Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Cincinnati VA Medical Center Cincinnati, Ohio

Report No. 07-01149-182 **August 2, 2007**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

The Department of Veterans Affairs, Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Cincinnati VA Medical Center (the medical center), Cincinnati, OH, during the week of March 26–30, 2007. The purpose of the review was to evaluate selected medical center operations, focusing on patient care administration and quality management (QM). During the review, the Office of Investigations provided four fraud and integrity awareness briefings to 298 employees.

Results of Review

This review focused on six areas. The medical center complied with standards in the following three areas:

- Cardiac Catheterization Laboratory Standards.
- Community Based Outpatient Clinics (CBOCs).
- Survey of Healthcare Experiences of Patients (SHEP).

We identified three areas that needed additional management attention. To improve operations we made the following recommendations:

- Revise business rules for veterans health information systems.
- Resolve environment of care (EOC) discrepancies.
- Improve QM oversight of peer review, medical record review, and patient flow.

This report was prepared under the direction of Randall Snow, JD, Associate Director, and Gail Bozzelli, RN, Health Systems Specialist, Washington, DC, Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–16 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

Facility Profile

Organization. The medical center is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five CBOCs located in Greendale, IN; Bellevue and Florence, KY; and Cincinnati and Hamilton, OH. The medical center is part of Veterans Integrated Service Network (VISN) 10 and serves a veteran population of approximately 210,000 in a primary service area that includes 17 counties in Indiana, Kentucky, and Ohio.

Programs. The medical center provides medical, surgical, mental health, geriatric, rehabilitation, dentistry, and interventional radiology services. The medical center has 116 hospital beds, 64 nursing home beds, and operates several regional referral and treatment programs. These programs include a 50-bed domiciliary for homeless veterans, a 10-bed substance abuse facility, and a 22-bed (10 female and 12 male) post-traumatic stress disorder (PTSD) domiciliary.

Affiliations and Research. The medical center is affiliated with the University of Cincinnati and supports over 100 medical resident intern and student positions in medical, surgical, neurological, and mental health training programs. Other affiliations include dentistry, pharmacy, nursing, social work, and psychology. In fiscal year (FY) 2006, the research program had approximately 210 projects and a $4.6 million research budget. Important areas of research include biomedical and clinical (mental health, PTSD, addiction and smoking cessation, infectious disease, pulmonary diseases, digestive diseases, rheumatology, cardiology, endocrinology, and oncology). Collaborative research with the University of Cincinnati and Cincinnati Children's Hospital is achieved through the General Clinical Research Center, which is jointly funded.

Resources. In FY 2006, medical care expenditures totaled more than $212 million. The FY 2007 medical care budget is more than $214 million. FY 2006 staffing totaled 1,316 full-time employee equivalents (FTE), including 97.9 physician and 393.1 nursing FTE.

Workload. In FY 2006, the medical center treated 31,632 unique patients. The medical center provided 35,324 inpatient days of care in the hospital and 20,032 inpatient days of care in the Nursing Home Care Unit (NHCU). The inpatient care workload totaled 5,799 discharges; the average daily census, including nursing home patients, was 151.6. The outpatient workload was 337,984 visits.

Objectives and Scope of the Combined Assessment Program Review

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 and employees; and reviewed clinical and administrative records. The review covered the following six activities:

Business Rules for Veterans Health Information Systems	CBOCs
Cardiac Catheterization Laboratory Standards	EOC
	QM
	SHEP

The review covered facility operations for FYs 2005, 2006, and 2007 through March 26, 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, Cincinnati, Ohio*, Report No. 04-03120-151, June 6, 2005).

During the review, we presented four fraud and integrity awareness briefings for 298 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 section titled "Other Observations" have no reportable conditions.

Results of Review

Opportunities for Improvement

Business Rules for Veterans Health Information Systems

The health record, as defined in Veterans Health Administration (VHA) Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, includes the electronic medical record and the paper record, combined, and is also known as the legal health record. It includes items, such as physician orders, chart notes, examinations, and test reports. Once notes are signed, they must be kept in unaltered form. New information, corrections, or different interpretations may be added as further entries to the record, as addenda to the original notes, or as new notes—all reflecting accurately the time and date recorded.

