November 13, 2017).

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Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2016 through September 30, 2017, and patient experience survey results that relate to the period of October 1, 2016 through June 30, 2017. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership.

Tables 1 and 2 provide relevant survey results for VHA and the facility. Facility leaders have made patient satisfaction a top priority and informed OIG that the response rate for FY 2017 employee satisfaction survey was nearly 80 percent. The facility leaders' results (Director's office average) were rated markedly higher than both the facility and VHA averages.[8] Each of the four patient survey results reflected higher care ratings than the VHA average. In addition to VHA patient experience surveys, the facility has been using Press Ganey[9] and "Vet to Vet"[10] inpatient interviews to understand patient experience in its ongoing effort to move toward patient-centered care. In all, both employees and patients appear generally satisfied with the leadership and care provided.

Table 1. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2016 through September 30, 2017)

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[11]
All Employee Survey[12] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.4	4.1
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	69.1	83.9

Source: VA All Employee Survey (downloaded October 13, 2017).

[8] OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.
[9] Press Ganey is a private consulting firm and a leading patient experience company in South Bend, Indiana. For more than 30 years, the company's mission is "to support health care providers in understanding and improving the entire patient experience." Source: http://www.pressganey.com/about (Accessed: November 27, 2017)
[10] Facility program where a hospitalized veteran patient is interviewed by a veteran volunteer or a veteran employee to ascertain their hospital (inpatient) experience.
[11] Rating is based on responses by employees who report to the Director.
[12] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

Table 2. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016 through June 30, 2017)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients[13] (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of "Definitely Yes" responses.	66.9	69.4
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.3	87.5
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		74.6	83.6
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		75.0	80.9

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (RAPID) (downloaded October 13, 2017).

Accreditation/For-Cause[14] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 3 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[15] all recommendations for improvement as listed in Table 3.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[16] and College of American Pathologists,[17] which demonstrates the facility leaders' commitment to quality care and services.

[13] VHA's Patient Experiences Survey Reports provide results from surveys administered by the Survey of Healthcare Experience of Patients (SHEP) program. Industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program are utilized to evaluate patients' experiences of their health care and to support the goal of benchmarking VHA performance against the private sector. VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys.

[14] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

[15] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.

[16] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

[17] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

Additionally, the Long Term Care Institute (LTCI)[18] conducted an inspection of the facility's Community Living Center. It is important to note that the facility had no recommendations from its LTCI survey in March 2017, and the Community Living Center received praise for several "best practices." This resulted in an exceptional "finding-free" certificate from VHA's Office of Geriatrics and Extended Care in recognition of this notable achievement.

Table 3. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Combined Assessment Program Review of the VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska, May 15, 2015)*	March 2015	10	0
VA OIG (*Community Based Outpatient Clinics and Other Outpatient Clinics of VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska, May 5, 2015)*	March 2015	5	0
VA OIG (*Healthcare Inspection – Vascular Surgery Resident Supervision, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska, July 9, 2015*)	Not Applicable	2	0
TJC[19] • Hospital Accreditation • Nursing Care Center Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	July 2016	 19 1 4 4	 0 0 0 0

Sources: VA OIG and TJC (inspection/survey results verified with Facility Director on November 21, 2017).

[18] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

[19] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 4 summarizes key indicators of risk since OIG's previous March 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of November 13, 2017.

Table 4. Summary of Selected Organizational Risk Factors[20] (March 2015 to November 13, 2017)

Factor	Number of Occurrences
Sentinel Events[21]	6
Institutional Disclosures[22]	11
Large-Scale Disclosures[23]	0

Source: VA Nebraska-Western Iowa Health Care System's Patient Safety Manager and QSV Chief (received November 13, 2017).

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[24] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015 through June 30, 2017.

[20] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the VA Nebraska-Western Iowa Health Care System is a high complexity (1b) affiliated facility as described in Appendix B.)

[21] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.

[22] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.

[23] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

[24] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

Table 5. October 1, 2015 through June 30, 2017, Patient Safety Indicator Data

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 23	Facility
Pressure Ulcers	0.60	0.85	0.40
Death among surgical inpatients with serious treatable conditions	103.19	99.06	172.41
Iatrogenic Pneumothorax	0.18	0.22	0.00
Central Venous Catheter-Related Bloodstream Infections	0.14	0.15	0.00
In Hospital Fall with Hip Fracture	0.08	0.16	0.00
Perioperative Hemorrhage or Hematoma	2.00	1.92	0.00
Postoperative Acute Kidney Injury Requiring Dialysis	0.98	0.89	0.00
Postoperative Respiratory Failure	5.98	4.91	6.81
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.33	2.91	1.52
Postoperative Sepsis	4.04	3.17	4.74
Postoperative Wound Dehiscence	0.50	1.33	0.00
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.53	0.72	3.10

Source: VHA Support Service Center.

Four of the Patient Safety Indicator measures (death among surgical inpatient with serious treatable conditions, postoperative respiratory failure, postoperative sepsis, and unrecognized abdominopelvic accidental puncture/laceration) show an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 23 and VHA. Program managers told OIG that all mortality and complications are reviewed by the facility's In-Hospital Preventable Medical & Surgical Complication Work Team. Managers discussed the review process and reported that the number of patients in the reported rates was small and included chronically ill patients and those with high comorbidities (simultaneous presence of two or more diseases or conditions). Although the numerators for these measures are small, the facility had instituted several actions that included educating providers, reviewing coding accuracy, developing an early ambulation team, using incentive spirometry in non-surgical patients, and using intensive care beds for bed-bound patients who would benefit from more frequent interventions and monitoring. Program managers also reported implementing a sepsis bundle.[25]

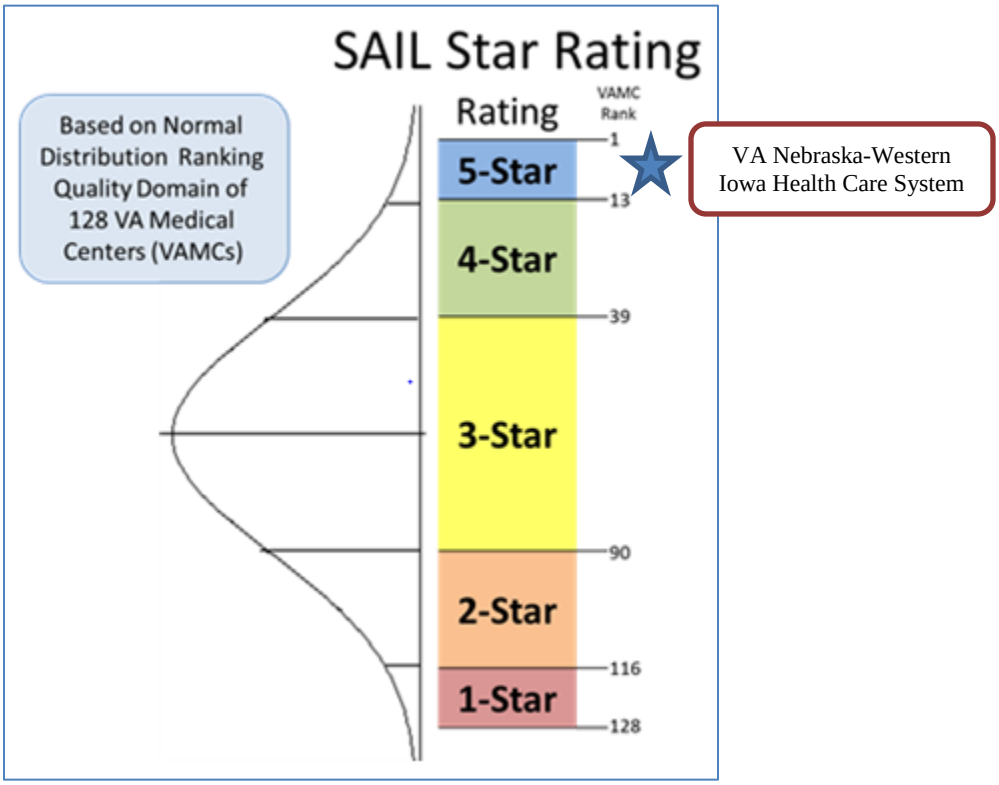
Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[26] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency but has noted limitations for

[25] A bundle is a set of evidence-based practices intended to improve patient outcomes.
[26] The model is derived from the Thomson Reuters Top Health Systems Study.

identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[27]

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of June 30, 2017, the VA Nebraska-Western Iowa Health Care System received a rating of 5 stars for overall quality. This means the facility is in the 1st quintile (top 10 percent range).

Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)

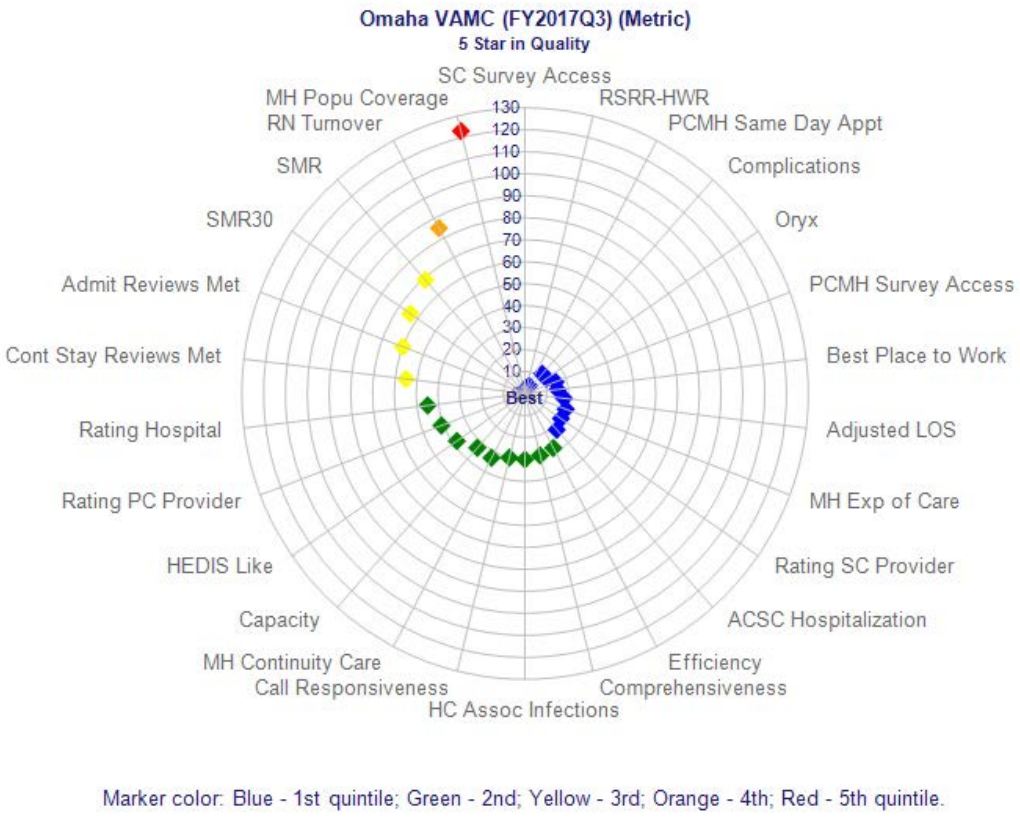


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting (retrieved October 13, 2017).

[27] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146.

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of June 30, 2017. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Complications, Comprehensiveness, Capacity, and Rating of Primary Care [PC] Provider). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (Registered Nurse [RN] Turnover and Mental Health [MH] Population [Popu] Coverage).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2017)



Source: VHA Support Service Center (retrieved January 19, 2018).

Note: OIG did not assess VA's data for accuracy or completeness. Also see Appendix D for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix E.

Conclusions. The facility has generally stable executive leadership and active engagement with employees and patients as evidenced by high satisfaction scores. Organizational leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors. The senior leadership team was knowledgeable about selected SAIL metrics likely contributing to the most current 5-star ranking.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all health care professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges. These health care professionals are also referred to as licensed independent practitioners (LIP).[28]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, mental and physical health, and skill to fulfill the requirements of the position and to support the requested clinical privileges.[29]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Facility Director. Clinical privileges are granted for a period not to exceed 2 years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[30]

The purpose of this review was to determine whether the facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. OIG interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within the previous 11 months prior to OIG's onsite visit[31] and 20 LIPs who were re-privileged within the 12 months prior to the onsite visit.[32] OIG reviewed the following performance indicators.

- Credentialing
  - At least one current license
  - Evidence of primary source verification for all medical licenses
- Privileging
  - Two efforts made to obtain verification of clinical privileges currently or most recently held at other institutions
  - Requested privileges:
    - Facility-specific
    - Service-specific
    - Provider-specific
  - Documentation of service chief recommendation of approval for requested privileges

[28] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. *(Due for recertification October 31, 2017, but has not been updated.)*
[29] Ibid.
[30] Ibid.
[31] July 10, 2016 through June 25, 2017.
[32] October 13, 2016 through October 13, 2017.

  - Medical Staff Executive Committee documentation of decision to recommend the requested privileges
  - Approval of privileges for a period of ≤2 years
- Focused Professional Practice Evaluation (initial or new privileges)
  - Evaluation initiated:
    - Timeframe clearly documented
    - Criteria developed
    - Results documented and based upon evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee documentation of decision to recommend continuing initially-granted privileges based on results
- Ongoing Professional Practice Evaluation (re-privileging)
  - Evidence determination to continue current privileges based in part on results of Ongoing Professional Practice Evaluation activities
    - Criteria specific to the service/section
    - Results based on evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee documentation of decision to recommend continuing privileges based on results

Conclusions. OIG found general compliance with the above performance indicators. OIG made no recommendations.

Quality, Safety, and Value

One of VA's strategies is to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and efficiency.[33] VHA set the goal of serving as the Nation's leader in delivering high-quality, safe, and reliable care, centered on the veteran, while promoting population health throughout the coordinated care continuum. To meet this goal, VHA must foster a culture that acts with integrity to achieve accountability; that is vigilant and mindful, proactively risk aware, highly reliable, and predictable; and that seeks to continuously improve.[34]

VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. The purpose of this review was to determine whether the facility implemented and incorporated selected key functions of the Enterprise Framework for QSV into local activities. To assess this area of focus, OIG evaluated: (1) protected peer review[35] of clinical care, (2) utilization management (UM) reviews,[36] and (3) patient safety incident reporting and root cause analyses.[37]

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. OIG reviewed the following performance indicators.

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary Review of UM data

[33] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[34] VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
[35] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff. *(Due for recertification June 30, 2015, but has not been updated.)*
[36] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.
[37] According to VHA Handbook 1050.01 (March 4, 2011), VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to VHA National Center of Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement root cause analysis (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

- Patient safety
  - Entry of all reported patient incidents into WebSPOT database[38]
  - Completion of required minimum of eight root cause analyses
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report

Conclusions. OIG found general compliance with the above performance indicators. OIG made no recommendations.

[38] WebSPOT is the software application used for reporting and documenting adverse events in the VHA Patient Safety Information System.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the health care environment. VHA requires managers to conduct EOC inspection rounds and resolve EOC issues in a timely manner.[39] The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a health care organization must not only be functional but should also promote healing.

