Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04226-125

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

February 25, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	VA Ann Arbor Healthcare System
FY	fiscal year
MRI	magnetic resonance imaging
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of December 1, 2014.

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

- Environment of Care

The facility's reported accomplishments were the Planetree model of patient care and veteran-centered care principles and receipt of the VA National Center for Patient Safety Gold Cornerstone Award.

Recommendations: We made recommendations in the following seven activities:

Quality Management: Ensure credentialing and privileging folders do not contain information that is not permitted. Require that the Surgical Work Group meets monthly and that the Chief of Staff attends meetings. Ensure the Morbidity and Mortality Conference reviews all surgical deaths with identified problems or opportunities for improvement.

Medication Management: Revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users.

Coordination of Care: Designate a committee to oversee consult management.

Magnetic Resonance Imaging Safety: Ensure Level 2 personnel conducting secondary patient safety screenings date the forms upon review prior to the scan. Require that radiologists and/or Level 2 personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan.

Acute Ischemic Stroke Care: Revise the stroke policy to address all required items. Complete and document National Institutes of Health stroke scales for each stroke patient. Obtain and document signed informed consent. Screen patients for difficulty swallowing prior to oral intake. Provide printed stroke education to patients upon discharge. Ensure employees who assess and treat stroke patients receive the training required by the facility.

Surgical Complexity: Ensure critical care unit employees have 12-lead electrocardiogram competency assessment and validation completed and documented.

Emergency Airway Management: Revise the emergency airway management policy to include that portable videolaryngoscopes be available at all times for clinician use.

Ensure clinician reassessment for continued emergency airway management competency includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–31, for the full text of the Directors' comments.) We consider recommendation 15 closed. We will follow up on the planned actions for the open recommendations 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 quality and the EOC.
- 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

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- MRI Safety
- Acute Ischemic Stroke Care
- Surgical Complexity
- EAM

We have listed the general information reviewed for each of these activities. Some of the items listed may 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 2013, FY 2014, and FY 2015 through December 1, 2014, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Ann Arbor Healthcare System, Ann Arbor, Michigan,* Report No. 11-03660-114, March 15, 2012).

During this review, we presented crime awareness briefings for 120 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 501 responded. We shared summarized 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

Planetree Model of Patient Care and Veteran-Centered Care Principles

The facility is fully engaged in the education and implementation of the Planetree model of patient care and veteran-centered care principles. In October 2013, the facility became the first health care organization in the United States to receive Planetree Silver Merit Recognition for Significant Advancement in Patient-Centered Care. This Planetree recognition has led to the national capital asset management team working with the facility and the Veterans Engineering Resource Center for the upcoming front lobby design and construction as a national template.

Gold Cornerstone Award

In FY 2014, the VA National Center for Patient Safety awarded the facility the Gold Cornerstone Award for quality, timeliness, and quantity of root cause analysis reviews.

Results and Recommendations

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 met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 10 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• All 10 credentialing and privileging folders reviewed contained curriculum vitaes and cardiopulmonary resuscitation certifications, and one folder contained licensure registration information.	**1.** We recommended that the facility ensure that credentialing and privileging folders do not contain information that is not permitted.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.	• The Surgical Work Group only met six times over the past 12 months. Six months of Surgical Work Group meeting minutes reviewed: • The Chief of Staff did not attend any meetings. Several surgical deaths that occurred May 1, 2013–April 30, 2014, had identified problems or opportunities for improvement: • The Morbidity and Mortality Conference did not review any of these deaths.	**2.** We recommended that the Surgical Work Group meet monthly and that the Chief of Staff attend meetings. **3.** We recommended that the Morbidity and Mortality Conference review all surgical deaths with identified problems or opportunities for improvement.
	Clinicians appropriately reported critical incidents.		
	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.		
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in critical care and the CLC.[b]

