Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-04567-179

Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center Milwaukee, Wisconsin

May 21, 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

ACLS	Advanced Cardiac Life Support
C&P	compensation and pension
CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
CPR	cardiopulmonary resuscitation
CRC	colorectal cancer
EOC	environment of care
facility	Clement J. Zablocki VA Medical Center
FY	fiscal year
HF	heart failure
MH	mental health
MRI	magnetic resonance imaging
OIG	Office of Inspector General
PRRC	Psychosocial Rehabilitation and Recovery Center
QM	quality management
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary: Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, WI

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 January 23, 2012.

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

- Medication Management
- Moderate Sedation
- Quality Management

The facility's reported accomplishments were improving the timeliness of compensation and pension examinations and improving the guardianship process in the transitional care unit.

Recommendations: We made recommendations in the following five activities:

Colorectal Cancer Screening: Thoroughly review the specified patient's care, and initiate appropriate actions, including consulting with Regional Counsel, if warranted. Notify patients of biopsy results within the required timeframe, and document notification.

Environment of Care: Adequately clean bowel care and shower chairs after use. Protect sensitive patient information in the shared specialty care unit suite. Ensure all laser users complete laser safety training, and monitor compliance. Display valid expiration dates for medications and supplies on the tag attached to each crash cart.

Polytrauma: Provide interdisciplinary treatment plans to polytrauma outpatients, and document it in the medical record. Ensure all required services are available to polytrauma outpatients, and maintain minimum staffing levels.

Psychosocial Rehabilitation and Recovery Centers: Ensure that the facility's center has individual therapy rooms and a recovery resource area and offers individual psychotherapy or that the facility obtains an approved action plan or modification.

Coordination of Care: Consistently schedule follow-up appointments within the timeframes requested by providers.

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 January 26, 2012, 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 Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin,* Report No. 09-03274-110, March 18, 2010). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 145 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 240 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

Improved Timeliness of C&P Examinations

The facility's average wait time for a C&P examination was reduced from 36 days in FY 2011 to 17 days during the first 4 months of FY 2012. The facility took the following actions in order to decrease the wait time: (1) hired additional examiners, including an audiologist; (2) established additional specialty clinics; and (3) used Saturday clinics to decrease the backlog and improve access.

Additionally, the facility developed a partnership clinic with the Veterans Benefits Administration's regional office to assist with improving the timeliness of C&P determinations. A facility provider goes to the regional office 1 day a week and reviews incomplete examinations, provides medical opinions, and answers questions, all of which help to expedite the final determination of C&P claims.

Improved Guardianship Process in the Transitional Care Unit

During FY 2011, 50 percent of the patients in the transitional care unit required guardianship and/or placement, which resulted in an increased length of stay. A workgroup was established to address this issue. The workgroup's goals were to: (1) streamline the guardianship process, (2) decrease the length of stay, (3) improve hospital flow, and (4) decrease costs and diversion rates. As a result of revising the guardianship policy, streamlining the approval process, and assigning a full-time social worker to the transitional care unit, the length of stay on the unit was reduced from 57 days in FY 2011 to 36 days during the first 4 months of FY 2012. This has resulted in significant cost savings.

Results

Review Activities With Recommendations

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 20 patients who had 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
	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.
X	Patients received a diagnostic test within the required timeframe.
	Patients were notified of the diagnostic test results within the required timeframe.
X	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Follow-Up on Positive CRC Screening Tests and Diagnostic Testing Timeliness. 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.[1] Additionally, VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated. One patient had four positive fecal occult blood tests confirmed in November 2010. The provider did not document a follow-up plan or that no follow-up was indicated for this patient. Diagnostic testing was not ordered until March 2011, and the colonoscopy was not performed until July. The patient was subsequently diagnosed with CRC.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[2] Of the 17 patients who had a biopsy, 7 records did not contain documented evidence of timely notification.

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

Recommendations

1. We recommended that the facility thoroughly review the specified patient's care and initiate appropriate actions, including consulting with Regional Counsel, if warranted.

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

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 and whether the facility's MH RRTPs were in compliance with selected requirements.

