



CLEMENT J. ZABLOCKI VAMC | MILWAUKEE, WI

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Overview

The Clement J. Zablocki VA Medical Center (ZVAMC) provides primary, secondary, and tertiary medical care to more than 70,000 eligible veterans throughout 16 counties or 7,500 square miles in Wisconsin. The 10-story facility has a total of 189 beds and provided close to 1 million outpatient visits in Fiscal Year 2016. The director of ZVAMC also oversees four clinics that include the 162,000 square-foot Green Bay Milo Huempfer Health Care Center.

The hospital also boasts many innovative programs especially in its domiciliary program where 150 beds exist for Alcohol/Drug Rehabilitation Program, Post – Traumatic Stress Disorder (PTSD) Treatment program, General Rehabilitation, and Treatment Unit for veterans with chronic mental health problems. The medical center also has a Transitional Program at the domiciliary that helps veterans obtain career opportunities. Lastly, the domiciliary provides specialized treatment designed to also meet the needs of women veterans.

Town Hall Meeting

Dr. Zomchek has served as the director of the Zablocki VAMC since June 27, 2016. Prior to his current appointment, he served as Associate Director of the Edward Hines Jr. VA Hospital for nearly 5 years. He attended the town hall meeting and answered questions from Legionnaires. Legionnaires asked a variety of questions ranging from eligibility to opioid prescribing. One attendee spoke extensively about his battle with pain as the discussion segued to medical marijuana versus opioids.

Attendees at the town hall meeting heard from a former U.S. Army Chaplain's Assistant whose vehicle struck a landmine in Afghanistan. The blast hurled the Chaplain's Assistant upward and through a crew-served weapons mount. He suffered devastating injuries to his head, neck and shoulders. If that was not enough, his convoy came under fire as his fellow soldiers tried to pull him from the burning vehicle. They received gunfire and the Chaplain's Assistant was hit in the thigh with a bullet that caused a femoral shaft comminuted fracture.

Although the unit was able to rescue and later transfer him to a field medical hospital, the Chaplain's Assistant suffered injuries that caused unbearable physical pain and emotional distress or

as he called it, Post-Traumatic Stress. The gentleman told of excruciating physical pain and the emotional trauma of learning to walk again and have his wife care of him as if he were a child.

He spoke about physicians at the VA medical prescribing opioids for pain. He also described how his body first accepted the medication but after several months his pain could not be controlled by the prescription drug, and as his pain increased, so did his mental anguish and depression. The Chaplain said he began researching medical marijuana after hearing other wounded veterans talk about its benefits.

The Chaplain conducted his research and decided to talk with his VA primary care physician at the VA. Although the doctor did not extol the benefits of medical marijuana or prescribe it, the physician admitted that if permitted by law, he would prescribe medical marijuana for patients suffering from severe pain stemming from combat-related injuries. The Chaplain says he uses medical marijuana daily. Moreover, he stated his pain and PTSD have improved tremendously, and he is able to perform physical functions in ways he had not while taking prescription opioids.

Although turnout was not as expected, Dr. Zomchek conducted an excellent discussion session with veterans and staff of The American Legion. The town hall ended with Dr. Zomchek inviting veterans to talk with him after the meeting and anytime at his office.

Executive Leadership Briefing

During the System Worth Saving sessions with the executive leadership team at ZVAMC, they identified the following as their "Top Challenges."

Challenges

Nurse Recruitment

The executive leadership team expressed concern about funding cuts to a program used to recruit experienced nurses and recent nursing-school graduates. The VA National Nurse Expansion Initiative in the future, at Zablocki, will be damaged because no one will apply out of fear of the program's lack of funding and instability. Moreover, the nursing program seeks demographic diversity and working with a local university was one way in



fulfilling that goal. A lack of funding seriously jeopardizes the ability to achieve that goal in the future.

Aging Infrastructure (physical plant)

The Department of Veterans Affairs activated the main hospital in 1966. A half century later the facility does not provide sufficient space for the delivery of both physical and mental health services to a growing veteran population in the area. The lack of space ultimately affects access to care and could potentially cause the exponential growth of patient wait times.

Multiple Personnel Systems

The Department of Veterans Affairs uses several personnel management systems in accordance with federal laws and regulations. The VA has Civil Service through the Office of Personnel Management (Title 5), Title 38, and Title 38 Hybrid employees. Human Resources explained the depth of the difficulty trying to operate within all three systems – the long timelines to hire, conflicting policies, and forced obligations. Similar to HR staff at other VA medical facilities, the representatives believe VA Central Office tells them “what to do when it comes to staffing, but not how to do it.”

