Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03660-114

Combined Assessment Program Review of the VA Ann Arbor Healthcare System Ann Arbor, Michigan

March 15, 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
CLC	community living center
COC	coordination of care
CRC	colorectal cancer
DUSHOM	Deputy Under Secretary for Health for Operations and Management
EOC	environment of care
facility	VA Ann Arbor Healthcare System
FY	fiscal year
HF	heart failure
JC	Joint Commission
MH	mental health
MRI	magnetic resonance imaging
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, MI

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 October 24, 2011.

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

- Coordination of Care
- Medication Management
- Polytrauma

The facility's reported accomplishments were establishing a safe day call and receiving an architectural award.

Recommendations: We made recommendations in the following five activities:

Environment of Care: Ensure patient care areas are clean. Correct identified environmental safety deficiencies, and conduct and document daily monitoring checks of the community living center's elopement prevention system. Correct identified infection prevention deficiencies, secure medications, and protect sensitive patient information.

Moderate Sedation: Ensure that staff have annual competency-based education/training prior to assisting with moderate sedation and that pre-sedation assessment documentation includes all required elements.

Colorectal Cancer Screening: Ensure that patients are notified of positive screening test results within the required timeframe and that clinicians document notification. Ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Psychosocial Rehabilitation and Recovery Centers: Initiate steps to fully implement the Psychosocial Rehabilitation and Recovery Center or request a Deputy Under Secretary for Health for Operations and Management approved modification or exception.

Quality Management: Ensure that Medical Records Oversight Committee minutes document action plans for copy and paste function deficiencies and track action items to completion.

Comments

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

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- COC
- CRC Screening
- EOC
- Medication Management
- Moderate Sedation
- Polytrauma
- PRRCs
- 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 October 27, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from

our prior CAP review of the facility (*Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, Michigan,* Report No. 09-03271-84, February 16, 2010). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we presented crime awareness briefings for 109 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 386 responded. Survey results were shared 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

Safe Day Call

The safe day call is a daily 15-minute telephone call that was established in March 2010 to improve the safety of the care provided to veterans. It is a deliberate and intentional report and conversation among multidisciplinary facility staff that focuses on issues that may affect patient safety. The safe day call facilitates interdepartmental communication, allows earlier recognition of safety problems, and promotes safety awareness. Three timeframes are addressed during the safety call: (1) looking back involves reviewing significant safety or quality issues from the past 24 hours, (2) looking at the present focuses on following up on critical issues that require immediate attention, and (3) looking ahead involves anticipating safety or quality issues that may occur during the next 24 hours. During FY 2010, 168 issues were identified and closed, and during FY 2011, 607 issues were identified and closed.

Architectural Award

In 2011, the facility received an Honorable Mention Award in the Interior Architecture Category from the Grand Valley Chapter of the American Institute of Architects for the design of the inpatient MH unit. Staff from patient safety, facilities, interior design, and inpatient MH worked closely together to design the new acute inpatient MH unit. Emphasis was placed on incorporating a home-like, non-institutional, and patient-centered atmosphere while ensuring a safe environment. Unique designs were created for the kitchen, pressure sensitive alarms were placed on the tops of doors, sinks and showers were designed to be safe and aesthetic, and amber lighting was installed in order to prevent falls.

Results

Review Activities With Recommendations

EOC

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

We inspected the operating room, the emergency department, the CLC, one medical-surgical unit, the medical intensive care and locked behavioral health units, and the dental and physical medicine and rehabilitation clinics. Additionally, we reviewed facility policies, meeting minutes, training records, and other relevant documents, and we interviewed employees and managers. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed for EOC
X	Patient care areas were clean.
	Fire safety requirements were properly addressed.
X	Environmental safety requirements were met.
X	Infection prevention requirements were met.
X	Medications were secured and properly stored, and medication safety practices were in place.
X	Sensitive patient information was protected.
	If the CLC had a resident animal program, facility policy addressed VHA requirements.
	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH Residential Rehabilitation Treatment Program
	There was a policy that addressed safe medication management, contraband detection, and inspections.
	MH Residential Rehabilitation Treatment Program inspections were conducted, included all required elements, and were documented.
	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.