We inspected the medical and surgical intensive care, medicine/oncology, surgery, spinal cord injury, and locked acute MH units and one CLC unit. Additionally, we inspected the Domiciliary Care for Homeless Veterans Program, the Domiciliary Post-Traumatic Stress Disorder and Substance Abuse RRTP units, and the two general Domiciliary RRTP units. We also inspected the emergency department, the operating room suite, a shared specialty clinic suite, one primary care clinic, and the dental clinic. 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.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	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.
X	Laser safety requirements in the operating room were properly addressed, and users received medical laser safety training.
X	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.
	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 Joint Commission requires that patient equipment be clean. We found three bowel care chairs[3] in the spinal cord injury unit and one shower chair in the CLC that were not adequately cleaned after patient use.

[3] Specialized chairs used for patient care that can be wheeled over the toilet and then wheeled to the shower.

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 the shared specialty clinic suite.

Laser Safety Training. Local policy requires that all laser users be trained on the proper use of this equipment. We reviewed five employee training records and found that three records did not have this training documented for FY 2011.

Patient Safety. Local policy requires that medications and supplies in crash carts be current. Expiration dates for medications and supplies are displayed on a tag attached to each crash cart. We found one crash cart in the intensive care unit that did not include the expiration date for medications on the tag and one crash cart in the dental clinic with an outdated expiration date for supplies on the tag.

Recommendations

3. We recommended that processes be strengthened to ensure that bowel care and shower chairs are adequately cleaned after use.

4. We recommended that processes be strengthened to protect sensitive patient information in the shared specialty care unit suite.

5. We recommended that all laser users complete laser safety training and that compliance be monitored.

6. We recommended that processes be strengthened to ensure that valid expiration dates for medications and supplies are displayed on the tag attached to each crash cart.

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 outpatients with positive traumatic brain injury results, and training records, and we interviewed key staff. 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 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.
X	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.
	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.

Outpatient Treatment Plans. VHA requires that a copy of the treatment plan developed by the interdisciplinary polytrauma team be provided to the patient.[4] Nine records did not include documentation that the plans had been provided to the patients.

Available Services and Staffing. VHA requires that specific services are available for polytrauma patients and that minimum staffing levels are maintained.[5] The Polytrauma Support Clinic Team did not provide rehabilitation nursing services. In addition, the facility did not meet the minimum staffing requirement for the rehabilitation physician.

[4] VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.
[5] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

Recommendations

7. We recommended that processes be strengthened to ensure that interdisciplinary treatment plans are provided to polytrauma outpatients and that this is documented in the medical record.

8. We recommended that all required services be available to polytrauma outpatients and that minimum staffing levels be maintained.

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 Deputy Under Secretary for Health for Operations and Management approved modification or exception. Facilities with missing PRRC programmatic or clinical elements must have an Office of MH Services' approved action plan or Deputy Under Secretary for Health for Operations and Management approved modification.

We reviewed facility policies and relevant documents, inspected the PRRC, and interviewed employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	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.
X	The PRRC met space and therapeutic resource requirements, or the facility had an approved action plan or modification.
X	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.

Physical Environment. VHA requires that PRRCs have individual and group treatment rooms and a recovery resource area.[6] The facility's PRRC did not meet the minimum physical space requirements. It did not have individual therapy rooms or a recovery resource area. In addition, the facility did not have an approved action plan or modification for this requirement.

Clinical Services. VHA requires a minimum array of clinical services for veterans enrolled in PRRC programs, including individual psychotherapy.[7] The PRRC program did not offer individual psychotherapy. In addition, the facility did not have an approved action plan or modification for this requirement.

Recommendations

9. We recommended that the facility's PRRC have individual therapy rooms and a recovery resource area or that the facility obtains an approved action plan or modification.

[6] Deputy Under Secretary for Health for Operations and Management, "Formal Designation of Psychosocial Rehabilitation and Recovery Centers," memorandum, November 6, 2009.
[7] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

10. We recommended that processes be strengthened to ensure that the PRRC offers individual psychotherapy or that the facility obtains an approved action plan or modification.