A communication (software informational patch[1] USR*1*26) was sent from the VHA Office of Information (OI) on October 20, 2004, to all medical centers, providing guidance on a number of issues relating to the editing of electronically signed documents in the electronic medical records system.[2] 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." On June 7, 2006, VHA issued a memorandum to all VISN Directors instructing all VA medical centers to comply with the informational patch sent in October 2004.

Business rules define what functions certain groups or individuals are allowed to perform in the medical record. OI has recommended institution of a VHA-wide software change that limits the ability to edit a signed medical record document to the medical center's Privacy Officer. We reviewed VHA and medical center information and technology policies and interviewed Information Resource Management Service staff. We found that the medical center had no rules that allowed editing of a signed note by users other than the author. We found three rules that needed to be changed to limit retraction, amendment, or deletion of notes to the Privacy Officer or the Chief of Health Information Management Service. Medical center staff took action to edit and remove these business rules while we were onsite.

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance related to the altering of signed notes in the health record.

[1] A patch is a piece of code added to computer software in order to fix a problem.
[2] VA's electronic medical records system is called VistA, which is the acronym for Veterans Health Information Systems and Technology Architecture.

The VISN and Medical Center Directors agreed with the findings and recommendation. The improvement actions taken by medical center staff while we were onsite are acceptable. We consider this recommendation closed.

Environment of Care

The purpose of the evaluation was to determine whether the facility established a comprehensive EOC program that met selected VHA, Occupational Safety and Health Administration, and Joint Commission[3] standards. To evaluate EOC, we inspected selected clinical and non-clinical areas for cleanliness, safety, infection control, and general maintenance. Overall, we found the facility to be clean and well-maintained. Interim Life Safety Measures were implemented and monitored at all construction sites. The following condition required management attention.

Administrative Rounds. Administrative rounds by medical center management allows high-level staff to identify and correct sanitation discrepancies, unsafe working conditions, and occupational safety and health regulatory violations. The medical center program provides for semi-annual environmental inspections of the medical center, the Ft. Thomas NHCU, the domiciliaries, and the CBOCs. Local policy designates the Associate Medical Center Director (the Associate Director) as the team leader for conducting rounds. Attendance records demonstrated that the Associate Director, or designee, attended rounds 35 percent of the time in FY 2005 and 13 percent of the time in FY 2006. During part of this timeframe, the Associate Director position was staffed by an acting staff member. Additionally, rounds must be attended by each member of the 12-member inspection team or a designated alternate. For FYs 2005 and 2006, only 1 member of the 12-member team made administrative rounds in the CBOCs.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the Associate Director, or designee, participate in all administrative rounds and that CBOCs are inspected by all 12 members of the administrative rounds team.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center now monitors administrative rounds attendance to assure leadership presence in official rounds and also includes any items identified for attention in an administrative rounds report. The planned improvement actions are acceptable, and we will follow up on reported implementation actions to ensure that they have been completed.

[3] The Joint Commission was formerly the "Joint Commission on Accreditation of Healthcare Organizations," also known as JCAHO.

Quality Management

To evaluate QM activities, we interviewed the medical center Director, Chief of Staff, and QM personnel, and we evaluated plans, policies, and other relevant documents. We found that the QM program generally provided appropriate oversight of patient care. However, the following areas needed improvement.

Follow-Up on Corrective Actions. It was difficult to determine the effectiveness of performance improvements because committee minutes did not clearly document all actions and did not evaluate corrective actions for effectiveness. There was a lack of consistency and standardization of reporting among the program components. It was difficult to follow committee meeting minutes because there was no standardized, systematic reporting format. Not all reports identified action items and assigned responsibility and timeframes for completion and re-evaluation. For example, committee meeting minutes identified the need for training, but no one was assigned responsibility to accomplish the training, no target date was established for completion of the training, and no follow-up was noted indicating that the training had corrected the problem.