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[40] OIG also determined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on construction safety[41] and Nutrition and Food Services.[42]

The implementation of a proactive and comprehensive construction safety program reduces the potential for injury and illness from unsafe and unhealthy construction activities. Construction safety programs reduce the potential for construction-related accidents, injuries, or exposures.[43]

The Nutrition and Food Services Program must provide quality meals that meet the regulatory requirements for food safety. The highest standard of quality and safety must be maintained in accordance with the Food and Drug Administration Food Code and the VHA-established food safety program.[44]

In all, OIG inspected nine patient care areas. At the Omaha campus, OIG inspected two inpatient units (critical care and 6E-medical/surgical), the Emergency Department, two outpatient clinics (primary and surgical care), one construction site, and Nutrition and Food Services. At the Grand Island campus, OIG inspected a Community Living Center inpatient unit, two outpatient clinics (primary care and optometry), and Nutrition and Food Services. OIG also inspected the Shenandoah CBOC.[45] Additionally, OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Prevention

[39] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.
[40] Applicable requirements also include VHA Directive 1116(2) (March 23, 2016), VHA Directive 1131 (November 7, 2017), VHA Directive 1229 (July 7, 2017), VHA Directive 1330.01 (amended September 8, 2017), VHA Directive 1761(1) (October 24, 2016), VHA Directive 2012-026 (September 27, 2012), Joint Commission hospital accreditation standards (Environment of Care, Infection Prevention and Control, Information Management, Leadership, Life Safety, Medication Management, and Rights and Responsibilities of the Individual), Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).
[41] VHA Directive 7715, *Safety and Health during Construction*, April 6, 2017.
[42] VHA Handbook 1109.04, *Food Service Management Program*, October 11, 2013.
[43] VHA Directive 7715.
[44] VHA Handbook 1109.04.
[45] Each outpatient site selected for physical inspection was randomized from all PC CBOCs, multi-specialty CBOCs, and health care centers reporting to the parent facility and was operational and classified as such in VA's Site Tracking Database by August 15, 2017.

Committee minutes for the past 6 months, and other relevant documents and interviewed key employees and managers. OIG reviewed the following location-specific performance indicators.

Parent Facility
- EOC rounds
- EOC deficiency tracking
- Infection prevention
- General safety
- Environmental cleanliness
- General privacy
- Women veterans' exam room privacy
- Availability of medical equipment and supplies

Community Based Outpatient Clinic
- General safety
- Medication safety and security
- Infection prevention
- Environmental cleanliness
- General privacy
- Exam room privacy
- Availability of medical equipment and supplies

Construction Safety
- Completion of infection control risk assessment for all sites
- Infection Prevention/Infection Control Committee discussions on construction activities
- Dust control
- Safety/security
- Type C – Class III specific requirements

Nutrition and Food Services
- Annual Hazard Analysis Critical Control Point Food Safety System plan
- Food Services inspections
- Emergency operations plan for food service
- Safe transportation of prepared food
- Environmental safety
- Infection prevention
- Storage areas

Conclusions. General safety, infection prevention, and privacy measures were in place at the parent facility in Omaha, Grand Island campus, and at a representative CBOC. Nutrition and Food Services met the performance indicators reviewed. OIG did not note any issues with construction safety or with the availability of medical equipment and supplies. However, OIG identified deficiencies in EOC rounds attendance and with

discussions regarding high-risk infection prevention elements that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[46] From October 1, 2016 through September 30, 2017, 7 of 13 required members did not attend rounds consistently. This resulted in a lack of subject matter experts on EOC rounds. Facility managers were aware of the inconsistent rounds attendance and failed to take actions due to competing priorities and lack of staff.

Recommendation

1. The Associate Director ensures required team members consistently participate on environment of care rounds and monitors members' compliance.

Facility concurred.

Target date for completion. 6/29/2018

Facility Response: The Environment of Care Council has set EOC Rounds attendance target at 85%. A message has been sent to the members who are not meeting the 85% goal to reconfirm team attendance expectations. Exploring other options to improve attendance such as altering the schedule to allow increased participation at one site. A monthly attendance report will be submitted to the Pentad to monitor and act on attendance issues.

Infection Prevention/Control: Goals and Identification of Risks. TJC requires the facility's written infection prevention and control goals include addressing prioritized risks.[47] TJC also requires that the facility identifies risks for acquiring and transmitting infections based on the analysis of surveillance activities and other infection control data.[48] These requirements help to ensure that infection prevention and control programs are effective. The absence of routine discussions may delay identification of infection trends. OIG noted that Infection Prevention Committee meeting minutes did not consistently document discussions of high-risk elements such as CLABSI, ventilator-associated pneumonias, and hand hygiene or analysis of surveillance data. Managers cited a lack of attention to detail.

[46] According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements.
[47] TJC. Infection Prevention and Control. IC.01.04.01, EP 1. July 2017.
[48] TJC. Infection Prevention and Control. IC.01.03.01, EP 1. July 2017.

Recommendation

2. The Chief of Staff ensures the Infection Prevention Committee consistently documents discussions of the high-risk elements and analysis of surveillance data and monitors compliance.

Facility concurred.

Target date for completion: Implemented 11/30/2017 with quarterly review ongoing

Facility Response: The Infection Prevention Committee Chairman implemented changes to the Infection Prevention Committee meeting minutes (November and December 2018 meeting minutes provided) to reflect discussions of the high-risk elements and analysis of surveillance data and monitor compliance. The Infection Prevention Committee will submit their minutes quarterly to the Executive Committee of the Medical Staff. This committee will review to insure compliance.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[49] Diversion—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—by health care workers remains a serious problem that increases the potential for serious patient safety issues, causes harm to the diverter, and elevates the liability risk to health care organizations.[50]

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.[51,52] Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[53] OIG interviewed key managers and reviewed CS inspection reports for the past 2 completed quarters;[54] monthly summaries of findings, including discrepancies, provided to the Facility Director for the past 12 months;[55] CS inspection quarterly trend reports for the last 4 quarters;[56] and other relevant documents. OIG reviewed the following performance indicators.

- Controlled Substance Coordinator reports
  - Provision of monthly summary of findings to the Facility Director
  - Provision of quarterly trend report to the Facility Director
  - Actions taken to resolve identified problems
- Pharmacy operations
- Annual physical security survey of the pharmacy/pharmacies by VA Police
- CS ordered separately from non-CS
  - Acknowledgement of CS orders
- Processes with permanent change in appointment of the Chief of Pharmacy

[49] Drug Enforcement Agency Controlled Substance Schedules. Retrieved August 21, 2017, from https://www.deadiversion.usdoj.gov/schedules/.
[50] American Society of Health-System Pharmacists. October 2016. *ASHP Publishes Controlled Substances Diversion Prevention Guidelines*. Retrieved August 21, 2017, from https://www.ashp.org/news/2017/03/10/19/22/ashp-publishes-controlled-substances-diversion-prevention-guidelines.
[51] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (Due for recertification November 30, 2015, but has not been updated.)
[52] VHA Directive 1108.02, *Inspection of Controlled Substances*, November 28, 2016.
[53] VA OIG, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, June 10, 2014.
[54] From April through September 2017.
[55] From October 2016 through September 2017.
[56] From Quarter 1 through Quarter 4, 2017.

- Restriction of staff involved in monthly review of balance adjustments
- CSC(s)
  - Free from conflicts of interest
  - Position description or functional statement includes CSC duties
  - Completion of required CSC orientation training course
- CSIs
  - Free from conflicts of interest
  - Appointed in writing by Facility Director for a term not to exceed 3 years
  - 1-year hiatus between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Completion of monthly inspections
  - Rotation of CSIs
  - No identification of distinguishable patterns
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CSC CS inspections
- Pharmacy inspections
  - Completion of a complete physical count by CSIs
  - Completion of inspection on day initiated
  - Verification of sealed evidence bag and destruction holding numbers[57]
  - Accountability for all prescription pads in pharmacy
  - Verification of outpatient pharmacy hard copy prescriptions
  - Verification of 72-hour inventories of the main vault
  - Quarterly inspections of emergency drugs
  - Monthly CSI checks of locks and verification of lock numbers

Conclusions. Generally, OIG noted compliance with requirements for most of the performance indicators reviewed, including monthly and quarterly CSC reports, annual physical security surveys, ordering/procurement process, monthly inspections, and the CSC and CSIs having no conflicts of interest and completing required training. However, during inspections of patient care areas, OIG identified deficiencies in 1-day reconciliation and return of stock processes and in 72-hour inventories of the pharmacy.

Controlled Substances Area Inspections: Reconciliation of 1-Day's Dispensing and 1-Day's Return of Stock. VHA requires CS program staff to reconcile one random day's stocking/refilling from the pharmacy to every automated dispensing cabinet and one random day's return of stock to pharmacy from every automated dispensing cabinet

[57] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

during CS area inspections.[58] The reconciliation provides the opportunity to identify potential drug diversion activities and any discrepancies with refilling or returning CS.