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 23 HF patients' medical records and relevant facility policies, and we interviewed employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Follow-Up Appointments. VHA requires that discharge instructions include recommendations regarding the initial follow-up appointment.[8] Seventeen records included a specific timeframe for the follow-up appointment. Three appointments were not scheduled within the timeframe requested by the provider.

Recommendation

11. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

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

Review Activities Without Recommendations

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 details the areas reviewed. 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.

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 table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
	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.

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 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 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 CPR 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 ACLS 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.
	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.

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 23–28, for the full text of the Directors' comments.) We consider Recommendations 6, 9, and 10 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[9]		
Type of Organization	Tertiary care medical center	
Complexity Level	1a	
VISN	12	
Community Based Outpatient Clinics	Appleton, WI Cleveland, WI Green Bay, WI Union Grove, WI	
Veteran Population in Catchment Area	280,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	194	
• **CLC/Nursing Home Care Unit**	113	
• **Domiciliary**	357	
Medical School Affiliation(s)	Medical College of Wisconsin	
• **Number of Residents**	167.8 Full-time employee equivalents	
	Prior FY (2011)	**Prior FY (2010)**
Resources (in millions):		
• **Total Medical Care Budget**	$508.1	$453.0
• **Medical Care Expenditures**	$453.2	$425.2
Total Medical Care Full-Time Employee Equivalents	2,757	2,582
Workload:		
• **Number of Station Level Unique Patients**	61,846	60,665
• **Inpatient Days of Care:**		
o **Acute Care**	49,421	50,650
o **CLC/Nursing Home Care Unit**	31,934	32,246
Hospital Discharges	8,464	8,967
Total Average Daily Census (including all bed types)	450	486
Cumulative Occupancy Rate (in percent)	67.8	73.3
Outpatient Visits	702,288	668,287

[9] All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	**Current Status of Corrective Actions Taken**	**Repeat Recommendation? Y/N**
QM Program		
1. Document extensions for peer reviews that exceed 120 days, in accordance with VHA policy.	All peer reviews that have been initiated since July 1, 2010, were completed within the 120-day timeframe. Therefore, there was no need to request extensions.	N
2. Ensure designated staff maintain current CPR and/or ACLS certification, and establish a process to document, review, and track life support training.	Local policy was revised to specify which staff are required to have CPR and/or ACLS training. Designated staff hold current CPR and/or ACLS certification. Talent Management System computerized reports are used to document, review, and track life support training for non-licensed independent practitioners. The Medical Staff Credentialing Office tracks completion of life support training for privileged, licensed independent practitioners.	N
EOC		
3. Correct the identified medication security, patient privacy, maintenance, and employee training concerns.	Annual training is provided to staff on environmental hazards and infection control. Managers review compliance reports. Ongoing environmental rounds, tracers, and self-assessments are occurring in a continuous manner. When a problem is identified, action is taken to address the finding in the areas of medication security, patient privacy, and maintenance. This includes submission of work orders, ordering/purchasing privacy screens, and reinforcement with staff at the time the deficiency is noted.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
MRI Safety		
4. Complete and document patient MRI safety screenings in the medical record.	A process was implemented to monitor documentation of MRI screenings in the computerized medical record. The average compliance rate from December 2010 to November 2011 was 94 percent.	N
5. Secure the MRI area.	The stairway door leading to the MRI corridor is continuously locked. Staff members are permitted to exit the second floor in the event of fire or other emergencies.	N
COC		
6. Ensure that providers complete discharge documentation in accordance with VHA policy.	The ongoing audit of discharge documentation has identified an issue in transcription of follow-up appointments. The task force has developed a new process to reduce the discrepancy, and the audit following implementation shows 93 percent or higher compliance.	N
7. Ensure that patients discharged from the locked acute MH unit receive timely post-discharge care and that care is documented, as required by VHA policy.	A yearlong monitor showed that all patients discharged from the locked acute MH unit received timely follow-up. A discharge follow-up clinic with eight appointments per week was established for patients who cannot be seen by their provider in a timely manner.	N
Medication Management		
8. Ensure that nursing personnel consistently assess and document as needed pain medication effectiveness within the timeframe specified by local policy.	Monthly, random audits of documentation of as needed pain medication effectiveness were conducted for more than 12 consecutive months. The results indicated overall compliance above 90 percent. Periodic audits will be conducted to ensure that compliance is sustained.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
Contracted/Agency Registered Nurses		
9. Ensure that nurse managers validate the clinical competence of contracted/agency registered nurses prior to patient care assignments.	Since 2009, the facility has not used contract/agency registered nurses for patient care services.	N
Follow-Up on Cardiac Catheterization		
10. Complete the cardiac catheterization laboratory informed consent process in accordance with VHA policy.	Recent audits demonstrate compliance with VHA policy. The consenting provider and the provider undertaking the cardiac catheterization procedure matched in all cases reviewed.	N

