
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 12-01337-267**

# Combined Assessment Program Review of the Tomah VA Medical Center Tomah, Wisconsin

**September 5, 2012**

**Washington, DC 20420**

## Why We Did This Review

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

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

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

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# Glossary

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

# Table of Contents

# Executive Summary: Combined Assessment Program Review of the Tomah VA Medical Center, Tomah, WI

**Review Purpose:** The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of May 7, 2012.

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

- Coordination of Care
- Environment of Care
- Medication Management
- Nurse Staffing
- Point-of-Care Testing
- Quality Management

The facility's reported accomplishments were starting a "Women of Valor" group to provide an opportunity for outpatient female veterans to meet and network and starting an audiology walk-in clinic to improve access for veterans whose hearing aids needed minor adjustment and/or cleaning.

**Recommendations:** We made recommendations in the following three activities:

*Colorectal Cancer Screening:* Ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

*Mental Health Treatment Continuity:* Ensure that all discharged mental health patients receive follow-up within the specified timeframes and that compliance is monitored. Ensure that all discharged mental health patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance is monitored.

*Polytrauma:* Ensure that all patients with positive traumatic brain injury screening results have a comprehensive evaluation within the required timeframe. Maintain minimum staffing levels on the polytrauma support clinical team.

## Comments

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

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

# Objectives and Scope

## Objectives

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

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

## Scope

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

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

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

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

The review covered facility operations for FY 2011 and FY 2012 through May 10, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Tomah VA Medical Center, Tomah, Wisconsin,* Report No. 09-03277-214, July 28, 2010).

During this review, we presented crime awareness briefings for 85 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 191 responded. We shared survey results with facility managers.

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

# Reported Accomplishments

## "Women of Valor" Group

The "Women of Valor" group started in July 2011 to provide an opportunity for outpatient female veterans to meet and network. Female veterans had expressed feelings of isolation and neglect with respect to available programs. Invitations to attend this monthly support group are mailed to 12–15 female outpatients each month. Group facilitators and a variety of guest speakers focus on the needs and areas of interest that have been identified during previous meetings. As a result of attending the "Women of Valor" group, female veterans are forming their own support systems of peers that reflect their needs, interests, and concerns. Plans are underway to develop a similar group for inpatient female veterans that will provide exposure to the creative arts.

## Audiology Walk-In Clinic

The audiology walk-in clinic began in May 2009 to improve access for veterans whose hearing aids needed minor adjustments and/or cleaning. Initially, this clinic was staffed with one audiologist and one health technician and served 60–80 patients per month. Currently, staffing includes two audiologists and one health technician. In March 2012, the clinic had 175 walk-in visits. Benefits of this clinic include: (1) improved timeliness of restoring veterans' hearing aids, (2) reduced waiting time for audiology clinic appointments due to the efficient use of audiologists' time, and (3) improved patient satisfaction.

# Results

## Review Activities With Recommendations

### CRC Screening

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

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

| Noncompliant | Areas Reviewed |
|---|---|
| | Patients were notified of positive CRC screening test results within the required timeframe. |
| X | Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe. |
| | Patients received a diagnostic test within the required timeframe. |
| | Patients were notified of the diagnostic test results within the required timeframe. |
| | Patients who had biopsies were notified within the required timeframe. |
| | Patients were seen in surgery clinic within the required timeframe. |

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[1] Two patients did not have a documented follow-up plan within the required timeframe. One patient had three positive fecal occult blood tests confirmed in March 2011. The provider did not document a follow-up plan or that no follow-up was indicated for this patient until September 2011. The second patient had two positive fecal occult blood tests confirmed in March 2010. The provider did not document a follow-up plan or that no follow-up was indicated for this patient until July 2010.

#### Recommendation

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

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

## MH Treatment Continuity

The purpose of this review was to evaluate the facility's MH patients' transition from the inpatient to outpatient setting. Specifically, we evaluated compliance with selected requirements from VHA Handbook 1160.01 and VHA's performance metrics.