Peer Review. The peer review process did not include all components required by VHA Directive 2004-054, *Peer Review for Quality Management*. Peer review is a confidential, non-punitive, and systematic process to evaluate quality of care at the individual provider level. The peer review process includes an initial review by a peer of the same discipline to determine the level of care,[4] with subsequent Peer Review Committee (PRC) evaluation and concurrence with findings. We reviewed peer reviews completed in FY 2006 and the 1st quarter of FY 2007 and identified issues relating to timeliness and evaluation of reviews.

Timeliness. Once the need for peer review is determined, VHA policy requires initial reviews to be completed within 45 days and PRC evaluations within 120 days. The peer reviews that we evaluated showed that 10 of 26 initial reviews were not completed within the required 45 days, and 6 of the 26 final reviews were not completed by the PRC within the required 120 days.

Level Evaluation. VHA policy requires the review of a representative sample of Level 1 peer review cases to ensure reliability of the findings and to evaluate the peer review process. We found that the PRC did not complete required reviews for the Level 1 cases during FY 2006.

[4] Peer review levels: Level 1– Most experienced, competent practitioners would have managed the case similarly; Level 2 – Most experienced, competent practitioners might have managed the case differently; Level 3 – Most experienced, competent practitioners would have managed the case differently.

Medical Records Review. Joint Commission standards require medical record review on an ongoing basis at the point of care.[5] We reviewed Medical Records Committee minutes for FY 2006 and interviewed the Chief of Health Information Management Service. Medical records were not being reviewed on an ongoing basis by personnel at the point of care. Instead, they were reviewed on a retrospective basis by a medical records coder, which delayed identification of problems as they occurred and necessary corrective actions.

Patient Flow. Medical center management is required by Joint Commission standards to assess patient flow issues within the medical center, to assess the impact on patient safety, and to implement plans to mitigate the impact of those issues.[6] We reviewed committee minutes for FY 2006 and interviewed the Chief of Quality Management. Medical center leadership had completed one section of the mandated Joint Commission review and had written action plans to thoroughly review the patient flow in other areas of the institution. The completion of this assessment is necessary to assist medical center leadership to manage the flow of patients and to prevent or mitigate patient crowding, which can lead to lapses in patient safety and quality of care.[7]

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires standardization of committee meeting minutes and identification of action items and persons assigned responsibility for tracking timeframes for completion and evaluation; completion of peer reviews within the required 120 days and appropriate review of Level 1 cases; completion of medical record reviews at the point of care and on an ongoing basis; and completion of the patient flow assessment in accordance with Joint Commission guidelines.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center has implemented standardized committee meeting minutes, peer review improvements, medical record risk assessment procedures, and patient flow monitoring. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure that they have been completed.

[5] JCAHO Comprehensive Accreditation Manual for Hospitals (CAMH), Section 2: Organization Functions, Management of Information, Standard IM.6.10, Element 12.
[6] JCAHO CAMH, Section 2: Organization Functions, Leadership, Standard LD.3.15, Element 1.
[7] JCAHO CAMH, Section 2: Organization Functions, Leadership, Standard LD.3.15, Rationale for LD.3.15.

Other Observations

Cardiac Catheterization Laboratory Standards

Coronary artery disease is the leading cause of death in America. The American Heart Association estimated that 1.2 million Americans would have a new or recurrent heart attack in 2006. Cardiac catheterization is a specialty procedure used to diagnose defects in the heart chambers, valves, and blood vessels and to provide treatment for certain heart problems. There are two types of catheterization procedures—diagnostic and therapeutic. The diagnostic procedure uses radiographic equipment to record images of the heart, which may identify a blockage that requires therapeutic intervention. The therapeutic procedure is a combination of specialized procedures designed to open blockages of coronary blood vessels.

The American College of Cardiology (ACC) has developed standards, which include benchmarks for: (1) the clinical experience of physicians who direct cardiac catheterization laboratories, (2) physicians who perform cardiac catheterizations, and (3) the volume of cases that a laboratory must perform. According to the ACC, there is a direct correlation between low-volume laboratories, low-volume physicians, and increased complication rates. The minimum number of interventional cases per year is 75 for a physician and 400 for a laboratory. A low-volume physician (less than 75 interventional cases per year) should only work in a high-volume laboratory (greater than 600 interventional cases per year).