Best Practices

Spinal Cord Injury Center: The Spinal Cord Injury program has gained national recognition through the leadership of its doctors, clinicians, and therapists. The Spinal Cord Injury Center is a state-of-the-art equipment facility that has provided specialized care to nearly 500 patients from more than 22 states. The program has developed many innovative approaches to serving veterans with spinal cord injuries that have been adopted by other VA medical centers and hospitals in the commercial sector. In fact, Dr. Kenneth Lee, the program’s manager, has been invited to speak at events across the country on rehabilitative processes for patients with spinal cord injuries. Dr. Lee is also the recipient of 2016 Wisconsin State Disabled Veteran of the Year award from the Disabled American Veterans (DAV) for excellence in serving veterans and the community.

Patient Engagement with Primary Care Physicians: According to the administration and clinical management team, Zablocki VA Medical Center enjoys exceptional patient clinical outcomes. They attribute the outcomes to the primary care physicians who establish and maintain excellent relations with patients.

The claim suggests a herculean undertaking by the Chief of Staff to ensure patient experiences and health outcomes for the more than 800,000 outpatient visits, nearly 5,000 surgical procedures, and 7,789 inpatient admissions in the fiscal year 2016.

Community Engagement and Support: Zablocki staff actively

participate in a variety of community events. This includes local parades honoring veterans to state events to end homelessness among veterans. For instance, the program manager of the Spinal Cord Injury Center participated in 15 community partnerships and took 13 veterans with spinal cord injuries to the National Wheelchair Games in 2016. Their efforts have reaped great benefits as donations and gifts surged in 2016. The director of Community Engagement reported to the SWS team that as of July 2017 community donations and gifts totaled \$2 million. Total gifts and donations in 2016 reached \$9 million.

Exit Briefing and Recommendations

Nurse Recruitment

Recommendation: The American Legion recommends expanding recruiting efforts to other states and cities where experienced nurses find difficulty obtaining employment. Nurses in states like New Jersey, California, Nevada, and Florida have complained about the difficulty of finding jobs in these states. Some have expressed interests in relocating even though they may face the prospect of losing their home state license.

Moreover, some national groups such as the National Council of State Boards of Nursing offer a potential solution through the Enhanced Nurse Licensure Compact (eNLC) for experienced nurses seeking multi-state licensure in “eNLC States.” However, Wisconsin Statute § 441.50 (4) offers recruiters additional guidance as to licensing nurses with valid credentials from other states.

Recommendation: We also offer recommendations with a longer-term focus but with the potential of benefitting Zablocki VAMC. We recommend recruiting more men for nurse training and employment. According to the National Center for Health Workforce Analysis, men comprise 9.1 percent of Registered Nurses and 7.6% of Licensed Practical Nurses. A plethora of surveys and literature exists outlining barriers males face in nursing schools and clinical settings. Additionally, many organizations often overlook this demographic in active nurse recruitment campaigns.

Aging Infrastructure (physical plant)

Recommendation: Leadership should continue identifying the need for space through the Strategic Capital Investment Program and leverage their relationships with local Veteran Service Organizations to champion their cause.

However, the medical center completed a business case under the SCIP for FY2018 to FY 2027. The business case proposed 52 projects with a total projected monetary outlay of \$439.1 million. The Veterans Health Administration amended its policies on the types of projects that could be submitted that obliged Za-



blocki leadership to reduce the number of projects. The medical facility resubmitted 7 business cases with a projected budget of nearly \$24 million. Leadership awaits the approval of those 7 projects by VHA. The leadership staff did not disclose the nature of the projects to the SWS team.

Multiple Personnel Systems

Recommendation: The HR staff discussed during the SWS visit the difficulty of managing four separate Human Resource Management Systems and various policies associated with those systems and associated requirements. Title 5 for Senior Executive Service or SES staff, Title 38 for about 67 percent of VHA employees including health care professionals, a so-called Title 38 Hybrid for other VA health professionals, and Title 38-7306 for IT related and technical positions.

The American Legion recommends the medical center wait for the outcome of the special commission initiated by the 115th Congress – VA Commission on Care. The Commission is looking into creating a single personnel system for the VA and other issues across the Veterans Health Administration. The Commission was initiated in 2016 and has already proposed the alternative personnel management system that is more streamlined, less cumbersome, and with consideration for market-based compensation. ,

Conclusion

The scope of the SWS visit included looking at the general operations of the medical facility by conducting structured and unstructured interviews with staff. The SWS team also conducted tours of various areas of the hospital. The Zablocki Veterans Medical Center has great leadership, medical expertise, and efficient operations. However, the medical center has seen its share of allegations and investigations by the VA Office of the Inspector General or VAOIG.

After the SWS visit, the VAOIG published two Healthcare Inspection reports. The VAOIG published a report titled, Healthcare Inspection Management of Mental Health Care Concerns, Zablocki VA Medical Center, on July 27, 2017. The second report was published on August 22, 2017, which reviewed opioid prescribing practices among physicians at Zablocki.

