Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Louis Stokes VA Medical Center Cleveland, Ohio

Report No. 07-00268-110

March 29, 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 Louis Stokes VA Medical Center (the medical center), Cleveland, Ohio, during the week of November 13–17, 2006. The purpose of the review was to evaluate selected system operations focusing on patient care administration and quality management (QM). During the review, the Office of Investigations provided three fraud and integrity awareness briefings to 213 employees. The medical center is part of Veterans Integrated Service Network (VISN) 10.

Results of Review

We identified information technology (IT) support and management as an organizational strength, with several locally created IT tools used to monitor and improve patient care.

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

- Environment of Care (EOC).
- Diabetes and Atypical Antipsychotic Medications.
- Survey of Healthcare Experiences of Patients (SHEP).

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

- Revise business rules for Veterans Health Administration (VHA) information systems.
- Ensure documentation of patient notification of mammography results in the medical center's electronic medical records system.
- Improve cardiac catheterization laboratory informed consent documentation and quality improvement processes.
- Update community based outpatient clinic (CBOC) mental health emergency plans and complete and document background checks on providers.
- Strengthen Contract Community Nursing Home (CNH) Program administrative controls and documentation practices.
- Standardize QM minutes, monitor action items until completed, and strengthen peer review practices.

This report was prepared under the direction of Mr. Randall Snow, JD, Associate Director, and Ms. Donna Giroux, RN, BSN, CPHQ, 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 Appendix A, pages 17–21 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 has two divisions located in the Cleveland, Ohio, communities of Wade Park and Brecksville. The medical center provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 13 CBOCs located in Akron, Canton, Youngstown, New Philadelphia, East Liverpool, Warren, Ravenna, McCafferty, Wooster, Sandusky, Lorain, Mansfield, and Painsville, Ohio. The medical center is part of VISN 10 and serves a veteran population of about 400,000 in a primary service area that includes 24 counties in northeast Ohio.

Programs. The Wade Park campus is a 218-bed tertiary care facility providing a full range of services in medicine, surgery, psychiatry, rehabilitation, and oncology. The Brecksville campus is a 420-bed geriatric facility that provides mental health inpatient services, Nursing Home Care Unit (NHCU) services, and domiciliary (DOM) care. Special programs include Spinal Cord Injury Care, Gambling Treatment Program, and Women Veterans Substance Abuse. The medical center is the site of a research center of excellence in functional electrical stimulation.

Affiliations and Research. The medical center is affiliated with the Case Western Reserve School of Medicine and supports 120 medical resident positions in 28 training programs. In fiscal year (FY) 2005, the medical center research program had 150 projects and a budget of $20 million. Important areas of research include functional electrical stimulation, cardiovascular disease, neurology, ocular motility, and infection control.

Resources. In FY 2005, medical care expenditures totaled $412 million. The FY 2006 medical care budget was $435 million. FY 2005 staffing totaled 3,570 full-time equivalent employees (FTE), including 289 physician and 692 nurse FTE.

Workload. In FY 2005, the medical center treated 85,369 unique patients. The medical center provided 90,328 inpatient days of care in the hospital and 58,743 inpatient days of care in the NHCU. The inpatient care workload totaled 10,372 discharges from the medical center, DOM, and NHCU. The average daily census was 247.47 for the medical center and 160.94 for the nursing home. The outpatient workload totaled 724,954 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. 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 nine activities:

Breast Cancer Management	CNH Program
Business Rules for Veterans Health Information Systems	Diabetes and Atypical Antipsychotic Medications
Cardiac Catheterization Laboratory Standards	EOC
CBOCs	QM
	SHEP

The review covered facility operations for FYs 2005 and 2006 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 Louis Stokes VA Medical Center Cleveland, Ohio,* Report No. 04-02247-12, November 3, 2004).

During this review, we presented three fraud and integrity awareness briefings for 213 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 Other Observations section have no reportable conditions.

Results of Review

Organizational Strength

The widespread use of IT tools throughout the medical center and the IT support and maintenance program are an organizational strength, which the medical center leverages to improve veterans' healthcare in the following ways:

- Deployment of a secure, web-based information sharing program, "Sharepoint," throughout the medical center.
- Local development of an IT program that monitors 100 percent of provider performance data on a daily basis.
- Staffing the Quality Information Management Service with clinical application coordinators having both IT and medical/nursing expertise has created an environment that is supportive and responsive to the end users of the computerized patient medical record system.
- Interfacing database programs has allowed local online review of quality reports, patient satisfaction data, and clinical performance measures at the department, service, and unit level.

