Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-02599-03

Combined Assessment Program Review of the Minneapolis VA Health Care System Minneapolis, Minnesota

October 10, 2012

Washington, DC 20420

Why We Did This Review

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

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

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

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Glossary

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

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Executive Summary: Combined Assessment Program Review of the Minneapolis VA Health Care System, Minneapolis, MN

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of August 6, 2012.

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

- Colorectal Cancer Screening
- Coordination of Care
- Environment of Care
- Medication Management
- Mental Health Treatment Continuity
- Quality Management

The facility's reported accomplishments were a facility physician's receipt of an award for outstanding achievement in clinical research and receipt of multiple awards for collaborating with other Veterans Integrated Service Network 23 teams to improve the coordination of cancer assessment and treatment.

Recommendations: We made recommendations in the following four activities:

Moderate Sedation: Include all required elements in pre-sedation assessment documentation, and monitor compliance.

Polytrauma: Ensure all patients with positive traumatic brain injury screening results receive a comprehensive evaluation as outlined in Veterans Health Administration policy. Maintain minimum polytrauma staffing levels. Monitor compliance with polytrauma training requirements. Ensure Case Managers consistently communicate with polytrauma inpatients and/or their families at the required intervals. Require that polytrauma patient care areas are clean and well maintained.

Point-of-Care Testing: Ensure staff document all required elements in response to critical values on a nursing progress note or the Nursing Critical Value Template note.

Nurse Staffing: Monitor the staffing methodology that was implemented in May 2012.

Comments

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

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

Objectives and Scope

Objectives

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

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

Scope

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

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

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

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

The review covered facility operations for FY 2011 and FY 2012 through August 9, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Minneapolis VA Health Care System, Minneapolis, Minnesota,* Report No. 11-01610-278, September 13, 2011).

During this review, we presented crime awareness briefings for 128 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 187 responded. We shared survey results with facility managers.

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

Reported Accomplishments

Barnwell Research Award

The Clinical Science Research and Development division of the VHA Office of Research and Development presented Dennis Niewoehner, M.D., the 2012 John B. Barnwell Award for outstanding achievement in clinical research. The award recognizes Dr. Niewoehner's exemplary service to the VA and to the clinical profession as well as his seminal contributions to understanding the pathophysiology and treatment of patients with chronic obstructive pulmonary disease. His work has had a broad impact on the clinical care of veterans and the population at large.

VISN 23 Multi-Site and Multidisciplinary Cooperation for Cancer Care

Collaborative teams worked to improve the coordination of cancer assessment and received the 2010 VISN 23 Star Award and a 2010/2011 Deputy Under Secretary for Health for Operations and Management Systems Redesign Champion Award. The teams implemented standardized best practices for CRC, head and neck cancers, and lung cancers and coordinated between medical and surgical specialties. Hand-offs were improved within and outside of the facility. A pilot electronic chemotherapy ordering project was also implemented. A Cancer Care Community of Practice was chartered in 2011 to provide a forum for shared decision making, problem solving, and knowledge sharing for clinical personnel providing cancer care to veterans.

Results
Review Activities With Recommendations

Moderate Sedation

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

We reviewed relevant documents, 18 EHRs, and 35 training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[1] Four patients' EHRs did not include a history of previous adverse experience with sedation or analgesia, and six patients' EHRs did not have documentation of a history of substance use or abuse.

Recommendation

1. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements and that compliance be monitored.

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

Polytrauma

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

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

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

Comprehensive Evaluation. VHA requires that patients with positive TBI screening results be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[2] Six of the 10 patients who screened positive for TBI were evaluated by a non-specialist.

Staffing. VHA requires that minimum polytrauma staffing levels are maintained.[3] The facility did not meet the minimum staffing requirement for a prosthetist and a full-time nurse educator.