We inspected the Emergency Department, the primary care purple clinic, the surgical and critical care units, and the CLC. Additionally, we reviewed relevant documents, including inspection documentation for five alarm-equipped medical devices in critical care, and 20 employee training records (10 critical care and 10 CLC) and conversed with key employees and managers. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	Selected employees received training on updated requirements regarding chemical labeling and safety data sheets.		
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Critical Care		
	Designated critical care employees received bloodborne pathogens training during the past 12 months.		
	Alarm-equipped medical devices used in critical care were inspected/checked according to local policy and/or manufacturers' recommendations.		
	The facility met fire safety requirements in critical care.		
	The facility met environmental safety requirements in critical care.		
	The facility met infection prevention requirements in critical care.		
	The facility met medication safety and security requirements in critical care.		
	The facility met medical equipment requirements in critical care.		
	The facility met privacy requirements in critical care.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for CLC	Findings	Recommendations
	Designated CLC employees received bloodborne pathogens training during the past 12 months.		
	For CLCs with resident animal programs, the facility conducted infection prevention risk assessments and had policies addressing selected requirements.		
	For CLCs with elopement prevention systems, the facility documented functionality checks at least every 24 hours and documented complete system checks annually.		
	The facility met fire safety requirements in the CLC.		
	The facility met environmental safety requirements in the CLC.		
	The facility met infection prevention requirements in the CLC.		
	The facility met medication safety and security requirements in the CLC.		
	The facility met medical equipment requirements in the CLC.		
	The facility met privacy requirements in the CLC.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the intensive care unit, Emergency Department, post-anesthesia care unit, and CLC and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least every 30 days, fully implemented corrective actions, and monitored the changes.		
X	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.	• Facility policy for safe use of automated dispensing machines did not include employee training and minimum competency requirements for users.	**4.** We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 44 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	A committee oversaw the facility's consult management processes.	• The facility did not have a committee to oversee consult management.	**5.** We recommended that the facility designate a committee to oversee consult management.
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
NA	The facility met any additional elements required by VHA or local policy.		

MRI Safety

The purpose of this review was to determine whether the facility ensured safety in MRI in accordance with VHA policy requirements related to: (1) staff safety training, (2) patient screening, and (3) risk assessment of the MRI environment.[e]

We reviewed relevant documents and the training records of 18 employees (seven randomly selected Level 1 ancillary staff and 11 designated Level 2 MRI personnel), and we conversed with key managers and employees. We also reviewed the EHRs of 35 randomly selected patients who had an MRI January 1–December 31, 2013. Additionally, we conducted a physical inspection of one MRI area. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility completed an MRI risk assessment, had documented procedures for handling emergencies in MRI, and conducted emergency drills in the MRI area.		
X	Patients had two safety screenings conducted prior to MRI; the patient, family member, or caregiver signed the secondary patient safety screening form; and a Level 2 MRI personnel reviewed and signed the secondary patient safety screening form.	• Eight secondary patient safety screening forms (23 percent) were not dated; therefore, we could not confirm that a Level 2 MRI personnel reviewed the forms prior to MRI.	**6.** We recommended that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings date the forms upon review prior to the scan and that facility managers monitor compliance.
X	Secondary patient safety screening forms contained notations of any MRI contraindications, and a Level 2 MRI personnel and/or radiologist addressed the contraindications and documented resolution prior to MRI.	• Nineteen of the 21 applicable EHRs did not contain documentation that a Level 2 MRI personnel and/or radiologist addressed all identified contraindications prior to MRI.	**7.** We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.
	The facility designated Level 1 ancillary staff and Level 2 MRI personnel and ensured they received level-specific annual MRI safety training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had signage and barriers in place to prevent unauthorized or accidental access to Zones III and IV.		
	MRI technologists maintained visual contact with patients in the magnet room and two-way communication with patients inside the magnet, and the facility regularly tested the two-way communication device.		
	The facility provided patients with MRI-safe hearing protection for use during the scan.		
	The facility had only MRI-safe or compatible equipment in Zones III and IV or appropriately protected the equipment from the magnet.		
NA	The facility complied with any additional elements required by VHA or local policy.		

