Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-01230-210

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

September 25, 2007

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 fraud and integrity awareness training 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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Executive Summary

Introduction

During the week of June 4–8, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Tomah VA Medical Center (the medical center). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 87 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 12.

Results of the Review

The CAP review covered five operational activities. We identified the following organizational strengths and reported accomplishments:

- Nursing Home Care Unit Tasting Program.
- Outpatient Pharmacy Telephone Services.

We made recommendations in three of the activities reviewed. For these activities, the medical center needed to:

- Ensure community based outpatient clinic (CBOC) staff is educated on the current clinical emergency standard operating procedure (SOP).
- Require all clinical staff to maintain current Basic Life Support (BLS) certifications.
- Require that computerized patient record system (CPRS) business rules are in compliance with Veterans Health Administration (VHA) policy and Office of Information (OI) guidance.
- Ensure that the medical center's inspection team conducts semi-annual environment of care (EOC) inspections at the CBOCs.
- Comply with VHA's patient safety alert on louvered heating, ventilating, and air conditioning (HVAC) grilles in locked behavioral health units.
- Make certain that sensitive patient information is protected from unauthorized disclosure.
- Correct the identified deficiencies on the residential post-traumatic stress disorder (PTSD) unit and establish processes to ensure that EOC standards are maintained.

The medical center complied with selected standards in the following two activities:

- QM Program.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Verena Briley-Hudson, Director, Chicago Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings. They agreed with the recommendations with one exception. They did not agree with our recommendation regarding the HVAC louvered grilles because one of the units we inspected is being converted from a locked long-term behavioral health unit to an unlocked unit through installation of the Wander Guard System, and the requirement will no longer apply. They provided acceptable improvement plans for the other recommendations. (See Appendixes A and B, pages 10–14, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

Profile

Organization. The medical center is located in Tomah, WI, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four CBOCs in La Crosse, Wausau, Wisconsin Rapids, and Loyal, WI. The medical center is part of VISN 12 and serves a veteran population of 62,974 in a primary service area that includes 14 counties in Wisconsin and 1 county in Minnesota.

Programs. The medical center provides primary care, mental health services, and nursing home care. It has 26 hospital beds and 200 nursing home beds and operates 45 residential beds. Inpatient programs include acute medicine, acute and long-term psychiatry, vocational and social rehabilitation, psycho-geriatric care, Alzheimer's assessment and management, and residential substance abuse and PTSD treatment programs. Outpatient programs include primary and specialty care, a mental hygiene clinic, an on-campus homeless program, and a community support program. The medical center maintains strong relationships with area military bases and operates the Troop Medical Clinic at Fort McCoy, WI. The medical center also has sharing agreements with a local community hospital and with the Ho-Chunk Nation.

Affiliations. The medical center supports local medical-related education programs but has no medical (physician) resident positions.

Resources. In fiscal year (FY) 2006, medical care expenditures totaled $83.9 million. The FY 2007 medical care budget is $80 million. FY 2006 staffing was 709.5 full-time employee equivalents (FTE), including 23.5 physician and 100.5 nursing FTE.

Workload. In FY 2006, the medical center treated 29,572 unique patients and provided 3,367 inpatient hospital days and 64,183 inpatient Nursing Home Care Unit (NHCU) days. The inpatient care workload totaled 1,378 discharges, and the average daily census, including nursing home patients, was 219.7. Outpatient workload totaled 161,796 visits.

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 fraud and integrity awareness training 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 work areas; interviewed managers, employees, and patients; and reviewed clinical and administrative records. The review covered the following five activities:

- CBOCs.
- CPRS Business Rules.
- EOC.
- QM Program.
- SHEP.

The review covered medical center operations for FY 2006 and FY 2007 through June 1, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the VA Medical Center, Tomah, Wisconsin,* Report No. 06-00511-131, April 17, 2006). We concluded that managers had implemented the appropriate corrective actions in response to the recommendations.

During this review, we also presented fraud and integrity awareness briefings to 87 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.