Cleanliness. The JC requires that areas used by patients be clean. We found two restrooms in the basement that needed cleaning and general maintenance and high-use restrooms close to the lobby entrance that needed increased monitoring for cleanliness. We also found holes in a dry-wall barrier that did not allow containment of dust and debris from a construction site in the basement. In addition, we found sticky mats that were no longer adhesive at several construction sites and dusty window

shelving at one entrance to the facility and at the entrance to the emergency department.

Environmental Safety. The JC requires that the facility minimize safety risks. Additionally, VHA and local policy require that the facility conduct daily monitoring checks of the CLC's elopement prevention system.[1] We found a construction site that was unsecured on two separate occasions, an unlocked electrical panel in a public restroom, and two unsecured soiled utility rooms containing potentially dangerous items. We also found that the facility was not conducting daily monitoring checks of the CLC's elopement prevention system.

Infection Prevention. The JC requires that facilities minimize the risk of transmitting infections. We found clean items stored with dirty items on several units, and we observed a nurse enter the room of a patient who was in contact isolation without donning personal protective equipment. We also found Food and Nutrition Service items stored in a room accessible only through an area where soiled linen was stored.

Medication Security. The JC requires that medications be secured from unauthorized persons. We found two open drawers in a medication cart on the medical intensive care unit and an unlocked box used to store medications in a patient's room in the CLC.

Sensitive Patient Information. The Health Insurance Portability and Accountability Act requires confidential, personally identifiable information to be secured. We found unsecured, personally identifiable information in two locations—the nuclear medicine reception area and the cardiology clinic.

Recommendations

1. We recommended that processes be strengthened to ensure that patient care areas are clean.

2. We recommended that processes be strengthened to ensure that the identified environmental safety deficiencies are corrected and that the facility conducts and documents daily monitoring checks of the CLC's elopement prevention system.

3. We recommended that processes be strengthened to ensure that the identified infection prevention deficiencies are corrected.

4. We recommended that processes be strengthened to ensure that medications are secured.

5. We recommended that processes be strengthened to protect sensitive patient information.

[1] VHA Directive 2010-052, *Management of Wandering and Missing Patients,* December 3, 2010.

Moderate Sedation

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

We reviewed relevant documents, 12 medical records, and training/competency records, and we interviewed key individuals. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	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.

Competency-Based Education/Training. VHA requires that staff and providers have the education, training, and competency to provide moderate sedation.[2] Twenty-four (28 percent) of the 86 staff training records reviewed did not contain documentation that staff had received annual competency-based education/training prior to assisting with moderate sedation.

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.[3] Eight patients' medical records did not include all required elements of the history and physical examination, such as a review of substance abuse.

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

Recommendations

6. We recommended that processes be strengthened to ensure that staff have annual competency-based education/training prior to assisting with moderate sedation.

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

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 VHA's CRC screening.

We reviewed the medical records of 13 patients who had positive CRC screening tests, and we interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Patients were notified of positive CRC screening test results within the required timeframe.
X	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.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal immunochemical tests.[4] All 13 patients had positive fecal immunochemical test results. Three patients' records did not contain documented evidence of timely notification.

Follow-up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[5] Three patients did not have a documented follow-up plan within the required timeframe.

Recommendations

8. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

9. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

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

PRRCs

The purpose of this review was to determine whether the facility had implemented a PRRC and whether VHA required programmatic and clinical elements were in place. VHA directed facilities to fully implement PRRCs by September 30, 2009, or to have a DUSHOM approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or DUSHOM approved modification.

We interviewed employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Elements Reviewed
X	A PRRC was implemented and was considered fully designated by the Office of MH Services, or the facility had an approved modification or exception.
	There was an established method for soliciting patient feedback, or the facility had an approved action plan or modification.
	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
	PRRC staff provided required clinical services, or the facility had an approved action plan or modification.
	The facility complied with any additional elements required by local policy.

PRRC Modification or Exception. VHA directed that facilities fully implement PRRCs by September 30, 2009, or have an approved modification or exception.[6] The facility did not have an operational PRRC and had not requested an appropriate modification or exception.