Opportunities for Improvement

Business Rules for Veterans Health Information Systems

The health record, as defined in 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 an addendum to the original note, or as a new note—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[2] system. 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. The medical center had 13 rules that allowed editing of a signed note by users other than the author. Six additional rules needed to be changed to limit retraction or deletion of notes to the Privacy Officer only. 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.

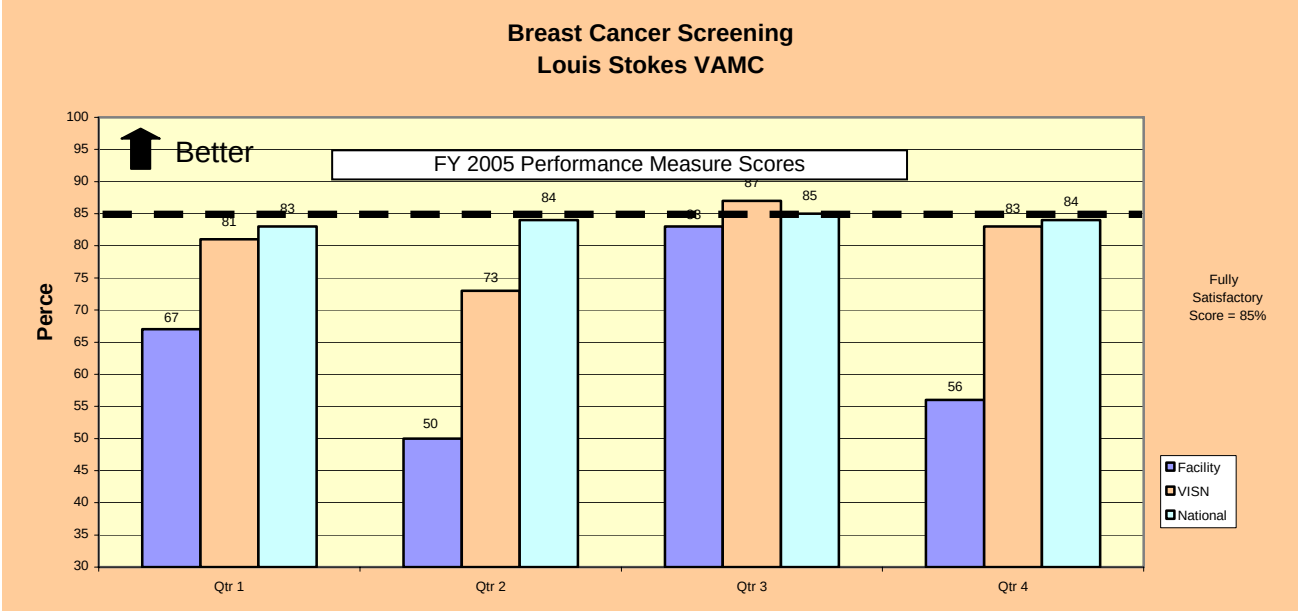
[1] A patch is a piece of code added to computer software in order to fix a problem.
[2] VA's electronic medical records system is called VistA, which is the acronym for Veterans Health Information Systems and Technology Architecture.

Breast Cancer Management

VHA's breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. Timely screening, diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. VHA mammography standards require normal findings to be documented in the medical record within 30 days of the procedure. Suspicious or abnormal results must be communicated to the ordering provider within 3 working days. Communication can be by telephone contact between the mammography procedure site and the ordering provider. If this is the method adopted, the communication must be documented in the patient's medical record. Timely results need to be available and accessible to guide patient care and treatment. We assessed these items in a review of nine patients who were diagnosed with breast cancer or had abnormal mammography findings during FY 2005.

The medical center refers all patients to community facilities for mammography procedures. Community facilities communicated suspicious or abnormal results to the providers within 3 working days after the procedures and sent written reports of all procedures, including recommendations for follow-up, to the medical center within the required 30-day timeframe. However, five out of nine patients we reviewed did not have notification of abnormal or suspicious mammograms documented in their electronic medical record (VistA). Two of nine did not have notification of biopsy results documented. Two other patients had a recommendation for a biopsy documented, but there was no documentation delineating the medical reason for the biopsy and no documentation of the actual biopsy procedure.

Although the medical center did not meet the VHA performance measure for breast cancer screening in FY 2005 (see chart on page 6), 100 percent of the cases we reviewed were appropriately screened. Medical center personnel had taken measures to increase their performance by developing coordinated interdisciplinary treatment plans and by providing timely surgery and hematology/oncology consultative and treatment services.



Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
9/9	5/9	2/9	9/9	7/9

In four of nine cases, there was no documentation that the medical center notified patients regarding the results of the mammogram or biopsy. Although timeliness of biopsies was not impacted, medical center managers agreed that to ensure continuity of care and compliance with prescribed documentation practices, the notification must be documented in the patient's medical record, as well as in the medical center's VistA.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director takes action to: (a) implement a process for documenting notification of suspicious or abnormal mammography and biopsy results to patients, (b) improve documentation of any communication with patients regarding mammograms or biopsies, and (c) continue to increase the number of women veterans receiving timely mammograms.

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) 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.

Informed consent standards require that the patient be informed of the risks, benefits, and alternatives of the procedure. VHA Directive 1004.1, *VHA Informed Consent for Clinical Treatments and Procedures,* indicates that the names and professions of any other individuals responsible for authorizing or performing the treatment or procedure under consideration must also be disclosed. For example, if advanced practice registered nurses, physician assistants, or cardiology trainees are to perform any part of the procedure, this information should be stated in the informed consent.

The medical center has two new, state-of-the-art cardiac catheterization laboratories and three cardiologists who perform diagnostic cardiac catheterizations. One full-time cardiologist performs therapeutic interventions, and there are several cardiology fellows and residents in training. In FY 2005, the laboratories performed 704 coronary diagnostic procedures and 230 interventional procedures. This exceeded the minimal number of interventional procedures recommended for an individual physician but was less than the 400 interventional cases recommended for a cardiac catheterization laboratory.

We reviewed the medical records of 10 patients who underwent diagnostic and therapeutic catheterization. Nine of the 10 patient records had incomplete, missing, or incorrect consents. One consent form was missing, three did not state the name of the provider performing the procedure, and on six, the names of the providers did not match the names in the medical records as being the providers who actually performed the procedures. The consent forms did not identify the major risks associated with cardiac catheterization.

Although an interdisciplinary cardiovascular conference that reviews cases and complications is held weekly, the medical center does not have a systematic quality review process that tracks, trends, analyzes, and reports cardiac catheterization procedures and complications.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) staff follow VHA Directive 1004.1 when completing informed consents for cardiac catheterization procedures and (b) staff implement a quality improvement process that tracks, trends, analyzes, and reports cardiac catheterization procedures and complications.

Contract Community Nursing Home Program

CNH Program managers needed to improve monitoring and oversight of CNH activities and amend local policies to ensure that veterans receive quality care in safe environments.

Review Team. VHA Handbook 1143.2[3] requires that a CNH Review Team be established for evaluation of nursing homes that care for veterans. The CNH Review Team must include a registered nurse, a social worker and other disciplines, as appropriate, to evaluate areas of non-compliance. The CNH Review Team at the medical center is responsible for more than 108 veterans in 32 CNHs. The team was comprised of four nurses, three social workers, one dietician, and one safety inspector. We reviewed documentation on five nursing homes and found that the team conducted initial and annual reviews and consistently documented findings in meeting minutes. We reviewed the medical records of 10 CNH veterans and found that the team did not visit the veterans monthly or consistently arrange for a monthly review of each patient's condition by telephone or fax.

Oversight Committee. VHA policy requires oversight of the CNH Review Team to ensure that veterans receive quality care. Facilities with CNH programs must establish a CNH multidisciplinary oversight committee with management-level representation from social work, nursing, quality management, acquisition, and medical staff to effectively administer and monitor the program. The committee is established by the medical center Director and is responsible for completing and monitoring mandated CNH reviews. The medical center had a CNH Oversight Committee, but the committee did not have the required representation. Although the committee is required to meet at least quarterly, in June of 2006, the committee decided to meet every 6 months instead.

Documentation. The results of all patient evaluation and follow-up visits must be documented in VistA, including appropriate event capture documentation for workload statistics and ongoing monitoring. Not all CNH Review Team members promptly

[3] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

documented their visits. In one case, a nurse documented all prior visits for 1 year at a single time at the end of the year rather than documenting concurrently.

Reporting Events. VHA policy requires sentinel events or adverse patient occurrences discovered in nursing homes to be immediately reported to the medical center Director, the Network Geriatrics and Extended Care Office, and the Geriatric and Extended Care Strategic Health Group via the "Certification Report" on VA's CNH Website. One veteran suffered an adverse event in a nursing home, and it was not reported or documented as required by VHA policy.

