Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-01876-239

Combined Assessment Program Review of the St. Cloud VA Health Care System St. Cloud, Minnesota

August 6, 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

ASC	ambulatory surgery center
CAP	Combined Assessment Program
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	St. Cloud VA Health Care System
FY	fiscal year
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
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the St. Cloud VA Health Care System, St. Cloud, MN

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 June 18, 2012.

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

- Environment of Care
- Medication Management
- Moderate Sedation
- Point-of-Care Testing
- Quality Management

The facility's reported accomplishments were opening an ambulatory surgery center and receiving the Veterans Integrated Service Network 23 Mental Health Team of the Year award.

Recommendations: We made recommendations in the following three activities:

Colorectal Cancer Screening: Notify patients of diagnostic test results within the required timeframe, and document notification.

Polytrauma: Ensure the polytrauma support clinic team meets the rehabilitation registered nurse minimum staffing requirement.

Mental Health Treatment Continuity: Ensure all discharged mental health patients receive follow-up within the specified timeframe, and monitor compliance.

Comments

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

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

Objectives and Scope

Objectives

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

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

Scope

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

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

- CRC Screening
- EOC
- Medication Management
- MH Treatment Continuity
- Moderate Sedation
- 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 June 21, 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 St. Cloud VA Medical Center, St. Cloud, Minnesota,* Report No. 09-03074-221, August 12, 2010).

During this review, we presented crime awareness briefings for 181 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 487 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

ASC

The ASC opened in August 2011. The 9,000 square foot ASC is equipped with state-of-the-art surgical equipment and technology. The facility's Sterile Processing Services department also underwent a major renovation to support the ASC.

The availability of same day surgery services significantly improved the facility's capabilities to meet the health care needs of veterans in central Minnesota. The ASC provides convenient same day urological, orthopedic (including arthroscopy), oral, and general surgery procedures closer to home for many of the 37,000 veterans who receive their health care through the facility. The addition of the ASC has resulted in fewer referrals to the Minneapolis VA Health Care System, decreased costs for non-VA care, and an increased array of surgical procedures available at the facility.

VISN 23 MH Team of the Year

In May 2011, the facility's MH RRTP was awarded the VA Midwest Health Care Network MH Team of the Year Award at the annual MH conference in Sioux Falls, SD. This regional award is given annually to the team that best exemplifies the VISN's MH strategic plan and provides a best practice model that can be duplicated at other regional clinics and medical centers.

The MH RRTP is a 148-bed residential program that specializes in treating veterans with substance abuse and MH disorders. The current treatment program is the result of a significant systems redesign over the past 3 years.

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 we 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.
	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.
X	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.
	The facility complied with any additional elements required by local policy.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[1] Two of the 11 patients who received diagnostic testing did not have documented evidence of timely notification in their EHRs.

Recommendation

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

[1] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.

Polytrauma

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

We reviewed relevant documents, 10 EHRs of patients with positive traumatic brain injury results, 10 EHRs of patients who received outpatient polytrauma services, and 8 training records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

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

Staffing. VHA requires that the polytrauma support clinic team maintains minimum staffing levels.[2] The facility did not meet the rehabilitation nurse minimum staffing requirement.

Recommendation

2. We recommended that the polytrauma support clinic team meet the rehabilitation registered nurse minimum staffing requirement.

[2] VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

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 30 patients discharged from acute MH (including 10 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.[3] Six of the 20 patients who were not on the high risk for suicide list did not receive outpatient MH follow-up within 7 days of discharge.

Recommendation

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

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

Review Activities Without Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's MH RRTP units were in compliance with selected MH RRTP requirements.

We inspected the community living center, inpatient acute MH, and MH RRTP (substance abuse and post-traumatic stress disorder) units. We also inspected the primary care, dental, polytrauma rehabilitation, and women's 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.

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

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[4] 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 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.

[4] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, 10 EHRs, and 10 training/competency records, and we interviewed key employees. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

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, 16 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
	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 16–20, 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	Non-tertiary	
Complexity Level	3	
VISN	23	
Community Based Outpatient Clinics	Brainerd, MN Montevideo, MN Alexandria, MN	
Veteran Population in Catchment Area	60,930	
Type and Number of Total Operating Beds:		
• **Acute Care MH**	15	
• **Psychosocial RRTP**	225	
• **Community Living Center/Nursing Home Care Unit**	148	
Medical School Affiliation(s)	None	
• **Number of Residents**	N/A	
	Current FY (through March 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$225.9	$252.4
• **Medical Care Expenditures**	$125.4	$252.4
Total Medical Care Full-Time Employee Equivalents	1,420	1,431
Workload:		
• **Number of Station Level Unique Patients**	29,976	37,683
• **Inpatient Days of Care:**		
○ **Acute Care (inpatient MH)**	1,094	2,573
○ **Community Living Center/Nursing Home Care Unit**	38,439	75,289
○ **MH RRTP**	25,222	50,284
Hospital Discharges	1,292	2,491
Total Average Daily Census (including all bed types)	354	351
Cumulative Occupancy Rate (in percent)	91.2	90.4
Outpatient Visits	181,202	348,993

[5] All data provided by facility management.