We interviewed key employees and reviewed relevant documents and the EHRs of 19 patients discharged from acute MH (including 3 patients deemed at high risk for suicide). The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Outpatient Follow-Up. VHA requires that all patients discharged from inpatient MH receive outpatient follow-up from a MH provider within 7 days of discharge and that if this contact is by telephone, an in-person or telemental health evaluation must occur within 14 days of discharge.[2] Although the facility scheduled follow-up appointments prior to patient discharge and made contact attempts, 2 of the 16 patients who were not on the high risk for suicide list did not receive outpatient MH follow-up within 7 days of discharge. Additionally, four patients were contacted by telephone within 7 days of discharge but did not have an in-person or telemental health evaluation within 14 days.

Follow-Up for High Risk for Suicide Patients. Through its MH performance measures, VHA requires that patients discharged from inpatient MH who are on the high risk for suicide list receive two outpatient follow-up evaluations within 14 days of discharge and two outpatient follow-up evaluations within days 15–30 from discharge. Although the facility scheduled follow-up appointments prior to patient discharge and made contact attempts, none of the three patients discharged who were on the high risk for suicide list received MH follow-up at the required intervals.

### Recommendations

**2.** We recommended that processes be strengthened to ensure that all discharged MH patients receive follow-up within the specified timeframes and that compliance is monitored.

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

**3.** We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance is monitored.

## Polytrauma

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

We reviewed relevant documents, 12 EHRs of patients with positive TBI results and/or outpatients who needed interdisciplinary care, and 7 employee training records, and we interviewed key employees. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

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

Timely Evaluation. VHA requires that patients with positive TBI screening results have a comprehensive TBI evaluation within 30 days of the positive screening.[3] Six of the 10 EHRs of patients with positive screenings did not contain evidence that the patients were evaluated within 30 days.

Staffing. VHA requires that the polytrauma support clinic team maintains minimum staffing levels.[4] The facility did not meet the minimum staffing requirement for the rehabilitation physician, rehabilitation nurse, physical and occupational therapists, psychologist, social worker, and speech-language pathologist.

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

## Recommendations

**4.** We recommended that processes be strengthened to ensure that all patients with positive TBI screening results have a comprehensive evaluation within the required timeframe.

**5.** We recommended that the polytrauma support clinic team maintains minimum staffing levels.

# Review Activities Without Recommendations

## COC

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

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

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

## EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's Post-Traumatic Stress Disorder and Substance Abuse RRTPs were in compliance with selected MH RRTP requirements.

We inspected the acute medicine, transitional medicine, acute MH, and Post-Traumatic Stress Disorder and Substance Abuse RRTP units; the hospice/palliative care, rehabilitation, and MH CLCs; and the dental, SCI, and urgent care clinics. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

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

## Medication Management

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

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

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

## Nurse Staffing

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

We reviewed relevant documents and 16 training files and interviewed key employees. Additionally, we reviewed the actual nursing hours per patient day for one acute care unit (400A) for 30 randomly selected days (holidays, weekdays, and weekend days) between October 2011 and March 2012. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

## POCT

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

We reviewed the EHRs of 30 patients who had glucose testing, 20 employee training and competency records, and relevant documents. We also performed physical inspections of four patient care areas where glucose POCT was performed, and we interviewed key employees involved in POCT management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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

## QM

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

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

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

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

# Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–25, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

| **Facility Profile[5]** | | |
|---|---|---|
| **Type of Organization** | Medical center with primary care, rehabilitation, extended care, and MH services | |
| **Complexity Level** | 3 | |
| **VISN** | 12 | |
| **Community Based Outpatient Clinics** | La Crosse, WI<br>Owen, WI<br>Wausau, WI<br>Wisconsin Rapids, WI | |
| **Veteran Population in Catchment Area** | 58,786 | |
| **Type and Number of Total Operating Beds:**<br>• **Acute Medicine**<br>• **Acute MH**<br>• **Psychosocial RRTPs** | <br>10<br>11<br>45 | |
| • **CLC/Nursing Home Care Unit** | 200 | |
| **Medical School Affiliation(s)** | None | |
| • **Number of Residents** | 0 | |
| | **Current FY (through January 2012)** | **Prior FY (2011)** |
| **Resources (in millions):** | | |
| • **Total Medical Care Budget** | $135 | $146 |
| • **Medical Care Expenditures** | $57 | $142 |
| **Total Medical Care Full-Time Employee Equivalents** | 955 | 949 |
| **Workload:** | | |
| • **Number of Station Level Unique Patients** | 16,627 | 24,557 |
| • **Inpatient Days of Care:** | | |
| o **Acute Care** | 731 | 1,501 |
| o **CLC/Nursing Home Care Unit** | 21,432 | 61,088 |
| **Hospital Discharges** | 658 | 1,766 |
| **Total Average Daily Census (including all bed types)** | 227.1 | 238.6 |
| **Cumulative Occupancy Rate (in percent)** | 85.4 | 89.7 |
| **Outpatient Visits** | 72,581 | 199,108 |

[5] All data provided by facility management.

