Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-03077-04

Combined Assessment Program Review of the Salem VA Medical Center Salem, Virginia

October 6, 2009

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.

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Executive Summary

Introduction

During the week of June 8–12, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Salem VA Medical Center (the medical center), Salem, VA. 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 506 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 6.

Results of the Review

The CAP review covered eight operational activities. We identified the following organizational strengths and reported accomplishments:

- SupraVista Clinical Support System.
- Metabolic Assistance Group Intervention Clinic (MAGIC).
- Mental Health Intitiative (MHI).

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

- Ensure that emergency department (ED) staff document discharge instructions and evaluate patient and/or caregiver understanding of the discharge instructions provided.
- Ensure that the process for requesting and granting ED staff privileges complies with Veterans Health Administration (VHA) regulations.
- Conduct a comprehensive review of QM monitoring and the committee reporting structure and update policies as appropriate to reflect responsibilities for reporting and oversight.
- Ensure that contract physicians' privileges do not extend beyond the terms of their contracts.
- Implement a tracking system to ensure that all designated clinically active staff maintain their cardiopulmonary resuscitation (CPR) certifications.
- Establish a process to review and evaluate the use of the copy and paste functions in the Computerized Patient Record System (CPRS).

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

- Contracted/Agency Registered Nurses (RNs).
- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- Suicide Prevention Program.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Victoria Coates, 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 14–19, 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 Salem, VA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) located in Hillsville, Lynchburg, Danville, and Tazewell, VA. The medical center is a part of VISN 6 and serves a veteran population of approximately 112,500 throughout southwest Virginia.

Programs. The medical center provides comprehensive health care through primary care, acute care (medicine, surgery, and psychiatry), physical medicine and rehabilitation, and dentistry. In addition, the medical center's Imaging Service's Interventional Radiology Program is a resource for VISN 6. The medical center has 208 hospital beds and 90 community living center (CLC)[1] beds.

Affiliations and Research. The medical center is affiliated with the University of Virginia's School of Medicine, the Edward Via Virginia College of Osteopathic Medicine, and Virginia Polytechnic Institute and State University. In addition, the medical center has a close working relationship for residency training with Carilion Health System. The medical center provides training for medical residents, interns, nursing students, and students in other allied health disciplines.

In fiscal year (FY) 2008, the medical center had 60 active research projects. Important areas of research included obesity, diabetes, osteoporosis, asthma, anemia, and substance abuse. The Association for the Accreditation of Human Research Protection Programs, Inc., accredited the medical center's research program in December 2008.

Resources. In FY 2008, medical care expenditures totaled $226 million. The FY 2009 medical care budget was $231 million. FY 2008 staffing was 1,450 full-time employee (FTE) equivalents, including approximately 210 physician and 400 nursing FTE.

Workload. In FY 2008, the medical center treated 32,824 unique patients and provided 49,929 inpatient days

[1] A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

in the hospital and 24,292 inpatient days in the CLC. The inpatient care workload totaled 4,619 discharges, and the average daily census, including CLC patients, was 232. Outpatient workload totaled 312,422 visits.

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 eight activities:

- Contracted/Agency RNs.
- Coordination of Care.
- Emergency/Urgent Care Operations.
- EOC.
- Medication Management.
- QM.
- SHEP.
- Suicide Prevention Program.

The review covered medical center operations for FY 2008 and FY 2009 through June 12, 2009, 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 Salem VA Medical Center, Salem, Virginia,* Report No. 06-01706-209, September 14, 2006). During our follow-up review, we found that the medical center had implemented appropriate actions to address all recommendations related to health care.

During this review, we also presented fraud and integrity awareness briefings for 506 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 findings requiring corrective actions.

Organizational Strengths

SupraVista Clinical Support System

In 2006, the medical center initiated the use of SupraVista, which has reduced clinical errors and increased provider efficiency. SupraVista was developed in response to increasing workload demands and decreased time for clinical assessment. It provides clinical staff with automated, patient-specific data analysis of important clinical issues by identifying actual and potential problems that need to be addressed during the patient's visit.

Recently, using SupraVista, the medical center's Anticoagulation Therapy Program (ATP) found that Danville CBOC patients' International Normalization Ratio (INR)[2] ranges were consistently subtherapeutic or unacceptable for their respective diagnoses. The ATP Coordinator provided onsite training to Danville CBOC staff to improve their usage of SupraVista for INR range tracking and trending. Over several weeks, physicians made the appropriate medication adjustments for patients. As a result, patients with normal INRs increased from 43 percent (April 24, 2009) to 65 percent (June 5, 2009).

[2] Standard used for reporting the clotting time of blood for patients on anticoagulation therapy. http://www.ptinr.com, accessed on June 18, 2009.