VHA Satisfaction Surveys

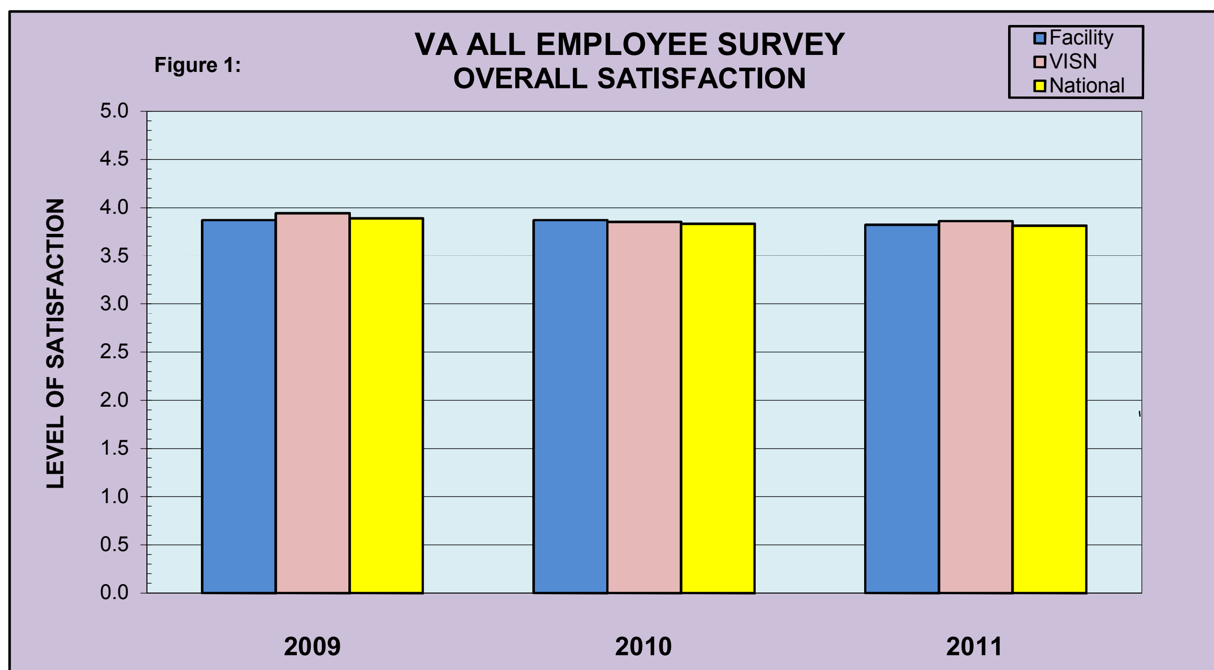
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for FY 2011 and overall outpatient satisfaction scores for quarters 2–4 of FY 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	*	*	58.8	58.7	64.6	62.9
VISN	67.2	66.5	58.1	60.4	58.8	57.9
VHA	63.9	64.1	55.3	54.2	54.5	55.0

* A score is not reported because there were fewer than 30 cases.

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.



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 23, 2012

From: Director, VA Midwest Health Care Network (10N23)

Subject: **CAP Review of the St. Cloud VA Health Care System, St. Cloud, MN**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

I have reviewed the findings within the report of the Combined Assessment Program Review of the St. Cloud VA Health Care System. I am in agreement with the findings of the review.

Corrective actions plans have been established with planned completion dates as outlined in this report.

Janet P. Murphy, MBA

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 20, 2012

From: Director, St. Cloud VA Health Care System

Subject: **CAP Review of the St. Cloud VA Health Care System, St. Cloud, MN**

To: Director, VA Midwest Health Care Network

I have reviewed the findings within the report of the Combined Assessment Program Review of the St. Cloud VA Health Care System. I am in agreement with the findings of the review.

Corrective actions plans have been established with planned completion dates as outlined in this report.

(original signed by:)
BARRY BAHL

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 patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: 10-1-12

Prior to the OIG Survey, the opportunities for improvement were recognized in Veteran notification and documentation of diagnostic test results. Several improvement processes have been implemented across Service Lines related to handoff communication.

All pathology reports from non-VA colonoscopy procedures are received and reviewed by the Referrals Center nurse prior to forwarding to medical records. The Referral Center nurse notifies the Surgical Nurse electronically that results have been received and require review by the designated surgeon. The surgeon notifies the Veteran of the results and follow-up recommendations, places orders as clinically indicated, and documents in the medical record.

We will continue to monitor compliance of timely results notification and documentation as a part of the Surgical Specialty Care Service Performance Improvement Plan, which is reported to the Medical Executive Board and the Quality Leadership Council on a quarterly basis.

Recommendation 2. We recommended that the polytrauma support clinic team meet the rehabilitation registered nurse minimum staffing requirement.