# VHA Satisfaction Surveys

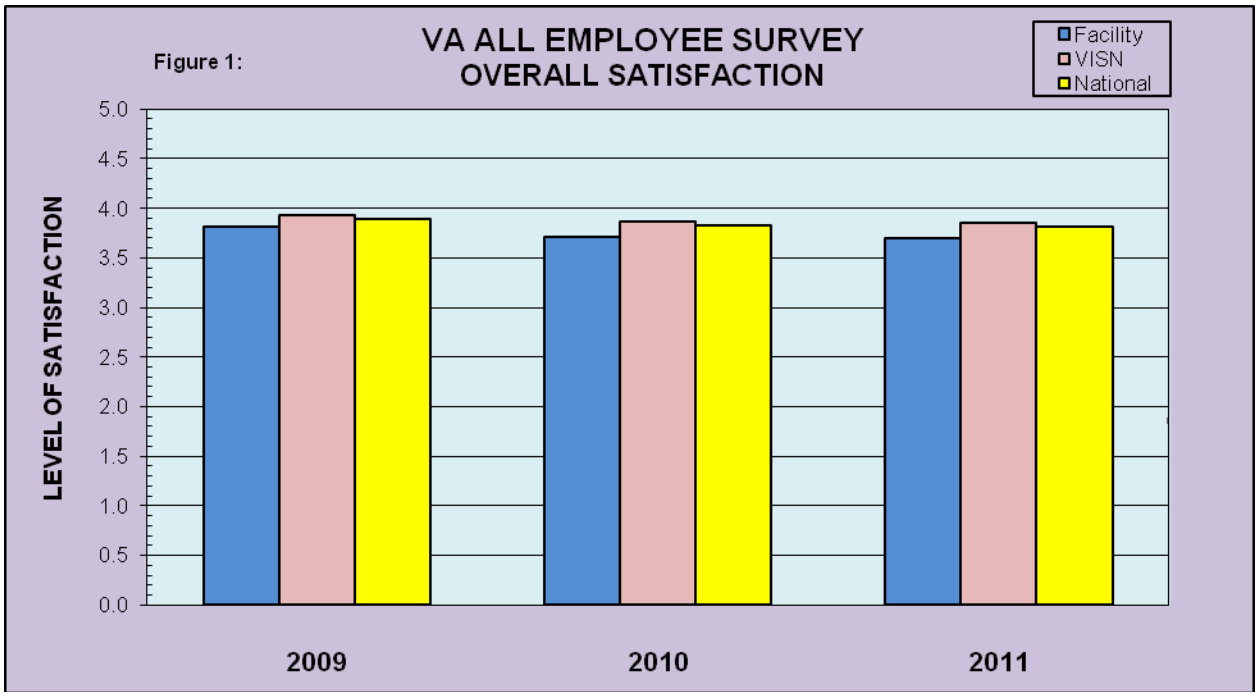
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for FY 2011 and overall outpatient satisfaction scores for quarters 2–4 of FY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

**Table 1**

| | Inpatient Scores | | Outpatient Scores | | | |
|---|---|---|---|---|---|---|
| | FY 2011 | | FY 2011 | | | FY 2012 |
| | Inpatient Score Quarters 1–2 | Inpatient Score Quarters 3–4 | Outpatient Score Quarter 2 | Outpatient Score Quarter 3 | Outpatient Score Quarter 4 | Outpatient Score Quarter 1 |
| Facility | 79.9 | 67.7 | 50.3 | 60.4 | 52.9 | 56.6 |
| VISN | 67.2 | 65.0 | 59.4 | 56.6 | 58.3 | 59.2 |
| VHA | 63.9 | 64.1 | 55.3 | 54.2 | 54.5 | 55.0 |