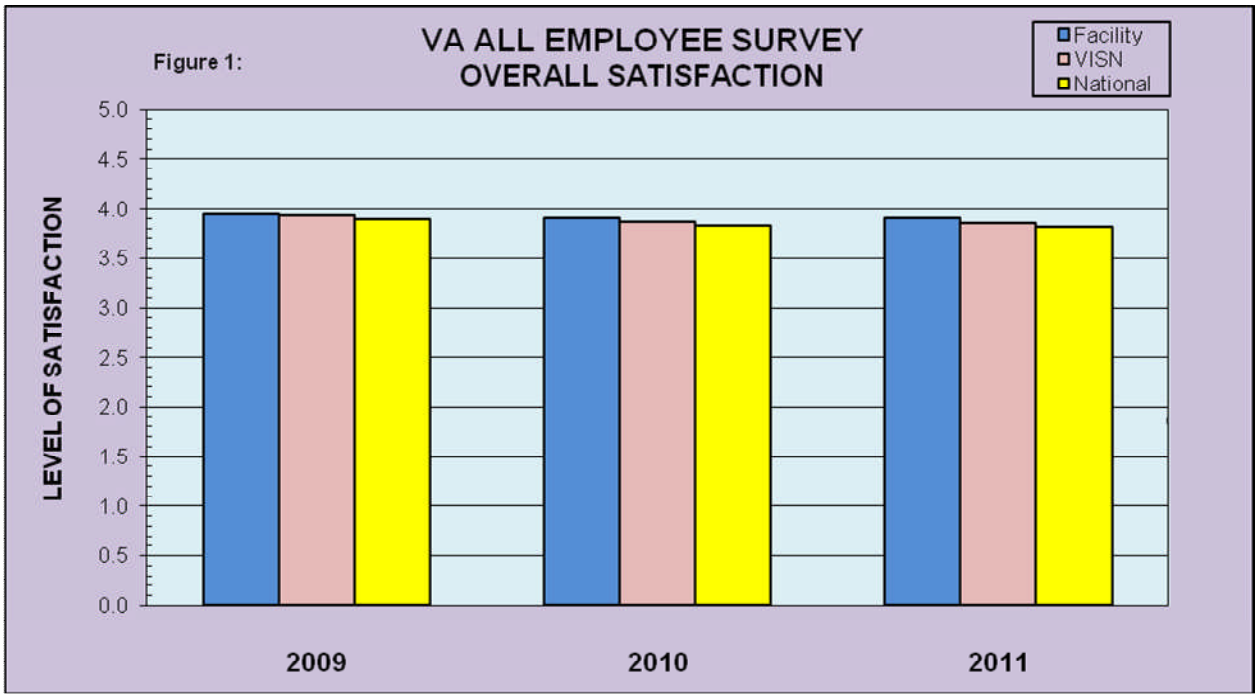
VHA Satisfaction Surveys

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 and outpatient satisfaction scores and targets for FY 2011.