Due to the advancements in cardiac catheterizations, the risks of the procedure are low; however, complications such as death, stroke, heart attack, and emergency bypass surgery do occur.

The medical center has one cardiac catheterization laboratory with state-of-the-art equipment. One full-time cardiologist performs diagnostic cardiac catheterizations and is the Director of Cardiology. Additional staff includes two part-time interventional cardiologists, a part-time electrophysiologist, three part-time cardiologists, and cardiology fellows in training. The laboratory performed 497 coronary diagnostic cases and 131 interventional procedures in FY 2005, exceeding the minimal number of interventional procedures recommended for an individual physician. The laboratory had an active quality assurance program that monitored complications of diagnostic and interventional cardiac catheterizations.

The laboratory is using IMED (a computer-based informed consent program) to complete the required patient consents, which eliminates common problems in the consent process, such as listing all practitioners performing care during the procedure and identifying the major risks associated with cardiac catheterization. We made no recommendations.

Community Based Outpatient Clinics

A CBOC is a VA-operated, VA-funded, or VA-reimbursed health care facility or site geographically distinct or separate from a parent medical facility. VHA expanded ambulatory and primary care areas under Federal legislation passed in 1996, which included the creation of CBOCs throughout the United States. The enactment of this legislation requires that VA maintain its capacity to provide for the specialized treatment and rehabilitation needs of disabled veterans (including those with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities that are dedicated to the specialized needs of those veterans in a manner that affords them reasonable access to care and services. We reviewed compliance with VHA regulations regarding selected standards of operation, services, patient safety, credentialing and privileging, and provision of emergency care.

We visited the CBOC located in Bellevue, KY, that currently treats 3,161 veterans. We interviewed primary care service line employees and reviewed documents related to the CBOC's services, specifically the management of patients taking warfarin (an anticoagulant medication). We reviewed credentialing and privileging files and background investigations. We also evaluated the clinic's EOC and interviewed 10 veterans.

CBOC clinicians were properly credentialed, privileged, and licensed, and Human Resources Service had completed background investigations on all CBOC employees. Registered nurses managed the anti-coagulation clinic at Bellevue and at the medical center. The same standards of care provided to patients at the medical center are in effect at the CBOC. The 10 veterans, who were being treated at the CBOC the day of our inspection, reported a high level of satisfaction with their providers and the care they receive.

The facility was clean and safe with current emergency preparedness plans and training. The automated external defibrillator was in working order, and maintenance documentation was current. We found that the CBOC was in compliance with all regulations and standards. We made no recommendations.

Survey of Healthcare Experiences of Patients

Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. The Performance Analysis Center for Excellence of the Office of Quality & Performance is the analytical, methodological, and reporting staff for SHEP. To meet Measure 21 of the VHA Executive Career Field Performance Plan for FY 2006, the medical center must achieve patient satisfaction scores of "very good" or "excellent" in 77 percent of

outpatients and 76 percent of inpatients surveyed. The following graphs show the medical center's reported SHEP results for inpatients and outpatients.

Cincinnati Inpatient SHEP Results
Q3 and Q4 FY 2006

	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	82.9+	79.70	89.70	66.2-	64.90	76.00	82.40	73.60	68.50	**
Medical Center	75.9-	66.6-	80.8-	54.5-	48.6-	56.7-	72-	64.6-	52.3-	50-

* Less than 30 respondents
+ Significantly better than national average
- Significantly worse than national average
** No data available

