Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 17-01854-115

Comprehensive Healthcare Inspection Program Review of the Clement J. Zablocki VA Medical Center Milwaukee, Wisconsin

March 14, 2018

Washington, DC 20420

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Glossary

CHIP	Comprehensive Healthcare Inspection Program
EHR	electronic health record
EOC	environment of care
facility	Clement J. Zablocki VA Medical Center
FY	fiscal year
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Clement J. Zablocki VA Medical Center (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

1. Leadership and Organizational Risks
2. Quality, Safety, and Value
3. Medication Management
4. Coordination of Care
5. Environment of Care
6. High-Risk Processes
7. Long-Term Care

This review was conducted during an unannounced visit made during the week of July 10, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the Clement J. Zablocki VA Medical Center, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Deputy Director, and Assistant Director. Organizational communication and accountability are carried out through a committee reporting structure with the Operations Council having oversight for leadership groups such as the Environment of Care Council, Medical Executive Committee, and Information and Improvement Council. The leaders are members of the Operations Council and track, trend, and monitor quality of care and patient outcomes.

Except for the Assistant Director and Nurse Executive, OIG found that the executive leaders had been working together as a team since June 2016. The Nurse Executive position was filled on September 3, 2017, and the Assistant Director position was filled

on October 1, 2017. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted satisfaction scores that reflected active engagement with patients. OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences but have opportunities to improve perceptions about facility leadership.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and identified multiple organizational risk factors that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[1]

The senior leadership team should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 3-star SAIL rating. In the review of key care processes, OIG issued 10 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Deputy Director. Of the six areas of clinical operations reviewed, OIG noted findings in five. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. OIG found general compliance with requirements for protected peer reviews, utilization management, and patient safety. However, OIG noted a deficiency in credentialing and privileging.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy and that the facility complied with requirements for nurse documentation of transfer assessments/notes and provider documentation for emergent transfers. However, OIG identified deficiencies in data collection and reporting, transfer documentation, resident supervision, and communication with the accepting facility.

Environment of Care. OIG found compliance with requirements for environment of care deficiency tracking, safety, infection prevention, and privacy at the parent facility. Additionally, OIG found compliance with the performance indicators evaluated at the

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

representative community based outpatient clinic and in radiology areas. The locked mental health unit met requirements for most performance indicators reviewed. However, OIG identified deficiencies at the parent facility with environment of care rounds and training for locked mental health unit employees and Interdisciplinary Safety Inspection Team members.

High-Risk Processes Related to Moderate Sedation. OIG noted compliance with reporting and trending reversal agent use, pre-procedure assessments, informed consent and post-procedure documentation, discharge practices, and availability of equipment and medications. However, OIG identified a deficiency in training for staff who perform, assist with, or supervise moderate sedation procedures.

Long-Term Care Related to Community Nursing Home Oversight. OIG found compliance with Community Nursing Home Oversight Committee requirements, program integration, hand-off documentation, and annual reviews. However, OIG identified a deficiency with clinical visits for patients residing in community nursing homes.

Summary

In the review of key care processes, OIG issued 10 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Deputy Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 46-47, and the responses within the body of the report for the full text of the Directors' comments.) OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General for
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Purpose and Scope

Purpose

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

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home Oversight (see Figure 1).

Figure 1. Fiscal Year 2017 Comprehensive Healthcare Inspection Program Review of Health Care Operations and Services

Source: VA OIG.

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

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[2] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[3] and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for May 12, 2014[4] through July 10, 2017, the date when an unannounced week-long site visit commenced. On August 30, 2017, OIG presented crime awareness briefings to 93 of the facility's 4,296 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

While onsite, OIG referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation. We conducted the inspection in accordance with Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

[2] Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.
[3] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.
[4] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

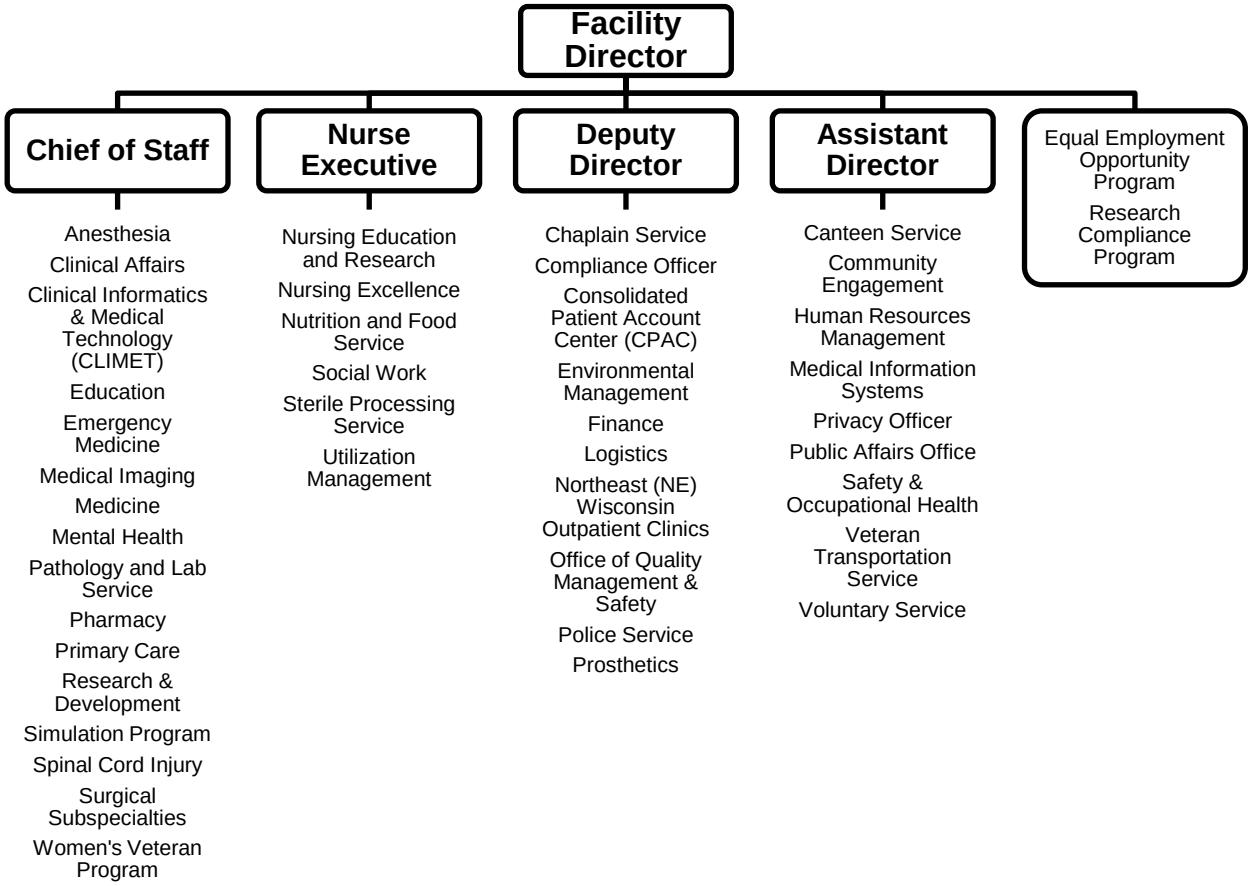
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and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

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

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

It is important to note that the Nurse Executive and Assistant Director positions were not permanently assigned at the time of OIG's onsite visit. Both positions had been vacant since April 2017; however, OIG was informed by facility managers after the onsite visit that the Nurse Executive position was filled on September 3, 2017, and the Assistant Director position was filled on October 1, 2017. With these two exceptions, the executive leaders had been working together as a team since June 2016.

Figure 2. Facility Organizational Chart



Source: Clement J. Zablocki VA Medical Center (received July 25, 2017).