Acute Ischemic Stroke Care

The purpose of this review was to determine whether the facility complied with selected requirements for the assessment and treatment of patients who had an acute ischemic stroke.[f]

We reviewed relevant documents, the EHRs of 29 patients who experienced stroke symptoms, and 23 employee training records (5 Emergency Department, 5 critical care unit, and 13 Neurology Department), and we conversed with key employees. We also conducted onsite inspections of the Emergency Department, one critical care unit, and three acute inpatient units. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	The facility's stroke policy addressed all required items.	• The facility's policy did not address: o Timeliness of completion and interpretation of computed tomography scans o Timeframe for the availability of the stroke team o The difference in approach to patients presenting within the facility's defined timeframe and those presenting outside the defined timeframe	**8.** We recommended that the facility revise the stroke policy to address timeliness of completion and interpretation of computed tomography scans, timeframe for the availability of the stroke team, and the difference in approach to patients presenting within the facility's defined timeframe and those presenting outside the defined timeframe and that the facility managers fully implement the revised policy.
X	Clinicians completed the National Institutes of Health stroke scale for each patient within the expected timeframe.	• For eight of the 21 applicable patients, clinicians did not document evidence of completion of stroke scales.	**9.** We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.
X	Clinicians provided medication (tissue plasminogen activator) timely to halt the stroke and included all required steps, and the facility stocked tissue plasminogen activator in appropriate areas.	• Of the three patients who received tissue plasminogen activator, clinicians did not document informed consent in two patients' EHRs.	**10.** We recommended that clinicians obtain and document signed informed consent and that facility managers monitor compliance.
	Facility managers posted stroke guidelines in all areas where patients may present with stroke symptoms.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians screened patients for difficulty swallowing prior to oral intake of food or medicine.	• For 14 of the 25 applicable patients, clinicians did not document in the EHRs that they screened the patients for difficulty swallowing prior to oral intake.	**11.** We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.
X	Clinicians provided printed stroke education to patients upon discharge.	• For 17 of the 20 applicable patients, clinicians did not document in the EHRs that they provided stroke education to the patients/caregivers.	**12.** We recommended that clinicans provide printed stroke education to patients upon discharge and that facility managers monitor compliance.
X	The facility provided training to employees involved in assessing and treating stroke patients.	• Six employees had not completed the web-based training required by the facility.	**13.** We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.
	The facility collected and reported required data related to stroke care.		
	The facility complied with any additional elements required by VHA or local policy.		

Surgical Complexity

The purpose of this review was to determine whether the facility provided selected support services appropriate to the assigned surgical complexity designation.[g]

We reviewed relevant documents and the training records of 20 employees, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy defined appropriate availability for all support services required by VHA for the facility's surgical designation.		
X	Employees providing selected tests and patient care after operational hours had appropriate competency assessments and validation.	• Two of 10 employees on the critical care unit did not have 12-lead electrocardiogram competency assessment and validation documentation completed.	**14.** We recommended that facility managers ensure that critical care unit employees have 12-lead electrocardiogram competency assessment and validation completed and documented.
	The facility properly reported surgical procedures performed that were beyond the facility's surgical complexity designation. • The facility reviewed and implemented recommendations made by the VISN Chief Surgical Consultant.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[h]

We reviewed relevant documents, including competency assessment documentation of five clinicians applicable for the review period January 1 through June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