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. Activities in the "Review Activities without Recommendations" section have no reportable findings.

Organizational Strengths

Nursing Home Care Unit Tasting Program

NHCU staff developed a tasting program to provide a better quality of life for those residents who are significantly cognitively and physically impaired. Residents who receive nourishment through a feeding tube are evaluated by speech therapy staff prior to initiating a tasting program, and nursing staff receive training so that patients will be safe during tastings. At meal times, while in the dining room, nursing staff rub small amounts of food across patients' lips so that patients can enjoy the taste and smell of food without actually swallowing anything. This approach has allowed some patients to progress from tube feedings to regular meals and has improved the quality of life for all participants in the tasting program.

Outpatient Pharmacy Telephone Services

Since 2004, the medical center's outpatient pharmacy telephone services had experienced a consistent reduction in overall grade of service (GOS) to a low of 29 percent. GOS measures the number of telephone calls answered within 60 seconds. In September 2006, managers initiated a project to improve these services; within 4 months, the GOS had significantly improved to 75 percent. These dramatic results were achieved by initiating a toll-free direct dial automated telephone system for refills of prescriptions and by directing patients to the My Health***e***Vet web site for prescription refills. Workflow processes were redesigned to increase employee participation and ownership. In September 2006, technicians took 4 minutes and 52 seconds to answer telephone calls; however, in January 2007, technicians answered telephone calls within 39 seconds.

Results

Review Activities with Recommendations

Community Based Outpatient Clinics

The purpose of this review was to assess the effectiveness of CBOC operations and VHA oversight and to determine whether CBOCs are in compliance with selected standards of operations (such as patient safety, QM, credentialing and privileging, emergency plan) and whether CBOCs improve access, convenience, and timeliness of VA health care services. We inspected the La Crosse CBOC and found that managers needed to improve the process of educating staff regarding

clinical emergency response and to ensure that staff maintain certification in BLS.

In May 2007, La Crosse CBOC managers developed a new SOP for managing clinical emergencies. According to this procedure, patients presenting with clinical emergencies are first evaluated by a clinical provider. The provider will then instruct staff if a 911 (emergency) telephone call is needed. Staff we interviewed were not aware of this procedure; they told us that they call 911 immediately for all clinical emergencies, in accordance with the medical center's emergency services plan.

Medical center policy states that ambulatory care providers are required to maintain Advanced Cardiac Life Support or BLS certification. We reviewed training records for clinical staff and found two expired licensed practical nurse certifications. Both are scheduled to attend recertification classes in July.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires CBOC staff to be educated on the current clinical emergency SOP.

The VISN and Medical Center Directors agreed with the findings and recommendation. Medical center managers developed a plan to ensure that all staff working in each CBOC would receive training on the current policy, *Patients with Unanticipated Triage Needs – Standard Operating Procedure*. We will follow up on their reported implementation plan.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that all clinical staff maintain current BLS certifications.

The VISN and Medical Center Directors agreed with the findings and recommendation. They developed a plan to ensure that clinical staff have and maintain current BLS certifications. We will follow up on their reported implementation actions.

Computerized Patient Record System Business Rules

The purpose of this review was to determine whether business rules governing CPRS comply with VHA policy. VHA policy states that only the Chief of Health Information Management Service and the Privacy Officer are allowed to retract, amend, or delete signed medical record notes. CPRS business rules define what functions certain groups or individuals are allowed to perform in the medical record.

In October 2004, VHA's OI provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. The OI cautioned that, "The practice of editing a document that was signed by the author might have a patient safety implication and should not be allowed." Following this guidance, OI has recommended that any editing of signed records be limited to the medical center's Privacy Officer. On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all facilities to comply with the OI guidance sent in 2004.

We reviewed the medical center's business rules and policies related to computerized records and interviewed Information Resource Management Service staff. The medical center had one business rule that needed to be changed to limit retraction, amendment, or deletion of signed medical record notes to the Privacy Officer or the Chief of Health Information Management Service. Medical center staff took immediate action to remove this business rule.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that CPRS business rules are in compliance with VHA policy and OI guidance.