Recommendation

10. We recommended that the facility initiate steps to fully implement the PRRC or request a DUSHOM approved modification or exception.

[6] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

QM

The purpose of this review was to determine whether VHA facility senior managers actively supported and appropriately responded to QM efforts and whether VHA facilities complied with selected requirements within their QM programs.

We interviewed senior managers and QM personnel, and we evaluated meeting minutes, medical records, and other relevant documents. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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 providers 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 a medical record 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.
X	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in 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.

Copy and Paste Action Plans. VHA requires facilities to monitor the copy and paste functions and to ensure that identified problems are addressed.[7] Although the copy and paste functions in the electronic medical record were monitored, Medical Records Subcommittee (currently named the Medical Records Oversight Committee) minutes did not document action plans when deficiencies were identified or track corrective actions to completion.

Recommendation

11. We recommended that processes be strengthened to ensure that Medical Records Oversight Committee minutes document action plans for copy and paste function deficiencies and track action items to completion.

[7] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

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 22 HF patients' medical records and relevant facility policies, and we interviewed employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

Medication Management

The purpose of this review was to determine whether VHA facilities had properly provided selected vaccinations according to Centers for Disease Control and Prevention guidelines and VHA recommendations.

We reviewed a total of 20 medical records for evidence of screening and administration of pneumococcal vaccines to CLC residents and screening and administration of tetanus and shingles vaccines to CLC residents and primary care patients. We also reviewed documentation of selected vaccine administration requirements and interviewed key personnel.

The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff screened patients for pneumococcal and tetanus vaccinations.
	Staff properly administered pneumococcal and tetanus vaccinations.
	Staff properly documented vaccine administration.
	Vaccines were available for use.
	If applicable, staff provided vaccines as expected by the VISN.
	The facility complied with any additional elements required by local policy.

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 medical records of patients with positive traumatic brain injury results, and training records, and we interviewed key staff. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 20–25, 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	1b	
VISN	11	
Community Based Outpatient Clinics	Toledo, OH Flint, MI Jackson, MI	
Veteran Population in Catchment Area	142,137	
Type and Number of Total Operating Beds: • **Hospital**	105	
• **CLC/Nursing Home Care Unit**	40	
• **Other**	0	
Medical School Affiliation(s)	University of Michigan Medical School The University of Toledo College of Medicine	
• **Number of Residents**	760	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$369.0	$336.8
• **Medical Care Expenditures**	$369.0	$336.8
Total Medical Care Full-Time Employee Equivalents	1,928	1,783
Workload:		
• **Number of Station Level Unique Patients**	56,645	54,685
• **Inpatient Days of Care:**		
o **Acute Care**	36,508	29,456
o **CLC/Nursing Home Care Unit**	19,091	13,913
Hospital Discharges	5,751	5,536
Total Average Daily Census (including all bed types)	82.8 (Hospital) 37.1 (CLC)	80.8 (Hospital) 37.0 (CLC)
Cumulative Occupancy Rate (in percent)	78.9 (Hospital) 92.8 (CLC)	80.0 (Hospital) 92.5 (CLC)
Outpatient Visits	455,075	436,136