[2] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010.
[3] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Training. The facility expects staff working with polytrauma patients to have training in age-appropriate interventions, amputation care, assistive technology, auditory impairment, blast injuries, and blind rehabilitation system of care.[4] None of the 10 training records reviewed contained evidence of all required training**.**

Inpatient Case Management. VHA requires that Case Managers communicate with the patient and/or their family at specific intervals, such as prior to an inpatient polytrauma admission, on the day of admission, and each day during the inpatient stay.[5] Nine of the 10 inpatient EHRs contained no evidence that Case Managers communicated with the patient and/or their family at the required intervals.

Cleanliness and Maintenance. The Joint Commission requires that areas used by patients are clean and well maintained. In the 3R outpatient therapy area, we found dirty floors and walls. Additionally, floor tiles in the area were cracked, broken, chipped, and stained.

2. We recommended that processes be strengthened to ensure that all patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

3. We recommended that minimum polytrauma staffing levels be maintained.

4. We recommended that the facility monitor compliance with polytrauma training requirements.

5. We recommended that processes be strengthened to ensure that Case Managers consistently communicate with the inpatient and/or their family at the required intervals.

6. We recommended that processes be strengthened to ensure that polytrauma patient care areas are clean and well maintained.

[4] VHA Handbook 1172.1, *Polytrauma Rehabilitation Procedures*, September 22, 2005.
[5] VHA Directive 2006-043, *Social Work Case Management in VHA Polytrauma Centers*, July 10, 2006.

POCT

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

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Test Results Management. When glucose values are determined to be critical, the facility requires the employee performing the test to repeat the test with a new finger stick, notify the responsible clinician, and document notification in a nurse progress note or the Nursing Critical Value Template note. Five of the 10 patients who had critical test results did not have the required documentation in their EHRs.

Recommendation

7. We recommended that processes be strengthened to ensure that staff document all required elements in response to critical values on a nursing progress note or the Nursing Critical Value Template note.

Nurse Staffing

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

We reviewed relevant documents and 23 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (2L) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Facility Methodology Deadline. VHA required that the steps to develop the facility's staffing methodology for nursing personnel be completed by September 30, 2011.[6] The facility did not complete all required staffing methodology steps until May 4, 2012.

Recommendation

8. We recommended that nursing managers monitor the staffing methodology that was implemented in May 2012.

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

Review Activities Without Recommendations

COC

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

We reviewed 30 HF patients' EHRs and relevant documents and interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

CRC Screening

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

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

EOC

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

We inspected the medical inpatient care, surgical inpatient care, locked MH, community living center, hospice, and polytrauma units; the outpatient surgical suites; the primary care, dental, dialysis, ear-nose-throat, women's health, and SCI outpatient clinics; occupational and physical therapy; radiology; dermatology; urology; the emergency department; and the SCI Center. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

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

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[7] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

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

MH Treatment Continuity

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

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

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

QM

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

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

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

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

Comments

The VISN Director and Acting Facility Director agreed with the CAP review findings and recommendations and provided acceptable improvement plans. See Appendixes C and D, pages 18–22, for the full text of the Directors' comments. We will follow up on the planned actions until they are completed.

Facility Profile[8]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	23	
Community Based Outpatient Clinics	Cook, MN Hibbing, MN Mankato, MN Maplewood, MN Ramsey, MN Rochester, MN St. James, MN Chippewa Falls, WI Hayward, WI Rice Lake, WI Superior, WI	
Veteran Population in Catchment Area	389,870	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	225 (medicine, surgery, psychiatry, neurology, rehabilitation, spinal cord, and transitional rehabilitation)	
• **Community Living Center/Nursing Home Care Unit**	80	
Medical School Affiliation(s)	University of Minnesota	
• **Number of Residents**	690 (estimated)	
	Current FY (through March 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$578.1	$562.8
• **Medical Care Expenditures**	$264.5	$562.8
Total Medical Care Full-Time Employee Equivalents	3,251.6	3,226.6
Workload:		
• **Number of Station Level Unique Patients**	69,477	89,768
• **Inpatient Days of Care:**		
o **Acute Care**	24,724	48,670
o **Community Living Center/Nursing Home Care Unit**	11,525	20,124
Hospital Discharges	4,323	8,476
Total Average Daily Census (including all bed types)	198	189
Cumulative Occupancy Rate (in percent)	71.0	67.7
Outpatient Visits	385,439	729,580

[8] All data provided by facility management.