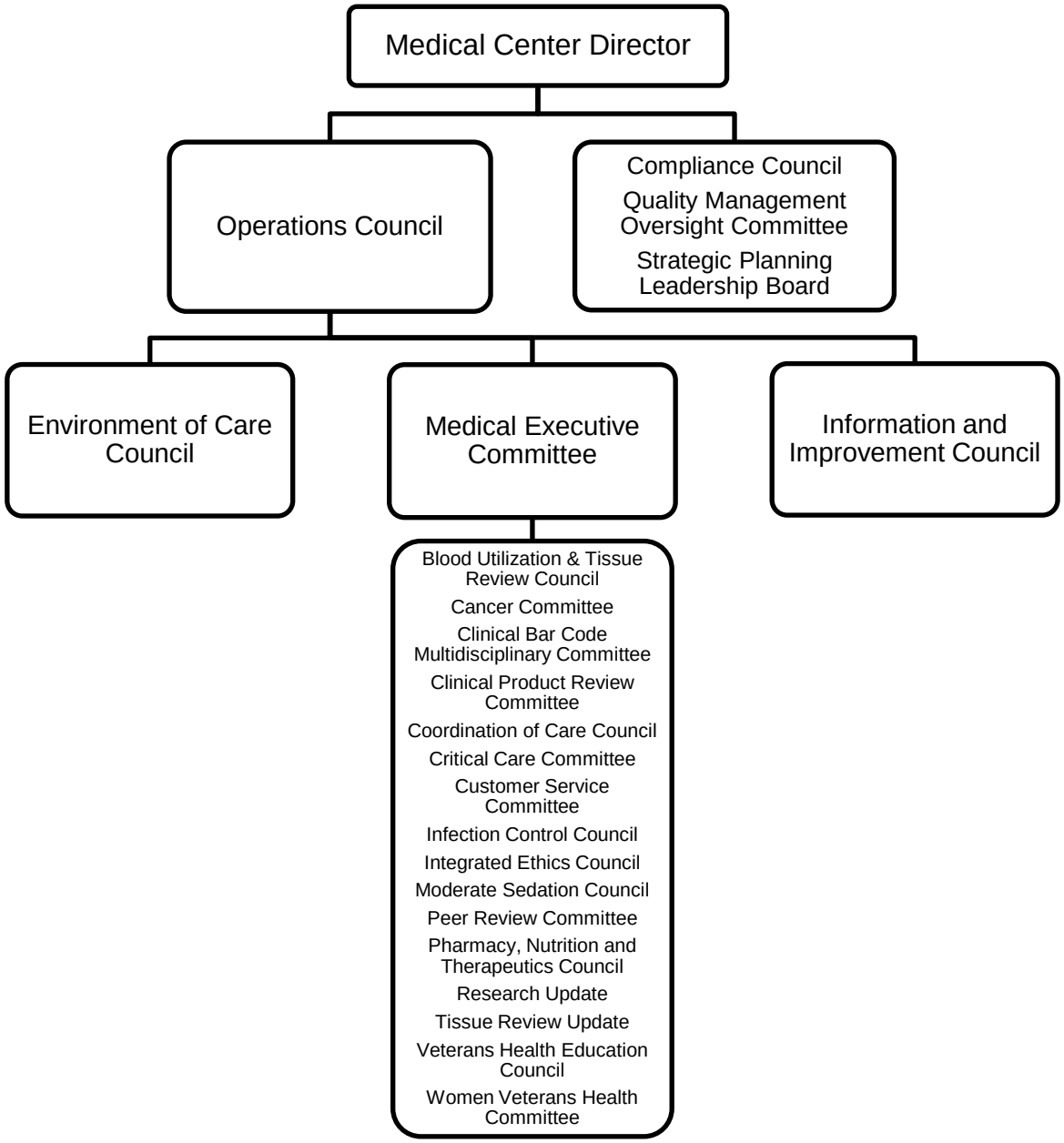
To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Deputy Director, Chief of Staff, and Acting Nurse Executive regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance.

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

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the facility's Operations Council, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Operations Council also oversees various working committees, such as the Medical

Executive Committee, EOC Council, and Information and Improvement Council. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: Clement J. Zablocki VA Medical Center (received July 25, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. Facility employee survey results (Facility Average) were similar to the VHA average while one of the facility leaders' results (Director's office average) was rated above the VHA and facility average and the other was rated below.[5] All four patient survey results reflected higher care ratings than the VHA average. In all, both employees and patients appear generally satisfied with the leadership and care provided.

Table 1. Survey Results on Employee and Patient Attitudes toward Facility Leadership (October 1, 2015 through September 30, 2016)

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[6]
All Employee Survey[7] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.4	3.6
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	65.2	61.2
Survey of Healthcare Experiences of Patients (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of "Definitely Yes" responses.	65.8	72.6	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.8	88.5	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	79.7	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	79.4	

[5] OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.
[6] Rating is based on responses by employees who report to the Director.
[7] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

Accreditation/For-Cause[8] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[9] all recommendations for improvement as listed in Table 2.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[10] and College of American Pathologists,[11] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute,[12] conducted an inspection of the facility's Community Living Center, and the Paralyzed Veterans of America also conducted an inspection of the facility's spinal cord injury/disease unit and related services.[13]

[8] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.
[9] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.
[10] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.
[11] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.
[12] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.
[13] The Paralyzed Veterans of America inspection took place September 26–27, 2017. This Veteran Service Organization review does not result in accreditation status.

Table 2. Office of Inspector General Inspections/Joint Commission Surveys

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin, August 12, 2014)*	May 2014	11	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin, August 12, 2014)*	June 2014	7	0
TJC[14]			
• Extension–New Service	August 2014	0	Not Applicable
• Special Unannounced Event[15]	June 2015	1	0
• Regular	October 2015		0
o Hospital Accreditation		17	
o Nursing Care Center Accreditation		1	
o Behavioral Health Care Accreditation		1	
o Home Care Accreditation		2	
• For-Cause	November 2016	0	Not applicable

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

[15] TJC conducted special focused surveys of VHA organizations and selected CBOCs from October 2014 to September 2015 at VHA's request in response to whistleblower accounts of improprieties and delays in patient care at the Phoenix VA Health Care System. The Clement J. Zablocki VA Medical Center was surveyed as part of this VHA review.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous May 2014 Combined Assessment Program and Community Based Outpatient Clinic and Primary Care (PC) review inspections through the week of July 10, 2017.

Table 3. Summary of Selected Organizational Risk Factors[16] (May 2014 to July 10, 2017)

Factor	Number of Occurrences
Sentinel Events[17]	6
Institutional Disclosures[18]	20
Large-Scale Disclosures[19]	0

[16] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Clement J. Zablocki VA Medical Center is a high-complexity (1a) affiliated facility as described in Appendix B.)
[17] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.
[18] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.
[19] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[20] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

Table 4. October 1, 2015 through September 30, 2016, Patient Safety Indicator Data

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 12	Facility
Pressure Ulcers	0.55	0.65	1.25
Death among surgical inpatients with serious treatable conditions	103.31	101.91	152.17
Iatrogenic Pneumothorax	0.20	0.12	0
Central Venous Catheter-Related Bloodstream Infection	0.12	0	0
In Hospital Fall with Hip Fracture	0.08	0	0
Perioperative Hemorrhage or Hematoma	2.59	4.40	8.13
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	2.99	4.68
Postoperative Respiratory Failure	6.31	4.71	5.43
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	3.80	7.11
Postoperative Sepsis	4.45	4.10	6.16
Postoperative Wound Dehiscence	0.65	0	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0.54	1.92

Source: VHA Support Service Center.