Recommendation 4: We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) social worker and nursing visits are conducted per VHA Handbook 1143.2, (b) CNH Oversight Committee meetings are held quarterly with proper multidisciplinary management-level representation, (c) local policy is amended to meet VHA requirements, (d) timeliness of documentation is strengthened, and (e) VA nursing home evaluation tools are used to report adverse events.

Community Based Outpatient Clinics

A CBOC is a VA-operated, VA-funded, or VA-reimbursed health care facility or site that is 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 those veterans reasonable access to care and services.

We visited the McCafferty CBOC in Cleveland, Ohio. We conducted environmental rounds; interviewed key personnel and 10 veterans; and evaluated policies, procedures, and other relevant documents. The CBOC generally provided a high quality of care that improved access, timeliness, and convenience of services. Veterans were satisfied with all aspects of care received, and the clinic was compliant with most VHA standards of operation that we reviewed.

Background Investigations. We reviewed credentialing and privileging folders for five health care providers at the CBOC. VA Directive 0710, *Personnel Suitability and Security Program*, requires appropriate background screenings of individuals, both employees and non-employees, who have access to non-national security, sensitive information (including patient records). Three of these five employees did not have completed background checks. The Office of Human Resource Management-Labor Relations reported that an additional five employees at the CBOC did not have completed background checks.

Local Emergency Policy. VHA Handbook 1006, *Minimum Standards for CBOC Operations*, requires that each CBOC must have a local policy or standard operating procedure defining how health emergencies are handled, including mental health emergencies. We found such a policy for the medical center but did not find a similar policy for the McCafferty CBOC, although the CBOC did have a local Emergency Conditions and Response flow chart. Interviews with two staff nurses confirmed that the local response to a medical emergency does not reflect the generic CBOC emergency response policy prepared by the medical center for all their CBOCs.

Recommendation 5: We recommended that the VISN Director ensure that the Medical Center Director takes action to ensure that (a) human resources staff complete and maintain background investigations for CBOC providers and (b) a specific McCafferty CBOC emergency response policy is published.

Quality Management

The QM program was generally effective with appropriate review structures in place for 10 of the 14 program activities reviewed. However, the peer review process, disclosure of adverse events to patients, utilization management oversight, documentation of action items, and follow-up needed improvement.

Peer Review Process. Peer review is the ongoing evaluation of a provider's professional performance by their colleagues. VHA's peer review policy requires that a medical center's Peer Review Committee report to the Medical Executive Committee on a quarterly basis. Our review of the committee meeting minutes revealed one peer review report during the last year. Furthermore, CBOCs are required to participate in the Peer Review Committee. The medical center has 13 CBOCs, and we found only one peer review on a CBOC patient. Twelve CBOCs did not report patient incidents requiring peer review to the medical center.

Adverse Event Disclosure. When serious adverse events occur as a result of patient care, VHA policy requires staff to discuss the events with patients, inform them of their right to file tort or benefit claims, and document the notification in the patients' medical records. We reviewed all adverse events from April 2006 through September 2006. We found four records of patients who had experienced serious adverse events. All four had documentation of patient notification of the event; however, none had documentation of the advisement of the right to file tort or benefit claims.

Safety Assessment Code. In accordance with VHA policy, QM staff investigate adverse events and assign a Safety Assessment Code (SAC) score,[4] which dictates whether any

[4] The SAC score determines the severity of the adverse event and the probability of the event occurring again. SAC scores include a severity and probability category for either an actual event or close call, with a ranked matrix score of 3 (highest risk), 2 (intermediate risk), and 1(lowest risk). This SAC score is used for comparative analysis and to determine whom to notify about the event.

further definitive action (peer review, patient notification, or initiation of a root cause analysis) is required concerning a particular incident. Four adverse events that resulted in serious injuries were reviewed. All four were assigned a SAC score that was too low for the adverse event experienced.

Action Items and Outcome Evaluation. Program managers needed to ensure that designated committees consistently analyze data and make recommendations for improvement. We reviewed committee minutes from nine committees. In all nine committees, discussion identified opportunities for improvement; however, the committees did not consistently identify the action and assign responsibility and timeframes for completion and reevaluation.

