Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-01408-197

Combined Assessment Program Review of the Memphis VA Medical Center Memphis, Tennessee

September 11, 2007

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide 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.

Table of Contents

Executive Summary

Introduction

During the week of April 23–27, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Memphis VA Medical Center (the medical center). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 224 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 9.

Results of the Review

The CAP review covered seven operational activities. We identified the following organizational strength:

- Operation Enduring Freedom/Operation Iraqi Freedom Veterans Combat Veteran Transition.

We made recommendations in four of the activities reviewed. For these activities, the medical center needed to:

- Improve the QM processes of disclosure, peer review, root cause analysis (RCA), and Clinical Executive Board (CEB) oversight.
- Improve monitoring of staff compliance with cardiopulmonary resuscitation (CPR) training.
- Improve the security of confidential patient information.
- Assure that business rules governing the computerized patient record system (CPRS) comply with Veterans Health Administration (VHA) policy.

The medical center complied with selected standards in the following three activities:

- North Memphis Community Based Outpatient Clinic (CBOC).
- Cardiac Catheterization (CC) Program.
- Patient Satisfaction.

This report was prepared under the direction of Christa Sisterhen, Associate Director, Atlanta 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 14–18, 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

Profile

Organization. The medical center is a tertiary care facility located in Memphis, TN, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at six CBOCs. There are two VA-staffed CBOCs located in the Memphis area. The remaining CBOCs are located in Byhalia and Smithville, MS; Savannah, TN; and Jonesboro, AR. The medical center is part of VISN 9 and serves a veteran population of about 206,000 throughout 53 counties in western Tennessee, northeast Mississippi, and eastern Arkansas.

Programs. The medical system provides medical, surgical, mental health, geriatric, physical medicine and rehabilitative, spinal cord injury (SCI), and dental services. The medical center has 244 operating hospital beds and a 60-bed SCI unit. Specialized outpatient services are provided through general, specialty, and subspecialty outpatient clinics, including a women's health center.

Affiliations and Research. The medical center is affiliated with the University of Tennessee Health Science Center in Memphis and supports 115 medical and 8 dental resident positions. Training is provided for 321 medical and dental students and 475 nursing and associated health students.

In fiscal year (FY) 2006, the medical center research program had 220 projects and a budget of $15.5 million. An important area of research is a vaccine for group A streptococcus that is presently in the initial stages of clinical trials. Also, the medical center served as the lead VA site for the largest and most definitive hypertension trial in the world, the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT), with nearly 45,000 enrolled subjects.

Resources. In FY 2006, medical care expenditures totaled $236 million. The FY 2007 medical care budget is $240 million. FY 2006 staffing totaled 1,723 authorized full-time employee equivalents (FTE), including 150 physician and 384 nursing FTE.

Workload. In FY 2006, the medical center treated 44,486 unique patients. The medical center provided 62,938 inpatient days of care in the hospital. The inpatient

care workload totaled 6,362 discharges, and the average daily census was 172.

Services for Military Personnel Returning from Iraq and Afghanistan. The medical center offers a comprehensive program of services to military personnel returning from duty in Iraq and Afghanistan that includes a complete physical examination and screening for deployment-associated disorders, such as substance abuse, post-traumatic stress disorder (PTSD), depression, and other chronic symptoms and infectious diseases. Each returning veteran also receives an orientation to VA benefits and eligibility. Through its outreach efforts, the medical center has made initial contact with about 1,640 returning military personnel and enrolled 720 for VA care.

Objectives and Scope

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

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide 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 seven activities:

- CC Program.
- CPR Training.
- CPRS Business Rules.

- Environment of Care (EOC).
- North Memphis CBOC.
- Patient Satisfaction.
- QM.

The review covered medical center operations for FYs 2005, 2006, and 2007 through April 27, 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, Memphis, Tennessee,* Report No. 04-00631-190, August 27, 2004*.)*

OIG had asked that VHA's Office of the Medical Inspector (OMI) investigate allegations regarding the medical center which related primarily to the Mental Health Service and the local Process Improvement (PI) process. OMI published a report (*Final Report: Site Visit to the Memphis Veterans Affairs Medical Center, Memphis, Tennessee, Department of Veterans Affairs, VISN 9*) issued June 28, 2006. Since this report is undergoing a separate follow-up, we did not review this during the CAP site visit.

During this review, we also presented fraud and integrity awareness briefings to 224 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 "Review Activities Without Recommendations" section have no reportable findings.