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

Seven of the 12 Patient Safety Indicator measures (pressure ulcers, death among surgical inpatients with serious treatable conditions, perioperative hemorrhage or hematoma, postoperative acute kidney injury requiring dialysis, perioperative pulmonary embolism or deep vein thrombosis, postoperative sepsis, and unrecognized abdominopelvic accidental puncture/laceration) show an observed rate per 1,000 hospital discharges in excess of the observed rates for Veterans Integrated Service Network (VISN) 12 and VHA. Facility managers acknowledged that complication rates were a measure for which facility managers are implementing action plans for improvement. Facility managers also acknowledged that the results for two of the seven measures (postoperative acute kidney injury requiring dialysis and postoperative sepsis) were correct as shown on Table 4. However, for the remaining measures, leaders identified provider documentation and staff coding errors as contributing factors for the results of these measures being higher than the observed rates for VISN 12 and VHA. Although facility managers reported that correction of documentation and coding errors would not have reduced the facility's observed rates to below VHA averages, facility managers reported continuing efforts to review and

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

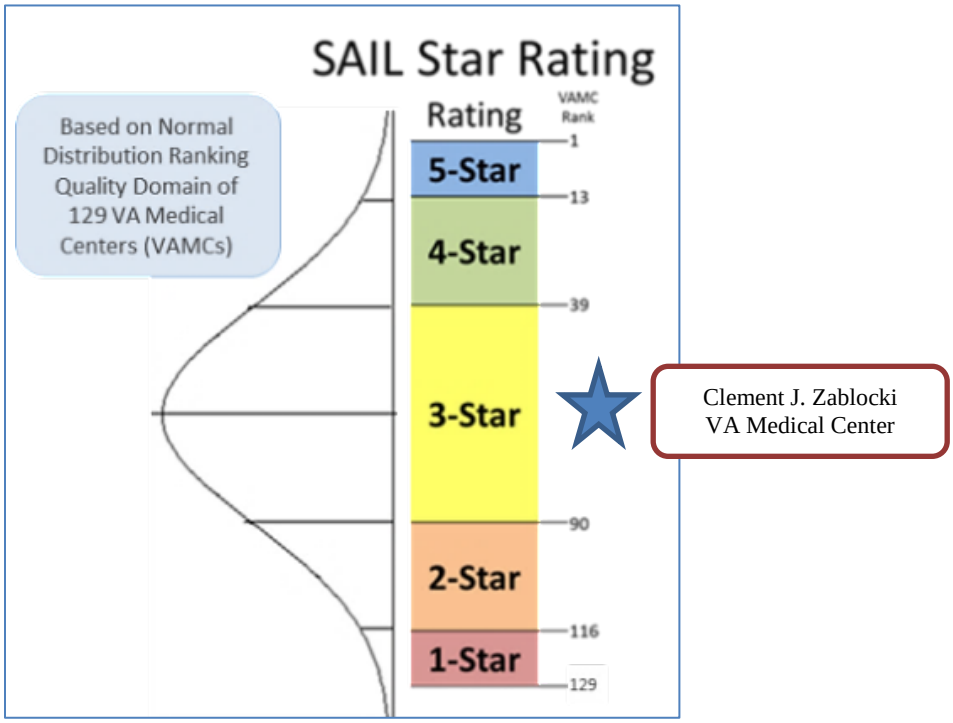
implement evidence-based practices and procedures to avoid complications and to educate staff on documentation and coding practices.

Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[21] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[22]

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of September 30, 2016, the Clement J. Zablocki VA Medical Center received an interim rating of 3 stars for overall quality. This means the facility is in the 3rd quintile (30–70 percent range). Since our site visit, updated data as of June 30, 2017, indicates that the facility has remained at 3 stars for overall quality.

[21] The model is derived from the Thomson Reuters Top Health Systems Study.
[22] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146

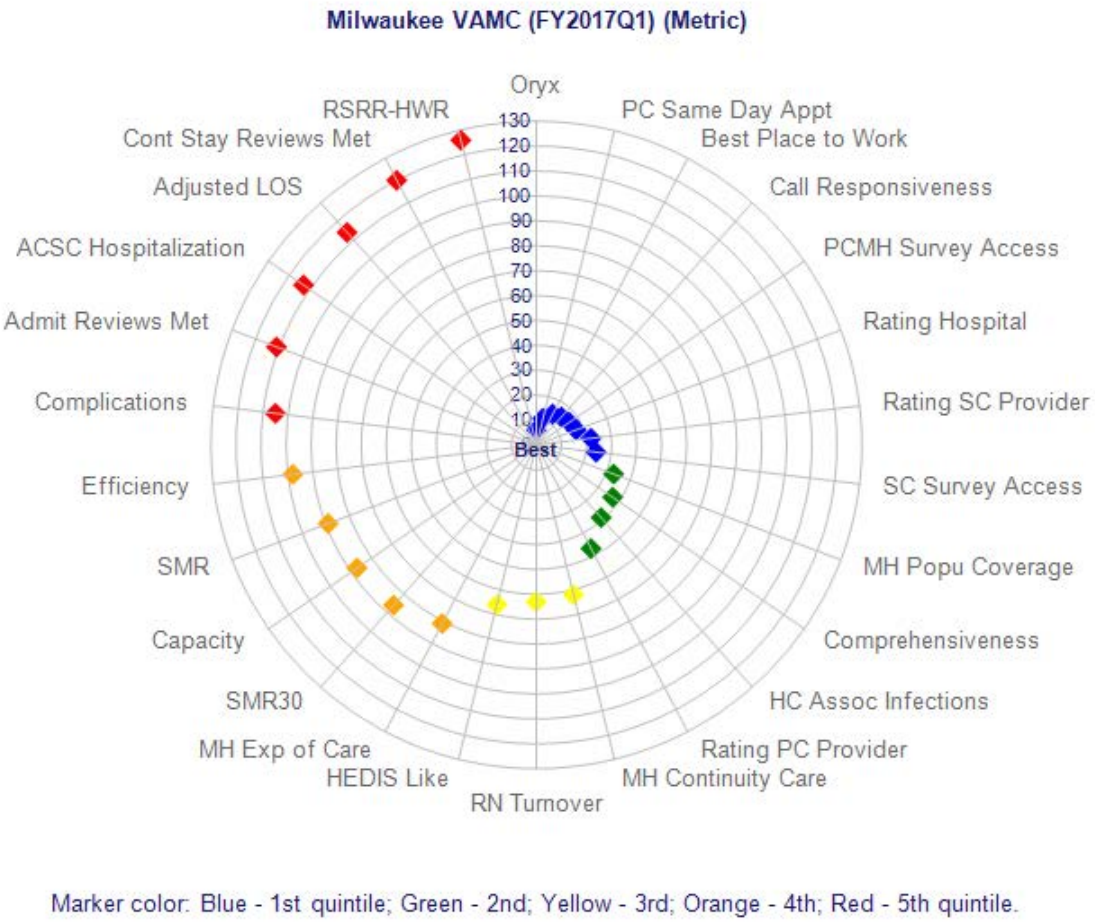
Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)



Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of December 31, 2016. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, PC Same Day Appointment (Appt), Best Place to Work, and Healthcare-Associated (HC Assoc) Infections). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Capacity, Complications, and 30-Day Risk Standardized Readmission Rate [RSRR] – Hospital-Wide Readmission [HWR]).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2016)



Source: VHA Support Service Center.

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

Conclusions. The facility currently has generally stable executive leadership and active engagement with employees and patients as evidenced by high satisfaction scores. The senior leadership team has opportunities to improve patient safety, quality care, and perceptions about facility leadership. OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results identified multiple organizational risk factors that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.[23] Additionally, the senior leadership team leaders should continue to take actions to improve care and performance of these metrics, particularly Quality of Care and Efficiency metrics likely contributing to the current 3-star SAIL ranking.

[23] OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk. OIG is using it as "a way to understand the similarities and differences between the top and bottom performers" within the VHA system.

Quality, Safety, and Value

One of VA's strategies is to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and efficiency.[24] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities.

The purpose of this review was to determine whether the facility complied with key QSV program requirements.[a] To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review[25] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[26]
5. Patient safety incident reporting and root cause analyses

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, root cause analyses, and other relevant documents.

The list below shows the performance indicators for each of the following QSV program activities.