OIG found that the 1-day's reconciliation was not conducted in 4 of the 10 CS areas for 2 of the 6 months of inspection reports reviewed. OIG also noted that the facility had not implemented the reconciliation of 1-day's return to pharmacy stock in any of the CS areas. The CSCs stated that there was a lack of attention to detail by some inspectors and they did not ensure completion and accurate documentation of 1-day's reconciliation of CS refills to automated dispensing cabinets in patient care areas. Additionally, the CSC reported that the 1-day's reconciliation of return to pharmacy stock was a relatively new item to the inspection program and that the plan for implementation has not yet been discussed with pharmacy.

Recommendation

3. The Facility Director ensures that 1-day reconciliation of controlled substance refills to automated dispensing units in patient care areas and 1-day reconciliation of returns to pharmacy stock are performed consistently during controlled substance inspections, and the Facility Director monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility Response: Modification of Pharmacy inspection forms completed late November 2017 and implemented for inspections immediately. Modification of inspection form included separate sections for the Pyxis Re-Stock and Pyxis De-Stock (modified inspection forms provided). In each section, the areas that need to be reviewed are listed and the inspectors must indicate the date they reviewed the Re-Stock or De-Stock activity. Every month the pharmacy inspection forms are reviewed by either the CSC or ACSC to ensure this element has been completed by the CS inspector.

Pharmacy Inspections: Verification of 72-hour Inventories. VHA requires a physical inventory of the pharmacy vault, including working stocks, be maintained and verified by Pharmacy Service at a minimum of every 72 hours.[59] CSIs are to verify and document that inventories have been completed as required. This ensures that CS quantity discrepancies are resolved timely and that stocks received, dispensed, and destroyed in the pharmacy vaults were accounted for and accurately recorded. Failure to verify pharmacy vault 72-hour physical inventories could potentially delay identification of discrepancies and potential drug diversions.

OIG reviewed 6 months of pharmacy inspection reports and found no evidence of 72-hour inventories over the course of 5 months for the Omaha Division outpatient vault

[58] VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016. Amended March 6, 2017.
[59] VHA Directive 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. *(Due for recertification November 30, 2015, but has not been updated.*)

and 2 months for the Lincoln Division pharmacy vault. The CSCs stated that the CSI form combined the 72-hour pharmacy inventory and drug cache inspections into a single element and a lack of attention to detail by CSIs resulted in noncompliance.

Recommendation

4. The Facility Director ensures that 72-hour pharmacy inventories are consistently completed during controlled substance inspections in pharmacy areas and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility Response: Modification of Pharmacy inspection forms (provided with the response) completed late November 2017 and implemented for inspections immediately. The modification included separate inspection forms for each Pharmacy. For the 72 hour inventories of the vault and CACHE, the inspectors are to annotate the dates of the inventories. Every month the pharmacy inspection forms are reviewed by either the CSC or ACSC to ensure this element has been completed by the CS inspector.

Mental Health Care: Post-Traumatic Stress Disorder Care

Post-Traumatic Stress Disorder (PTSD) is a disorder that may occur "…following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[60] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[61]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[62] VHA requires that:

1. PTSD screening is performed for every new patient and then is repeated every year for the first 5 years post-separation and every 5 years thereafter, unless there is a clinical need to re-screen earlier.
2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk.
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.

The purpose of this review was to assess whether the facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care. OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the electronic health records (EHR) of 46 randomly selected outpatients who had a positive PTSD screen from July 1, 2016 through June 30, 2017. OIG reviewed the following performance indicators.

- Completion of suicide risk assessment by acceptable provider within required timeframe
- Offer of further diagnostic evaluation
- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

[60] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010. *(Due for recertification March 31, 2015 and revised December 8, 2015, but has not been updated.)*
[61] VHA Handbook 1160.03.
[62] A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

Conclusions. OIG found general compliance with the above performance indicators. OIG made no recommendations.

Long-Term Care: Geriatric Evaluations

In 2016, more than 42 percent of the nearly 22 million veterans were age 65 and over, and 5.5 percent of veterans (1.25 million) were over age 85. More than 9 million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[63]

As a group, veterans experience more chronic disease and disability than age-matched, non-veterans, requiring VA to plan for growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[64] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience increased health-related restrictions in their daily activities, have possible depression, or use home health care services.[65]

In 1999, Public Law 106-117, the Veterans Millennium Benefits and Healthcare Act, mandated that the veterans' standard benefits package include access to geriatric evaluation. This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. Management of the patient would then include treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[66] From a facility standpoint, the GE program must be evaluated through a review of program objectives, procedures for monitoring care processes and outcomes, and analysis of findings.[67]

The purpose of this review was to determine whether the facility provided effective GE. OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the EHRs of 36 randomly selected patients who received a geriatric evaluation from July 1, 2016 through June 30, 2017. OIG reviewed the following performance indicators.

- Provision of or access to geriatric evaluation
- Program oversight and evaluation
  - Evidence of GE program evaluation
  - Evidence of performance improvement activities through leadership board

[63] VHA Handbook 1140.04, *Geriatric Evaluation*, November 28, 2017.
[64] Ibid.
[65] Boult C, et al. A randomized clinical trial of outpatient geriatric evaluation and management. *J Am Geriatric Soc*. 2001; 49:351–9.
[66] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.
[67] VHA Handbook 1140.04.

- Geriatric evaluation
  - Medical evaluation by GE provider
  - Assessment by GE nurse
  - Comprehensive psychosocial assessment by GE social worker
  - Evidence of patient or family education
  - Development of plan of care based on geriatric evaluation
- Geriatric management
  - Evidence of implementation of interventions noted in plan of care

Conclusions. Generally, OIG noted compliance with access to and provision of geriatric evaluation, medical evaluation, patient education, psychosocial assessment, plan of care development, and interventions implementation, when indicated. However, OIG identified deficiencies in GE program oversight and nursing assessments.

Program Oversight and Evaluation. VHA requires ongoing GE program evaluation and performance improvement activities.[68] This provides the opportunity to identify practice improvements, ensures appropriate actions were taken, and measures the effectiveness of actions on a regular basis. OIG's review of the facility's Extended Care and Rehabilitation provider committee meeting minutes from November 2016 through October 2017 did not find evidence of program oversight and evaluation. The GE program manager stated that the Extended Care and Rehabilitation Committee had recently been assigned oversight responsibility of the GE program. During the transition, the committee missed collecting data on quality improvement measures and program evaluation. The reason for noncompliance was lack of program oversight.

Recommendation

5. The Chief of Staff ensures that the geriatric evaluation program receives the required oversight and that quality improvement data are regularly reviewed and documented in committee minutes, and the Chief of Staff monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility Response: The Chief of Extended Care and Rehabilitation, in collaboration with the members of the GEM program, will identify quality improvement metrics, and establish a regular interval for quarterly reporting the same to NWIHCS executive leadership via the Quality, Safety, Value Council.

Nursing Assessments. VHA requires GE program registered nurse(s) to assess patients to identify any problems based on the health and functional status data collected, coordinate plan of care, refer to GE program those patients meeting admission criteria, provide patient and family education, and facilitate interdisciplinary team meetings.[69] This ensures a comprehensive, multidimensional, and

[68] VHA Dir 1140.04, *Geriatric Evaluation and Management (GEM) Procedures*, May 13, 2010.
[69] VHA Dir 1140.04, *Geriatric Evaluation and Management (GEM) Procedures*, May 13, 2010.

interdisciplinary assessment of the patients' physical and mental health, as well as functional and socioeconomic status. The lack of a consistent assessment by a GE registered nurse may result in missed opportunities to implement interventions that may alleviate patients' declining functional status. OIG estimated that the GE registered nurse assessed patients in 33 percent of the EHRs reviewed.[70] Clinical managers believed that allowing licensed practical nurses and nursing assistants to complete basic nursing assessments met requirements.