Organizational Strength

Operation Enduring Freedom/Operation Iraqi Freedom Combat Veteran Transition

The Shared Medical Appointment (SMA) is a program designed to help Operation Enduring Freedom/Operation Iraqi Freedom combat veteran transition from Department of Defense to VHA care. It employs a group approach to address the unique emotional and physical needs of returning combat veterans while introducing them to VHA care and services. The SMA addresses preventative health; provides PTSD, depression, substance abuse, and traumatic brain

injury screening; offers education; and promotes timely follow-up appointments and referrals to ensure that combat veterans receive prompt access to care with shorter waiting times.

A physician performs individual physical examinations on each veteran prior to the group meeting. After signing statements that address confidentiality and release of personal medical information, veterans allow the physician-lead multidisciplinary team, which includes mental health professionals, to discuss their current physical and emotional problems in a group clinic. This group clinic offers a forum for veterans to talk about their conditions, such as PTSD and depression, and receive support from their peers. The group approach helps reduce the stigma of seeking psychological help, a stigma that reportedly prevented some Vietnam veterans from seeking treatment for more than 20 years. In FY 2006, patient satisfaction surveys found that veterans preferred the SMA approach to the traditional individual clinic appointment. Eighty-two percent of veterans strongly agreed that the group interaction and peer support was helpful, 89 percent strongly agreed that they received enough information about their health, and 91 percent strongly agreed that all their medical needs were addressed.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to determine if the medical center (a) had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. To evaluate QM processes, we interviewed senior managers and reviewed committee minutes, documents related to the functioning of the Executive Management Board and CEB,[1] and other relevant QM information.

The QM program was generally effective in providing oversight of the quality of patient care. Credentialing and privileging (C&P), patient complaints, national patient safety goals, utilization management, resuscitation outcomes, medical records, restraint and seclusion, patient flow, and

[1] The CEB is the oversight committee responsible for performance improvement activities.

advanced clinic access were monitored appropriately. However, we identified several program areas that needed strengthening, as follows:

Adverse Event Disclosure. The medical center had no formal process to identify and evaluate cases that may require disclosure; as a result, the medical center did not complete any institutional disclosures between October 1, 2006, and April 23, 2007. Medical center policy and VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, issued October 27, 2005, require that medical errors or harmful events be evaluated. If a patient was harmed because of an error or event, responsible providers are required to disclose this to the patient. In some serious cases, patients must be advised of their legal rights and options (institutional disclosure). While reviewing QM documents, we identified cases that required further evaluation for possible institutional disclosure due to serious injury, death, or potential legal liability. Without adequate disclosure processes, managers could not be assured that patients received important medical and legal information needed to make decisions when adverse events occur.

Peer Review. During the 2004 CAP, the OIG identified that the peer review process needed improvement. Managers implemented corrective actions, which included closing open peer review cases and revising medical center policy to meet VHA requirements. At the time of this review, we found the peer review process to be much improved, yet still not in full compliance with VHA Directive 2004-054, *Peer Review for Quality Management*, issued September 29, 2004.

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, with subsequent Peer Review Committee (PRC) evaluation and concurrence with the findings. We noted that completed initial peer reviews showed clear and comprehensive documentation of issues and findings. We also noted that in an effort to improve the timeliness of peer reviews, the Chief of Staff increased the frequency of the meetings.

We evaluated the peer review activities conducted from January 2006 through January 2007 and identified the following issues:

- All of the peer reviews exceeded the required timeframes for completion and discussion by the PRC. VHA requires initial reviews to be completed within 45 days and PRC discussions to occur within 120 days. We noted that while timeliness of peer review completion is still not in compliance with policy, it has improved from an average of 180 days in January 2006 to an average of 126 days in November 2006.

- The PRC did not review quarterly summaries containing the following elements: (1) number of reviews, (2) outcomes by level, (3) number of changes from one level to another, and (4) follow-up of action items and recommendations resulting from completed peer reviews. The PRC submitted only one report to the CEB for review, which did not include some elements.

- The PRC did not review a representative sample of Level 1[2] peer review cases, as required, to ensure reliability of findings.

Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in individual providers' practices. Peer reviews should be completed timely and in accordance with policy to ensure that providers perform according to accepted community standards. Peer reviews should be evaluated to identify trends and improvement opportunities.