- Senior-level committee responsible for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the Facility Director
  - Reviewed aggregated data routinely
- Protected peer reviews
  - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Resulted in implementation of Peer Review Committee recommended improvement actions

[24] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[25] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.
[26] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[27] data review
  - Indicated a Focused Professional Practice Evaluation[28]
- UM personnel
  - Completed at least 75 percent of all required inpatient reviews
  - Documented Physician UM Advisors' decisions in the National UM Integration database
  - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight root cause analyses
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

Conclusions. Generally, OIG found that senior managers were engaged with QSV activities, and when opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring for effectiveness. OIG found general compliance with requirements for protected peer reviews, UM, and patient safety. However, OIG identified the following deficiency in credentialing and privileging that warranted a recommendation for improvement.

Credentialing and Privileging. VHA requires clinical managers to review OPPE data every 6 months. The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. Nine of the 25 profiles did not contain evidence that clinical managers reviewed OPPE data every 6 months for these licensed independent practitioners. Managers stated that maintaining provider profiles was not high priority, and administrative staffing shortages contributed to the breakdown of the OPPE processes.

Recommendation

1. The Chief of Staff ensures clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and monitors the managers' compliance.

[27] OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.
[28] Focused Professional Practice Evaluation is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility. It typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges. The Focused Professional Practice Evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

Facility Concurred.

Target date for completion: September 30, 2018

Facility response: The Chief of Staff, through the Credentialing and Privileging Office, will implement and monitor an audit process as a component of provider recredentialing. This process will require the monthly submission of OPPE review documentation by clinical leaders to the Credentialing and Privileging Office for review by the Professional Standards Board. OPPE data will be monitored monthly for all LIPs until 90% compliance is achieved, and then quarterly for sustainment. The facility Chief of Staff will communicate the requirement as a reminder to the Service Chiefs as this audit process is implemented.

Medication Management: Anticoagulation Therapy

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[29] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC's National Patient Safety Goal (3.05.01) focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

Within medication management, OIG selected a special focus on anticoagulation therapy given its risk and common usage among veterans. The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[b]

OIG reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 37 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

- Development and implementation of anticoagulation management policies
- Algorithms, protocols, or standardized care processes
  - Initiation and maintenance of warfarin
  - Management of anticoagulants before, during, and after procedures
  - Use of weight-based, unfractionated heparin
- Provision of a direct telephone number for patient anticoagulation-related calls
- Designation of a physician anticoagulation program champion
- Risk minimization of dosing errors
- Routine review of quality assurance data
- Provision of transition follow-up and education for patients with newly prescribed anticoagulant medications
- Laboratory testing
  - Prior to initiating anticoagulant medications
  - During anticoagulation treatment
- Documentation of justification/rationale for prescribing the anticoagulant when laboratory values did not meet selected criteria
- Competency assessments for employees actively involved in the anticoagulant program

[29] Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

Conclusion. Generally, the facility met requirements with the above performance indicators. OIG made no recommendations.

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care also involves implementing a plan of care and avoiding unnecessary duplication of services. OIG selected a special focus on inter-facility transfers because they are frequently necessary to provide patients with access to specific providers or services. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately under circumstances that provide maximum safety for patients and comply with applicable standards.

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[c]

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 26 randomly selected patients who were transferred out of facility inpatient beds or the Emergency Department to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

- Development and implementation of patient transfer policy
- Collection and reporting of data about transfers out of the facility
- Completion of VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer
  - Date of transfer
  - Patient or surrogate informed consent
  - Medical and/or behavioral stability
  - Identification of transferring and receiving provider or designee
  - Details of the reason for transfer or proposed level of care needed
- Documentation by acceptable designees in the absence of staff/attending physicians
  - Staff/attending physician approval
  - Staff/attending physician countersignature on the transfer note
- Nurse documentation of transfer assessments/notes
- Provider documentation for emergent transfers
  - Patient stability for transfer
  - Provision of all medical care within the facility's capacity
- Communication with the accepting facility
  - Available history
  - Observations, signs, symptoms, and preliminary diagnoses
  - Results of diagnostic studies and tests

Conclusions. OIG noted that the facility developed and implemented a patient transfer policy and that the facility complied with requirements for nurse documentation of transfer assessments/notes and provider documentation for emergent transfers. However, OIG identified the following deficiencies in data collection and reporting,

transfer documentation, resident supervision, and communication with the accepting facility that warranted recommendations for improvement.

Data Collection and Reporting. VHA requires facilities to collect and report data for patient inter-facility transfers, such as date of transfer, documentation of informed consent and medical or behavioral stability, and identification of transferring and receiving provider, as part of VHA's quality management program. The collection and reporting of data allows the facility to analyze and improve the inter-facility transfer process to maximize patient safety. There was no evidence the facility collected and reported data about transfers out of the facility. Staff acknowledged that they did not have a data collection process or a reporting structure related to patient transfers to another facility; facility managers have chartered a committee which will collect and report patient access and flow data to the Medical Executive Committee for leadership oversight.

Recommendation

2. The Facility Director ensures inter-facility patient transfer data are collected and reported to the Medical Executive Committee and monitors compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: The facility leadership chartered a new committee, the Facility Flow Committee. The Bed Coordinator/Patient Flow Program Manager and the Coordination of Care Council Chair serve as team leaders and facilitators of the Facility Flow Committee. The Facility Flow Committee collects and monitors monthly inter-facility transfer data, addresses improvement opportunities, and reports to the Medical Executive Committee (MEC) on a quarterly basis. Thirty records or 100% if less than 30 transfers per month will be reviewed until 90% compliance is achieved for three consecutive months.

Transfer Documentation. VHA requires that transferring clinicians complete VA Form 10-2649A and/or transfer/progress notes that include all required elements prior to or within a few hours after the transfer. This ensures that patients are part of the decision-making process and that receiving providers are aware of patients' needs and level of care after transfer. Clinician transfer documentation did not include evidence of patient or surrogate informed consent in 7 of applicable 25 EHRs or identification of transferring and receiving provider or designee in 4 of the 26 EHRs. Staff reported that they complete a paper copy of VA Form 10-2649A and informed consent with every transfer; however, program managers stated that administrative employees did not consistently scan transfer documents in a timely manner due to other priorities.

Recommendation

3. The Chief of Staff ensures that for patients transferred out of the facility, clinicians consistently include documentation of patient or surrogate informed consent and

identification of transferring and receiving provider or designee in transfer documentation and monitors the clinicians' compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: The facility developed a new CPRS template that includes and prompts a Veteran's care team to document all required elements involved in inter-facility transfers, including informed consent of the Veteran or surrogate and the transferring/receiving provider names. The CPRS template was implemented November 1, 2017. The Flow Committee will report monthly data to the MEC on a quarterly basis ensuring the 10-2649A is completed. Thirty records or 100% if less than 30 transfers per month will be reviewed until 90% compliance is achieved for three consecutive months.

Resident Supervision. VHA requires that when staff/attending physicians do not write transfer notes, acceptable designees obtain and document staff/attending approval and obtain countersignature on the transfer note. This ensures the decision to transfer patients out of VHA facilities was made by a credentialed provider. In two of the six applicable EHRs, transfer notes written by acceptable designees did not document staff/attending physician approval, and three of the six applicable EHRs did not include a staff/attending physician countersignature. Staff reported that they did not have a process to monitor appropriate staff/attending physician approval and countersignature on transfer notes written by acceptable designees.

Recommendation

4. The Chief of Staff ensures that transfer notes written by acceptable designees document staff/attending physician approval and include a staff/attending physician countersignature and monitors acceptable designees' compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: The facility developed a new CPRS template that includes and prompts a Veteran's care team to document all required elements involved in inter-facility transfers, including staff/attending physician signature. The Facility Flow Committee will collect and monitor inter-facility transfer data monthly ensuring compliance with staff/attending physician signature for all inter-facility transfers and report to the MEC on a quarterly basis. Thirty records or 100% if less than 30 transfers per month will be reviewed until 90% compliance is achieved for three consecutive months.