[8] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM		
1. Require that designated employees maintain current life support training certification and that facility policy is updated and reflects actions to be taken when life support training expires.	Of the 1,120 employees required to maintain life support certification, 99 percent are in compliance. Facility policy was updated and includes actions to be taken when life support training expires. A system was developed for tracking life support training and certification.	N
2. Monitor the copy and paste functions in the electronic medical record.	Copy and paste functions are monitored monthly by the Medical Records Committee and reported quarterly to the Clinical Executive Board.	N
EOC		
3. Correct identified infection control, patient privacy, and environmental safety deficiencies.	EOC rounds are completed in administrative and clinical areas. Data is reported to the Shared Governance QM Committee and the Nurse Executive Board. Actions are implemented to address any deficiencies.	N
4. Require that all locked MH unit staff receive environmental hazards training, as required by VHA policy.	Environmental hazards training is completed annually by MH unit staff.	N
5. Complete and document fire drills in accordance with JC standards.	Fire drills are conducted in all patient care and business occupancy buildings. Results are tracked, monitored, and reported at EOC Committee meetings.	N
MRI Safety		
6. Require MRI personnel to complete comprehensive patient screenings and document follow-up of affirmative screening responses in the medical record.	MRI screening forms are completed on every patient and reviewed with them prior to scanning. Items requiring radiologist review are addressed and documented. Forms are scanned into the medical record before the end of the day and attached to image reports.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
7. Provide MRI safety education for non-MRI employees who have access to the MRI area, in accordance with JC requirements.	All MRI and non-MRI staff who have access to the MRI area complete an education module annually, which is tracked for compliance of completion.	N
8. Comply with VHA policy regarding documentation of informed consents for high-risk patients who will have intravascular contrast during their MRI procedures.	Patients determined to be high risk are redirected to another imaging modality, or the protocol is changed to avoid contrast use. Due to this, there are few patients who require contrast consent for MRI. Radiology has a policy defining who is high risk and requires consent.	N
COC		
9. Require that providers consistently document medication and diet information in patient discharge instructions and discharge summaries.	The discharge physician instruction template documents medication reconciliation and diet. Random chart audits are completed monthly and reported to the Medical Records Committee.	N
10. Require that staff document that the patient or caregiver has received a copy of the discharge instructions.	The nursing discharge template is used to document that the patient or caregiver has been given a copy of the physician discharge instruction sheet. Monthly audits demonstrate compliance.	N
11. Require staff to provide discharge education and document patient or caregiver understanding.	The nursing discharge template is used to document discharge education provided and patient or caregiver understanding. Monthly audits demonstrate compliance.	N
Medication Management		
12. Require that nurses document as needed pain medication effectiveness within the timeframe specified by facility policy.	As needed pain medication effectiveness documentation is monitored monthly and reported to the Shared Governance QM Committee, which develops actions plans and tracks improvement. Overall compliance is greater than 92 percent.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Physician Credentialing and Privileging		
13. Require that Ongoing Professional Practice Evaluation plans, provider files, and privileges are in compliance with VHA requirements.	The facility's Ongoing Professional Practice Evaluation policy and forms were revised in August 2010. All competencies were addressed during the reprivileging process.	N
Follow-Up On Diabetes and Atypical Antipsychotic Medications		
14. Require that MH patients who are on atypical antipsychotic medications receive laboratory follow-up that includes documentation of fasting status.	The laboratory package was changed to include fasting glucose orders. MH patients who are on atypical antipsychotic medications receive laboratory follow-up that includes documentation of fasting glucose status. Results of ongoing glucose monitoring are reported to MH leadership and are broken out by provider to ensure follow-up.	N