Root Cause Analysis. We found that elements of the RCA process did not comply with VHA guidelines. RCAs are designed to identify and resolve the root cause of system and/or process deficiencies involved in an actual or potential adverse event. VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, issued January 30, 2002, requires completion of RCAs within 45 days of the medical center's identification of need. RCAs should be initiated with a specific charter memorandum to provide protection and confidentiality of the documents under Title 38 United States Code Section 5705 and should be signed by the medical center Director, indicating concurrence with the findings and recommendations of the RCA team.

We found that 10 of the 13 RCAs conducted for events occurring in FY 2006 were not completed within the required

[2] Level 1 – Most experienced, competent practitioners would have managed the case similarly.

45 days. One RCA, chartered in September 2006, remained incomplete at the time of our visit. We found that 11 of the RCAs did not have a charter memorandum, and 8 were not signed by the medical center Director. However, we noted that in eight of the RCAs, actions were tracked to completion, and the effectiveness of the outcomes was well documented. Timely and complete RCAs are a critical component of an effective and efficient patient safety program.

Clinical Executive Board Oversight. The Joint Commission[3] requires that medical staff leadership monitor high-risk processes. Although performance improvement activities were conducted at the service and committee levels, we could not find evidence in meeting minutes that the CEB reviewed data related to the performance and outcomes of some high-risk processes. The minutes did not reflect reviews of:

- The PRC and the Blood Usage Committee meeting minutes.
- The mortality data compiled by QM, which requires discussion and evaluation on a regular basis per VHA directive.
- The Surgical Case and Quality Improvement Committee (SCQIC) meeting minutes. As a result, the CEB was not aware that the SCQIC did not review non-operating room invasive procedures and major pre- and post-operative discrepant diagnoses.

Without CEB oversight and evaluation of important performance outcomes and findings, managers could not be assured that improvement opportunities were identified and that corrective actions were taken in high-risk areas.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that adverse events are evaluated and disclosed appropriately.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that the peer review process complies with medical center and VHA policy.

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

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that the RCA process is completed in accordance with VHA policy.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that CEB minutes reflect discussion and evaluation of subordinate committee findings from high-risk processes.

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. Medical center managers implemented action plans to strengthen several QM program areas. They will (1) discuss the need for clinical or institutional disclosure on a case-by-case basis at PRC meetings; (2) improve the peer review process by completing reviews within 120 days, including all elements required in quarterly PRC reports, and by reviewing a sample of Level 1 reviews; (3) improve the RCA process by completing RCAs within 45 days and including the charter memorandum and medical center Director's concurrence signature with each RCA; (4) review committee meeting minutes that reflect performance and outcomes of high-risk processes at CEB meetings. We will follow up on planned actions until they are completed.

Cardiopulmonary Resuscitation Training

Medical center policy on CPR states that each clinical service will identify, by position, those staff who need to be certified in either Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS). The Associate Chief of Staff for Education (ACOS/E) should maintain training records. We found the monitoring of compliance with BLS/ACLS training to be deficient.

While we found that some clinical service chiefs could produce a list of employees trained in BLS or ACLS, neither the CPR Committee nor the ACOS/E could produce evidence that staff compliance with BLS/ACLS training requirements was routinely monitored. No master list or database existed that showed all currently certified employees or employees in need of training. The ACOS/E did not provide clinical service chiefs with training records identifying employees with BLS or ACLS certification, as required. When training compliance is not monitored, managers cannot plan and coordinate staff education needed to ensure the prompt and skillful resuscitation of patients.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires monitoring of BLS/ACLS training.

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. The CPR Committee will monitor compliance with required BLS/ACLS training and provide the information to the appropriate service chiefs. We will follow up on planned actions until they are completed.

Environment of Care

VHA requires that health care facilities have a comprehensive EOC program that complies with VHA policy, Occupational Safety and Health Administration regulations, Joint Commission standards, and the Nuclear Regulatory Commission Master Materials License. We inspected 19 clinical areas for cleanliness, safety, privacy, infection control, and general maintenance. We also followed up on EOC concerns cited in the previous CAP report and found those issues to be resolved.

Our inspection revealed that the medical center maintained a safe and clean environment. Infection Control clinicians monitored exposures and infections appropriately. The medical center maintained accurate inventories of tritium (also known as H3), a radioactive substance used in research that emits low levels of radiation, in accordance with all VA policies and procedures. However, we identified a deficiency related to the security of confidential patient information that required management attention.