Communication with Accepting Facility. VHA requires that communication with the accepting facility or documentation sent for inter-facility patient transfers include pertinent patient information. Communication of relevant information ensures continuity

of care for patients transferred out of VHA facilities. In 3 of the 13 applicable EHRs, OIG found no evidence that providers sent or communicated pertinent patient information with the accepting facility. Staff knew the requirements and expressed confidence that results of diagnostic studies and tests are sent to the accepting facility; however, they failed to consistently document these actions.

Recommendation

5. The Chief of Staff ensures that for patients transferred out of the facility, providers document sending or communicating to the accepting facility pertinent patient information and monitors providers' compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: The facility developed a new CPRS template that includes and prompts a Veteran's care team to document all required elements involved in inter-facility transfers to include documentation that pertinent patient information was sent or communicated to the accepting facility. The Facility Flow Committee will monitor inter-facility transfer data monthly. Thirty records or 100% if less than 30 transfer per month will be reviewed until 90% compliance is achieved for three consecutive months. The Facility Flow Committee will report quarterly to the MEC.

Environment of Care

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. OIG also determined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on Radiology Service and the locked mental health (MH) unit.[d]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[30] Although an integral part of health care, fluoroscopic imaging can deliver large doses of radiation to patients and employees. Large doses of radiation are known to increase the incidence of cancer and can cause fetal abnormalities.

VHA provides various MH services to patients with acute and severe emotional and/or behavioral symptoms. These services are often provided in an inpatient setting.[31] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected the ambulatory procedure center; the post-anesthesia recovery, intensive care (2 CS), medicine (6 CN), surgery (6-S), and locked MH units; the Community Living Center (9 CN), the Emergency Department, Radiology Service, the Red PC clinic, and the women's health clinic. OIG also inspected the Union Grove community based outpatient clinic. Additionally, OIG reviewed relevant documents and 16 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

- EOC Deficiency Tracking
- EOC Rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

[30] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[31] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

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

Radiology
- Safe use of fluoroscopy equipment
- Environmental safety
- Infection prevention
- Medication safety and security
- Radiology equipment inspection
- Availability of medical equipment and supplies
- Maintenance of radiological equipment

Locked Mental Health Unit
- MH EOC inspections
- Environmental suicide hazard identification and abatement
- Environmental safety
- Infection prevention
- Employee training on MH environmental hazards
- Availability of medical equipment and supplies

Conclusions. Generally, OIG noted compliance with requirements for EOC deficiency tracking and privacy at the parent facility. OIG also found compliance with the performance indicators evaluated at the representative community based outpatient clinic and in radiology areas. The locked MH unit had MH EOC inspection and environmental suicide hazard identification and abatement processes in place and met requirements for the safety and infection prevention indicators OIG evaluated. OIG did not note any issues with the availability of medical equipment and supplies. OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds. VHA requires EOC rounds to be conducted at a minimum of once per FY in non-patient care areas and twice per FY in patient care areas. This ensures a safe, clean, and functional health care environment. OIG reviewed records for FY 2016 facility EOC rounds and observed that 61 of 113 facility areas (54 percent) were not inspected at the required frequency. Facility managers believed that they were meeting requirements for conducting the required number of inspection; however, they failed to inspect all areas at the required frequency.

Recommendation

6. The Deputy Director ensures all areas of the facility are inspected at the required frequency and monitors compliance.

Facility Concurred.

Target date for completion. October 15, 2018

Facility Response: The facility is addressing inaccuracies in the Performance Logic Tool that are (incorrectly) creating duplicative reporting requirements. As of October 1, 2017, EOC rounds were scheduled in accordance with VHA Directive requirements. The location of rounds is captured correctly in the Performance Logic Tool to ensure 90% compliance for core team member designees. The Environment of Care Committee will receive monthly updates regarding areas scheduled for rounding to ensure 90% of areas are inspected as required for the first 2 quarters FY 18.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[32] Six of 13 core team members did not consistently attend EOC rounds. Staffing issues, vacancies, and staff's lack of awareness of requirements prevented participation by all required team members.

Recommendation

7. The Deputy Director ensures core team members consistently attend environment of care rounds and monitors compliance.

Facility Concurred.

Target date for completion. April 15, 2018

Facility Response: Attendance at the Environment of Care Rounds is tracked for each scheduled inspection. In the absence of a required EOC team member, a knowledgeable individual will be delegated as the representing inspector, as required by VHA Directive. Attendance data will be reported monthly at the Environment of Care (EOC) Committee to ensure 90% compliance with attendance by all required team members. Compliance and issues will be reported to the EOC Committee and addressed by the applicable leadership team member. This will occur on an ongoing basis.

Locked Mental Health Unit: Employee Training. VHA requires that locked MH unit employees and Interdisciplinary Safety Inspection Team members receive training on

[32] According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements.

the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist. This ensures employees and inspection team members possess the necessary knowledge and skills to perform inspections of the locked MH unit to ensure the safety of staff and patients, especially those patients at risk for suicide. Facility managers were unable to provide training records for any of the 16 selected locked MH unit employees and Interdisciplinary Safety Inspection Team members. Managers and staff claimed awareness of the requirements; however, they could not explain why training was not provided.

Recommendation

8. The Deputy Director ensures locked mental health unit employees and Interdisciplinary Safety Inspection Team members receive annual training on the identification and correction of environmental hazards, including the proper use of the Mental Health Environment of Care Checklist, and monitors compliance.

Facility Concurred.

Target date for completion. June 30, 2018

Facility Response: The Mental Health Division Quality Analyst, in collaboration with the Program Managers of the locked mental health unit, assigned the required training by January 18, 2018. The Mental Health Division is tracking compliance monthly until three consecutive months of 90% compliance is achieved. The Mental Health Division will report training compliance quarterly to the Mental Health Environment of Care workgroup on an ongoing basis.

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[33] Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patient's airway, spontaneous ventilations, or cardiovascular function. The administration of moderate sedation could lead to a range of serious adverse events, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death.[34]

Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and employee performance.[35] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[36] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[e]

OIG reviewed relevant documents, interviewed key employees, and inspected the interventional radiology, gastroenterology, cardiology, intensive care unit, and dental clinic procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 43 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The list below shows the performance indicators OIG reviewed.

- Reporting and trending the use of reversal agents in moderate sedation cases
- Performance of history and physical examinations and pre-sedation assessment within 30 calendar days prior to the moderate sedation procedure
- Re-evaluation of patients immediately before administration of moderate sedation
- Documentation of informed consent prior to the moderate sedation procedure

[33] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[34] VA National Center for Patient Safety. March 2015. Moderate Sedation Toolkit for Non-Anesthesiologists: Facilitator's Guide, Retrieved March 20, 2017 from: https://www.patientsafety.va.gov/docs/modSedationtoolkit/FacilitatorGuide.pdf.
[35] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.
[36] Per VA Corporate Data Warehouse data pull on February 22, 2017.

- Performance of timeout[37] prior to the moderate sedation procedure
- Post-procedure documentation
- Discharge practices
- Clinician training for moderate sedation
- Availability of equipment and medications in moderate sedation procedure areas

Conclusions. Generally, OIG found compliance with reporting and trending the use of reversal agents, pre-procedure assessments, informed consent and post-procedure documentation, discharge practices, and availability of equipment and medications. However, OIG identified a deficiency in moderate sedation training that warranted a recommendation for improvement.

Moderate Sedation Training. VHA requires that an individual who administers, monitors, or supervises moderate sedation must demonstrate successful completion of Talent Management System moderate sedation training. This ensures staff have demonstrated sufficient knowledge to care and respond to an adverse event for a patient receiving moderate sedation. Ten of the 15 employees' training records did not contain evidence of the required Talent Management System training. The facility used training that was created by its anesthesiology staff for the provider credentialing and privileging process. Facility managers stated that because the training aligned with the content in the required training, they considered it an acceptable substitute.