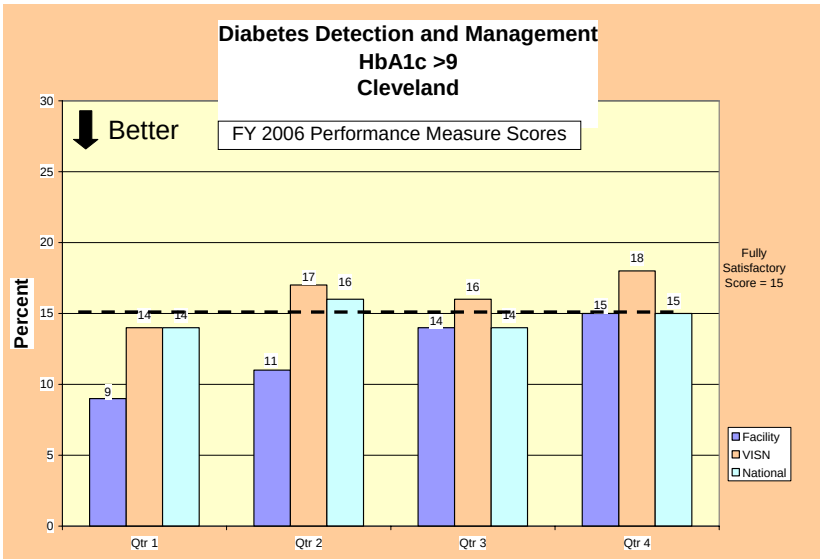
Recommendation 6: We recommended that the VISN Director ensure that the Medical Center Director requires: (a) regular peer review of CBOCs and quarterly Peer Review Committee meetings with reporting to the Medical Executive Committee, (b) documentation of patient notification of the right to file tort or benefits claims after adverse events, (c) proper SAC scoring, and (d) QM committees to consistently identify improvement actions and assign responsibility for tracking actions, deadlines, and reevaluations.

Other Observations

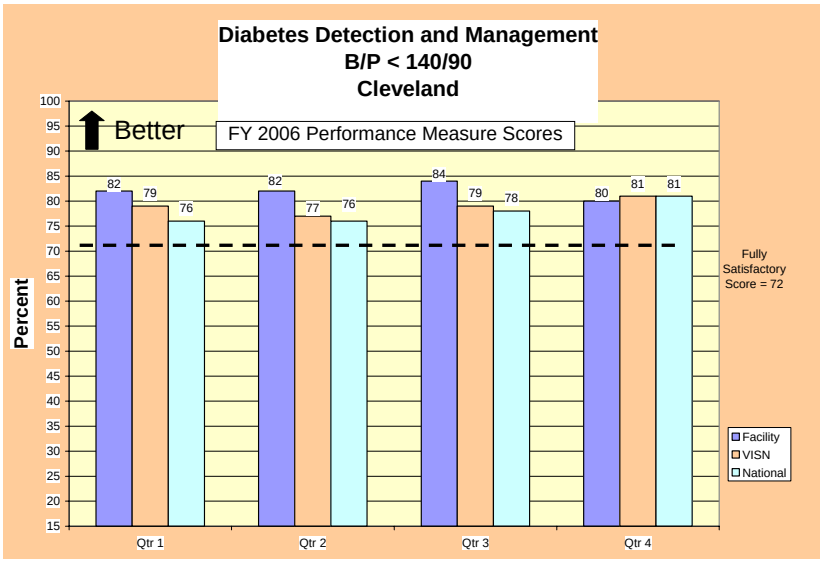
Diabetes and Atypical Antipsychotic Medications

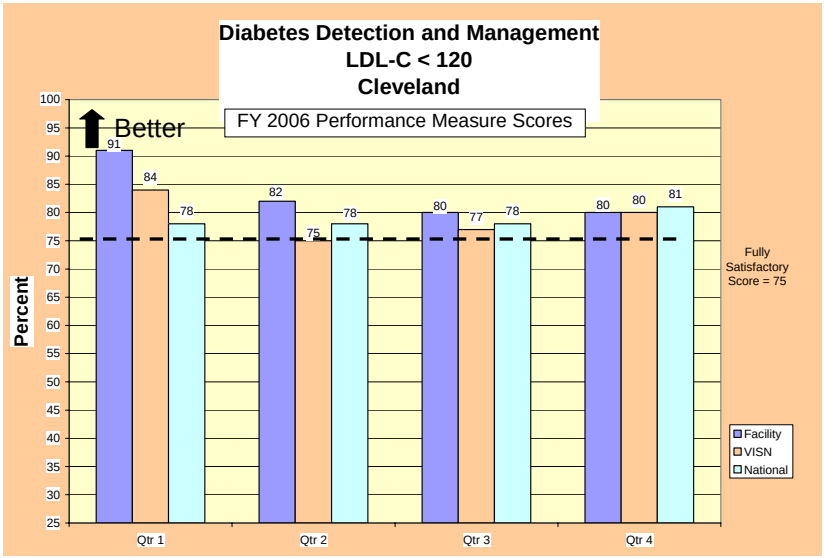
Mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes) require effective diabetes screening, monitoring, and treatment.