Metabolic Assistance Group Intervention Clinic

MAGIC was developed after 2007 external peer review outcomes indicated that 13–15 percent of medical center patients had uncontrolled diabetes, hypertension, and/or lipid values. One of MAGIC's goals is to provide comprehensive health care that better addresses the medical, motivational, nutritional, and behavioral needs of patients with high-risk metabolic conditions. Patients are referred to MAGIC by their primary care provider (PCP) and participate in three interventions: (1) medication management, (2) lifestyle intervention, and (3) individualized treatment planning and education. July 2009 data shows that after three or more encounters or discharge from the program,[3] patients had mean changes in several physiological outcomes, including decreases in hemoglobin A1c[4] and systolic and diastolic blood pressures.

Mental Health Initiative

MHI involves the strategies of co-location, integration, open access, and coverage. MHI utilizes a "warm-hand-off-system" in which a patient with a positive mental health screen is seen by an MHI provider during the primary care visit. MHI provides same visit access during regular clinic hours to any primary care patient requesting immediate assistance and to any PCP requesting decisional support or patient assessment. Data from the first 8 months of MHI implementation shows a 17 percent decrease in consultations to the Center for Traumatic Stress and a 61 percent decrease in consultations to Behavioral Medicine. In addition, there were decreases in no-shows, cancellations, and wait times for initial substance abuse appointments and increases in screening for suicidality and homicidality.

Results

Review Activities With Recommendations

Emergency/Urgent Care Operations

The purpose of this review was to evaluate selected aspects of the ED, such as clinical services, consultations, inter-facility transfers, staffing, and staff competencies. We interviewed ED physicians, the ED program manager, and other Critical Care Service Line staff. We reviewed policies and other pertinent documents, including competency files and credentialing and privileging (C&P) folders. We also

[3] Once a patient has achieved targeted goals for blood pressure, low density lipoprotein, and/or hemoglobin A1c, care is returned back to their PCP with recommendations for ongoing treatment and maintenance.
[4] A measure of the percentage of hemoglobin coated with sugar (glycated). The higher the A1c level, the higher the risk of diabetes complications. http://www.nlm.nih.gov/medlineplus, accessed on July 2, 2009.

reviewed selected medical records of patients who had consultations to other services or who were transferred from the ED to other medical facilities.

The ED is located in the main hospital building and is open 24 hours per day, 7 days per week, as required for ED designation. Emergency services provided are within the medical center's patient care capabilities. Also, the medical center has a procedure in place for the management of patients whose care may exceed the medical center's capability.

We toured the ED and found that the environment was clean and safe and that equipment was maintained appropriately. However, we identified the following conditions that needed improvement.

Discharge Instructions. We reviewed the medical records of six discharged patients and found that four did not contain adequate documentation of discharge instructions. VHA regulations[5] require that discharge instructions be documented. In addition, Joint Commission (JC) standards require an evaluation of the patient's and/or caregiver's understanding of the discharge instructions.

Provider Privileges. We reviewed three provider C&P folders and found that they did not include comprehensive privileges for out-of-operating room airway management or identify the settings where procedures could be performed. We also found that two folders lacked adequate documentation to justify the privileges granted. VHA regulations[6] require that clinical managers ensure the competence of clinicians who perform out-of-operating room airway management. Additionally, VHA regulations[7] require that privileges are setting specific and justified with evidence that a practitioner has (a) performed the procedure and (b) had good outcomes when performing the procedure.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that ED staff document discharge instructions and evaluate patient and/or caregiver understanding of the discharge instructions provided.

[5] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[6] VHA Directive 2005-031, *Out-Of-Operating Room Airway Management*, August 8, 2005.
[7] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center implemented a discharge template on June 22, 2009. Monthly reviews will be conducted to ensure compliance, and results will be reported on a recurring basis to the Medicine Service Line and to top leadership boards. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that the process for requesting and granting ED staff privileges complies with VHA regulations.

The VISN and Medical Center Directors agreed with the findings and recommendation. Site specific out-of-operating room airway management privileges were approved by the Medical Executive Board (MEB). ED physicians were observed performing these competencies during September 2009. The privileges granted will be documented in the October MEB minutes. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Quality Management

The purposes of this review were to determine whether (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts and (b) senior managers actively supported QM efforts and appropriately responded to QM results. To evaluate QM processes, we interviewed senior managers and reviewed the self-assessment completed by QM staff regarding compliance with QM requirements.

The QM program was in compliance with standards in the following areas of review: (a) mortality review and analysis, (b) peer review, (c) patient complaints, (d) adverse event disclosure, (e) patient safety related to the use of anticoagulation therapy, (f) medication reconciliation, (g) root cause analysis, (h) utilization management, (i) operative and other procedure review, and (j) system redesign/patient flow. However, we identified the following areas that needed improvement.