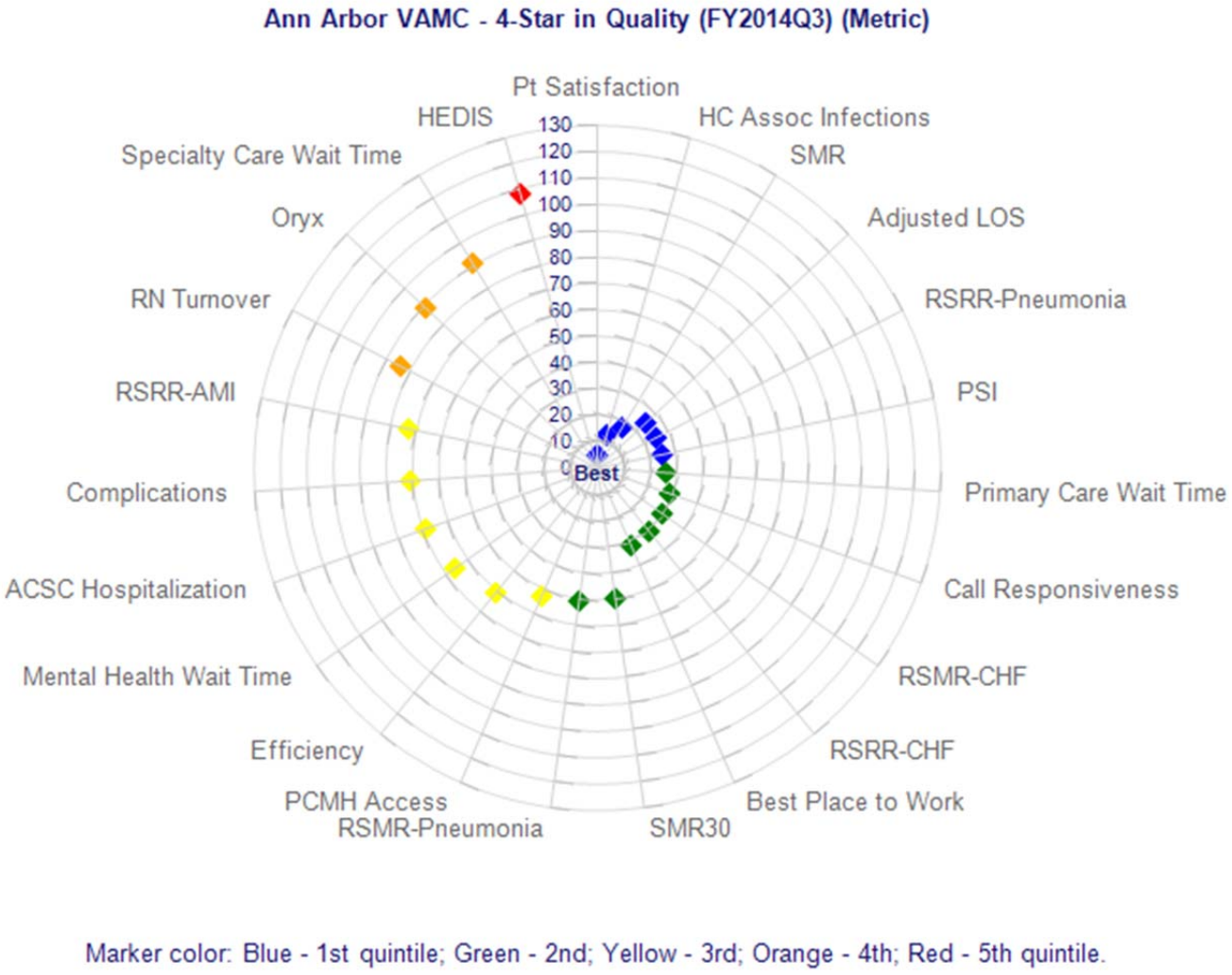
NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
X	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway	• Facility policy did not address that portable videolaryngoscopes must be available at all times for use by clinicians for EAM.	**15.** We recommended that the facility revise the emergency airway management policy to include that portable videolaryngoscopes be available at all times for use by clinicians.
	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner	• None of the five clinicians had evidence of successful demonstration of all required procedural skills on airway simulators or mannequins.	**16.** We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance.
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Ann Arbor/506) FY 2015 through December 2014[1]	
Type of Organization	Tertiary
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$372.2
Number of:	
• **Unique Patients**	33,789
• **Outpatient Visits**	111,507
• **Unique Employees**[2]	2,175
Type and Number of Operating Beds (as of November):	
• **Hospital**	109
• **CLC**	46
• **Mental Health**	NA
Average Daily Census (as of November):	
• **Hospital**	78
• **CLC**	34
• **Mental Health**	NA
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Toledo/506GA Flint/506GB Jackson/506GC
VISN Number	11