We found two unattended computer monitors displaying confidential patient information. One monitor was located at the nurses' station on the Behavioral Health Unit and the other in an examination room in the Emergency Department. In addition, we found that a monitor in the Pulmonary Clinic, visible to clinic patients, displayed x-ray films identified with patient names. The monitor was located at a workstation where physicians showed patients their films and discussed treatment options. The Health Insurance Portability and Accountability Act (HIPAA) and VHA policy require that patient health information be protected at all times. Managers cannot be assured that patient information is secure if it can be seen by individuals who do not have a legitimate need to know.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that the security of confidential patient information is maintained.

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. The Privacy Officer conducted an assessment of clinical areas to determine the need for privacy screens. The medical center has begun the installation of screens where needed. We will follow up on planned actions until they are completed.

Computerized Patient Record System Business Rules

Business rules define which groups or individuals are allowed to edit, amend, or delete documentation in electronic medical records. The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records*, issued August 25, 2006, includes both the electronic and paper medical record. It includes items, such as physician orders, progress notes, and examination and test results. In general, once notes are signed, they should not be altered.

On October 20, 2004, the VHA Office of Information (OI) sent software informational patch USR*1*26 to all medical centers with instructions to assure that business rules complied with VHA regulations. The guidance 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." In January 2006, the OIG identified a facility in the Northeast where progress notes could be improperly altered and recommended that VHA address the issue on a national basis. On June 7, 2006, VHA issued a memorandum to VISN Directors, instructing all VA medical centers to comply with the informational patch sent in October 2004.

During our review, we found that the medical center still had 13 business rules that did not comply with VHA policy. Eight business rules allowed editing of a signed note by users other than the author, and five rules allowed amendment or deletion of notes by staff other than the author. However, 4 of these 13 business rules were no longer in use, and medical center staff took action to remove all 13 while we were onsite.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires continued compliance with

VHA policy and the October 2004 OI guidance regarding the altering of signed notes.

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable improvement plans. Managers established a process to annually monitor business rule compliance with VHA regulations. Based on this action, we consider this recommendation closed.

Review Activities Without Recommendations

North Memphis Community Based Outpatient Clinic

The purpose of this review was to assess CBOC operations and delivery of health care services. CBOCs were designed to improve veterans' access to care by offering primary care in local communities, while delivering the same standard of care as the parent facility. The North Memphis CBOC, located about 12 miles from the medical center, was staffed by VA employees and served 6,642 veterans in FY 2006.

We reviewed CBOC policies, performance documents, and provider C&P files. We conducted an EOC inspection to assess compliance with environmental standards. To determine if patients received the same standard of care, we compared the management of patients receiving warfarin[4] at the parent facility with those receiving warfarin at the CBOC. We also interviewed 10 patients about their perceptions of care.

We found that the CBOC's emergency management plan was current, and staff were knowledgeable about rendering emergency care. CBOC providers' C&P files contained appropriate background screening and professional practice documentation. The facility was clean, well maintained, and met Joint Commission, HIPAA, and Life Safety requirements.

Patients on warfarin received the same standard of care at the CBOC as patients at the parent facility. Pharmacists managed the warfarin clinic at both the parent facility and the CBOC. They conducted patient education on warfarin use and side effects and gave patients the same toll-free telephone number to call if they had problems or concerns. The patients we interviewed reported being satisfied with their care. We made no recommendations.

[4] Medication used to prevent blood clots.

Cardiac Catheterization Program

The purpose of this review was to determine if the medical center's CC laboratory practices were consistent with VHA policy and the American College of Cardiology/Society for Cardiac Angiography and Interventions *Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards*. These standards define requirements for provider procedure volumes, laboratory procedure volumes, cardiac surgery resources, performance improvement, provider CPR training, and the informed consent process.

We found that providers had performed the required volume of procedures. The CC laboratory performed 754 cardiac catheterization procedures and 194 interventional procedures in FY 2005 and reported an acceptable complication rate, with only two major complications. The medical center has onsite cardiac surgery to support the CC laboratory. We found evidence that staff conducted ongoing performance improvement activities, and providers were current in their CPR certifications.

We reviewed the medical records of five patients who had undergone diagnostic CC procedures and five who had undergone interventional CC procedures in FY 2005. We found appropriately completed informed consents for 9 of 10 patients; one informed consent did not include the names of the physicians who performed the procedure. The Chief of Cardiology told us they now use the iMED[5] consent process, which ensures that physician names are listed on all informed consents. Since the medical center has improved the informed consent process, we made no recommendations.