Table 1

	FY 2011 Inpatient Scores		FY 2011 Outpatient Scores			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	62.9	64.7	59.3	52.9	53.2	54.5
VISN	67.2	65.0	58.6	59.4	56.6	58.3
VHA	63.9	64.1	55.9	55.3	54.2	54.5

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.[10] 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.[11]

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive HF	Pneumonia	Heart Attack	Congestive HF	Pneumonia
Facility	15.6	10.3	8.6	18.7	25.5	19.1
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

[10] 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.

[11] 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 D

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 19, 2012

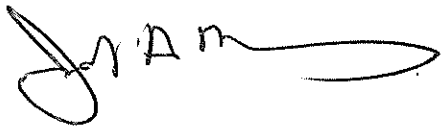
From: Director, VA Great Lakes Health Care System (10N12)

Subject: **CAP Review of the Clement J. Zablocki VA Medical Center, Milwaukee, WI**

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

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

I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.



Jeffrey A. Murawsky, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 19, 2012

From: Director, Clement J. Zablocki VA Medical Center (695/00)

Subject: **CAP Review of the Clement J. Zablocki VA Medical Center, Milwaukee, WI**

To: Director, VA Great Lakes Health Care System (10N12)

1. Enclosed are the responses to the recommendations in the draft Office of Inspector General's report of our Combined Assessment Program review.

2. If you have any questions or wish to discuss the report, please contact me at (414) 384-2000 extension 41025.

Robert H. Beller

ROBERT H. BELLER, FACHE
Medical Center Director

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 the facility thoroughly review the specified patient's care and initiate appropriate actions, including consulting with Regional Counsel, if warranted.

Concur: Yes

Target date for completion: May 31, 2012

The specified patient's care was reviewed at the April 2, 2012 Peer Review Committee. The patient's primary care physician provided and documented clinical disclosure on April 11, 2012. The facility determined Institutional Disclosure is appropriate and the patient has been contacted. If patient is interested, meeting will be scheduled prior to May 31, 2012.

Recommendation 2. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur: Yes

Target date for completion: September 1, 2012

The current GI endoscopy templates are being modified to include a mandatory field as to whether or not a biopsy was done. A GI staff member will confirm that the biopsy results and treatment plan have been placed in the endoscopy report and written notification sent to the patient within 14 days of receipt of biopsy results.

Monthly audits will be performed to ensure process change is effective. Performance with written notification will be considered satisfactory if 95 percent or greater compliance is obtained for 3 consecutive months.

Recommendation 3. We recommended that processes be strengthened to ensure that bowel care and shower chairs are adequately cleaned after use.

Concur: Yes

Target date for completion: August 1, 2012

Under the direction and supervision of the Environmental Management Services Chief, a sweep of all inpatient areas was undertaken to locate all bowel care and shower

chairs. All surfaces, including removable components, were inspected, cleaned and disinfected prior to the close of business on January 27, 2012.

A revised cleaning procedure was communicated to all Environmental Management Service (EMS) personnel and to all Nursing personnel who provide direct patient care. This was completed on February 10, 2012.

The EMS Supervisor and the Nursing Program Managers are jointly conducting weekly inspections of all bowel care and shower chairs on each unit using a standardized data collection tool. The audits will be performed weekly until 100% compliance is achieved for three consecutive months after which monitoring and reporting will continue on a quarterly basis to ensure sustained compliance.

Recommendation 4. We recommended that processes be strengthened to protect sensitive patient information in the shared specialty care unit suite.

Concur: Yes

Target date for completion: August 1, 2012

The following actions have been taken in the shared specialty care unit suite:

1. Sensitive information, including all information containing patient identifiers, is locked in file cabinets at the end of the work day.
2. The shared printer is turned off at the close of business, preventing consults and any other documents from being printed during the clinic off hours.
3. Door to the suite is locked at close of business.
4. Physician mailboxes in the suite are locked at close of business.

The Program Manager/delegate of the shared specialty clinic suite is overseeing these actions and documenting compliance. Performance will be considered satisfactory if compliance with actions is observed 90 percent or greater for 3 consecutive months.

Recommendation 5. We recommended that all laser users complete laser safety training and that compliance be monitored.