VHA clinical practice guidelines suggest that diabetic patients' blood glucose levels be at a therapeutically acceptable level (glucose, HbA1c,[5] below 9 percent) to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl). The medical center must meet these standards to receive fully satisfactory ratings for these performance measures.



[5] Hemoglobin A1c (HbA1C) reflects the average blood glucose level over a period of time and should remain in control to prevent complications.





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Greater than = >

The performance standards for FY 2006 demonstrate that the medical center shows an increasing trend in rising HbA1c but remains fully satisfactory. However, local data collected for this standard shows that HbA1c levels were less than 9 more than 90 percent of the time over the last year. Scores for blood pressure and cholesterol management met and exceeded the fully satisfactory expectation. Actions taken by the medical center to achieve and improve these measures include a locally developed computer program that monitors all clinical performance measures for all providers in the outpatient clinics for 100 percent of the patients. The providers and clinics are given feedback and rewards on a monthly basis, and the data affects their annual performance appraisal ratings.

We reviewed the medical records of 13 randomly selected patients who were on one or more atypical antipsychotic medications for at least 90 days. The patients were screened appropriately. Two of the 13 had diabetes, which developed prior to the initiation of atypical antipsychotic medications. See the table below for a summary of results.

Diabetic patients with HbA1c > 9 percent	Diabetic patients with blood pressure > 140/90 mm/Hg	Diabetic patients with LDL-C > 120mg/dl	Non-diabetic patients appropriately screened
1/2	0/2	0/2	11/11

Legend: Greater than = >

Because of actions already taken, we made no recommendations.

Environment of Care

VHA regulations require that healthcare facilities have a comprehensive EOC program that meets VA, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Hospital Organization standards. We inspected four patient care areas at Brecksville and four at Wade Park to evaluate cleanliness, safety, medication security, infection control, and biomedical equipment maintenance. We toured the third floor construction at Wade Park to evaluate Interim Life Safety Measures (ILSM) put in place during the construction. The inspections demonstrated that the medical center maintained a clean and safe environment, secured medications, regularly inspected biomedical equipment, and monitored ILSM. We met with members of the EOC Committee and discussed root cause analysis and adverse event reporting and documentation. Additionally, we followed up on EOC concerns reported in the previous CAP report and found that those issues had been resolved.

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 had to 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 SHEP results for inpatients and outpatients.

Cleveland Inpatient SHEP Results
Q1 and Q2 FY 2006

	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03	**
VISN	81.70	79.40	89.40	67.30	64.3-	76.20	82.50	72.1-	69.00	**
Medical Center	82.60	78.60	89.10	67.40	64.90	79.3+	83.10	71.2-	71.00	**