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

Figure 1:



# Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[6] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.[7]

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Congestive HF | Pneumonia | Heart Attack | Congestive HF | Pneumonia |
| Facility | ** | 11.6 | 12.4 | * | 24.0 | 17.7 |
| U.S. National | 15.9 | 11.3 | 11.9 | 19.8 | 24.8 | 18.4 |

* No data is available from the facility for this measure.
** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

[6] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive HF is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.
[7] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** August 13, 2012

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

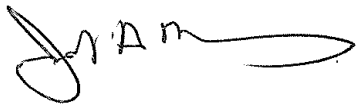
**Subject:** **CAP Review of the Tomah VA Medical Center, Tomah, WI**

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

Director, Management Review Service (VHA 10A4A4 MRS)

Thank you for the opportunity to review the draft report of the Combined Assessment Program (CAP) Review, Tomah Veterans Affairs Medical Center. I have reviewed the document and concur with the recommendations.

Corrective action plans have been established with planned completion dates, as detailed in the attached report. If additional information is needed please contact the Tomah VAMC Director's office at 608-372-1777.



Jeffrey A. Murawsky, M.D.

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** August 13, 2012

**From:** Director, Tomah VA Medical Center (676/00)

**Subject:** **CAP Review of the Tomah VA Medical Center, Tomah, WI**

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

Thank you for the opportunity to review the draft report of the Combined Assessment Program (CAP) Review, Tomah Veterans Affairs Medical Center. I have reviewed the document and concur with the recommendations.

Corrective action plans have been established with planned completion dates, as detailed in the attached report. If additional information is needed, please contact my office at 608-372-1777.

Sandra K. Gregar

*(For and in the absence of:)*
Mario V. DeSanctis, FACHE

# Comments to OIG's Report

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

**OIG Recommendations**

**Recommendation 1.** We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: October 30, 2012

The facility updated the Standard Operating Procedure (SOP) to include tracking of provider follow-up documentation of positive fecal immunochemical test (FIT) testing. The new SOP and tracking process was implemented July 11, 2012. Data collection has begun and will be reported to the Patient Safety/Regulatory Compliance Committee. The outcome measure is all patients will have a documented follow-up plan in the electronic medical record within 14 days of the test result. When the target is met for 3 consecutive months, reporting will decrease to quarterly.

**Recommendation 2.** We recommended that processes be strengthened to ensure that all discharged MH patients receive follow-up within the specified timeframes and that compliance is monitored.

Concur

Target date for completion: October 30, 2012

The Mental Health (MH) Service Line is coordinating with Patient Care Services (PCS) and Health Administration Services (HAS) to develop a defined protocol in order to meet the MH 7 day inpatient follow-up requirements. The protocol will ensure that the coordination of outpatient care after discharge to home from the acute psychiatry unit is based on the needs and preference of the Veteran (i.e., location and provider) while meeting the timeframes and technical requirements of the measure. The following components will be included in the changes:

- Inpatient MH nursing staff will verify and document accuracy and completeness of telephone contact information prior to discharge.
- Inpatient MH nursing staff will attempt follow-up telephone follow-up evaluations of all Veterans discharged to home within 72 hours from discharge. This evaluation will be captured in an encounter using an appropriate MH stop code.
- Inpatient unit schedulers will attempt to schedule an outpatient follow-up appointment with the Veteran's preferred regular provider or therapist. If neither is available during a 7 day timeframe, an appointment will be made with the

Psychiatric Nurse Practitioner in the Primary Care-Mental Health Integration Clinic at the Veteran's preferred Outpatient Clinic location.
- The local Suicide Prevention Coordinators will be sent the names of all Veterans discharged to home to provide additional oversight.

The 7 day inpatient follow-up measure will be reviewed for effectiveness on a monthly basis with the goal to exceed the 75 percent national benchmark for this measure. The data will be reviewed and provided for the facility performance measures scorecard and reported to the Performance Improvement Council monthly. When the target has been met for 3 consecutive months, reporting will decrease to quarterly.

**Recommendation 3.** We recommended that processes be strengthened to ensure that all discharged MH patients who are on the high risk for suicide list receive follow-up at the required intervals and that compliance is monitored.