Recommendation

6. The Chief of Staff ensures that geriatric evaluation program registered nurses perform the required patient assessments and monitors the nurses' compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility Response: An RN does a patient assessment and the charts are monitored monthly over the next 6 months for compliance by the Geriatric RN case manager. Currently Geriatrics uses a CPRS note titled Geriatric Assessment Screen. The note title is misleading regarding who is using the data collected for assessment. The LPN collects data, the Provider formulates the assessment in conjunction with other Geriatric team members. A more accurate reflection of the LPN activity would be a note titled Geriatric Nursing Intake Clinic Note (O)(T).

A CPRS Informatics Request Form has been submitted. CPRS acceptance, roll out and monitoring time line will be dependent upon CPRS priority assignment. Tracking and use of new note title compliance will be 100% of new patients, real time for each Geriatric clinic. The Chief of Extended Care and Rehabilitation reviews and signs. Audits to assess for 90 percent or better compliance will be completed monthly for the next six (6) months by the Specialty Nursing staff, Geriatric RN case manager to ensure sustained compliance. Audit results will be reported to the Executive Committee of Medical Staff Council (XCOM).

Geriatric RN case manager will use an existing note title, Geriatric RN note and pull in the existing Patient Education template to combine with a new Geriatric focused RN templated note. A CPRS Informatics Request Form has been submitted and accepted. Roll out anticipated for April 30, 2018. Tracking and use of new note title compliance will be 100% of new patients, real time for each Geriatric clinic. The Chief of Extended Care and Rehabilitation will review and sign. Audits to assess for 90 percent or better compliance will be completed monthly for the next six (6) months by the Specialty Nursing staff, Geriatric RN case manager to ensure sustained compliance. Audit results will be reported monthly to the Executive Committee of Medical Staff Council (XCOM).

[70] OIG is 95 percent confident that the true rate is somewhere between 19.4 to 50.0 percent, which OIG determined is statistically significantly below the 90 percent benchmark.

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among United States' women.[71] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

Public Law 98-160, The Veteran's Health Care Amendments of 1983, mandated VA to provide veterans with preventive care, including breast cancer screening. Public Law 102-585, Veterans Health Care Act of 1992, Title I, authorized VA to provide gender-specific services, including mammography services to eligible women veterans.

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering practitioner within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering practitioner. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering practitioner within 3 business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with 7 calendar days representing the outer acceptable limit. Verbal communication with patients must be documented.[72,73]

The purpose of this review was to determine whether the facility complied with selected VHA requirements for the reporting of mammography results. OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the EHRs of 50 randomly selected women veteran patients who received a mammogram from July 1, 2016 through June 30, 2017. OIG reviewed the following performance indicators.

- Electronic linking of mammogram results to radiology order
- Scanning of hardcopy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient
- Performance of follow-up mammogram if indicated

The performance indicator below did not apply to this facility.

- Performance of follow-up study if indicated

[71] U.S. Breast Cancer Statistics, http://www.BreastCancer.org website, accessed May 18, 2017.
[72] VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
[73] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011. (Due for recertification April 30, 2016, but has not been updated.)

Conclusions. OIG found general compliance with requirements for linking of results to the radiology order, scanning mammogram reports, including required components in the report, and performing follow-up mammograms when indicated. However, OIG identified a deficiency in the patient notification process that warranted recommendations for improvement.

Communication of Results to Patients. VHA requires that the ordering provider or designee notify patients of their mammogram results.[74] Timely communication of test results is essential to ensure safe and effective health care. OIG estimated that providers communicated results to patients in 76 percent of the EHRs reviewed.[75]

Program managers reported that lack of staff to monitor communication of test results resulted in noncompliance and that a healthcare coordinator will soon join the program to provide program oversight.

Recommendations

7. The Chief of Staff ensures ordering providers or designees communicate mammogram results to patients within the required timeframe and monitors providers' compliance.

Facility concurred.

Target date for completion: February 1, 2019

Facility Response: The Women's Health Program (WHP) recently hired a Women's Health Care Coordinator (WHCC) who is responsible for creating and streamlining improved processes for monitoring and oversight of breast cancer screening (mammograms) throughout NWI HCS. The improved processes will ensure timely communication of mammography results to patients and providers facilitating timely follow up of abnormal mammogram results. The WHP/WHCC will identify community imaging providers that consistently provide delayed mammogram reports and evaluate whether continuing a partnership with them is appropriate and/or the WHP/WHCC will work with the community providers to improve the timeliness of reports received. The Women's Health Program will evaluate progress at six months and one year for sustained improvement.

[74] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011.
[75] OIG is 95 percent confident that the true rate is somewhere between 64.0 to 86.0 percent, which OIG determined is statistically significantly below the 90 percent benchmark

High Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[76] Central lines "refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[77] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[78]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a CLABSI as a "primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site."[79]

An infection is considered to be health care-associated if it occurs on or after the 3rd calendar day of admission to an inpatient location where the day of admission is calendar day 1.[80] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased health care costs.[81]

The purpose of this review was to determine whether the facility established and maintained programs to reduce the incidence of health care-associated bloodstream infections in intensive care unit patients with indwelling central lines. OIG reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents, and OIG interviewed key employees and managers. Additionally, OIG reviewed the training records of 11 clinical employees involved in managing (inserting and/or maintaining) central lines. OIG reviewed the following performance indicators.

- Presence of facility policy on the use and care of central lines
- Performance of annual infection prevention risk assessment

[76] TJC. Infection Control and National Patient Safety Goals. IC.01.03.01, EP 4, 5. July 2017.
[77] Association for Professionals in Infection Control and Epidemiology. *Guide to Preventing Central Line-Associated Bloodstream Infections*. 2015.
[78] These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.
[79] The Centers for Disease Control and Prevention. *Guidelines for the Prevention of Intravascular Catheter-Related Infections*. 2011.
[80] The Centers for Disease Control and Prevention National Healthcare Safety Network. *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*. January 2017.
[81] Association for Professionals in Infection Control and Epidemiology, 2015.

- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients/families
- Use of checklist for central line insertion and maintenance

Conclusions. OIG noted the facility tracked healthcare-associated bloodstream infections due to central lines and experienced a low incidence of infection. However, OIG identified a deficiency with CLABSI data and prevention measures discussions that warranted a recommendation for improvement.

CLABSI Data and Prevention Outcome Measures. TJC requires that facilities routinely discuss CLABSI data and prevention outcome measures in committee minutes and report this information to key stakeholders, including leaders and clinical staff.[82] The absence of routine data monitoring and reporting prevents leaders from making evidence-based decisions to improve CLABSI prevention practices and processes. OIG noted that Infection Prevention Committee meeting minutes did not consistently document discussions and prevention of CLABSI. Managers cited a lack of attention to detail.

Recommendation

See Recommendation 2 on page 22 under EOC.

[82] TJC. National Patient Safety Goals (NPSG). NPSG.07.04.01, EP 5. July 2017.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Seven OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[83] for Improvement**	**Recommendations for Improvement**
Credentialing and Privileging	• Medical licenses • Privileges • Focused Professional Practice Evaluations • Ongoing Professional Practice Evaluations	None	None
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and root cause analyses	None	None

[83] OIG defines "critical recommendations" as those that rise above others and address vulnerabilities and risks that could cause exceptionally grave health care outcomes and/or significant impact to quality of care.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility o EOC rounds and deficiency tracking o Infection prevention o General Safety o Environmental cleanliness o General and exam room privacy o Availability of medical equipment and supplies • CBOC o General safety o Medication safety and security o Infection prevention o Environmental cleanliness o General and exam room privacy o Availability of medical equipment and supplies • Construction Safety o Infection control risk assessment o Infection Prevention/ Infection Control Committee discussions o Dust control o Safety/security o Type C – Class III specific requirements • Nutrition and Food Services o Annual Hazard Analysis Critical control Point Food Safety System plan o Food Services inspections o Safe transportation of prepared food o Environmental safety o Infection prevention o Storage areas	None	• Required team members consistently participate on EOC rounds. • Infection Prevention Committee consistently documents discussions of high-risk elements and analysis of surveillance data.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering • Processes with permanent change in Chief of Pharmacy • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	None	• One-day reconciliation of CS refills to automated dispensing units and 1-day reconciliation of return to pharmacy stocks are performed consistently during CS inspections. • Pharmacy 72-hour inventories are consistently completed during CS inspections in pharmacy areas.
Mental Health Care: Post-Traumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	None	None
Long-Term Care: Geriatric Evaluations	• Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements	None	• The GE program receives the required oversight and quality improvement data are regularly reviewed and documented in committee meeting minutes. • GE registered nurses perform the required patient assessments.
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	None	• The ordering providers or designees communicate mammogram results to patients.
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education • Educational materials • Checklist	None	None

Facility Profile and VA Outpatient Clinic Profiles

Facility Profiles

The table below provides general background information for this high-complexity (1b)[84] affiliated[85] facility reporting to VISN 23.