Recommendation

9. The Chief of Staff ensures staff who perform, assist with, or supervise moderate sedation procedures have current Talent Management System moderate sedation training and monitors their compliance.

Facility Concurred.

Target date for completion: April 30, 2018

Facility Response: The Chief of Staff, through the Credentialing and Privileging Office, made completion of TMS Module 32979 a requirement for Moderate Sedation privilege reappointment. All Licensed Independent Provider's (LIP's) who held Moderate Sedation privileges were informed of the TMS training requirement for reappointment by electronic mail on November 1, 2017. For LIPs who are not due for reappointment by April 30, 2018, TMS Module 32979 will be assigned by February 1, 2018, with a due date of April 30, 2018. The Moderate Sedation Committee will monitor monthly and report TMS Module 32979 completion rates to the Medical Executive Committee on a quarterly basis starting with the 1st Quarter Fiscal Year 2018 Medical Executive Committee report. Expected compliance will be 90%.

[37] A time out is the process of verifying correct patient, procedure, and procedure site/side. The procedure team (physician, nurses, and other support staff) also verifies that the patient has given consent for the procedure and that any specialty equipment needed is available. This is performed prior to the start of the procedure.

Long-Term Care: Community Nursing Home Oversight

Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their Quality Improvement Programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[38] Local oversight of CNHs is achieved through annual reviews and monthly visits.

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[f]

OIG interviewed key employees and reviewed relevant documents and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, OIG reviewed the EHRs of 33 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

- Implementation of a CNH Oversight Committee with representation by required disciplines and meetings at least quarterly
- Integration of CNH program into quality improvement program
- Documentation of hand-off for patients placed in CNHs outside catchment area
- Completion of CNH annual reviews by CNH Review Team
- Completion of exclusion review documentation when CNH annual reviews noted four or more exclusionary criteria.
- Documentation of social worker and registered nurse cyclical clinical visits

Conclusions. Generally, OIG noted compliance with CNH Oversight Committee requirements, program integration, hand-off documentation, and annual reviews. However, OIG identified a deficiency with clinical visits that warranted a recommendation for improvement.

Clinical Visits. VHA requires that every patient under contract in a nursing home must be visited by a social worker or registered nurse at least every 30 days (unless specific criteria allow an exception). Social workers and nurses alternate monthly visits, unless otherwise indicated by the patient's individualized visitation plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. Eleven of the 33 EHRs (33 percent) did not contain documentation of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy. Managers and staff knew the requirements, but staff availability and collateral duties prevented compliance.

[38] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures,* June 4, 2004.

Recommendation

10. The Associate Director for Patient Care Services ensures social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitors the social workers' and registered nurses' compliance.

Facility Concurred.

Target date for completion: July 31, 2018

Facility Response: On December 1, 2017, workload/visit assignment adjustments were implemented within the CNH monitoring team to ensure cyclical clinical visits are made at least every 30 days as required by VHA policy. The Tracking Tool/Spreadsheet used by the program has been modified to provide closer oversight by management to ensure 90% compliance with all required CNH oversight visits. The Community Based Services Program Manager will monitor the interval between the visits on a monthly basis, track compliance, and intervene as needed; this will occur on an ongoing basis. Quarterly reports regarding compliance will be provided to the CNH Oversight Committee until 90% compliance attained for 3 consecutive months.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Ten OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Deputy Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[39] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data every 6 months.	None
Medication Management	• Anticoagulation management policies and procedures • Management of patients receiving new orders for anticoagulants o Prior to treatment o During treatment • Ongoing evaluation of the anticoagulation program • Competency assessment	None	None

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Coordination of Care	• Transfer policies and procedures
	• Oversight of transfer process
	• EHR documentation
	  o Non-emergent transfers
	  o Emergent transfers
		• Providers consistently include documentation of patient or surrogate informed consent and identification of the transferring and receiving provider when patients are transferred out of the facility.
		• Transfer notes written by acceptable designees document staff/attending physician approval and include a staff/attending physician countersignature.
		• Providers document sending or communicating to the accepting facility pertinent patient information.
			• Inter-facility patient transfer data are collected and reported to the Medical Executive Committee.

Environment of Care	• Parent facility
	  o EOC deficiency tracking and rounds
	  o General Safety
	  o Infection prevention
	  o Environmental cleanliness
	  o Exam room privacy
	  o Availability of feminine hygiene products and medical equipment and supplies
	• Community Based Outpatient Clinic
	  o General safety
	  o Infection prevention
	  o Environmental cleanliness
	  o Medication safety and security
	  o Privacy
	  o Availability of feminine hygiene products and medical equipment and supplies
	  o IT network room security
		None	• All areas of the facility are inspected at the required frequency.
			• Core team members consistently attend environment of care rounds.
			• Locked MH unit employees and Interdisciplinary Safety Inspection Team members receive annual training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care (continued)	• Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention o Availability of medical equipment and supplies		
High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting • Patient safety and documentation o Prior to procedure o After procedure • Staff training and competency • Monitoring equipment and emergency management	• Staff who perform, assist with, or supervise moderate sedation procedures have current Talent Management System moderate sedation training.	
Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration • EHR documentation o Patient hand-off o Clinical visits • CNH annual reviews	• Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by VHA policy.	

Facility Profile

The table below provides general background information for this high-complexity (1a)[40] affiliated[41] facility reporting to VISN 12.

Table 5. Facility Profile for Milwaukee (695) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[42]	Facility Data FY 2015[43]	Facility Data FY 2016[44]
Total Medical Care Budget in Millions	$570.8	$602.7	$618.6
Number of:			
• **Unique Patients**	63,452	64,188	63,845
• **Outpatient Visits**	754,550	785,475	816,245
• **Unique Employees**[45]	3,176	3,314	3,564
Type and Number of Operating Beds:			
• **Acute**	162	162	162
• **Mental Health**	34	34	34
• **Community Living Center**	113	113	113
• **Domiciliary**	205	189	189
Average Daily Census:			
• **Acute**	125	112	113
• **Mental Health**	22	22	21
• **Community Living Center**	83	93	93
• **Domiciliary**	136	125	119

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

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

[40] VHA medical centers are classified according to a facility complexity model; 1a designation indicates a facility with high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs. Retrieved September 14, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx
[41] Associated with a medical residency program.
[42] October 1, 2013 through September 30, 2014.
[43] October 1, 2014 through September 30, 2015.
[44] October 1, 2015 through September 30, 2016.
[45] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[46]

The VA outpatient clinics in communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 6 provides information relative to each of the clinics.

Table 6. VA Outpatient Clinic Workload/Encounters[47] and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[48] Provided	Diagnostic Services[49] Provided	Ancillary Services[50] Provided
Appleton, WI	695BY	31,869	11,513	Dermatology Endocrinology Pulmonary/ Respiratory Disease Rheumatology Poly-Trauma Anesthesia Eye Podiatry Vascular	EKG Laboratory & Pathology Radiology	Nutrition Pharmacy Social Work Weight Management
Union Grove, WI	695GA	8,175	3,707	Dermatology Eye	EKG	Pharmacy Weight Management
Cleveland, WI	695GC	7,545	2,654	Dermatology Endocrinology Rheumatology Anesthesia Eye Vascular	EKG	Nutrition Weight Management

[46] Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Milwaukee, WI (695QA), as no workload/encounters or services were reported.
[47] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[48] Specialty care services refer to non-PC and non-MH services provided by a physician.
[49] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[50] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Green Bay, WI	695GD	29,550	8,463	Gastroenterology Cardiology Dermatology Endocrinology Hematology/ Oncology Nephrology Pulmonary/ Respiratory Disease Rheumatology Poly-Trauma Anesthesia Eye ENT General Surgery Gynecology Orthopedics Podiatry Urology Vascular	EKG Laboratory & Pathology Radiology	Dental Nutrition Pharmacy Prosthetics Social Work Weight Management