Concur: Yes

Target date for completion: May 1, 2012

All current laser users have been assigned the TMS Laser Safety Training as an annual requirement. New laser users will be assigned the TMS Laser Safety Training as an annual requirement. We will monitor compliance with this annual training requirement.

Recommendation 6. We recommended that processes be strengthened to ensure that valid expiration dates for medications and supplies are displayed on the tag attached to each crash cart.

Concur: Yes

Target date for completion: Completed

A Memorandum of Understanding between Sterile Processing Service (SPS) and Pharmacy was completed on January 26, 2012 delineating the process by which expiration dates for medications and supplies are managed. All SPS and Pharmacy staff were re-educated on the process. All code carts were immediately inspected and tagged correctly or returned to SPS for recheck. Nursing staff conducts daily review of code carts and verify expiration dates.

Recommendation 7. We recommended that processes be strengthened to ensure that interdisciplinary treatment plans are provided to polytrauma outpatients and that this is documented in the medical record.

Concur: Yes

Target date for completion: August 1, 2012

The Polytrauma Interdisciplinary Treatment Team meets weekly to review and revise the TBI/Polytrauma Rehabilitation/Reintegration Plan of Care. This interdisciplinary treatment plan is mailed to the patient along with a letter inviting patient/family input and questions. The mailing is documented in the patient's medical record.

Monthly audits are being conducted of all new patients. Performance will be considered satisfactory if 90 percent or greater compliance is obtained for 3 consecutive months.

Recommendation 8. We recommended that all required services be available to polytrauma outpatients and that minimum staffing levels be maintained.

Concur: Yes

Target date for completion: June 1, 2012

VHA Directive 2009-028, Polytrauma Traumatic Brain Injury (TBI) System of Care, describes the required services to be available to polytrauma outpatients and minimum staffing levels. Attachment E identifies the Polytrauma Support Clinic Team (PSCT) required core staffing to include 0.5 Rehabilitation Physician and 0.5 Rehabilitation Nurse. Effective January 27, 2012, 0.5 FTEE of the Rehabilitation Physician has been officially assigned the PSCT. Clarification received from the VHA National Polytrauma/TBI Coordinator indicates that a registered nurse or nurse practitioner (who is also a registered nurse) with knowledge and skills in rehabilitation can appropriately fulfill all required nurse based polytrauma services. The PSCT includes a 1.0 FTEE Nurse Practitioner who has demonstrated, over the last four years, rehabilitation

knowledge and skill. The Nurse Practitioner's Polytrauma Support Clinic Team Scope of Practice will be revised to reflect the full range of responsibilities including those that would be provided by a rehabilitation nurse. The revised scope of practice will be reviewed with the PSCT Nurse Practitioner to ensure understanding of the scope of practice and rehabilitation nursing responsibilities.

Recommendation 9. We recommended that the facility's PRRC have individual therapy rooms and a recovery resource area or that the facility obtains an approved action plan or modification.

Concur: Yes

Target date for completion: May 1, 2012

The PRRC is schedule to move to their new location the week of April 16, 2012, which includes the necessary individual therapy rooms as well as a designated recovery resource area.

Recommendation 10. We recommended that processes be strengthened to ensure that the PRRC offers individual psychotherapy or that the facility obtains an approved action plan or modification.

Concur: Yes

Target date for completion: Completed

An Advanced Licensed Social Worker joined the PRRC on March 16, 2012 and is providing individual psychotherapy.

Recommendation 11. We recommended that processes be strengthened to ensure that follow-up appointments are consistently scheduled within the timeframes requested by providers.

Concur: Yes

Target date for completion: August 1, 2012

The Congestive Heart Failure Nurse Practitioner will interact with all Class 3 and 4 heart failure inpatients and arrange for the follow-up in the Heart Failure Clinic. Follow up appointment for all patients with primary discharge diagnosis of heart failure will be scheduled prior to discharge and based on nurse practitioner or treating physician request.

First follow-up appointment for patients with discharge diagnosis of congestive heart failure will be audited to verify appointment consistent with requested timeframe. Performance will be considered satisfactory if 90 percent or greater compliance is obtained for 3 consecutive months.

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