Patient Satisfaction

The Survey of Healthcare Experiences of Patients (SHEP) is aimed at capturing patient perceptions of care in multiple service areas, including access to care, coordination of care, and courtesy. VHA relies on the analyses and interpretations of the survey data for making administrative and clinical decisions for improving the quality of care delivered to patients. The graphs on the next page show the medical center's performance in relation to national and VISN performance. VHA's Executive Career Field Performance Plan states that in FY 2006, at least 77 percent of ambulatory care patients treated and 76 percent of inpatients discharged during a specified date range will report their experiences as

[5] Computer software program for electronic completion, signing, and storage of informed consents.

"very good" or "excellent." Medical centers are expected to address areas in which they are underperforming.

Quarter 3 & Quarter 4, FY 2006

Memphis VA Medical Center

INPATIENT SHEP RESULTS

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition	Overall Quality
National	81.3	78.9	89.9	67.9	66	75.9	83.4	74.7	70.1	**
VISN	81.4	78.3	90	68.5	66.3	75.6	83.2	75.1	71.6	**
Medical Center	76.3	73.8	87.4	63.7	62.6	77.7	80.1	70	73.6	**

** Overall Quality is not reported by all bed sections

Quarter 4, FY 2006

Memphis VA Medical Center

OUTPATIENT SHEP RESULTS

Facility Name	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pickup	Preferences	Specialist Care	Visit Coordination
National	81.1	77.9	94.7	72.8	83.1	75.6	81.9	65.9	81.4	80.7	84.4
VISN 9 Overall	79.8	73.4	95.2	73.9	82.3	74.8	84.4	73.7	80.3	81.5	84.1
MEMPHIS OUTPATIENT CLINIC Overall	74.6	67.5	95.3	71.7	78.4	70.5	77.3	75	76.9	78.6	82.9
MEMPHIS	72	64.6	96.5	71.2	76	67.6	77.7	77.7	76.1	76.3	80.1
SMITHVILLE	83.1	67.2	94	74.7	86.7	86.5	74	*	80	85.2	94.2
JONESBORO	84.5	65.4	96.2	77.8	88.7	76.8	86	*	85.7	*	87.4
BYHALIA	81.2	56.6	89.7	65.6	78.3	69.9	89.9	*	84.8	*	80.9
SAVANNAH	89.4	72.5	98.9	77.9	85.5	83.6	82.5	*	82.4	78.7	94.5
COVINGTON	79.8	73.2	94.4	68.6	84.4	68.8	77.6	*	77.7	79.2	86.7
MEMPHIS	75.2	80.5	89.5	72.6	78.9	75.4	71.8	*	75.4	90.3	87.5

* Less than 30 respondents

As medical center scores for FY 2006 were below VISN and national averages, medical center managers were working to improve patient satisfaction and were aggressively pursuing the FY 2007 targets for overall patient satisfaction. The medical center appointed a new Customer Service Programs manager in October 2006. The manager has responsibility for the patient advocate program and serves as SHEP coordinator. The Customer Service Programs manager has taken action to improve communication, education, documentation, and outcome monitoring related to SHEP. More than 30 process improvement teams are working to improve patient satisfaction in their respective areas. Other examples of improvement initiatives included bedside "chats" with new admissions and the volunteer discharge feedback survey. Since the medical center had taken appropriate actions, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 20, 2007

From: Director, VA Mid South Healthcare Network (10N9)

Subject: **Combined Assessment Program Review of the Memphis VA Medical Center, Memphis, Tennessee**

To: Director Atlanta Healthcare Inspections Division (54AT)

Director, Management Review Office (10B5)

1. Attached please find VA Medical Center at Memphis' response to the Office of Inspector General Combined Assessment Program (OIG – CAP) Review conducted April 23–27, 2007.

2. If you have any questions regarding the information provided, please contact Donna Savoy, Staff Assistant to the Network Director, VISN 9. Ms. Savoy can be reached at (615) 695-2205.

(original signed by:)
John Dandridge, Jr.

Attachment

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 15, 2007

From: Director, Memphis VA Medical Center (614/00)

Subject: **Combined Assessment Program Review of the Memphis VA Medical Center, Memphis, Tennessee**

To: Director, VA Mid South Healthcare Network (10N9)

1. Attached please find VA Medical Center at Memphis' response to the Office of Inspector General Combined Assessment Program (OIG – CAP) Review conducted April 23–27, 2007.

2. If you have any questions regarding the information provided, please contact Jan Hopper, Accreditation Manager, Quality Management and Performance Improvement. Ms. Hopper can be reached at (901) 577-7379, #5.