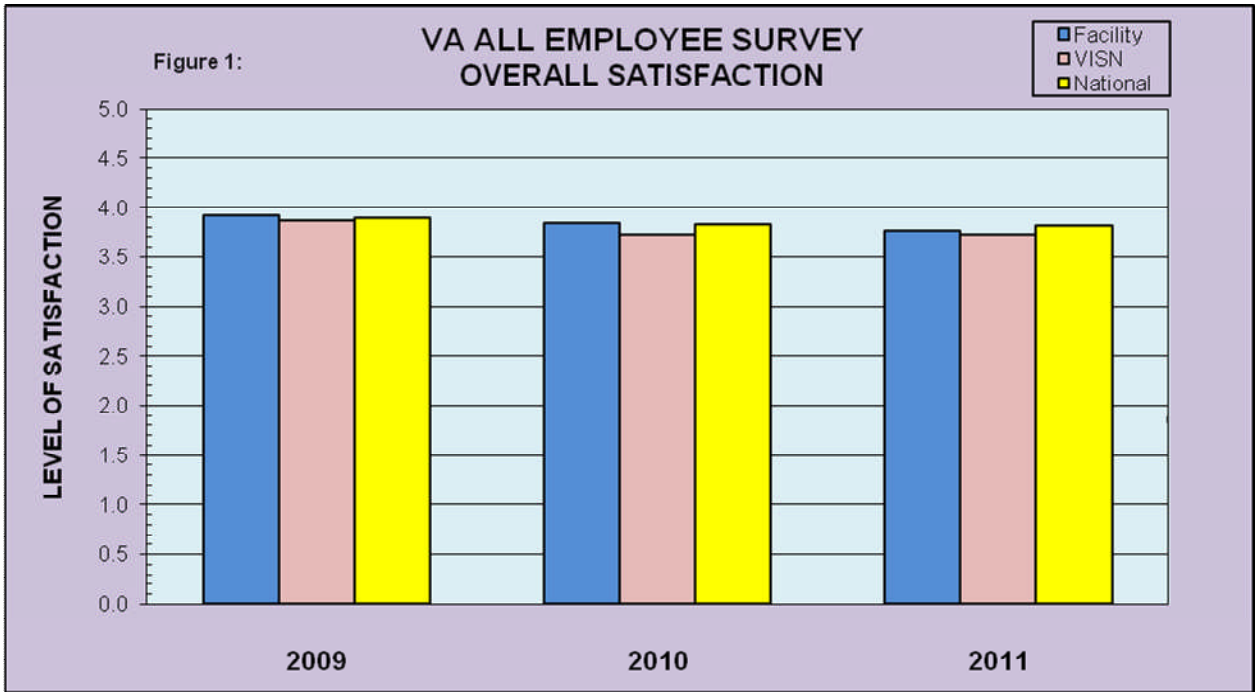
VHA Satisfaction Surveys

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 satisfaction scores and targets for quarters 3–4 of FY 2010 and quarters 1–2 of FY 2011 and overall outpatient satisfaction scores and targets for quarter 4 of FY 2010 and quarters 1–3 of FY 2011.

Table 1

	FY 2010		FY 2011			
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3
Facility	77.5	58.8	74.0	59.1	57.1	56.2
VISN	67.7	55.7	61.1	56.9	54.3	55.0
VHA	64.1	54.4	63.9	55.9	55.3	54.2

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.



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, 2007, and June 30, 2010.[10]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	13.0	11.0	12.4	18.8	21.3	18.2
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[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.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 29, 2012

From: Director, Veterans In Partnership (10N11)

Subject: **CAP Review of the VA Ann Arbor Healthcare System, Ann Arbor, MI**

To: Director, Chicago Office of Healthcare Inspections (54CH)

Director, Management Review Service (VHA 10A4A4 Management Review)

Attached is the response from Ann Arbor Healthcare System. If you have any questions please contact Kelley Sermak, Acting Quality Management Officer at 734-222-4302.

Michael S. Finegan

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 29, 2012

From: Director, VA Ann Arbor Healthcare System (506/00)

Subject: **CAP Review of the VA Ann Arbor Healthcare System, Ann Arbor, MI**

To: Director, Veterans In Partnership (10N11)

We appreciate the opportunity to review the draft report of recommendations from the OIG CAP Review conducted at the VA Ann Arbor Health Care System.

Please find the attached response to each recommendation provided in the report for your review. I concur with the recommendations and we have already initiated corrective actions.

If you have questions regarding the responses to the recommendations in the report feel free to call me at 734-845-5458.

(original signed by:)
Robert P. McDivitt, FACHE/VHA-CM

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 patient care areas are clean.

Concur

Target date for completion: May 30, 2012

A cleaning schedule was developed for the high use bathrooms. Facilities Maintenance will monitor the high use bathrooms on a daily basis to ensure cleanliness is maintained. A general cleaning schedule has been developed to ensure cleanliness and general maintenance is maintained hospital wide. An Environment of Care assessment tool will be used bi-weekly to monitor for facility cleanliness. The information will be reported monthly to Quality Management and quarterly to the Environment of Care Committee until sustained compliance has been achieved.

Recommendation 2. We recommended that processes be strengthened to ensure that the identified environmental safety deficiencies are corrected and that the facility conducts and documents daily monitoring checks of the CLC's elopement prevention system.

