Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03623-89

Combined Assessment Program Review of the Oscar G. Johnson VA Medical Center Iron Mountain, Michigan

March 5, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

CAP	Combined Assessment Program
CLC	community living center
COC	coordination of care
EHR	electronic health record
EOC	environment of care
facility	Oscar G. Johnson VA Medical Center
FY	fiscal year
ICU	intensive care unit
MEC	Medical Executive Committee
MH	mental health
MRC	Medical Records Committee
NA	not applicable
NM	not met
OIG	Office of Inspector General
PRC	Peer Review Committee
PT	physical therapy
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VTS	Veterans Transportation Service

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of November 4, 2013.

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

- Environment of Care
- Medication Management
- Coordination of Care

The facility's reported accomplishments were the opening of a physical therapy satellite clinic in the community living center and the Veterans Transportation Service, which significantly increased the number of trips it provided to outpatients traveling to and from scheduled medical appointments at the facility during fiscal year 2013.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure the Intensive Care Unit Committee reviews each code episode. Require the Medical Records Committee to analyze all reports of electronic health record review results. Ensure that a member from Surgery Service attends Ancillary Testing Committee meetings, that a clinical representative from Anesthesia Service is added as an Ancillary Testing Committee member, and that the blood/transfusions usage review process includes the results of peer reviews when transfusions did not meet criteria.

Nurse Staffing: Monitor the staffing methodology that was implemented in June 2013.

Pressure Ulcer Prevention and Management: Provide and document pressure ulcer education for patients with pressure ulcers and/or their caregivers. Establish staff pressure ulcer education requirements.

Community Living Center Resident Independence and Dignity: Provide timely restorative nursing services to residents who are candidates for those services. Document resident progress towards restorative nursing goals, modify interventions as needed, and document the modifications.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 20–24, for the full text of the Directors' comments.) 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 quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

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

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

- QM
- EOC
- Medication Management
- COC
- Nurse Staffing
- Pressure Ulcer Prevention and Management
- CLC Resident Independence and Dignity

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

The review covered facility operations for FY 2012, FY 2013, and FY 2014 through November 7, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the

recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Oscar G. Johnson VA Medical Center, Iron Mountain, Michigan,* Report No. 08-02603-05, October 7, 2009).

During this review, we presented crime awareness briefings for 218 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 139 responded. We shared summarized results with facility managers.

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

Reported Accomplishments

CLC PT Satellite Clinic

On July 22, 2013, the facility opened a PT satellite clinic in the CLC, the facility's long-term care and short-term rehabilitation unit. The primary goal of this clinic is to provide the highest quality physical medicine and rehabilitation care in as close to a home-like environment as possible. As of September 9, 2013, there had been 350 resident visits.

The PT satellite clinic offers CLC residents a variety of rehabilitation opportunities using the newest, state-of-the-art rehabilitation equipment, which includes the latest models of recumbent steppers; upper and lower extremity conditioning bikes; and full-power, adjustable parallel bars. Additional benefits of this clinic include the provision of timely and convenient PT and increased interdisciplinary care since the physical therapist is readily available to collaborate and share expertise with nursing and recreation therapy staff, social workers, physicians, and other providers.

VTS

The VTS provides timely and efficient transportation to outpatients traveling to and from scheduled medical appointments at the facility. Many of the outpatients who use this service reside in rural areas. The VTS has 2 16-passenger vehicles that are capable of transporting patients in wheelchairs and with oxygen. Two drivers and 2 escorts operate the vehicles weekdays from 5:00 a.m. to 8:00 p.m. Transportation is provided within a 50-mile radius of the facility and includes local runs for outpatients following appointments. The VTS has established routes and does not charge a fee. The table on the next page shows a comparison of the FY 2012 and FY 2013 metrics.