VHA Satisfaction Surveys

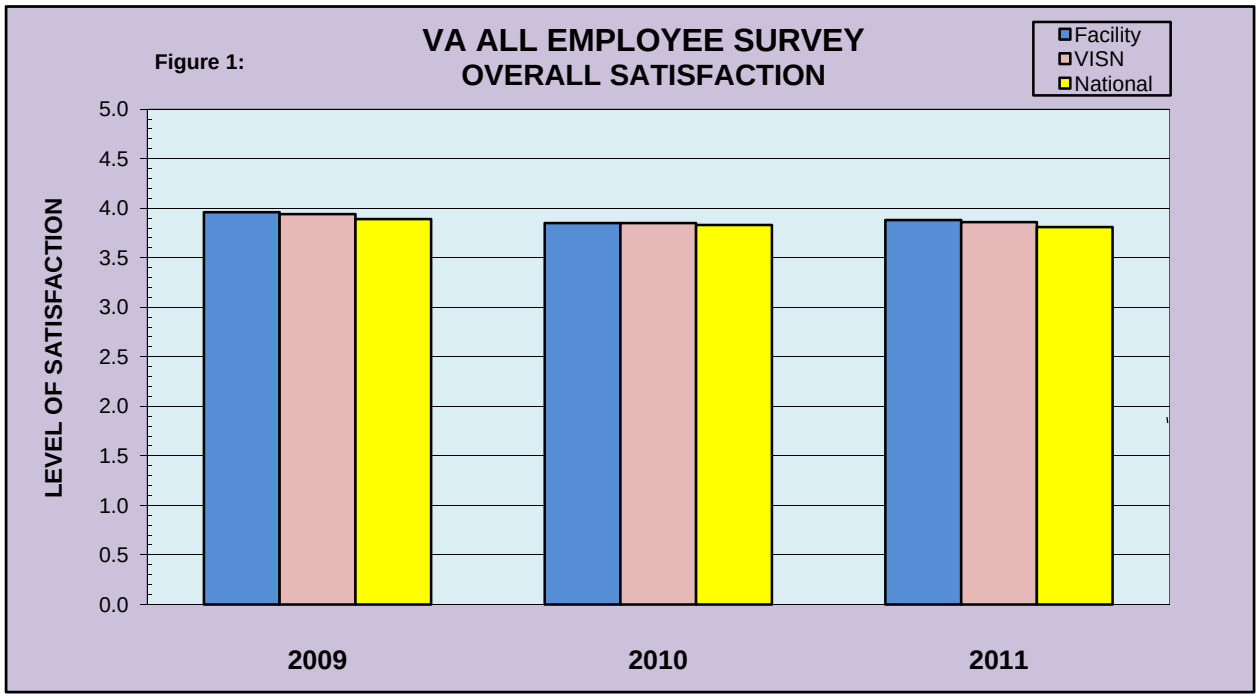
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	68.7	68.9	59.7	54.1	55.9	55.6
VISN	66.5	66.9	60.4	58.8	57.9	59.3
VHA	64.1	63.9	54.2	54.5	55.0	54.7

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

Figure 1:



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[9] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[10]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	12.6	9.3	10.0	19.4	23.2	18.2
U.S.	15.5	11.6	12.0	19.7	24.7	18.5

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

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

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 21, 2012

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

Subject: **CAP Review of the Minneapolis VA Health Care System, Minneapolis, MN**

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

Director, Management Review Service (VHA 10AR MRS)

I have reviewed the recommendations from to the OIG CAP conducted at the Minneapolis VA Health Care System. I concur with the facility response and action plans. Thank you for the opportunity to review and respond to this report.

(original signed by:)
Janet P. Murphy, MBA
Network Director VISN 23

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 21, 2012

From: Acting Director, Minneapolis VA Health Care System (618/00)

Subject: **CAP Review of the Minneapolis VA Health Care System, Minneapolis, MN**

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

Thank you for the opportunity to review the draft report of recommendations from the OIG CAP conducted at the Minneapolis VA Health Care System August 6–9, 2012. I have reviewed the report from the site visit and I concur with the recommendations and the action plans.