The VISN and Medical Center Directors agreed with the findings and recommendation. Based on acceptable corrective action taken during the CAP review, we consider this recommendation closed.

Environment of Care

The purpose of this review was to determine if the medical center established a comprehensive EOC program that contributed to a safe and clean environment, complied with safety standards and guidelines, and maintained an effective infection control program.

We inspected six inpatient units, the residential PTSD unit, and common areas of the medical center. The medical center was generally clean and effectively maintained. Managers were responsive and took immediate action to correct deficiencies identified while the team was onsite. We identified the following deficiencies that required further management attention.

Team Inspections of Patient Care Areas. Medical center policy requires that a team comprised of the Industrial Hygiene/Safety Manager, the Risk Manager, the Infection Control Officer, the Health Insurance Portability and Accountability Act/Privacy Representative, and housekeeping supervisors conduct semi-

annual inspections of patient care areas. Not all members of the team were participating in semi-annual inspections of the medical center's CBOCs. Because CBOCs are direct patient care areas, it is important that these facilities receive inspections that are consistent with those conducted at the medical center.

Patient Safety. VHA Patient Safety Alert, AL05-06, dated February 28, 2005,[1] required that by March 31, 2005, medical centers were to have (a) surveyed all locked behavioral health units to determine if louvered HVAC grilles were present that could be used as an anchor point and (b) upgraded them or replaced them with suitable grilles that could not be used as anchor points. We inspected two locked behavioral health units and found that on one unit, corrective action was completed on the grille in the seclusion room, but grilles in other patient rooms were not compliant. While we were inspecting the second unit, employees were installing corrective devices to grilles throughout that unit. Managers needed to ensure that the medical center is compliant with the patient safety alert.

Patient Privacy. VHA, medical center policies, and the Health Insurance Portability and Accountability Act of 1996 require that patient health information be protected at all times from unauthorized access. Multiple wall-mounted document holders in various clinical and administrative areas throughout the medical center contained routing envelopes and other correspondence that had confidential patient information inside them, such as patient names, social security numbers, and health information. This information was accessible to anyone walking past the document holders and could be removed by unauthorized persons.

Residential Post-Traumatic Stress Disorder Unit. We inspected the unit in response to patient concerns that were presented to the team during the onsite review. We identified several deficiencies during the unit inspection that required management attention. Food items in refrigerators were not labeled with patients' names and dates, and some spoiled food items were also present. Boxes of insulin were stored with food in a refrigerator. Refrigerated patient medication must be secured and stored separately from food items. Storage cabinets in two dayrooms were dirty. Grout between floor tiles in the patient restroom appeared dirty, and shower area wall tiles were stained. Linens were uncovered in the clean linen storage room.

[1] http://www.va.gov/NCPS/alerts/LouveredHVACGrilleFeb28.pdf.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires the inspection team to conduct semi-annual EOC inspections at the CBOCs.

The VISN and Medical Center Directors agreed with the findings and recommendation. The semi-annual EOC inspection schedule was expanded to include the CBOCs, and processes are being established to ensure follow-up of any issues identified. We consider this recommendation closed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director complies with VHA's patient safety alert on louvered HVAC grilles in locked behavioral health units.

The VISN and Medical Center Directors agreed with the findings but not our recommendation, as plans are underway to convert one of the locked long-term mental health units to an unlocked unit. They anticipate the work to be completed after staff and patients are oriented to the new system (no later than August 3) and expect to be fully operational by August 6. We will follow up on their planned actions.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director makes certain that sensitive patient information is protected from unauthorized disclosure.

The VISN and Medical Center Directors agreed with the findings and recommendation. Medical center managers have established a plan to secure sensitive patient information. We consider this recommendation closed.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director corrects the identified deficiencies on the residential PTSD unit and establishes processes to ensure that EOC standards are maintained.