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

Cleveland Outpatient SHEP Results
Q3 FY 2006

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.9	77.0	94.6	72.0	83.0	75.1	81.1	64.4	81.3	80.5	84.1
VISN	82.0	76.3	95.1	70.8	81.5	74.7	84.7	69.6	80.4	80.5	85.0
Outpatient Clinics - Overall	84.9 +	75.2	95.4	73.9	85.4	78.0	88.2	75.7	82.8	80.6	85.1
_ CLEVELAND OUTPATIENT CLINIC	74.7	68.7	91.8	69.5	85.2	71.1	90.3	58.7	78.9	77.3	78.8
_ BRECKSVILLE OUTPATIENT CLINIC	85.3	79.7	97.5	76.1	81.7	77.2	*	92.4 +	84.1	87.1	85.0
_ CANTON OUTPATIENT CLINIC	90.4 +	81.6	97.9	72.2	84.3	84 +	*	75.1	85.0	*	88.5
_ YOUNGSTOWN OUTPATIENT CLINIC	89.5 +	87.3	97.4	70.2	83.6	85.2 +	*	82.8	80.1	*	89.8
_ LORAIN OUTPATIENT CLINIC	88.8 +	68.6	97.1	73.3	83.9	78.4	95.2 +	*	83.2	74.7	87.7
_ SANDUSKY OUTPATIENT CLINIC	90.9 +	72.4	96.7	83 +	90.3 +	81.4	84.0	*	87.5	85.9	92.8 +
_ MANSFIELD VA OUTPATIENT CLINIC	93.2 +	71.8	98.4 +	80.9	88.1	83.4	78.7	*	85.0	96.5 +	89.6
_ MCCAFFERTY OUTPATIENT CLINIC	86.3	75.5	94.9	73.3	79.7	82.1	90.7	*	81.8	83.6	84.4
_ PAINESVILLE VA OUTPATIENT CLINIC	87.6 +	80.5	93.3	73.9	82.8	78.9	91.8	*	84.2	74.0	88.9
_ AKRON CBOC	88.9 +	73.8	95.7	77.7	90.7 +	76.9	*	87.8 +	84.8	77.4	82.2
_ EAST LIVERPOOL	91.8 +	83.1	98.8 +	76.3	85.8	87.1 +	89.9	*	88.8 +	*	92.8 +
_ WARREN CBOC	89.4 +	77.7	96.4	85.5 +	90.6 +	84.4 +	91.7	*	89.5 +	83.7	89.6
_ NEW PHILADELPHIA CBOC	92.5 +	75.3	95.7	72.5	86.9	77.3	77.3	*	83.3	84.9	87.4
_ RAVENNA CBOC	90.9 +	82.8	98 +	77.7	89.8 +	83.4 +	84.8	*	89.3 +	80.9	95.8 +

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

The medical center scored above the 76 percent threshold in 5 of the 10 areas, and one of those, Family Involvement, was significantly above the national average for inpatient SHEP. The medical center was below the threshold of 76 percent for Education and Information, Emotional Support, Preferences, and Transition.

The medical center scored above the 77 percent threshold in 6 of the 11 areas for outpatient SHEP. The medical center was below the threshold of 77 percent for Access, Continuity of Care, Education and Information, Overall Coordination, and Pharmacy Pick-Up.

The medical center has several programs and initiatives in place to address patient satisfaction, including "quik kards" (patient satisfaction tools completed on discharge from an inpatient unit or after an outpatient appointment), which provide constant evaluation of patient satisfaction; the "Ambassador" program, which provides training and skills for targeted employees to function as a point-of-contact patient advocate; and, in FY 2007, the payment of 25 percent of physician incentive pay funds will be based on SHEP data results.

Appendix A

Directors' Comments

Department of Veterans Affairs **Memorandum**

Date: December 15, 2006

From: Medical Center Director (541/00)

Subject: **Louis Stokes VA Medical Center Cleveland, Ohio**

To: Network Director, VA Healthcare System of Ohio, VISN 10

1. Please see the Cleveland VAMC response to the Draft Report of the Combined Assessment Program Review of the Louis Stokes VA Medical Center, Cleveland, Ohio.

2. If you have any questions or need additional information, please contact Kristen Guadalupe, PhD, RN, Quality Manager at (216) 231-3456.

WILLIAM D. MONTAGUE

CONCUR DO NOT CONCUR

JACK G. HETRICK, FACHE
Network Director, VISN 10

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

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

OIG Recommendations

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director takes action to require compliance with VHA Handbook 1907.1, *Health Information Management and Health Records*, and the October 2004 OI guidance.

Concur. Completion Date: November 16, 2006.

Medical Center staff immediately took action to edit and remove business rules that allowed editing of signed notes by users other than the author while the OIG team was on site.

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director takes action to (a) implement a process for documenting notification of suspicious or abnormal mammography and biopsy results to patients, (b) improve documentation of any communication with patients regarding mammograms or biopsies, and (c) continue to increase in the number of women veterans receiving timely mammograms.

Concur. Target Completion Date: June 30, 2007.

Contracts with outside mammography and breast ultrasound facilities have been reviewed for compliance with notification requirements that explicitly guarantee a letter will be sent to patients for normal and abnormal results. A surgical nurse has been assigned to provide monthly surgical consultation updates and biopsy results to the mammogram clerk. Beginning January 2007, the Chief of Women's Health and Chief of Surgery will meet quarterly to discuss results. The

Women Veterans Program Manager is now a regular member of the Tumor Board and Cancer Committee. Specific clerks have been designated for scanning all breast data into the medical record in a timely fashion. The frequency of mobile mammography units has been increased to enhance access and compliance with mammogram orders. Letter and phone call reminders to patients are now used as a follow-up for scheduled appointments.