Cincinnati Outpatient SHEP Results
Q4 FY 2006

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	81.10	77.90	94.7	72.8	83.1	75.6	81.9	65.9	81.4	80.7	84.4
VISN	84.3 +	75.00	95.6	71.1	82	75.9	89 +	70.9	81.7	83.1	84.3
Outpatient Clinics - Overall	80.10	78.50	92.6	70.5	86.5	79.2	89.4	51	85.8	91.1 +	86.9
Cincinnati Outpatient Clinic	78.3	79	92	69.4	86.4	79	89.9	*	85.9	92.5 +	87
Bellevue Outpatient Clinic	87	73.4	95.9	73.1	85	79	88.1	*	83.3	81.5	81.9
Clermont County VA Outpatient Clinic	91.7 +	72.5	93.2	75.6	87.8	79.4	91.5 +	*	85.9	80.5	86.1
Lawrenceburg CBOC	85.7	82.5	95.8	77.3	88.3	82.7	83.9	*	87.4	81	92 +

* Less than 30 respondents
+ Significantly better than national average
- Significantly worse than national average

The medical center scored above the 76 percent threshold in 1 of the 10 areas for inpatient SHEP. The medical center was below the threshold of 76 percent for Access, Coordination of Care, Education and Information, Emotional Support, Family Involvement, Physical Comfort, Preferences, and Transition factors. The Overall Quality factor was 50 percent.

Overall, the medical center scored above the 77 percent threshold in 9 of the 11 areas for outpatient SHEP. The medical center was below the threshold of 77 percent in overall outpatient clinic scores for Education and Information and Pharmacy Pick-up. Three of

the four outpatient clinics scored significantly better than national average in at least one area, and none were significantly worse than the national average in any area.

Specific measures taken by the medical center to address areas of concern include customer training for new employees; a Customer Service Fair in FY 2007 that focused on improving the lowest SHEP scores; Crucial Conversations, a 16-hour course on communications for employees; and the WOW Act Program, a rewards program for employees who have been complimented by patients or other employees.

The medical center hired a patient advocate for hospitalized veterans in FY 2007 and recently implemented a service level advocacy program, giving employees at the point of care the opportunity to assist veterans and correct problems. We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 14, 2007

From: Network Director, VA Healthcare System of Ohio-VISN 10

Subject: Combined Assessment Program Review Cincinnati, Ohio

To: Assistant Inspector General for Healthcare, Office of Inspector General

1. I concur with the Director's comments regarding Recommended Improvement Action Items 1 and 2. We respectfully request these items be closed.

2. Recommended Improvement Action Item 3 A through D are pending, with an anticipated completion date of June 30, 2007.

(original signed by:)
JACK G. HETRICK, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 14, 2007

From: Director, Cincinnati Veterans Affairs Medical Center

Subject: Combined Assessment Program Review Cincinnati, Ohio

To: Director, Veterans Integrated Service Network 10 (10N10)

1. We have received the Combined Assessment Program Review for Cincinnati Ohio.

2. The following items remain pending under Recommended Improvement Action Item 3:

   A. Standardization of Committee Minutes – Target completion date: June 30, 2007.

   B. Peer Review Process – Target Completion date: June 30, 2007.

   C. Medical Record Reviews – Target Completion date: June 30, 2007.

   D. Patient Flow – Target completion date: June 30, 2007.

3. The actions listed as closed have been accepted and implemented.

(original signed by:)

LINDA D. SMITH, FACHE

Director's Comments to Office of Inspector General's Report

The following Director's comments[8] 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 compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance related to the altering of signed notes in the health record.

Medical Center clarifying comments: The OIG stated that they found that the medical center had no rules that allowed editing of a signed note by users other than the author. Three rules needed to be changed to limit retraction, amendment, or deletion of notes to the Privacy Officer or Chief of Health Information Management Service.

Concur. Completion date: March 29, 2007.

Action: The OIG stated the Medical Center staff took action to edit and remove these business rules while they were onsite.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the Associate Director, or designee, participate in all administrative rounds and that CBOCs are inspected by all 12 members of the administrative rounds team.

[8] **Note:** After comments were received from the medical center, but before the report was published, the OIG made a policy decision to no longer have any multi-part recommendations. Recommendations will be numbered and tracked separately; any recommendations with more than one element will not be closed until all implementation actions have been taken. This will improve the tracking and reporting of recommendations. Any disparity in this report between the numbering of the recommendations in the body of the report and in the Directors' comments is the result of this action.