The VISN and Medical Center Directors agreed with the findings and recommendation. Deficiencies identified during the CAP review have been corrected, and processes to ensure that EOC standards are maintained have been established. The improvement actions are acceptable, and we consider this recommendation closed.

Review Activities Without Recommendations

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent to which the system used the results of VHA's patient satisfaction survey to improve care and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. VHA set FY 2006 SHEP target results of patients reporting overall satisfaction as "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients. The tables below show the national, VISN 12, and the medical center's SHEP results.

Tomah VA Medical Center Inpatient SHEP Results

FY 2006 (Quarters 3 and 4)	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	81.35	78.90	89.90	67.92	65.97	75.95	83.43	74.66	70.11	**
VISN	80.60	76.60	88.50	65.60	64.60	76.60	84.00	71.40	69.70	**
Medical Center	87.90	86.20	90.60	73.20	66.60	75.60	88.10	79.10	71.10	**

**Not reported

Tomah VA Medical Center Outpatient SHEP Results

FY 2007 (Quarter 1)	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-Up	Preferences	Specialist Care	Visit Coordination
National	81	77.8	94.9	72.7	83.5	75.7	82	65.3	82	81.1	84.8
VISN	81.7	69.9	96.1	72.8	83.1	76	86.8	64.7	82.6	79.3	84.9
Outpatient Clinics	90	61.7	96.3	72.7	82.7	75.5	85.3	81.6	83.6	69.9	89.9

SHEP results were communicated to employees through townhall meetings, service-level meetings, and bulletin board postings throughout the medical center and CBOCs. Medical center managers identified areas needing improvement and developed appropriate action plans to address education and information, continuity of care, overall coordination, and specialist care. Therefore, we made no recommendations.

Quality Management Program

The purpose of this review was to evaluate whether the medical center's QM Program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed medical center senior managers and QM personnel, and we evaluated plans, policies, and other relevant documents.

We also evaluated monitoring and improvement efforts in each program area. These efforts included the following:

- Identifying problems or potential improvements.
- Gathering and critically analyzing data.
- Comparing the data analysis with established goals and benchmarks.
- Identifying specific corrective actions when results do not meet goals.
- Implementing and evaluating actions until the problems are resolved or the improvements are achieved.

We evaluated whether clinical managers appropriately used the results of quality monitoring in the medical staff reprivileging process. We reviewed mortality analyses to determine the level of medical center compliance with VHA guidance.

We found that the QM Program provided comprehensive oversight of the quality of care. Generally, when problems were identified, actions were taken and adequately evaluated. We found excellent senior management support and clinician participation. We made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 26, 2007

From: VISN 12 Director

Subject: **Combined Assessment Program Review of the Tomah VA Medical Center, Tomah, Wisconsin**

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

Director, Management Review Office (10B5)

Attached please find the Combined Assessment Program Review response from VAMC Tomah. If anything additional is needed, please contact my office at (708) 202-8400.

Thank you.

(original signed by:)

James W. Roseborough

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 26, 2007

From: Medical Center Director

Subject: **Combined Assessment Program Review of the Tomah VA Medical Center, Tomah, Wisconsin**

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

Attached please find the Combined Assessment Program review from VAMC Tomah. If additional information is needed, please contact my office at (608) 372-1777.

Thank you.

(original signed by Donna Welch
for and in the absence of:)

Stan Johnson

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires CBOC staff to be educated on the current clinical emergency SOP.

Concur with recommended improvement action.

Planned Actions: All staff working at the CBOCs will receive an electronic copy of the Memorandum titled Patients with Unanticipated Triage Needs – Standard Operating Procedure along with instructions to read the memorandum and discuss it with their supervisor. The supervisor or clinic manager of each CBOC will schedule a review of the memorandum at the June and July staff meetings. A sign-up list will be used to verify attendance. Staff unable to attend the staff meeting will review the contents of the memorandum 1:1 with their supervisor and sign the attendance sheet by August 17, 2007.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that all clinical staff maintain current BLS certifications.

Concur with recommended improvement action.