Concur

Target date for completion: 8-15-12

VHA Directive 2009-028 Polytrauma-Traumatic Brain Injury System of Care outlines policy and procedures for TBI programs. The St. Cloud VA Health Care System provides a Polytrauma Support Clinic Team (PSCT). The required core staffing for PSCT is also included in the Directive. The complexity and volume of the level III polytrauma Veterans seen in the PSCT Clinic at the St. Cloud VA Health Care System is low and does not justify the hiring of a Certified Rehabilitation Registered Nurse as other team members are able to manage the Veterans' needs. A waiver will be

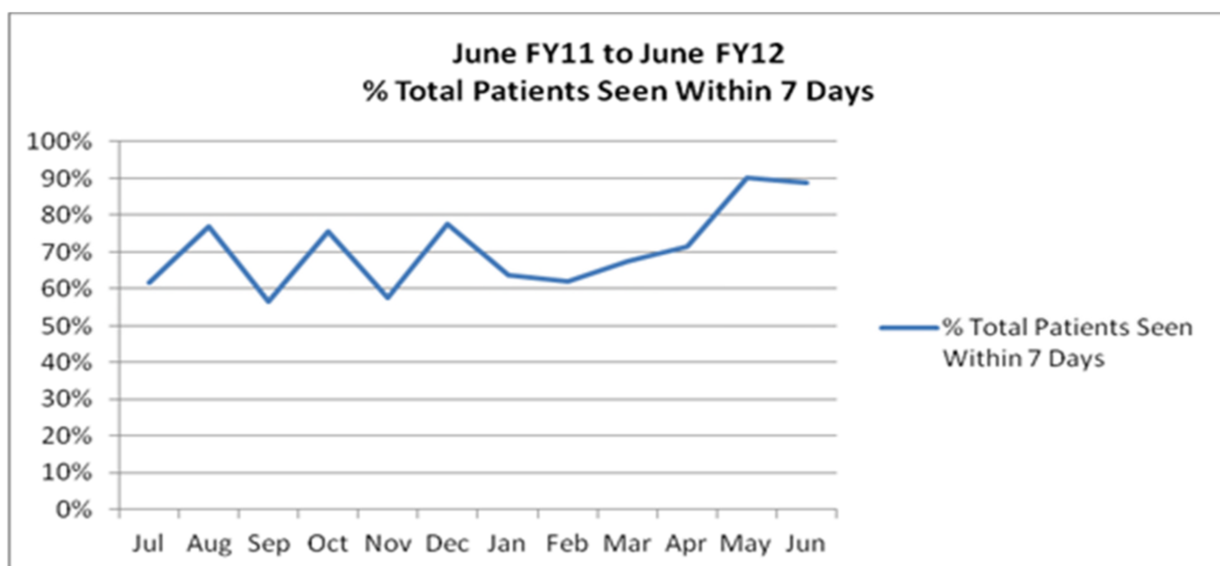
requested from the Physical Medicine and Rehabilitation Service Program Office explaining this variance in PSCT Clinic staffing.

Recommendation 3. We recommended that processes be strengthened to ensure that all discharged MH patients receive follow-up within the specified timeframe and that compliance is monitored.

Concur

Target date for completion: 9-30-12

Continuous effort will be made to strengthen major process changes which were implemented in May 2012 at which time the responsibility for closely monitoring and encouraging Veterans discharged from the MH Acute Unit to keep follow-up appointments was shifted from the MH Outpatient setting to the MH Acute Unit nursing staff. Current outcomes reflected in the graph below signify an upward trend and improved compliance with the 7 day monitor.



Action Plan/Goal: Meet or exceed the 7 day follow-up measure at 75% or greater.

Action	Expected Outcome	Responsible Party	Completion Date	Other Comments
Daily review/tracking of post-discharge follow-up status	Identify missed opportunities and barriers to appt. compliance and take corrective action when possible	Clinical Nurse Leader or delegate	Ongoing	Trends/results reviewed and discussed at weekly team meeting
Systems Redesign team established with key stakeholders	Data drill down on all failures analyzed by team to identify opportunities for process improvement	MH Associate Director, all MH Nurse Managers	Review outcomes at bi-monthly meetings, next scheduled meeting 7/23/12	SUD team and Homeless team representatives added to improvement efforts to increase outreach to Veterans whom no-show appointments or cannot be reached
Explore feasibility of providing a canteen beverage coupon as an incentive to keep appt.	If concept is approved, SOP and implemented by 8/31/12	System Redesign Team Leader/MH Acute Unit Nurse Manager	Implementation Target date:8/31	Once in place, effectiveness of intervention will be monitored
MH Acute Unit RNs will complete post discharge telephone calls as directed by the SOP.	Improve rate of completed telephone contacts from baseline by 10% until goal of 95% is reached	System Redesign Team Leader/MH Acute Unit Nurse Manager	Ongoing until goal is met.	Data reviewed at bi -monthly meetings

OIG Contact and Staff Acknowledgments

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