Comparison of FY 2012 and FY 2013 Metrics for the VTS			
	FY 2012*	**FY 2013**	**Growth Rate in Percent**
VTS Trips	1,398	2,439	74.5
Service Mileage	40,105	83,565	108.4
Beneficiary Travel Avoidance	$6,648.66	$12,316.81	85.3
Special Mode Savings	$34,710.00	$49,285.00	42.0
Total Cost Savings	$41,358.66	$61,601.81	48.9

* Metrics are for 10 months of FY 2012; the VTS became fully operational on November 22, 2011.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[1]

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

NM	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement that met regularly. • There was evidence that outlier data was acted upon. • There was evidence that QM, patient safety, and systems redesign were integrated.	
	The protected peer review process met selected requirements: • The PRC was chaired by the Chief of Staff and included membership by applicable service chiefs. • Actions from individual peer reviews were completed and reported to the PRC. • The PRC submitted quarterly summary reports to the MEC. • Unusual findings or patterns were discussed at the MEC.	
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners were initiated and completed, and results were reported to the MEC.	
	Specific telemedicine services met selected requirements: • Services were properly approved. • Services were provided and/or received by appropriately privileged staff. • Professional practice evaluation information was available for review.	

NM	Areas Reviewed (continued)	Findings
	Observation bed use met selected requirements: • Local policy included necessary elements. • Data regarding appropriateness of observation bed usage was gathered. • If conversions to acute admissions were consistently 30 percent or more, observation criteria and utilization were reassessed timely.	
	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee was responsible for reviewing episodes of care where resuscitation was attempted: • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • Data were collected that measured performance in responding to events.	Nine months of ICU Committee meeting minutes reviewed: • There was no evidence that the committee reviewed each code episode.
	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • All surgical deaths were reviewed. • Additional data elements were routinely reviewed.	
	Critical incidents reporting processes were appropriate.	
X	The process to review the quality of entries in the EHR met selected requirements: • A committee was responsible to review EHR quality. • Data were collected and analyzed at least quarterly. • Reviews included data from most services and program areas.	Twelve months of MRC meeting minutes reviewed: • The committee did not analyze all reports of EHR quality review results.
	The policy for scanning non-VA care documents met selected requirements.	

NM	Areas Reviewed (continued)	Findings
X	The process to review blood/transfusions usage met selected requirements: • A committee with appropriate clinical membership met at least quarterly to review blood/transfusions usage. • Additional data elements were routinely reviewed.	Four quarters of Ancillary Testing Committee meeting minutes reviewed: • A clinical representative from Surgery Service did not attend any of the four meetings. • The committee's membership did not include a clinical representative from Anesthesia Service. • The review process did not include the results of peer reviews when transfusions did not meet criteria.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	Overall, 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 met any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that the ICU Committee reviews each code episode.

2. We recommended that the MRC analyze all reports of EHR quality review results.

3. We recommended that processes be strengthened to ensure that a member from Surgery Service attends Ancillary Testing Committee meetings, that a clinical representative from Anesthesia Service is added as an Ancillary Testing Committee member, and that the blood/transfusions usage review process includes the results of peer reviews when transfusions did not meet criteria.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in radiology and acute MH were met.[2]

We inspected the medical/surgical and CLC units, the ICU, the emergency and radiology departments, and the Spirit and Freedom primary care clinics. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 10 radiology employee training records. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Auditory privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Radiology	
	The facility had a Radiation Safety Committee, the committee met at least every 6 months and established a quorum for meetings, and the Radiation Safety Officer attended meetings.	
	Radiation Safety Committee meeting minutes reflected discussion of any problematic areas, corrective actions taken, and tracking of corrective actions to closure.	
	Facility policy addressed frequencies of equipment inspection, testing, and maintenance.	

NM	Areas Reviewed for Radiology (continued)	Findings
	The facility had policy for the safe use of fluoroscopic equipment.	
	The facility Director appointed a Radiation Safety Officer to direct the radiation safety program.	
	X-ray and fluoroscopy equipment items were tested by a qualified medical physicist before placed in service and annually thereafter, and quality control was conducted on fluoroscopy equipment in accordance with facility policy/procedure.	
	Designated employees received initial radiation safety training and training thereafter with the frequency required by local policy, and radiation exposure monitoring was completed for employees within the past year.	
	Environmental safety requirements in x-ray and fluoroscopy were met.	
	Infection prevention requirements in x-ray and fluoroscopy were met.	
	Medication safety and security requirements in x-ray and fluoroscopy were met.	
	Sensitive patient information in x-ray and fluoroscopy was protected.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Acute MH	
NA	MH EOC inspections were conducted every 6 months.	
NA	Corrective actions were taken for environmental hazards identified during inspections, and actions were tracked to closure.	
NA	MH unit staff, Multidisciplinary Safety Inspection Team members, and occasional unit workers received training on how to identify and correct environmental hazards, content and proper use of the MH EOC Checklist, and VA's National Center for Patient Safety study of suicide on psychiatric units.	
NA	Locked MH unit(s) were in compliance with MH EOC Checklist safety requirements or an abatement plan was in place.	
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management