If you have any questions please feel free to contact me at (612) 725-2101.

(original signed by:)
Judith L. Johnson-Mekota, FACHE
Acting Medical Center Director, Minneapolis

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements and that compliance be monitored.

Concur

Target date for completion: December 31, 2012

The moderate sedation procedure areas reviewed the CPRS/CART/Provation documentation templates. The templates were updated to include documentation regarding a history of previous adverse experiences with sedation or analgesic, in addition to inclusion of any history of substance use/abuse. Nursing staff who conduct sedation procedure monitoring were educated on documentation requirements. Chart audits will be conducted to ensure that these historical references are included in the medical record for Veterans undergoing moderate sedation procedures. Audit results will be reported to the Invasive Procedures and Moderate Sedation Committee for monitoring.

Recommendation 2. We recommended that processes be strengthened to ensure that all patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Concur

Target date for completion: December 31, 2012

Six of the ten comprehensive TBI evaluations reviewed were completed by a Certified Nurse Practitioner (CNP) who was mentored and trained the Polytrauma Rehabilitation team. To comply with the OIG recommendation, all TBI comprehensive evaluations completed by the Polytrauma CNP will be reviewed and additionally signed by a Polytrauma Physiatrist until an alternative provider plan is approved by the VA Polytrauma Program Office.

Recommendation 3. We recommended that minimum polytrauma staffing levels be maintained.

Concur

Target date for completion: December 31, 2012

All vacant Polytrauma program positions have been approved for hire to comply with VHA minimum staffing levels cited in the CAP review.

Recommendation 4. We recommended that the facility monitor compliance with polytrauma training requirements.

Concur

Target date for completion: December 31, 2012

Though Polytrauma education is provided continuously to employees within the program, training is not currently tracked in employee files by the 21 areas listed in VHA Handbook 1172.1. A competency checklist will be created utilizing the 21 listed areas and competency completion will be required annually and verified by the employee's supervisor during annual performance reviews. The checklist will be monitored to ensure that polytrauma clinical staff meet competency requirements in the 21 areas annually.

Recommendation 5. We recommended that processes be strengthened to ensure that Case Managers consistently communicate with the inpatient and/or their family at the required intervals.

Concur

Target date for completion: December 31, 2012

Polytrauma social work staffing levels have limited the ability of inpatient social work case managers to maintain daily documentation of case management encounters as cited by the OIG. All vacant Polytrauma program positions have been approved for hire and the positions will be filled to ensure adequate staffing to support daily documentation. The Social Work discharge note was modified on 9/1/2012 to include all recommendations from discipline specific team members. Audits will be conducted quarterly in FY2013 by Polytrauma Lead Social Worker to ensure compliance with documentation requirements.

Recommendation 6. We recommended that processes be strengthened to ensure that polytrauma patient care areas are clean and well maintained.

Concur

Target date for completion: December 31, 2012

Facility engineering staff surveyed the 3R outpatient rehabilitation care area. Select tiles in the 3R area will be replaced and the subsurface will be leveled to prevent further marring. Damaged door frames and vinyl baseboards will also be repaired. Aesthetic rounds will be added to weekly environment of care rounds in the 3R area to routinely identify new areas of walls, floors, and doors marred or damaged by wheel chairs and other assistive devices in this heavily utilized area.

Recommendation 7. We recommended that processes be strengthened to ensure that staff document all required elements in response to critical values on a nursing progress note or the Nursing Critical Value Template note.

Concur

Target date for completion: December 31, 2012

All policies regarding critical values will be reviewed and revised for consistency in documentation requirements. Staff training will be provided and random audits of documentation will continue to ensure compliance.

Recommendation 8. We recommended that nursing managers monitor the staffing methodology that was implemented in May 2012.

Concur

Target date for completion: December 31, 2012

Nursing will monitor adherence to staffing methodology components per VHA Directive.

OIG Contact and Staff Acknowledgments

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