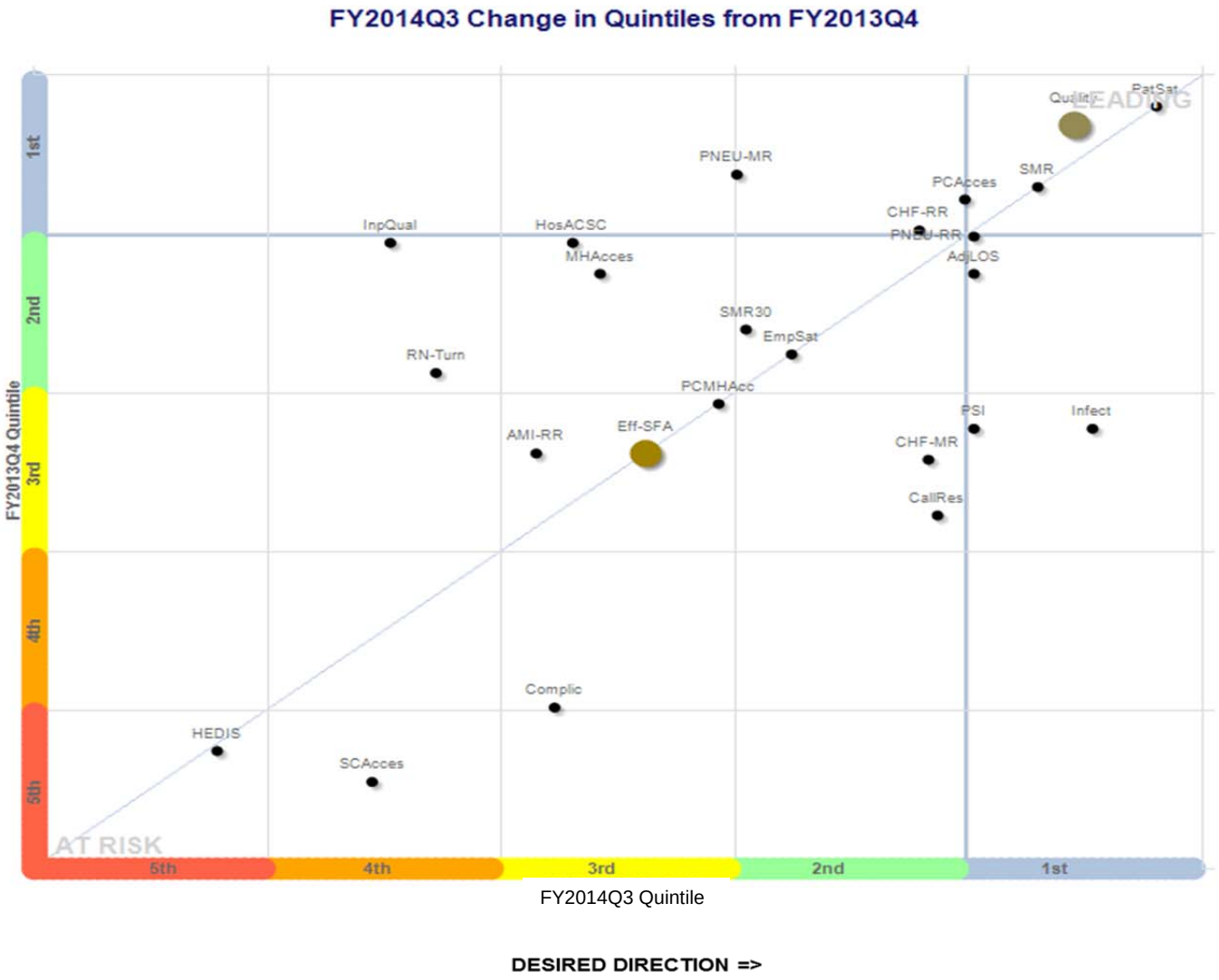
[1] All data is for FY 2015 through December 2014 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
Mental Health Status	Mental health status (outpatient only, the Veterans RAND 12 Item Health Survey)	A higher value is better than a lower value
Mental Health Wait Time	Mental health wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Physical Health Status	Physical health status (outpatient only, the Veterans RAND 12 item Health Survey)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 30, 2015

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 10AR MRS OIG CAP CBOC)

1. Attached is Ann Arbor Healthcare System's response to the draft report.

2. If you have any questions please contact Carol Jones, Quality Management Officer, at 734-222-4302.

(original signed by Tony Zapata for:)
Paul Bockelman, FACHE
Network Director VISN 11

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 16, 2015

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 the recommendations from the OIG CAP Review conducted at the VA Ann Arbor Healthcare 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 the facility ensure that credentialing and privileging folders do not contain information that is not permitted.