The purpose of this review was to determine whether the appropriate clinical oversight and education were provided to patients discharged with orders for fluoroquinolone oral antibiotics.[3]

We reviewed relevant documents and conversed with key managers and employees. Additionally, we reviewed the EHRs of 35 randomly selected inpatients discharged on 1 of 3 selected oral antibiotics. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Clinicians conducted inpatient learning assessments within 24 hours of admission or earlier if required by local policy.	
	If learning barriers were identified as part of the learning assessment, medication counseling was adjusted to accommodate the barrier(s).	
	Patient renal function was considered in fluoroquinolone dosage and frequency.	
	Providers completed discharge progress notes or discharge instructions, written instructions were provided to patients/caregivers, and EHR documentation reflected that the instructions were understood.	
	Patients/caregivers were provided a written medication list at discharge, and the information was consistent with the dosage and frequency ordered.	
	Patients/caregivers were offered medication counseling, and this was documented in patient EHRs.	
	The facility established a process for patients/caregivers regarding whom to notify in the event of an adverse medication event.	
	The facility complied with any additional elements required by VHA or local policy.	

COC

The purpose of this review was to evaluate discharge planning for patients with selected aftercare needs.[4]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 27 patients with specific diagnoses who were discharged from July 1, 2012, through June 30, 2013. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings
	Patients' post-discharge needs were identified, and discharge planning addressed the identified needs.	
	Clinicians provided discharge instructions to patients and/or caregivers and validated their understanding.	
	Patients received the ordered aftercare services and/or items within the ordered/expected timeframe.	
	Patients' and/or caregivers' knowledge and learning abilities were assessed during the inpatient stay.	
NA	The facility complied with any additional elements required by VHA or local policy.	

Nurse Staffing

The purpose of this review was to determine whether the facility implemented the staffing methodology for nursing personnel and completed annual reassessments and to evaluate nurse staffing on two inpatient units (acute medical/surgical and long-term care).[5]

We reviewed facility and unit-based expert panel documents and 16 training files, and we conversed with key employees. Additionally, we reviewed the actual nursing hours per patient day for 2 randomly selected units—acute medical/surgical unit 4E and a CLC unit—for 50 randomly selected days between October 1, 2012, and September 30, 2013. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
X	The facility either implemented or reassessed a nurse staffing methodology within the expected timeframes.	• Initial implementation was not completed until June 20, 2013.
	The facility expert panel followed the required processes and included the required members.	
	The unit-based expert panels followed the required processes and included the required members.	
	Members of the expert panels completed the required training.	
	The 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 VHA or local policy.	

Recommendation

4. We recommended that nursing managers monitor the staffing methodology that was implemented in June 2013.

Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[6]

We reviewed relevant documents, 13 EHRs of patients with pressure ulcers (2 patients with hospital-acquired pressure ulcers, 10 patients with community-acquired pressure ulcers, and 1 patient with a pressure ulcer at the time of our onsite visit), and 10 employee training records. Additionally, we inspected one patient room. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care.	
	The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist.	
	Pressure ulcer data was analyzed and reported to facility executive leadership.	
	Complete skin assessments were performed within 24 hours of acute care admissions.	
	Skin inspections and risk scales were performed upon transfer, change in condition, and discharge.	
	Staff were generally consistent in documenting location, stage, risk scale score, and date acquired.	
	Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers.	
	Required activities were performed for patients determined to not be at risk for pressure ulcers.	
	For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided.	
	If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies.	

NM	Areas Reviewed (continued)	Findings
X	The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers.	• For 3 of the applicable 12 patients with a pressure ulcer, EHRs did not contain evidence that education was provided.
X	The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings.	• The facility had not developed staff pressure ulcer education requirements.
	The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

5. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients with pressure ulcers and/or their caregivers and that compliance be monitored.

6. We recommended that the facility establish staff pressure ulcer education requirements and that compliance be monitored.