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

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

VHA Policies Beyond Recertification Dates

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

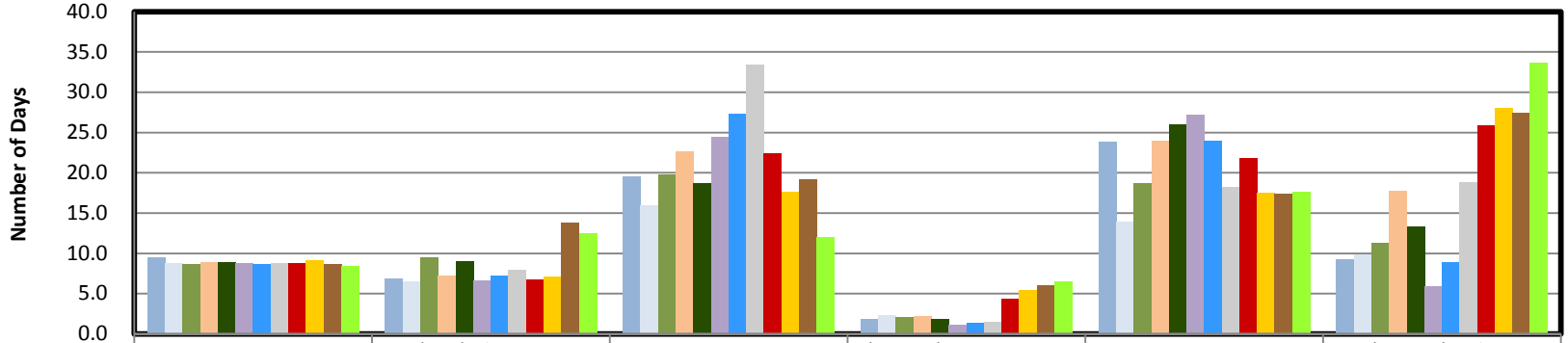
1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
3. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[51] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[52] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[53]

[51] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[52] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[53] Ibid.

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days

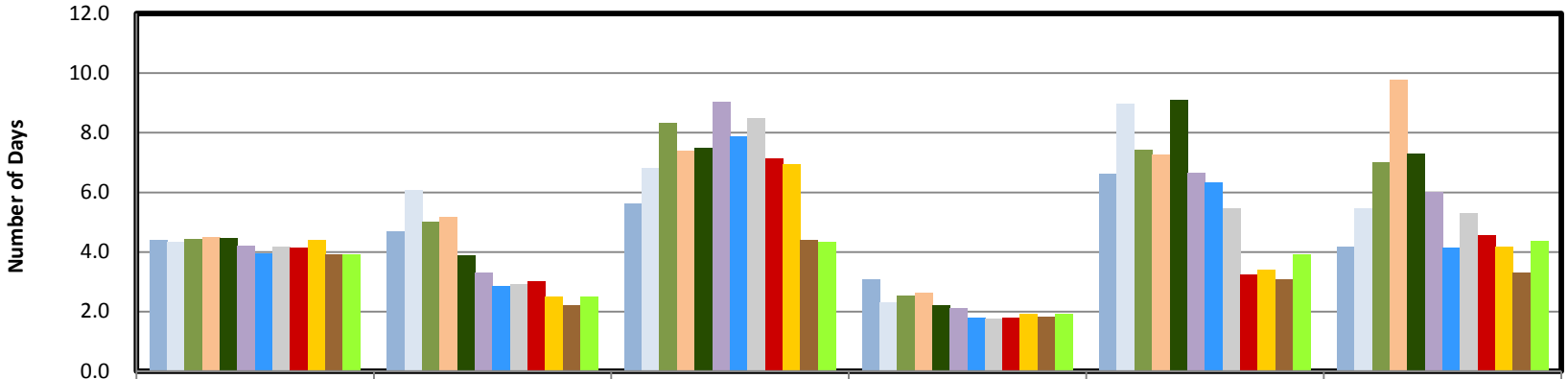


	VHA Total	(695) Clement J Zablocki VAMC	(695BY) Appleton	(695GA) Union Grove WI	(695GC) Cleveland	(695GD) Milo C Huempfner VA OPC
APR-FY16	9.5	6.9	19.5	1.9	23.8	9.2
MAY-FY16	8.7	6.5	15.9	2.3	13.9	9.9
JUN-FY16	8.7	9.5	19.7	2.0	18.7	11.3
JUL-FY16	8.9	7.2	22.7	2.2	24.0	17.7
AUG-FY16	8.9	9.1	18.7	1.9	26.0	13.3
SEP-FY16	8.7	6.7	24.4	1.2	27.2	5.9
OCT-FY17	8.7	7.2	27.3	1.3	24.0	8.9
NOV-FY17	8.8	8.0	33.4	1.5	18.3	18.8
DEC-FY17	8.8	6.7	22.4	4.4	21.8	25.9
JAN-FY17	9.2	7.1	17.6	5.4	17.5	28.1
FEB-FY17	8.7	13.9	19.1	6.1	17.4	27.4
MAR-FY17	8.4	12.6	12.0	6.5	17.7	33.6

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. We have on file the facility's explanation for the increasing wait times for the Appleton CBOC and the Milo C. Huempfner VA Outpatient Clinic.

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

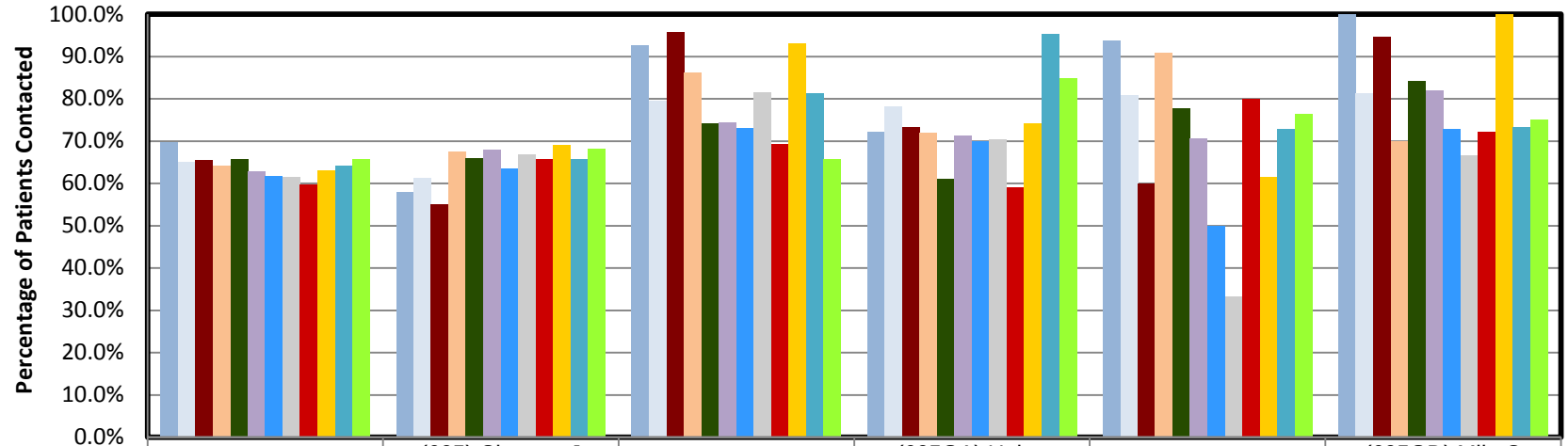


	VHA Total	(695) Clement J Zablocki VAMC	(695BY) Appleton	(695GA) Union Grove WI	(695GC) Cleveland	(695GD) Milo C Huempfner VA OPC
APR-FY16	4.4	4.7	5.6	3.1	6.6	4.2
MAY-FY16	4.3	6.1	6.8	2.3	9.0	5.5
JUN-FY16	4.4	5.0	8.3	2.5	7.4	7.0
JUL-FY16	4.5	5.2	7.4	2.6	7.3	9.8
AUG-FY16	4.5	3.9	7.5	2.2	9.1	7.3
SEP-FY16	4.2	3.3	9.0	2.1	6.7	6.0
OCT-FY17	3.9	2.9	7.9	1.8	6.3	4.1
NOV-FY17	4.2	2.9	8.5	1.7	5.5	5.3
DEC-FY17	4.1	3.0	7.1	1.8	3.2	4.6
JAN-FY17	4.4	2.5	6.9	1.9	3.4	4.2
FEB-FY17	3.9	2.2	4.4	1.8	3.1	3.3
MAR-FY17	3.9	2.5	4.3	1.9	3.9	4.4

Source: VHA Support Service Center.