(original signed by:)
PATRICIA O. PITTMAN

Medical Center Director

Attachment

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

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that adverse events are evaluated and disclosed appropriately.

Concur Target Completion Date: 7/31/2007

Effective with the July 2007 Peer Review Committee, the minutes will reflect the Committee's process and decision on a case-by-case basis of the need for possible clinical or institutional disclosure.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the peer review process complies with medical center and VHA policy.

Concur Target completion Date: 8/31/2007

Processes are in place to ensure peer reviews are completed within the required 120 days. Effective with 3rd quarter FY07, a quarterly summary containing the four (4) required elements will be prepared and is scheduled for presentation at the August CEB. Thereafter, quarterly summary reports will be presented at CEB 2 months following the end of the quarter.

At the June Peer Review Committee meeting, the members will discuss and agree on the process for reviewing a representative sample of Level 1 peer reviews, as required. The process will begin with a review of 3rd quarter FY07 Level 1 reviews for presentation at the August CEB.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that the RCA process is completed in accordance with VHA policy.

Concur Target Completion Date: 6/30/2007

The Patient Safety Manager now has processes in place to provide completion of RCAs within the required 45 days and ensure signed charter memorandum and Medical Center Director concurrence are maintained with each RCA file. Five of five RCAs conducted since January 2007

have been completed within the 45-day requirement. Any outstanding 2006 RCAs will be presented to the Executive Team for concurrence by June 30, 2007.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that CEB minutes reflect discussion and evaluation of subordinate committee findings from high-risk processes.

Concur Target Completion Date: 8/31/2007

The Chair, CEB, will ensure that data related to the performance and outcomes of certain high-risk processes are reviewed during CEB meetings and reflected in the minutes. The following committee minutes and/or reports will be reviewed quarterly by the CEB: Peer Review Committee Minutes, Blood Use Committee Minutes, Mortality Assessment Report, Surgical Case/Quality Improvement Committee Minutes, Medication Use Committee Minutes, CPR Committee Minutes, and Restraint and Seclusion Usage Report. The process will begin with a review of 3rd quarter FY07 reports for presentation at the August CEB.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires monitoring of BLS/ACLS training.

Concur Target Completion Date: 8/31/2007

Service Chiefs have been requested to identify, by position, those staff needing training in BLS/ACLS and to forward this list to the Chair, CPR Committee. The ACOS/E will provide training completion records for designated positions to the Chair, CPR Committee. The medical center policy memorandum, Cardiopulmonary Resuscitation (Blue Alert), 11-51, will be amended to reflect that the CPR Committee will monitor the training completion list for compliance at least semi-annually and provide this information to the Service Chiefs.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that the security of confidential patient information is maintained.

Concur Target Completion Date: 7/31/2007

The Privacy Officer has begun an intensive assessment throughout the medical center of locations of workstations in clinic and patient ward areas to ensure that privacy screens are provided to minimize the chances of patient information being viewed from a distance. As a result, 43 privacy screens were requested thus far, and installation has begun. As the assessment continues, additional privacy screens will be purchased, as needed. Special follow-up reviews have been done in Behavioral Health,

Emergency Department exam rooms, and the Pulmonary Clinic. In these areas where it is not possible to change the locations of monitors, privacy screens have been requested. The Privacy Officer developed a one-page sample of privacy breaches for distribution to all employees and for posting on bulletin boards.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires continued compliance with VHA policy and the October 2004 OI guidance regarding the altering of signed notes.

Concur Target Completion Date: 9/30/2007

The Supervisor, Clinical Applications Coordinator, has established a process to monitor medical center business rules to ensure compliance with VHA regulations. An annual review will be conducted at the end of each fiscal year. The next annual review will be done September 30, 2007.

OIG Contact and Staff Acknowledgments

Contact	Christa Sisterhen, Associate Director Atlanta Office of Healthcare Inspections (404) 929-5961
Contributors	Susan Zarter, Health Systems Specialist, Team Leader Deborah Howard, Health Systems Specialist Michael Keen, Resident Agent in Charge, Nashville Office of Investigations Toni Woodard, Health Systems Specialist

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Mid South Healthcare Network (10N9)
Director, Memphis VA Medical Center (614/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Lamar Alexander, Thad Cochran, Bob Corker, Blanche L. Lincoln, Trent Lott, Mark L. Pryor
U.S. House of Representatives: Marion Berry, Marsha Blackburn, Stephen Cohen, Roger Wicker

This report is available at http://www.va.gov/oig/publications/reports-list.asp.