CLC Resident Independence and Dignity

The purpose of this review was to determine whether VHA facilities provided CLC restorative nursing services and complied with selected nutritional management and dining service requirements to assist CLC residents in maintaining their optimal level of functioning, independence, and dignity.[7]

We reviewed 15 EHRs of residents (10 residents receiving restorative nursing services and 5 residents not receiving restorative nursing services but candidates for services). We also observed 3 residents during 2 meal periods, reviewed 10 employee training/competency records and other relevant documents, and conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings
	The facility offered restorative nursing services.	
X	Facility staff completed and documented restorative nursing services, including active and passive range of motion, bed mobility, transfer, and walking activities, according to clinician orders and residents' care plans.	Of the 5 residents on the unit for more than 3 months who were candidates for restorative nursing services: • Two had not received restorative nursing services. • Two did not receive restorative nursing services until October 30, 2013, and November 5, 2013, respectively.
X	Resident progress towards restorative nursing goals was documented, and interventions were modified as needed to promote the resident's accomplishment of goals.	• In 8 of the 10 applicable EHRs, there was no evidence that facility staff documented resident progress towards restorative nursing goals or that interventions were modified to promote the residents' accomplishment of goals.
	When restorative nursing services were care planned but were not provided or were discontinued, reasons were documented in the EHR.	
	If residents were discharged from PT, occupational therapy, or kinesiotherapy, there was hand-off communication between Physical Medicine and Rehabilitation Service and the CLC to ensure that restorative nursing services occurred.	
	Training and competency assessment were completed for staff who performed restorative nursing services.	
	The facility complied with any additional elements required by VHA or local policy.	

NM	Areas Reviewed for Assistive Eating Devices and Dining Service	Findings
	Care planned/ordered assistive eating devices were provided to residents at meal times.	
	Required activities were performed during resident meal periods.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

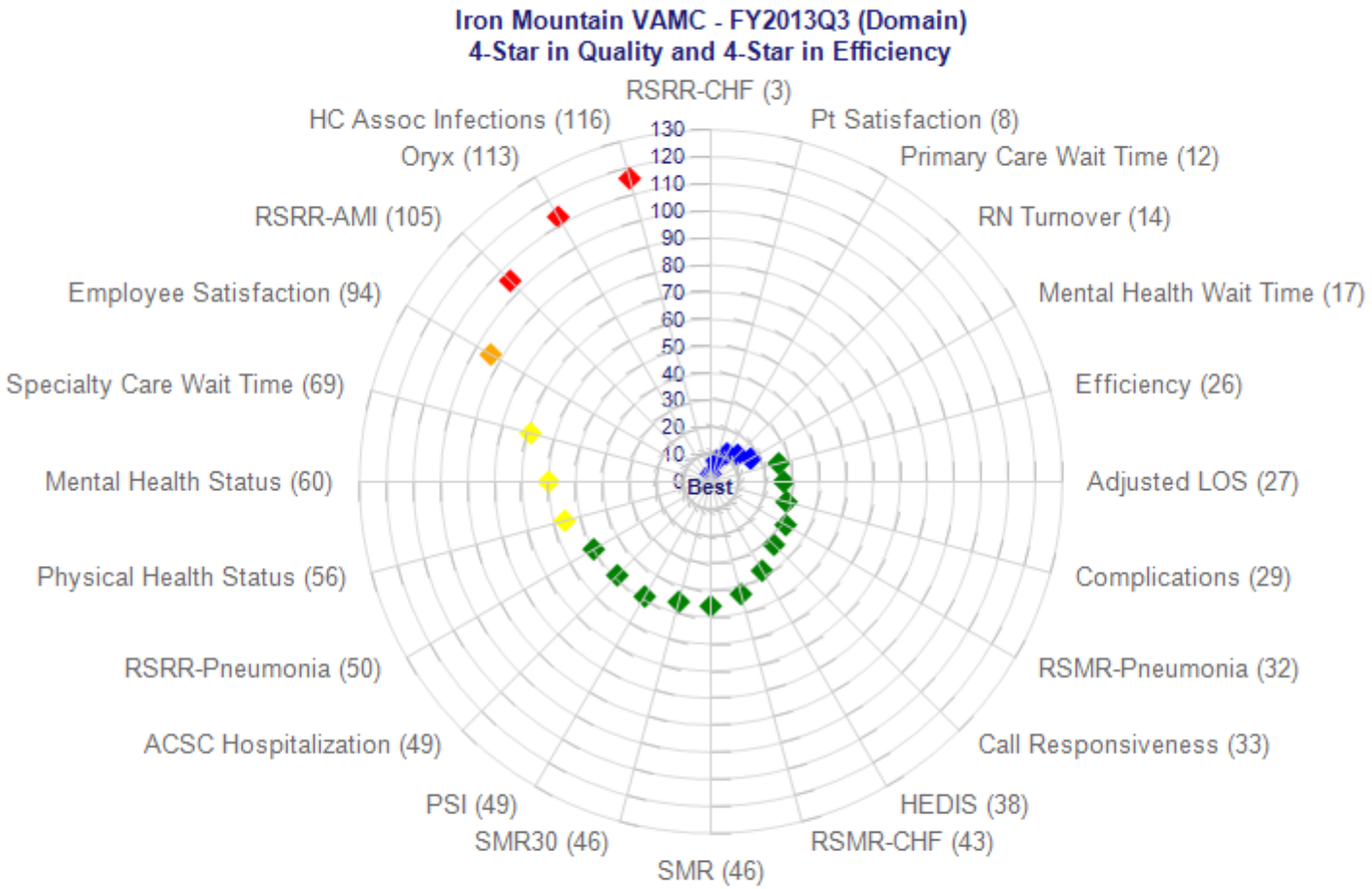
7. We recommended that processes be strengthened to ensure that staff provide timely restorative nursing services to residents who are candidates for those services and that compliance be monitored.

8. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals, modify interventions as needed, and document the modifications and that compliance be monitored.

Facility Profile (Iron Mountain/585) FY 2014 through December 2013[a]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions (as of September 2013)	$116.7
Number of:	
• **Unique Patients**	11,013
• **Outpatient Visits**	39,745
• **Unique Employees**[b]	521
Type and Number of Operating Beds (as of October 2013):	
• **Hospital**	17
• **CLC**	40
• **MH**	N/A
Average Daily Census (as of November 2013):	
• **Hospital**	14
• **CLC**	38
• **MH**	N/A
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Hancock/585GA Rhinelander/585GB Menominee/585GC Ironwood/585GD Marquette/585HA Sault Ste. Marie/585HB
VISN Number	12

[a] All data is for FY 2014 through December 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200) from most recent pay period.

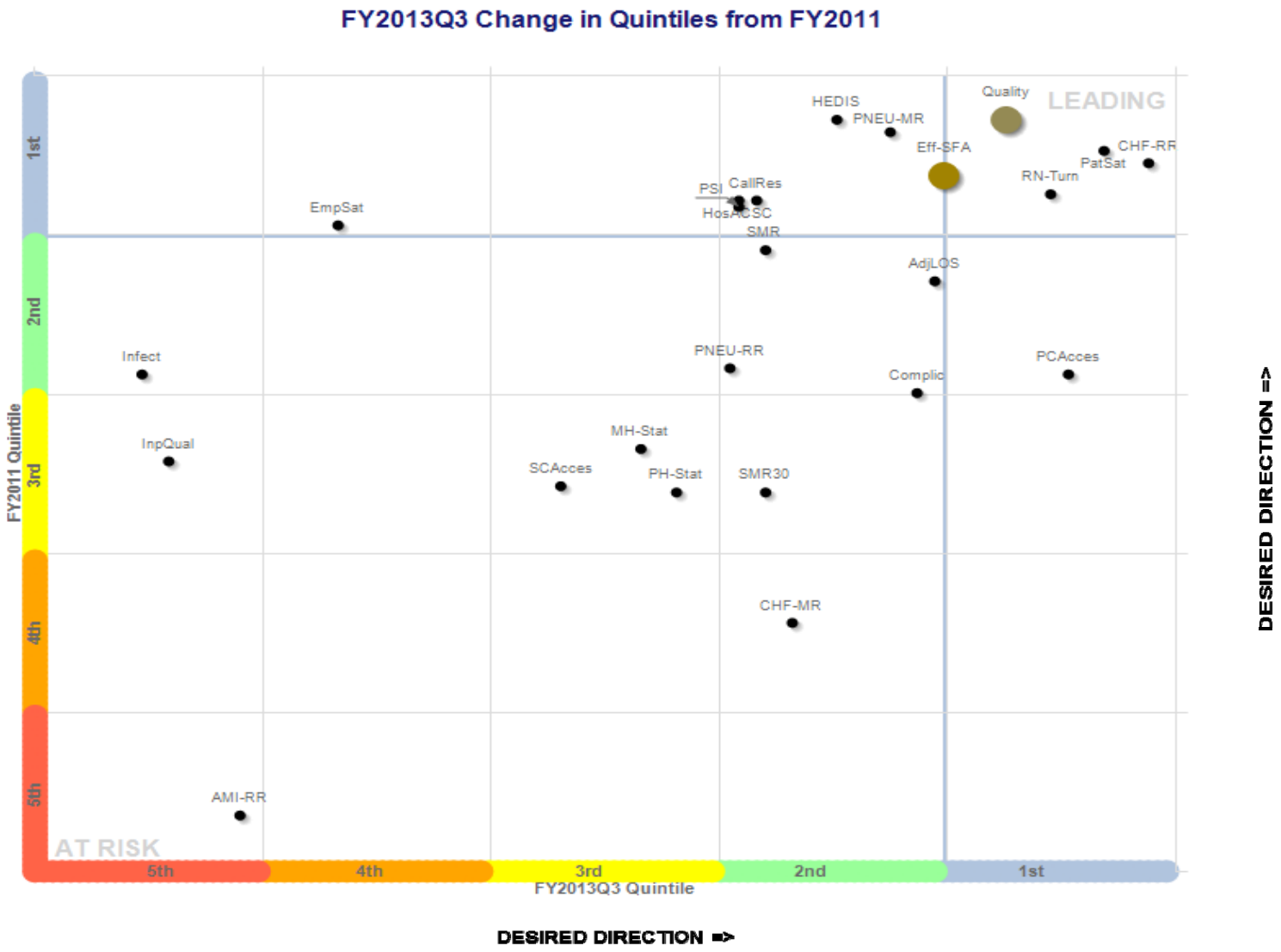
Strategic Analytics for Improvement and Learning (SAIL)[c]



Numbers in parentheses are facility ranking based on z-score of a metric among 128 facilities. Lower number is more favorable.
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

[c] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Metric Definitions

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

Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 2, 2014

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

Subject: **CAP Review of the Oscar G. Johnson VA Medical Center, Iron Mountain, MI**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have reviewed the draft report and I concur with the Office of Healthcare Inspections recommendations as well as the corrective action plans developed by the Oscar G. Johnson VA Medical Center.

2. Thank you for the opportunity to review the findings enclosed in this report.

Renee Oshirak

(For and in the absence of:)
Jeffrey A. Murawsky, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 27, 2013

From: Director, Oscar G. Johnson VA Medical Center (585/00)

Subject: **CAP Review of the Oscar G. Johnson VA Medical Center, Iron Mountain, MI**