Table 6. Facility Profile for Omaha (636) for October 1, 2014 through September 30, 2017

Profile Element	Facility Data FY 2015[86]	Facility Data FY 2016[87]	Facility Data FY 2017[88]
Total Medical Care Budget in Millions	$477.8	$426.4	$456.8
Number of: • **Unique Patients**	56,548	57,744	55,508
• **Outpatient Visits**	602,468	588,601	597,507
• **Unique Employees**[89]	1,743	1,771	1,899
Type and Number of Operating Beds: • **Acute**	74	74	74
• **Mental Health**	26	26	26
• **Community Living Center**	76	42	42
• **Domiciliary**	42	42	42
Average Daily Census: • **Acute**	44	36	34
• **Mental Health**	10	9	8
• **Community Living Center**	34	36	37
• **Domiciliary**	32	33	32

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse.

Note: OIG did not assess VA's data for accuracy or completeness.

[84] VHA medical centers are classified according to a facility complexity model; 1b designation indicates a facility with medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs. Retrieved November 17, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx
[85] Associated with a medical residency program.
[86] October 1, 2014 through September 30, 2015.
[87] October 1, 2015 through September 30, 2016.
[88] October 1, 2016 through September 30, 2017.
[89] Unique employees involved in direct medical care (cost center 8200).

Facility Profiles[90]

The VA outpatient clinics in communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 7 provides information relative to each of the clinics.

Table 7. VA Outpatient Clinic Workload/Encounters[91] and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2016 through September 30, 2017

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[92] Provided	Diagnostic Services[93] Provided	Ancillary Services[94] Provided
Grand Island, NE	636A4	18,644	9,147	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Pulmonary/ Respiratory Disease Blind Rehab Poly-Trauma Spinal Cord Injury Anesthesia Eye General Surgery Orthopedics Podiatry Urology	EKG Laboratory & Pathology Nuclear Med Radiology Vascular Lab	Alternative Nutrition Pharmacy Prosthetics Social Work Weight Management Dental

[90] Includes all outpatient clinics in the community that were in operation as of August 15, 2017. We have omitted Omaha-Dorcas Street, NE (636QA) and Omaha (636BX) as no workload/encounters or services were reported.
[91] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[92] Specialty care services refer to non-PC and non-MH services provided by a physician.
[93] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[94] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Lincoln, NE	636A5	23,790	13,888	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Pulmonary/ Respiratory Disease Blind Rehab Poly-Trauma Spinal Cord Injury Anesthesia Eye General Surgery Orthopedics Podiatry Urology	EKG Laboratory & Pathology Nuclear Med Radiology Vascular Lab	Nutrition Pharmacy Social Work Weight Management Dental Nutrition
Norfolk, NE	636GA	4,453	1,602	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Pulmonary/ Respiratory Disease General Surgery	EKG	Pharmacy Social Work Weight Management Nutrition
North Platte, NE	636GB	4,089	1,181	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Pulmonary/ Respiratory Disease General Surgery Vascular	EKG	Nutrition Pharmacy Social Work Weight Management
Bellevue, NE	636GL	5,545	692	Cardiology Dermatology Endocrinology Eye Podiatry	EKG	Nutrition Pharmacy Social Work Weight Management

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Shenandoah, IA	636GP	3,758	1,016	Cardiology Dermatology Endocrinology Hematology/ Oncology Infectious Disease General Surgery Podiatry	EKG	Pharmacy Social Work Weight Management Nutrition
Holdrege, NE	636GQ	3,459	761	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Pulmonary/ Respiratory Disease General Surgery	EKG	Pharmacy Social Work Weight Management Nutrition
O'Neill, NE	636GV	190	6	n/a	n/a	n/a

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: OIG did not assess VA's data for accuracy or completeness.

n/a = Not applicable.

VHA Policies Beyond Recertification Dates

In this report, OIG cited seven policies that were beyond the recertification date:

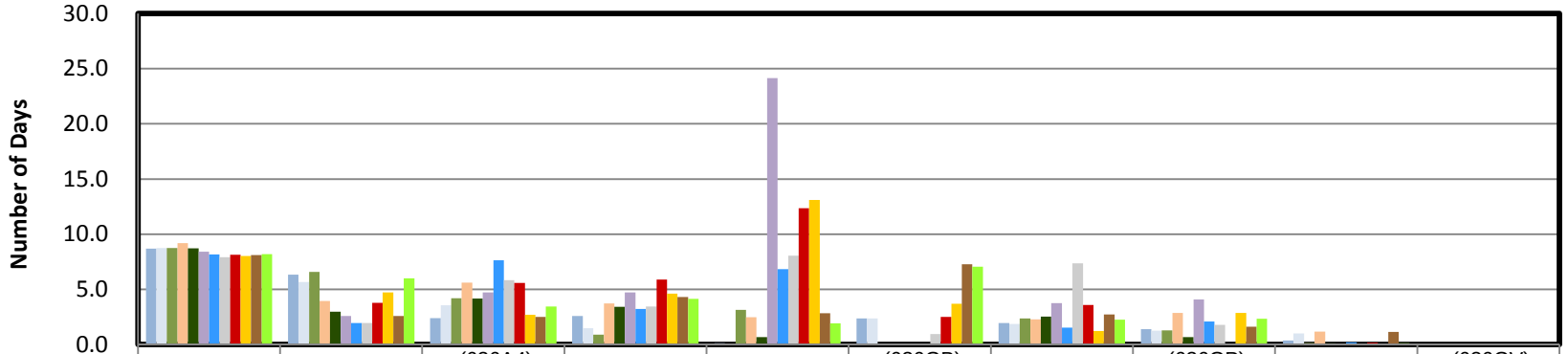
1. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
2. VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012 (recertification due date October 31, 2017).
3. VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011 (recertification due date April 30, 2016).
4. VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010 (recertification due date November 30, 2015).
5. VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD),* March 12, 2010 (recertification due date March 31, 2015), revised December 8, 2015.[95]
6. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
7. VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012 (recertification due date September 30, 2017).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[96] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[97] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[98]

[95] This handbook was in effect during the review period for this report; it was rescinded and replaced by VHA Directive 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, November 16, 2017.
[96] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[97] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[98] Ibid.