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

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

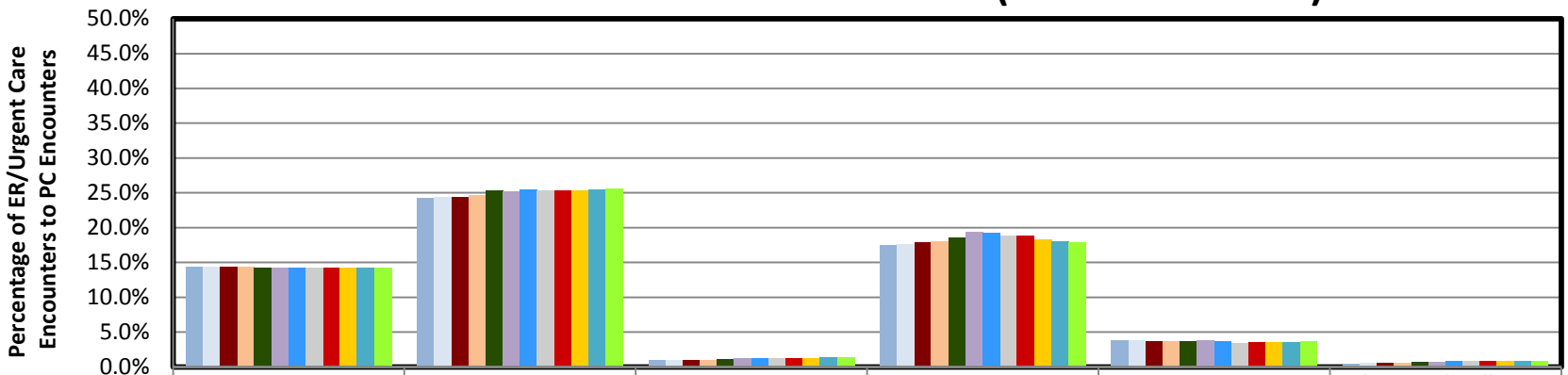


	VHA Total	(695) Clement J Zablocki VAMC	(695BY) Appleton	(695GA) Union Grove WI	(695GC) Cleveland	(695GD) Milo C Huempfner VA OPC
APR-FY16	69.7%	58.0%	92.6%	72.2%	93.8%	100.0%
MAY-FY16	65.0%	61.2%	79.4%	78.1%	81.0%	81.3%
JUN-FY16	65.5%	55.0%	95.7%	73.3%	60.0%	94.7%
JUL-FY16	64.3%	67.5%	86.2%	72.0%	90.9%	70.0%
AUG-FY16	65.7%	65.9%	74.2%	61.1%	77.8%	84.2%
SEP-FY16	62.9%	67.9%	74.4%	71.4%	70.6%	81.8%
OCT-FY17	61.8%	63.5%	73.0%	70.0%	50.0%	72.7%
NOV-FY17	61.4%	66.8%	81.5%	70.4%	33.3%	66.7%
DEC-FY17	59.8%	65.7%	69.2%	59.1%	80.0%	72.2%
JAN-FY17	63.0%	69.0%	93.1%	74.1%	61.5%	100.0%
FEB-FY17	64.2%	65.7%	81.3%	95.2%	72.7%	73.3%
MAR-FY17	65.6%	68.3%	65.8%	84.8%	76.5%	75.0%

Source: VHA Support Service Center.

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

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



	VHA Total	(695) Clement J Zablocki VAMC	(695BY) Appleton	(695GA) Union Grove WI	(695GC) Cleveland	(695GD) Milo C Huempfner VA OPC
APR-FY16	14.4%	24.3%	1.0%	17.5%	3.8%	0.5%
MAY-FY16	14.4%	24.4%	1.0%	17.6%	3.8%	0.6%
JUN-FY16	14.4%	24.4%	1.0%	17.9%	3.7%	0.6%
JUL-FY16	14.4%	24.7%	1.0%	18.1%	3.7%	0.6%
AUG-FY16	14.3%	25.3%	1.1%	18.6%	3.7%	0.7%
SEP-FY16	14.2%	25.2%	1.2%	19.4%	3.8%	0.8%
OCT-FY17	14.3%	25.5%	1.3%	19.3%	3.7%	0.8%
NOV-FY17	14.3%	25.4%	1.3%	18.9%	3.4%	0.9%
DEC-FY17	14.2%	25.3%	1.3%	18.8%	3.6%	0.8%
JAN-FY17	14.3%	25.3%	1.3%	18.4%	3.5%	0.8%
FEB-FY17	14.3%	25.5%	1.4%	18.0%	3.5%	0.9%
MAR-FY17	14.2%	25.7%	1.4%	17.9%	3.7%	0.8%

Source: VHA Support Service Center.

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

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

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

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
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower 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
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value

Measure	Definition	Desired Direction
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-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center.

Relevant OIG Reports

May 1, 2014 through February 1, 2018[54]

Healthcare Inspection – Review of Opioid Prescribing Practices, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin
8/22/2017 | 15-02156-346 | Summary | Report

Healthcare Inspection – Management of Mental Health Care Concerns, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin
7/27/2017 | 16-00748-319 | Summary | Report

Review of VHA Care and Privacy Standards for Women Veterans
6/19/2017 | 15-03303-206 | Summary | Report

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | 15-01579-457 | Summary | Report

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/18/2015 | 15-01297-368 | Summary | Report

Combined Assessment Program Review of the Clement J. Zablocki VA Medical Center
8/12/2014 | 14-01291-241 | Summary | Report

Community Based Outpatient Clinic and Primary Clinic Reviews at Clement J. Zablocki VA Medical Center
8/12/2014 | 14-00923-237 | Summary | Report

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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: February 6, 2018

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

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

To: Director, Atlanta Office of Healthcare Inspections (54AT)

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

1. I have reviewed the document and concur with the response as submitted.

2. If additional information is needed, please contact the Quality Manager.

Renee Oshinski

Renee Oshinski
Network Director, VISN 12

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 6, 2018

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

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

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

1. I have reviewed the draft report of the Office of Inspector General's Comprehensive Healthcare Inspection Program review of the Clement J. Zablocki VA Medical Center. We concur with all recommendations.

2. Please see the attached response to the recommendations identified in the review.

3. I appreciate the opportunity for this review as a continuing process to improve care to our Veterans.

4. If additional information is needed, please contact our Quality Manager.

Daniel S. Zomchek, Ph.D., FACHE
Medical Center Director

OIG Contact and Staff Acknowledgments

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Other Contributors	Elizabeth Bullock Patricia Calvin, RN, MBA Limin Clegg, PhD Anita Pendleton, AAS Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, RN, MSN

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U.S. Senate: Tammy Baldwin, Ron Johnson
U.S. House of Representatives: Sean P. Duffy; Mike Gallagher; Glenn Grothman; Ron Kind; Gwen Moore; Mark Pocan; Paul Ryan; Jim Sensenbrenner, Jr.

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

Endnotes

[a] The references used for QSV were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] The references used for Medication Management: Anticoagulation Therapy included:
- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[c] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007. This directive was in effect during the timeframe of OIG's review but has been rescinded and replaced with VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[d] The references used for EOC included:
- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 7, 2017.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

[e] The references used for Moderate Sedation included:
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.

- TJC. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[f] The references used for CNH Oversight included:

- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program*, (Report No. 05-00266-39, December 13, 2007).

[g] The reference used for PACT Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: April 28, 2017.

[h] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.