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

1. The recommendations made during the Office of Inspector General (OIG) Combined Assessment Program (CAP) Review Conducted November 4–7, 2013 have been reviewed and a plan of action for each recommendation is noted below. Each plan of action will be implemented expeditiously and thoroughly monitored to satisfactory completion.

2. I would like to thank the OIG CAP Survey Team for their professionalism and consultative feedback to our employees during our review. This review provided us the opportunity to continue improving care to our Veterans.

3. If you have questions or require additional information, please contact Ms. Mary Gagala, Quality Manager, at 906-774-3000, extension 32035.

James W. Rice

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 the ICU Committee reviews each code episode.

Concur

Target date for completion: June 1, 2014

Facility response: An interdisciplinary group comprised of an RN, physician, and a Respiratory Therapist have been assigned to review each code and discuss the information with the Intensive Care Unit (ICU) Management Committee. Individual codes and aggregate data will be included in this review. This topic has been added as a standing agenda item to the agenda of ICU Management Committee and will then be reported to CEB through ICU Management Committee minutes.

Recommendation 2. We recommended that the MRC analyze all reports of EHR quality review results.

Concur

Target date for completion: June 1, 2014

Facility response: The Medical Record Committee has revised their charter to include additional members including Chief of Medicine, Chief of Surgery, Social Work Executive, Chief of Behavioral Health, Chief of Dental, MDS Coordinator, ACOS of Primary Care, and Rehabilitation. Reviews are defined including population size using criteria as outlined in Handbook 1907.01 Health Information Management and Health Records. A schedule for reporting is included in the charter and is reviewed annually. The charter has been approved and implemented. Analysis of reviews will begin at the January 2014 MRC meeting.