Patient Aligned Care Team Compass Metrics[99]

New PC Patient Average Wait Time in Days



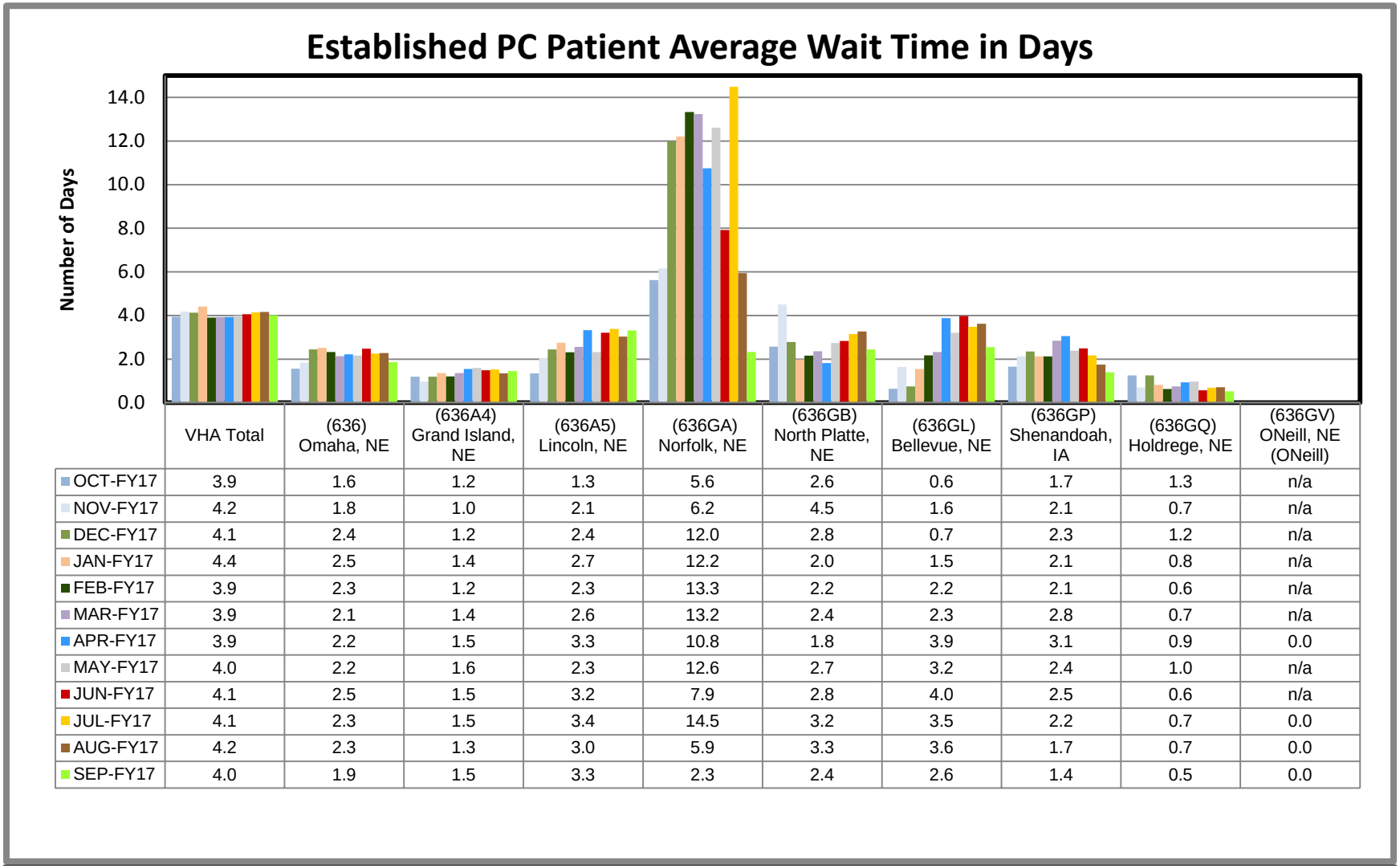
	VHA Total	(636) Omaha, NE	(636A4) Grand Island, NE	(636A5) Lincoln, NE	(636GA) Norfolk, NE	(636GB) North Platte, NE	(636GL) Bellevue, NE	(636GP) Shenandoah, IA	(636GQ) Holdrege, NE	(636GV) ONeill, NE (ONeill)
OCT-FY17	8.7	6.3	2.4	2.6	0.1	2.4	2.0	1.4	0.4	n/a
NOV-FY17	8.8	5.7	3.6	1.5	0.0	2.4	1.9	1.3	1.0	n/a
DEC-FY17	8.8	6.6	4.2	0.9	3.1	0.0	2.4	1.3	0.1	n/a
JAN-FY17	9.2	4.0	5.6	3.7	2.5	0.0	2.3	2.9	1.2	n/a
FEB-FY17	8.7	3.0	4.2	3.4	0.7	0.0	2.5	0.7	0.1	n/a
MAR-FY17	8.4	2.6	4.7	4.7	24.1	0.0	3.8	4.1	0.0	n/a
APR-FY17	8.2	1.9	7.6	3.2	6.8	0.0	1.5	2.1	0.2	n/a
MAY-FY17	7.9	2.0	5.8	3.5	8.1	0.9	7.4	1.8	0.0	n/a
JUN-FY17	8.2	3.8	5.6	5.9	12.3	2.5	3.6	0.0	0.2	n/a
JUL-FY17	8.0	4.7	2.7	4.6	13.1	3.7	1.2	2.9	0.0	0.0
AUG-FY17	8.1	2.6	2.5	4.3	2.8	7.3	2.7	1.6	1.1	0.0
SEP-FY17	8.2	6.0	3.5	4.1	1.9	7.1	2.3	2.3	0.1	0.0

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.* The absence of reported data is indicated by "n/a."

[99] Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: November 7, 2017.

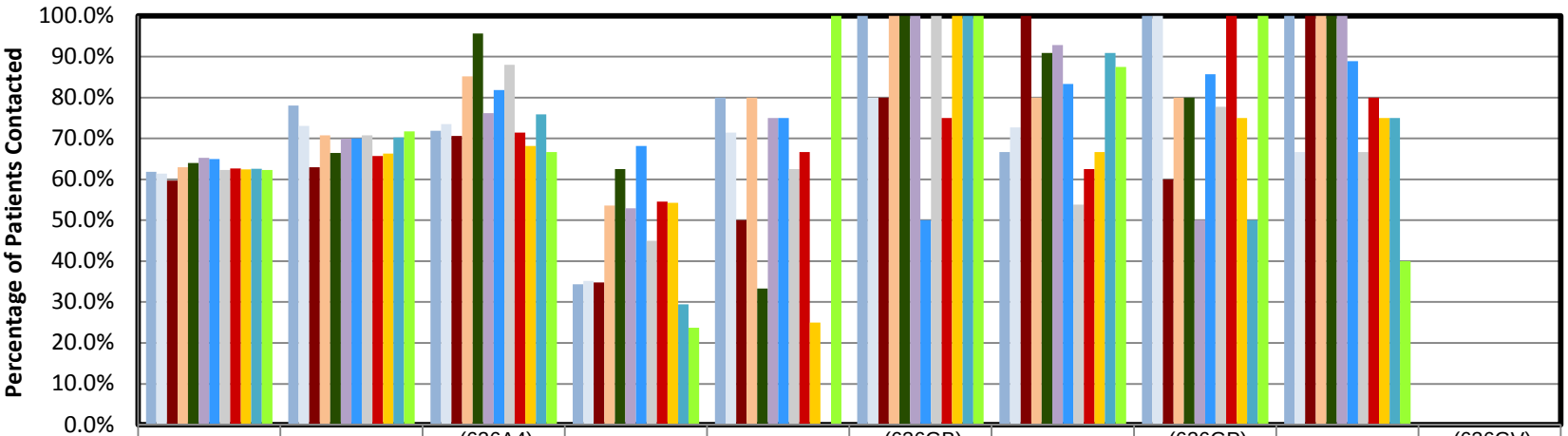


	VHA Total	(636) Omaha, NE	(636A4) Grand Island, NE	(636A5) Lincoln, NE	(636GA) Norfolk, NE	(636GB) North Platte, NE	(636GL) Bellevue, NE	(636GP) Shenandoah, IA	(636GQ) Holdrege, NE	(636GV) ONeill, NE (ONeill)
OCT-FY17	3.9	1.6	1.2	1.3	5.6	2.6	0.6	1.7	1.3	n/a
NOV-FY17	4.2	1.8	1.0	2.1	6.2	4.5	1.6	2.1	0.7	n/a
DEC-FY17	4.1	2.4	1.2	2.4	12.0	2.8	0.7	2.3	1.2	n/a
JAN-FY17	4.4	2.5	1.4	2.7	12.2	2.0	1.5	2.1	0.8	n/a
FEB-FY17	3.9	2.3	1.2	2.3	13.3	2.2	2.2	2.1	0.6	n/a
MAR-FY17	3.9	2.1	1.4	2.6	13.2	2.4	2.3	2.8	0.7	n/a
APR-FY17	3.9	2.2	1.5	3.3	10.8	1.8	3.9	3.1	0.9	0.0
MAY-FY17	4.0	2.2	1.6	2.3	12.6	2.7	3.2	2.4	1.0	n/a
JUN-FY17	4.1	2.5	1.5	3.2	7.9	2.8	4.0	2.5	0.6	n/a
JUL-FY17	4.1	2.3	1.5	3.4	14.5	3.2	3.5	2.2	0.7	0.0
AUG-FY17	4.2	2.3	1.3	3.0	5.9	3.3	3.6	1.7	0.7	0.0
SEP-FY17	4.0	1.9	1.5	3.3	2.3	2.4	2.6	1.4	0.5	0.0

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. The absence of reported data is indicated by "n/a."