Concur

Target date for completion: August 1, 2015

Facility response: Credentialing staff will review credentialing and privileging folders and remove documents not permitted. To ensure sustained compliance, credentialing will monitor folders monthly for unpermitted documents and report to the Clinical Executive Board and Quality Management until 90% compliance is sustained for 2 consecutive quarters.

Recommendation 2. We recommended that the Surgical Work Group meet monthly and that the Chief of Staff attend meetings.

Concur

Target date for completion: August 1, 2015

Facility response: Surgical Work Group will meet monthly. Chief of Staff will be formally invited to attend monthly Surgical Work Group meetings to ensure meetings are on his schedule. Chief of Staff will appoint a designee to attend on his behalf in the event of an absence. Attendance results will be recorded in the minutes. Meeting minutes will be forwarded to Quality Management by the Administrative Officer for Surgery. Quality Management will monitor monthly meetings and attendance until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 3. We recommended that the Morbidity and Mortality Conference review all surgical deaths with identified problems or opportunities for improvement.

Concur

Target date for completion: August 1, 2015

Facility response: Surgical deaths with identified problems or opportunities will be discussed monthly in the Surgical Work Group meeting. Meeting minutes will be forwarded to Quality Management by the Administrative Officer for Surgery. Quality Management will monitor discussion of identified problem and opportunities in the

Surgical Work Group meetings until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 4. We recommended that the facility revise the policy for safe use of automated dispensing machines to include employee training and minimum competency requirements for users and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2015

Facility response: Training on the use of automated dispensing machines is done during initial orientation as employees use this equipment on a routine basis. The policy for automated dispensing will be amended to reflect current practice and define minimal competencies. Quality Management will monitor training for all new nurses and pharmacy technicians who utilize the automated dispensing machines to ensure they have completed training within 90 days of hire. Quality Management will monitor until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 5. We recommended that the facility designate a committee to oversee consult management.

Concur

Target date for completion: August 1, 2015

Facility response: Ambulatory Care Utilization Committee (ACUC) will oversee consult management and report to the Clinical Executive Board (CEB). The Access Coordinator will ensure consults are discussed in ACUC and forward minutes to Quality Management. Quality Management will monitor until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 6. We recommended that Level 2 magnetic resonance imaging personnel conducting secondary patient safety screenings date the forms upon review prior to the scan and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2015

Facility response: The patient MRI safety screening form has been revised with signature and date of staff completing the review at the end of the form. The MRI safety screening form will be scanned into VISTA Imaging in the Computerized Patient Record System (CPRS). Quality Management will randomly audit 30 MRI safety screening forms per month until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 7. We recommended that radiologists and/or Level 2 magnetic resonance imaging personnel document resolution in patients' electronic health records of all identified magnetic resonance imaging contraindications prior to the scan and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2015

Facility response: All contraindications identified on the MRI screening form will require a radiologist and/or Level 2 magnetic resonance staff member to clear the contraindication prior to MRI. The MRI safety screening form will be scanned into VISTA Imaging in the Computerized Patient Record System (CPRS). Quality Management will randomly audit 30 screening forms per month until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 8. We recommended that the facility revise the stroke policy to address timeliness of completion and interpretation of computed tomography scans, timeframe for the availability of the stroke team, and the difference in approach to patients presenting within the facility's defined timeframe and those presenting outside the defined timeframe and that the facility managers fully implement the revised policy.

Concur

Target date for completion: March 1, 2015

Facility response: The facility has revised the policy for Management of Thrombolytic Therapy for Acute Ischemic Stroke (AIS) to address timeliness and interpretation of computed tomography scans, timeframe for the availability of the stroke team, and the difference in approach to patients presenting within the facility's defined timeframe and those presenting outside of the defined timeframe.