Recommendation Improvement Action 3. We recommend that the VISN Director ensure that the Medical Center Director takes action to require that (a) staff follow VHA Directive 1400.1 when completing informed consents for cardiac catheterization procedures and (b) staff implement a quality improvement process that tracks, trends, analyzes, and reports cardiac catheterization procedures and complications.

Concur. Target Completion Date: January 8, 2007.

A process to verify the attending physician name with the physician actually performing the procedure was implemented by cath lab staff on November 21, 2006. The hard copy consent form is being revised to include risks of the procedure in the body of the consent. Implementation of the I-med consent process in the cath lab is scheduled for January 9, 2006. During the week of November 20–24, 2006, a log of complications (both inside the lab and while the patient is hospitalized) was compiled, and a designated nurse has been assigned to track complications and patient outcomes related to the procedures. Beginning in January 2007, Quality Management will participate in weekly cath conferences to ensure documentation of discussions. Additional staff training for the current cath lab server system (GE centricity) that has the capability of entering patient complication data and later analysis is scheduled for early 2007. The Medical Center is currently evaluating the need for increased staffing to facilitate data entry and patient follow-up phone calls.

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) social worker and nursing visits are conducted per VHA Handbook 1143.2, (b) CNH Oversight

Committee meetings are held quarterly with proper multidisciplinary management-level representation, (c) local policy is amended to meet VHA requirements, (d) timeliness of documentation is strengthened, and (e) VA Nursing Home evaluation tools are used to report adverse events.

Concur. Target Completion Date: January 30, 2007.

Immediately after the OIG visit, two additional nursing FTEE were requested to handle the large volume of in-house referrals, screening, review, and renewal of orders for skilled home care. CNH Oversight Committee membership has been changed to include multidisciplinary Service Chiefs and Quality Management. The first CNH Oversight meeting with new members is schedule for December 18, 2006. MCP 122-012 (Home and Community Based Oversight Committee) has been amended to meet VHA requirements; final approval is pending. Staff was re-trained in using DSS-Event Capture, and laptops have been provided for field use. The Chief, Social Work has scheduled a meeting in January 2007 with IRM to discuss technical problems with connectivity and explore alternatives to permit the staff to do clinical notes in the field setting. A process for reviewing documentation has been implemented to identify individual staff problems with timeliness. All community care staff has been re-educated on the requirement to report all adverse and sentinel events which occur in the contract nursing home program to the Program Coordinator, Home and Community Based Care. The incident report form, which is located on the VA CNH Home page, is now being used by all staff.

Recommended Improvement Action 5: We recommend that the VISN Director ensure that the Medical Center Director takes action to ensure that (a) human resources staff complete and maintain background investigations for CBOC providers and (b) a specific McCafferty CBOC emergency response policy is published.

Concur. Target Completion Date: January 30, 2007

Human Resources is working with McCafferty CBOC providers to complete missing background investigations. Beginning January 2007, HR is conducting an audit of all

OPFs. McCafferty CBOC specific Emergency Response Policy is in draft form; final approval scheduled for January 2007.

Recommended Improvement Action 6: We recommend that the VISN Director ensure that the Medical Center Director requires (a) regular peer review of CBOCs and quarterly Peer Review Committee meetings with reporting to the Medical Executive Committee, (b) documentation of patient notification of the right to file tort or benefits claims after adverse events, (c) proper SAC scoring, and (d) QM committees to consistently identify improvement actions and assign responsibility for tracking actions, deadlines, and reevaluations.

Concur. Target Completion Date: January 30, 2007.

Beginning in January 2007, first level Peer Review Committee will include representatives from the CBOCs. Quarterly Committee minutes will be completed using standardized format to reflect quarterly meetings and reporting to Medical Executive Committee beginning January 2007. The process for documenting patient notification of the right to file Tort of claims benefits after adverse events was re-reviewed with Patient Representatives immediately following the CAP review. Beginning January 2007, periodic audits of Tort claims will be conducted by the Risk Manager. On November 20, 2006, the Patient Safety Manager began reviewing all Safety Assessment Code scoring to ensure appropriate score and follow up of incidents. Medical Center leadership has approved standardized meeting minute format throughout the Medical Center per suggestion of OIG team. Beginning January 2007, Quality Management will conduct monthly audits of committee meeting minutes to ensure follow up of identified improvement actions, deadlines, and reevaluations.

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Randall Snow, J.D., Associate Director, Office of Healthcare Inspections, Washington, D.C. 202-565-8452
Acknowledgments	Gail Bozzelli Donna Giroux Richard Horansky Gavin McClaren Carol Torczon

Appendix C

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