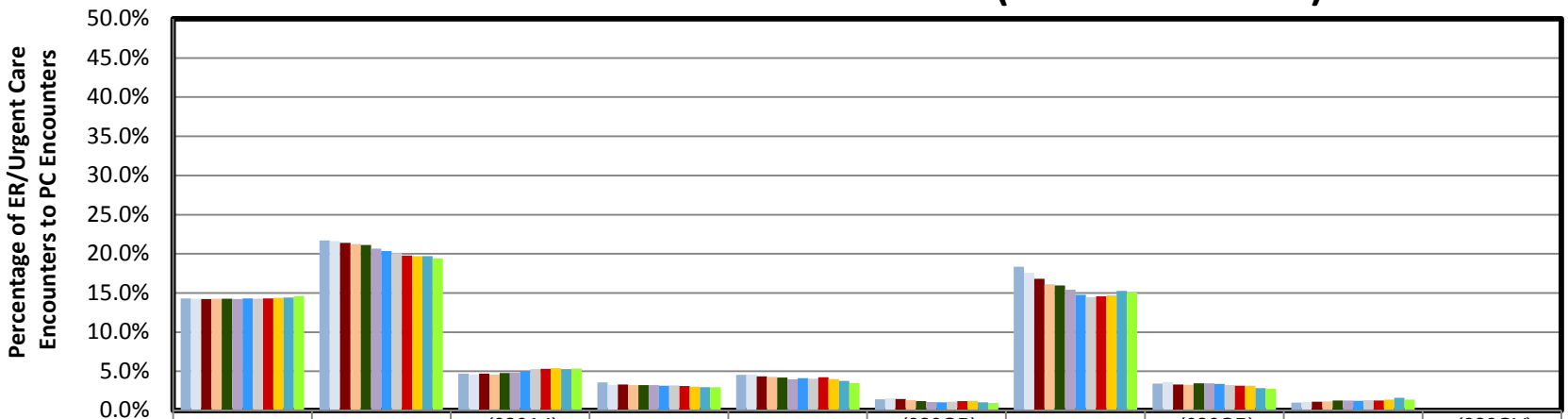


	VHA Total	(636) Omaha, NE	(636A4) Grand Island, NE	(636A5) Lincoln, NE	(636GA) Norfolk, NE	(636GB) North Platte, NE	(636GL) Bellevue, NE	(636GP) Shenandoah, IA	(636GQ) Holdrege, NE	(636GV) ONeill, NE (ONeill)
OCT-FY17	61.8%	78.0%	71.9%	34.4%	80.0%	100.0%	66.7%	100.0%	100.0%	n/a
NOV-FY17	61.4%	73.1%	73.5%	35.1%	71.4%	80.0%	72.7%	100.0%	66.7%	n/a
DEC-FY17	59.7%	62.9%	70.6%	34.8%	50.0%	80.0%	100.0%	60.0%	100.0%	n/a
JAN-FY17	62.9%	70.7%	85.2%	53.6%	80.0%	100.0%	80.0%	80.0%	100.0%	n/a
FEB-FY17	64.0%	66.4%	95.7%	62.5%	33.3%	100.0%	90.9%	80.0%	100.0%	n/a
MAR-FY17	65.3%	69.9%	76.2%	52.9%	75.0%	100.0%	92.9%	50.0%	100.0%	n/a
APR-FY17	65.0%	70.0%	81.8%	68.2%	75.0%	50.0%	83.3%	85.7%	88.9%	n/a
MAY-FY17	62.3%	70.7%	88.0%	45.0%	62.5%	100.0%	53.8%	77.8%	66.7%	n/a
JUN-FY17	62.7%	65.7%	71.4%	54.5%	66.7%	75.0%	62.5%	100.0%	80.0%	n/a
JUL-FY17	62.4%	66.3%	68.2%	54.3%	25.0%	100.0%	66.7%	75.0%	75.0%	n/a
AUG-FY17	62.6%	70.2%	75.9%	29.4%	0.0%	100.0%	90.9%	50.0%	75.0%	n/a
SEP-FY17	62.3%	71.8%	66.7%	23.7%	100.0%	100.0%	87.5%	100.0%	40.0%	n/a

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17." The absence of reported data is indicated by "n/a."



	VHA Total	(636) Omaha, NE	(636A4) Grand Island, NE	(636A5) Lincoln, NE	(636GA) Norfolk, NE	(636GB) North Platte, NE	(636GL) Bellevue, NE	(636GP) Shenandoah, IA	(636GQ) Holdrege, NE	(636GV) ONeill, NE (ONeill)
OCT-FY17	14.3%	21.7%	4.7%	3.6%	4.5%	1.4%	18.4%	3.4%	1.0%	n/a
NOV-FY17	14.3%	21.6%	4.6%	3.3%	4.6%	1.5%	17.6%	3.6%	1.1%	n/a
DEC-FY17	14.2%	21.4%	4.7%	3.3%	4.4%	1.5%	16.8%	3.3%	1.1%	n/a
JAN-FY17	14.3%	21.3%	4.6%	3.2%	4.3%	1.3%	16.1%	3.3%	1.2%	n/a
FEB-FY17	14.3%	21.1%	4.8%	3.3%	4.2%	1.2%	16.0%	3.5%	1.3%	n/a
MAR-FY17	14.2%	20.7%	4.8%	3.2%	4.0%	1.1%	15.4%	3.5%	1.3%	n/a
APR-FY17	14.3%	20.4%	5.0%	3.2%	4.1%	1.0%	14.7%	3.4%	1.3%	n/a
MAY-FY17	14.3%	20.1%	5.3%	3.2%	4.1%	1.1%	14.5%	3.2%	1.3%	n/a
JUN-FY17	14.3%	19.8%	5.3%	3.1%	4.2%	1.2%	14.6%	3.2%	1.3%	n/a
JUL-FY17	14.4%	19.7%	5.4%	3.0%	4.0%	1.2%	14.7%	3.2%	1.4%	n/a
AUG-FY17	14.4%	19.7%	5.3%	3.0%	3.8%	1.0%	15.3%	2.9%	1.6%	n/a
SEP-FY17	14.6%	19.4%	5.4%	3.0%	3.5%	0.9%	15.1%	2.8%	1.4%	n/a

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a LIP *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP. The absence of reported data is indicated by "n/a."

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[100]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	All Employee Survey Best Places to Work score	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value

[100] VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value

Measure	Definition	Desired Direction
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

Relevant OIG Reports

March 9, 2015 through March 1, 2018[101]

Healthcare Inspection – Vascular Surgery Resident Supervision, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska
7/9/2015 | *14-04037-404* | *Summary* | *Report*

Combined Assessment Program Review of the VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska
5/15/2015 | *15-00076-350* | *Summary* | *Report*

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska
5/6/2015 | *15-00124-227* | *Summary* | *Report*

[101] These are relevant reports that discuss review results for the Facility or were national-level evaluations of which the Facility was one of the sites sampled for review.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 7, 2018

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

Subject: CHIP Review of the VA Nebraska–Western Iowa Health Care System, Omaha, NE

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed the concurrence for each recommendation and action plan with measurable goals and target completion dates for the 2018 CHIP review at VA Nebraska-Western Iowa Health Care System.

Janet P. Murphy

JANET P. MURPHY, MBA

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 28, 2018

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

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

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

I have reviewed and concur with the findings of this report. Specific corrective actions have been provided for the recommendations.

B. DON BURMAN, MHA
Director

OIG Contact and Staff Acknowledgments

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