Clarifying Comments: Attendance at Administrative Rounds, including CBOC rounds, is now being carefully monitored to assure that the Associate Director (or another member of the Quadrad in his absence) participates, as well as the other designated team members. Prior to 2007, the Chief of Occupational Health and Safety often led Administrative Rounds in the absence of the Associate Director. The time period reviewed by the OIG (2005 to 2006) was a period when two different individuals served as Acting Associate Director, and there were other changes in facility leadership. Informal and formal rounds were being conducted by medical center leadership on a weekly basis but were not reflected in the documented reports from Administrative Rounds. Items for attention from these rounds were forwarded to the appropriate persons/teams for prompt response and action. These items are now being added to the Administrative Rounds reports for tracking.

Concur. Completion date: April 2007.

Actions: The policy Administrative Rounds 00-21 is being revised to include that the other members of the Quadrad will be the official designees in the absence of the Associate Medical Center Director for Administrative Rounds. It is required of all mandatory participants to assign a designee in their place when unable to attend and document the alternate in the minutes.

All Environmental/Administrative Rounds will be documented and added to the weekly Administrative Rounds reports.

A new Administrative Rounds report template has been developed, which has the entire FY attendance grid so that attendance is tracked on a continuous basis.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires standardization of committee meeting minutes and identification of action items and persons assigned responsibility for tracking timeframes for completion and evaluation; completion of peer reviews within the required 120 days and appropriate review of Level 1 cases; completion of medical record reviews at the point of care and on an

ongoing basis; and completion of the patient flow assessment in accordance with JCAHO guidelines.

Concur. Target Completion Date: June 30, 2007.

ACTIONS:

A. Committee Minutes

A templated, standardized grid for meeting minutes has been implemented throughout the medical center for meeting minutes, which document agenda item, discussion, corrective action plan/measure of success, proposed completion date, completion date, person responsible, status/comments.

Medical Center Memorandum 00-20 CARE LINE/SERVICE STAFF AND COMMITTEE MEETINGS has been revised to direct the implementation of the new meeting minute's format throughout the medical center. Some variation is allowed for specialized areas, such as Research, under other directives or clinical processes.

B. Peer Review

All physician members and internal/external peer reviewers have been given a copy of the Practitioner Performance Improvement Educational Tool on the peer review process. Each peer reviewer has or will provide proof of completing the education process by a written signature, which will be kept on file in the Quality Management Service.

Timeliness of the peer review process will be monitored by the use of a tracking report by the Quality Management representative of the Practitioners Performance Improvement Committee and reported to the Chief of Staff.

Peer Review Committee meeting minutes will use the grid templated format.

The sum of each number type reviewed will be tracked in the meeting minutes to assure that the number of required reviews is completed.

C. Medical Record Reviews

All clinical services are required to complete a risk assessment for their service to determine the areas to target for concurrent medical record review.

All clinical services are required to forward the concurrent reviews completed to the Medical Records Committee on a quarterly basis.

A reporting schedule for services to the Medical Records Committee has been developed.

Medical Record Committee minutes are forwarded to the Clinical Executive Board for review and appropriate action.

D. Patient Flow

The plan is being implemented to form three subcommittees of the Management Systems Redesign (MSR) Steering Committee (Administrative, Outpatient Clinical, and Patient Flow). The charter for the MSR Steering Committee was finalized in April 2007. Subcommittee meetings will begin in May 2007.

Daily interdisciplinary bed meetings regarding patient flow occur daily at 0830.

The discharge process is being revised to incorporate discharge appointments to facilitate patient flow by improving the discharge planning. The discharge appointment process is a performance monitor that will be tracked and trended.

Diversions in the Emergency Department are a performance monitor that is tracked.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Randall Snow, J.D., Associate Director Washington Regional Office of Healthcare Inspections 202 565-8305
Acknowledgments	Gail Bozzelli Donna Giroux Richard Horansky Carol Torczon

Appendix D

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