Recommendation 9. We recommended that clinicians complete and document National Institutes of Health stroke scales for each stroke patient and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2015

Facility response: Chief of Neurology will ensure that neurology clinicians document the National Institutes of Health Stroke Scale (NIHSS) for stroke patients in CPRS. Quality Management will monitor monthly until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 10. We recommended that clinicians obtain and document signed informed consent and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2015

Facility response: Physician Acute Stroke Checklist added to policy for Management of Thrombolytic Therapy for Acute Ischemic Stroke (AIS). Physician checklist indicates written informed consent required for Tissue Plasminogen Activator (r-TPA). Chief of Neurology will ensure Neurologists are educated and document written informed consent for r-TPA. Quality Management will monitor until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 11. We recommended that clinicians screen patients for difficulty swallowing prior to oral intake and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2015

Facility response: Dysphagia protocol was revised and staff education completed. Emergency Room Nurse Manager will ensure patients suspected of stroke are screened for difficulty swallowing prior to oral intake. The dysphagia screening will be documented in CPRS. Quality Management will monitor monthly until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 12. We recommended that clinicians provide printed stroke education to patients upon discharge and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2015

Facility response: Associate Chief Nurse for Patient Care Services will ensure staff provides stroke education to patients using KRAMES On-Demand or eVideon and education is documented in CPRS. Quality Management will monitor monthly until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 13. We recommended that the facility ensure that employees who are involved in assessing and treating stroke patients receive the training required by the facility and that facility managers monitor compliance.

Concur

Target date for completion: March 1, 2015

Facility response: Facility policy on Management of Thrombolytic Therapy for Acute Ischemic Stroke has been revised. Previous policy required members of the Neurology Service to be National Institute of Health Stroke Scale (NIHSS) certified. This goes above and beyond standard requirements for Neurologist. Policy will be amended to ensure that members of the Neurology Service are competent to conduct NIHSS.

Recommendation 14. We recommended that facility managers ensure that critical care unit employees have 12-lead electrocardiogram competency assessment and validation completed and documented.

Concur

Target date for completion: August 1, 2015

Facility response: ICU Nurse Manager will ensure that critical care unit employees have 12-lead electrocardiogram competency assessment and validation completed and documented. Associate Chief Nurse for Patient Care Services will monitor until 90% compliance is achieved for 2 consecutive quarters.

Recommendation 15. We recommended that the facility revise the emergency airway management policy to include that portable videolaryngoscopes be available at all times for use by clinicians.

Concur

Target date for completion: Closed

Facility response: Videolaryngoscopes are currently available at all time and clinicians are aware of their locations. Emergency Airway Management policy will be amended to include that videolaryngocope are available 24/7.

Recommendation 16. We recommended that the facility ensure that clinician reassessment for continued emergency airway management competency includes evidence of successful demonstration of all required procedural skills on airway simulators or mannequins and that facility managers monitor compliance.

Concur

Target date for completion: August 1, 2015

Facility response: Facility will ensure that clinician reassessment for continued emergency airway management competency include all the required procedural skills with an airway task trainer or human patient simulator as specified by facility policy for Emergency Airway Management. Documentation for training, skills, and competency will be monitored by the Chief of Anesthesia. Quality Management will monitor monthly until 90% compliance is achieved for 2 consecutive quarters.

Office of Inspector General
Contact and Staff Acknowledgments

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This report is available at www.va.gov/oig.

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2010-052, *Management of Wandering and Missing Patients*, December 3, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- Under Secretary for Health, "Non-Research Animals in Health Care Facilities," Information Letter 10-2009-007, June 11, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the National Fire Protection Association, the Health Insurance Portability and Accountability Act, Underwriters Laboratories.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Handbook 1105.05, *Magnetic Resonance Imaging Safety*, July 19, 2012.
- Emanuel Kanal, MD, et al., "ACR Guidance Document on MR Safe Practices: 2013," *Journal of Magnetic Resonance Imaging*, Vol. 37, No. 3, January 23, 2013, pp. 501–530.
- The Joint Commission, "Preventing accidents and injuries in the MRI suite," Sentinel Event Alert, Issue 38, February 14, 2008.
- VA National Center for Patient Safety, "MR Hazard Summary," http://www.patientsafety.va.gov/professionals/hazards/mr.asp.
- VA Radiology, "Online Guide," http://vaww1.va.gov/RADIOLOGY/OnLine_Guide.asp, updated October 4, 2011.

[f] The references used for this topic were:
- VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, November 2, 2011.
- Guidelines for the Early Management of Patients with Acute Ischemic Stroke (AHA/ASA Guidelines), January 31, 2013.

[g] References used for this topic included:
- VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, January 5, 2009.
- VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

[h] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.