Concur

Target date for completion: May 30, 2012

A checklist was developed for monitoring the elopement prevention system for CLC. The elopement prevention system will be tested daily by the CLC staff. Environmental Care Rounds will be conducted bi-weekly to address construction site issues including unlocked electrical panel and unsecured soiled utility rooms. Environment of Care Committee will monitor until sustained compliance has been achieved.

Recommendation 3. We recommended that processes be strengthened to ensure that the identified infection prevention deficiencies are corrected.

Concur

Target date for completion: May 30, 2012

Issues with separation of clean and dirty items were corrected at the time of the visit. Environmental Rounds will be completed monthly by Quality Management and nursing staff to ensure separation of clean and dirty items on the units is maintained. Data will

be reported quarterly to Quality Management until sustained compliance has been achieved. The use of inappropriate personal protective equipment was corrected at the time of the visit and education was provided to the staff. Issues with food and nutrition were corrected on site. There is no longer the ability to access food through the soiled linen area.

Recommendation 4. We recommended that processes be strengthened to ensure that medications are secured.

Concur

Target date for completion: May 30, 2012

The medication drawers in the Medical Intensive Care Unit were repaired in December 2011. The unlocked box used to store medications in a patient's room in the CLC was repaired on December 11, 2011. Environmental Rounds will be completed by Quality Management and nursing staff monthly to ensure security of medications is maintained. Data will be reported quarterly to Quality Management until sustained compliance has been achieved.

Recommendation 5. We recommended that processes be strengthened to protect sensitive patient information.

Concur

Target date for completion: May 30, 2012

The patient sensitive information located in Nuclear Medicine reception area and Cardiology Clinic was removed at the time of the visit. Nuclear Medicine and Cardiology now shred sensitive information at the end of each day. Quality Management will monitor monthly until sustained compliance has been achieved.

Recommendation 6. We recommended that processes be strengthened to ensure that staff have annual competency-based education/training prior to assisting with moderate sedation.

Concur

Target date for completion: May 30, 2012

A process is in place to ensure that prior to assisting with moderate sedation, nursing staff complete a Talent Management System (TMS) module annually. Verification of the annual competency/education will be completed by the procedural area managers and reported to the Invasive Procedure Committee until compliance is met.

Recommendation 7. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: May 30, 2012

The assessment tool has been modified to include all the required elements of the history and physical. The procedural area managers will monitor monthly for complete documentation of the history and physical elements as part of the quality management chart audits. Data will be reported to the Invasive Procedures Committee until sustained compliance has been achieved.

Recommendation 8. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: May 30, 2012

A letter will be sent to patients notifying them of positive CRC test results within 14 calendar days of the laboratory receipt date for fecal immunochemical tests. Ambulatory Care will complete monthly chart audits to ensure documented evidence of timely notification. The results will be reported monthly to the Ambulatory Care Utilization Committee until sustained compliance has been achieved.

Recommendation 9. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: May 30, 2012

Ambulatory Care adjusted the process for documentation of follow-up plans for positive and negative CRC test results. Ambulatory Care will complete monthly chart audits to ensure clinicians develop follow-up plans or document that no follow-up plans is indicated within the14-day timeframe. The results of the chart audits will be reported monthly to the Ambulatory Care Utilization Committee until sustained compliance has been achieved.

Recommendation 10. We recommended that the facility initiate steps to fully implement the PRRC or request a DUSHOM approved modification or exception.

Concur

Target date for completion: September 1, 2012

We are in the process of converting our present partial hospital program to meet the requirements of a PRRC. Modifications to the current program are under review with expectation of the plan being fully implemented by the end of August 2012. We will monitor progress monthly until completion.

Recommendation 11. We recommended that processes be strengthened to ensure that Medical Records Oversight Committee minutes document action plans for copy and paste function deficiencies and track action items to completion.

Concur

Target date for completion: May 30, 2012

The Medical Records Committee will document discussion of actions to address copy and paste deficiencies. Action items will be documented in the tracking log monthly and monitored for completion by the Medical Records Committee. Quality Management will monitor monthly until sustained compliance has been achieved.

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