Although both reports were published in 2017, VAOIG conducted both inspections in 2015. The August 22nd report did not find any evidence of “opioid diversion, criminal, or illegal activities associated with opioid prescriptions dispensed at the facility.” The VAOIG made 3 recommendation with target completion dates of September 2017. The recommendations were all directed toward VISN 12. As for the third recommendation, the VAOIG accepted the VISN director’s plan and closed that

recommendation in May 2017.

The Healthcare Inspection Management of Mental Health Care Concerns, Zablocki VA Medical Center report, published on July 27, 2017, was alarming because it alleged a suicide. The American Legion System Worth Saving team contacted the VAMC for follow-up since the report was released after the SWS visit. The initial allegations and subsequent allegations by Senators Tammy Baldwin and Ron Johnson included:

- Staff do not follow MH RRTP program policies including monitoring access to the units, performing rounds, maintaining physical presence and engagement in the milieu on the unit, and executing measures to diminish the potential flow of contraband onto the unit.
- Inadequate staff are present on the units therefore, staff are assigned to multiple units and are not performing assigned duties.
- A physician prescribed a patient a higher than indicated Suboxone (buprenorphine/naloxone) dose.
- The locked AMHIU is not safe and secure. A patient’s friend visited and the patient was later found unresponsive in his room after taking non-prescribed medications. The friend was not checked for contraband. The failure to check for contraband contributed to the availability of non-prescribed drugs on the secured unit.
- The management and operations in the MH RRTP are not meeting clinical, safety and security standards established by the Veterans Healthcare Administration (VHA):
 - » Staff are not conducting random contraband checks or limiting the flow of contraband onto the unit. These inconsistent practices may have resulted in a patient attempting suicide by an overdose and another patient having a syringe in his room.
 - » An Administrative Investigation Board determined that the domiciliary was not safe or secure and made 16 recommendations.
 - » A patient was denied admission to MH RRTP then left the facility and committed suicide.



The VAOIG made three recommendations:

1. *Recommendation:* We recommended that the Facility Director ensure that Mental Health Residential Rehabilitation Treatment Program local policies are consistent with the Veterans Health Administration Mental Health Residential Rehabilitation Treatment Program Handbook and Mental Health Residential Treatment Program leaders and staff adhere to the policies. **Target date for completion: November 1, 2017**
2. *Recommendation:* We recommended that the Facility Director ensure that the Mental Health Residential Rehabilitation Treatment Program managers monitor compliance as outlined by Veterans Health Administration Mental Health Residential Rehabilitation Treatment Program Handbook. **Target date for completion: November 1, 2017**
3. *Recommendation:* We recommended that the Facility Director ensure that the Mental Health Residential Rehabilitation Treatment Program has adequate resources, including staff, as specified by the Mental Health Residential Rehabilitation Treatment Program Handbook to provide a safe therapeutic environment. **Target date for completion: Completed**

The leadership at Zablocki concurred with each recommendation made by the VAOIG. The American Legion contacted staff at the medical center for a response to the VAOIG report as a supplement to this report. On August 7, 2017, Zablocki VAMC stated in an email to the SWS team:

“First is to clarify is the [sic] “allegation” was that he was denied care to the MHRRTTP. On page 17 of the OIG report, there is no indication that he was denied care to the MHRRTTP SAR as noted on page 28 of the report. Rather, he had been treated in the MHRRTTP SAR program and then irregularly discharged from the program prior to his suicide.

The next issue to clarify is the difficulty in [sic] providing care to this particular Veteran (Patient 5, case review is noted on Pages 17 & 18). His case is similar to many other Veterans who struggle with mental health and addiction problems. These Veterans with complicated family, vocational, mental health and addiction problems present us with significant challenges.

Patient 5 was difficult to engage in mental health treatment as noted in the background description in the report. On page 17, it is noted that he had refused inpatient mental health treatment on a few occasions and only sporadically attending outpatient mental health treatment offerings. He was brought to the facility at times by his family and even then he insisted in leaving the hospital against medical advice. Our staff attempted many times to reconnect him to our treatment programs with only limited

success.

During his final admission to our domiciliary, he initially attended the programming and was participating appropriately. However, as he continued in the program, he violated the rules (We cannot comment on the nature of the violations due to confidentially [sic] issue) to the point that he could not continue in the program. His behavior had begun impact the care other Veterans were receiving and it was not appropriate, clinically, for him to remain in the program due to his behaviors. In the process of his discharge, he was overheard expressing thoughts of suicide over the phone and was transferred to the Emergency Department and admitted to a medical unit. He was discharged after a short stay back to the MHRRTTP SAR. He was discharged by his MHRRTTP team with appropriate follow up instructions once he returned to the MHRRTTP. He did not follow up on these appointments and was found dead 3 days after this discharge... our goal in the VA is obtain Zero Suicides for Veterans per Dr. Shulkin and we will continue to strive for this goal. We appreciate the support and consultation you have provided to our facility. We hope that our response provides some answers to your concerns regarding our processes and the care we provided to this Veteran.