Concur

Target date for completion: October 30, 2012

The Mental Health (MH) Service Line is coordinating with Patient Care Services (PCS) and Health Administration Services (HAS) to develop a defined protocol in order to meet the MH "high risk" inpatient follow-up requirement. The protocol will ensure that the coordination of follow-up evaluations after inpatient discharge is based on preference of the Veteran (i.e., location, method, and provider) while meeting the specific timeframes and technical requirements required by regulation and the performance measure. The following components will be included in the protocol:

- Inpatient MH nursing staff will verify and document accuracy and completeness of telephone contact information prior to discharge.
- Inpatient MH nursing staff will attempt follow-up telephone follow-up evaluations of all Veterans discharged to home within 72 hours from discharge. This evaluation will be captured in an encounter, using stop codes and other technical requirements appropriate for the relevant performance measure. In the event they are not able to make contact, they will repeat the attempts and will notify the Suicide Prevention Coordinators.
- When clinically appropriate, the first face-to-face follow-up appointment will be scheduled by day 5 to allow for rescheduling in the event of a missed appointment. Inpatient unit schedulers will attempt to schedule this appointment with the Veteran's preferred regular provider or therapist. If that therapist is not available during a 7 day timeframe, an appointment will be made with the Psychiatric Nurse Practitioner in the Primary Care-Mental Health Integration Clinic at the preferred Outpatient Clinic location.
- Inpatient MH nursing staff will notify the Suicide Prevention Coordinators when any patient flagged high risk for suicide is discharged from the acute inpatient psychiatry unit to the community. A Suicide Prevention Coordinator will make contact with the patient, before discharge whenever possible. They will schedule any additional follow-up appointments with the Veteran necessary to ensure the

Veteran has the required number of evaluations, and additional evaluations as clinically appropriate.
- Suicide Prevention Coordinators will track individual high risk Veterans following discharge to ensure appropriate follow-up in the case of cancelled or missed appointments.
- Suicide Prevention Coordinators will assess and report the results of the above on a monthly basis.

The high risk suicide measure will be reviewed for effectiveness on a monthly basis with the goal to exceed the 85 percent national benchmark for this measure. In the event the measure is discontinued at the national level, the data gathered by the Suicide Prevention Coordinators (using the same standards) will be used. The data will be reviewed and provided for the facility performance measures scorecard and reported to the Performance Improvement Council monthly. When the target has been met for 3 consecutive months, reporting will decrease to quarterly.

**Recommendation 4.** We recommended that processes be strengthened to ensure that all patients with positive TBI screening results have a comprehensive evaluation within the required timeframe.

Concur

Target date for completion: October 30, 2012

Polytrauma coverage has been increased from three or four appointments per week to five or six to accommodate increased demand associated with Traumatic Brain Injury (TBI) follow-up. Implementation of the increased clinic days has led to a current wait time of 8 days or less from consult initiation as of July 10, 2012. The scheduling process has been changed so that patient services assistants call directly to confirm appointments 1 day prior, which has led to a reduced missed opportunity rate, leading to improved access.

Monthly reports of the TBI consults will be run and reviewed. The outcome measure will be that all patients with positive TBI screening results will have a comprehensive evaluation within the required timeframe. Monthly reporting of completed consults will be provided to the Patient Safety/Regulatory Compliance Committee. When the target is met for 3 consecutive months, reporting will decrease to quarterly to monitor sustainability.

**Recommendation 5.** We recommended that the polytrauma support clinic team maintains minimum staffing levels.

Concur

Target date for completion: Completed

The Polytrauma Clinic Team has appropriate staffing levels in place. Decision Support Systems (DSS) mapping of all Polytrauma Support Clinic Team members was reviewed

for compliance with Veterans Health Administration (VHA) Directive 2009-28, Polytrauma-Traumatic Brain Injury System of Care. The Rehabilitation Nurse is mapped 1.0 Full Time Equivalent (FTE). The Social Worker is mapped 0.5 FTE effective June 17, 2012. The Rehabilitation Physician, Speech-Language Pathologist, Physical Therapist, Occupational Therapist, and Psychologist are mapped 0.5 FTE effective July 18, 2012.

# OIG Contact and Staff Acknowledgments

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