Recommendation 3. We recommended that processes be strengthened to ensure that a member from Surgery Service attends Ancillary Testing Committee meetings, that a clinical representative from Anesthesia Service is added as an Ancillary Testing Committee member, and that the blood/transfusions usage review process includes the results of peer reviews when transfusions did not meet criteria.

Concur

Target date for completion: August 1, 2014

Facility response: Ancillary Services Liaison Committee charter will be updated to include the Chief of Medicine, Chief of Surgery, and Anesthesia as committee members. The Chief of Surgery and CRNA have been educated as to their membership on this committee and required attendance. Blood or blood products are a standing agenda item of this committee. Any transfusion not meeting criteria will be included in the facility protected peer review process.

Recommendation 4. We recommended that nursing managers monitor the staffing methodology that was implemented in June 2013.

Concur

Target date for completion: June 20, 2014

Facility response: The facility completed two nurse staffing methodology reports. The first report was dated October 31, 2011. However, the report was not signed by the staffing methodology panel members, the Associate Director, Nursing and Patient Care Services, and the Director. Suggested process improvement strategies in this document were implemented on the units.

The second report was dated October 1, 2012 and was sent back to the staffing methodology panel for further clarification and information by the Associate Director of Nursing and Patient Care Services. It was received and reviewed prior to June 20, 2013; however, it was an oversight that signatures were required and were not obtained until June 2013.

The unit level staffing panel is currently in the process of completing the most recent report to present to the facility expert panel. The next report will be signed no later than June 2014. We are in full compliance with the Directive as of June 20, 2013.

Recommendation 5. We recommended that processes be strengthened to ensure that acute care staff provide and document pressure ulcer education for patients with pressure ulcers and/or their caregivers and that compliance be monitored.

Concur

Target date for completion: June 1, 2014

Facility response: Wound care education booklets have been purchased and are utilized for patient and caregiver education. All nursing staff has received education regarding these booklets. The providers were also educated regarding the need for patient and caregiver education at the November 1, 2013 provider meeting. Education is provided to patients and their family during their hospitalization. Pressure ulcer discharge instructions have also been added to the unit clerk's discharge checklist as an additional staff reminder to provide this education upon discharge. Documentation of wound care education completion is being monitored by the Nurse Manager (NM) and will be added to the quarterly pressure ulcer report to Quality Board. In addition, the data is aggregated monthly by the NM and is reviewed monthly by Nursing Leadership.

Recommendation 6. We recommended that the facility establish staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: July 1, 2014

Facility response: Pressure ulcer education was added to Medical Center Memorandum 118-03 (Pressure Ulcer Policy) on November 18, 2013. Our TMS (Talent Management System) assigns the topic to required staff and reports are tracked to show compliance with the education requirement. Compliance with staff pressure ulcer education is monitored by Nursing Leadership and will be reported quarterly to the Quality Board.

Recommendation 7. We recommended that processes be strengthened to ensure that staff provide timely restorative nursing services to residents who are candidates for those services and that compliance be monitored.

Concur

Target date for completion: July 1, 2014

Facility response: In November 2014, an assessment was conducted of all long term care residents to determine which veterans were in need of restorative care. All veterans requiring restorative care are currently receiving these services. An RN on the CLC has completed restorative education and will sit for the next certification exam in 2014. The Interdisciplinary Team has weekly discussions to review the status of veterans who are receiving restorative care as well as identify additional veterans for restorative care services. Reports on residents reviewed for restorative services will be presented quarterly to the CLC Leadership Committee.

Recommendation 8. We recommended that processes be strengthened to ensure that staff document resident progress towards restorative nursing goals, modify interventions as needed, and document the modifications and that compliance be monitored.

Concur

Target date for completion: July 1, 2014

Facility response: All veterans receiving restorative care have goals identified. Progress toward goals, interventions, and modifications to goals are documented by the Restorative Care Team. The CLC Nurse Manager and MDS Coordinator will monitor report compliance to the CLC Leadership Committee to assure progress towards restorative goals and intervention modification is documented.

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Endnotes

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