Planned Actions: By July 7, 2007, a memo from the Director will be sent to supervisors instructing them to review the current BLS certification status of all eligible staff. The supervisor will be asked to develop a plan for each staff member whose certification has expired so that recertification occurs within 30 days. A plan will also be expected for staff whose certification expires within 30 days to ensure that those staff will be recertified before their expiration date. By close of business July 13, the supervisor will send to the Service Line Manager or Associate Chief Nurse, verification that the review occurred along with a list of staff members who are deficient and the plans of action. The Service Line Managers/Associate Chief Nurses will send a report to the Quadrad by August 20, which verifies that all staff members with expired certification completed recertification.

In addition, the expectation for continuous maintenance of BLS certification will be communicated to staff and supervisors. Supervisors will be held

responsible for scheduling staff training at least 30 days prior to the expiration of BLS certification. Effective September 1, the quarterly report form completed by Service Line Managers/Associate Director for Patient Care Services for presentation to the Executive Council will be modified to include the percentage of staff in compliance with required BLS certification.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that CPRS business rules are in compliance with VHA policy and OI guidance.

Concur with recommended improvement action.

Planned Actions: No further action is necessary. The one business rule which was in place and out of compliance with the memorandum sent previously by the VHA OI was removed while the survey team was present.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires the inspection team to conduct semi-annual EOC inspections at the CBOCs.

Concur with recommended improvement action.

Planned Actions: The existing semi-annual EOC inspection process has been expanded to include the CBOCs. These inspections include a focus on environment of care, safety, and infection control. Findings from the inspections will be forwarded in writing to the CBOC managers and their supervisors. Action plans will be developed with identified actions, timeframes, and responsible persons, which address issues/recommendations identified during the inspections. Based on their nature, the actions will be assigned to either the Environment of Care Committee or the Infection Control Committee for tracking through completion. In December and June of each year, the Performance Improvement Department will verify through minutes of the Environment of Care Committee and the Infection Control Committee that inspections occurred at each CBOC during the previous 6 months and that actions are being tracked and completed as scheduled.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director complies with VHA's patient safety alert on louvered HVAC grilles in locked behavioral health units.

Concur with the findings but not with the recommended action.

Planned Actions: Plans are in place to convert the locked long-term mental health unit (408B) to an unlocked unit through the installation of the Wander Guard system. The elevator mechanisms for Wander Guard

are scheduled for implementation the week of July 9, 2007. The remainder of the system will be installed after completion of the elevator work. Staff and patients will be oriented to the new system no later than August 3. The total system is scheduled for full operation by August 6.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director makes certain that sensitive patient information is protected from unauthorized disclosure.

Concur with recommended improvement action.

Planned Actions: Mail delivery drop boxes/document holders in public/easily accessible areas were identified and Service Line Managers notified June 15, 2007, to relocate drop points to more appropriate secured locations. Service Line Managers will conduct a walk-through of their responsible areas to determine other drop box locations in problem areas utilized by other than mail room personnel (i.e., Pony Express or internal service area use). Report is due from Service Line Managers on June 29, indicating completion of the assessment and relocation of problem drop points. Written justification from Service Line Managers is required for any drop points which cannot be relocated. Those areas will be reviewed by the Resources Service Line Manager and Privacy Officer by July 20 to determine a new location. If a new location is not feasible, a lockable drop box will be installed. Installation will be completed by August 4.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director corrects the identified deficiencies on the residential PTSD unit and establishes processes to ensure that EOC standards are maintained.

Concur with recommended improvement action.

Planned Actions: Immediately following the survey by the OIG inspectors, the Coordinator of 404 PTSD proceeded to get the unit cleaned. An additional refrigerator was designated for medication storage. The Coordinator was instructed to conduct monthly inspections effective July 1, 2007, using a designated inspection checklist. The Coordinator will be expected to initiate work orders as needed to maintain a clean, functional area. The inspection data will be submitted to the Safety Officer who will track the monthly inspections. Twice a year, the EOC rounds team will verify the inspections.

OIG Contact and Staff Acknowledgments

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