Committee Reporting and Oversight. Committee minutes did not consistently reflect data analysis, action tracking, or effectiveness monitoring. In addition, the Clinical Executive

Board (CEB), which had responsibility for QM oversight, did not review performance improvement (PI) information and was functioning under a medical center policy that expired October 2, 2008. CEB minutes did not regularly include analysis of statistical data, recommendations for corrective actions, or evaluation of actions taken. Accreditation standards and local policy require trending and analysis of PI data to identify opportunities for improvement.

C&P Review. The medical center routinely granted contract physicians' privileges for a 2-year period, which exceeded the lengths of the physicians' contracts. At the time of our visit, 16 contract physicians had been granted clinical privileges for 2 years; however, their contract periods ranged from 5 months to 23 months. VHA regulations[8] require that clinical privileges granted to contract physicians may not extend beyond the contract period. In addition, each new contract period requires reappraisal and reprivileging.

CPR Certification. Files of some designated clinically active staff did not contain documentation of current CPR certification. In addition, we found that the tracking and notification process for upcoming expirations was ineffective. At the time of our visit, we saw no evidence of current Basic Life Support certification for two pharmacists or current Advanced Cardiac Life Support certification for a cardiac catheterization technician, as required by medical center policy.

Service chiefs were notified of impending CPR expirations but did not take action to ensure that staff completed the necessary training. In addition, staff with lapsed certifications were not temporarily reassigned to administrative roles in accordance with medical center policy.

Medical Records Review. The medical center did not publish the first local policy for the use of the copy and paste functions in CPRS until May 15, 2009. In addition, the medical center did not have a review process in place to evaluate the appropriate use of these functions. VHA issued regulations[9] in August 2006 that required medical centers to

[8] VHA Handbook 1100.19.
[9] VHA Handbook 1907.01.

develop local policies and establish review processes to evaluate the use of the copy and paste functions.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director conducts a comprehensive review of QM monitoring and the committee reporting structure and updates policies as appropriate to reflect responsibilities for reporting and oversight.

The VISN and Medical Center Directors agreed with the findings and recommendation. The medical center plans to initiate an Executive Quality Council (EQC) to oversee all aspects of PI. The first EQC meeting is scheduled for January 2010. In addition, the medical center will revise policies and educate key staff on changes in committee alignment, reporting, and expectations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires that contract physicians' privileges do not extend beyond the terms of their contracts.

The VISN and Medical Center Directors agreed with the findings and recommendation. Privileges will only be granted for the period of the physicians' contracts. This change will be reflected in the Medical Staff Bylaws and in the C&P policy no later than November 30, 2009. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director implements a tracking system to ensure that all designated clinically active staff maintain their CPR certifications.

The VISN and Medical Center Directors agreed with the findings and recommendation. The Employee Education Department will initiate a supervisor notification process that will start 3 months prior to expiration of CPR certification. Additional notifications will occur as needed. Impending expirations and actions taken as a result of expiration will be monitored by the EQC. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires that a process to review and evaluate the use of the copy and paste functions in CPRS is established.

The VISN and Medical Center Directors agreed with the findings and recommendation. The Health Information Management Committee began monitoring the use of the copy and paste functions in July 2009. Results will be reported to the CEB for discussion and action, as appropriate. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Contracted/Agency Registered Nurses

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. We reviewed documents for several required components, including licensure, training, and competencies. We reviewed folders for seven contracted RNs' who worked at the medical center during the past 12 months and found the required documentation for each RN. In addition, we found that medical center managers had appropriate processes in place and followed them consistently with all contracted/agency RNs selected for review. We made no recommendations.

Coordination of Care

The purpose of this review was to evaluate whether inpatient consultations, intra-facility (ward-to-ward) transfers, and discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated consultations, transfers, and discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

We reviewed the medical records of 12 inpatients who had consultations ordered and performed internally. In general, we found that all records included in our review reflected that consultative services were provided within acceptable timeframes.

We determined that clinicians appropriately managed all 12 of the intra-facility transfers included in our review. We found transfer notes from sending to receiving units and

documentation by the receiving units in accordance with established timeframes.

We found that 14 (93 percent) of the 15 medical records of discharged patients we reviewed had documented written discharge instructions. We also found documentation that the patients understood the instructions. We made no recommendations.

Environment of Care

The purpose of this review was to determine whether the medical center maintained a safe and clean health care environment. Medical centers are required to provide a comprehensive EOC program that fully meets VHA, Occupational Safety and Health Administration, and JC standards.

We inspected the CLC and the inpatient medical/surgical, locked mental health, specialty care, and intensive care units. We found that the medical center maintained a generally clean and safe environment. The infection control program monitored exposures and reported data to clinicians for implementation of quality improvement actions.

We found that the medical center met safety guidelines and that risk assessments were in compliance with VHA standards. Managers on the locked mental health unit complied with safety regulations, and staff were trained to identify environmental hazards. We made no recommendations.

Medication Management

The purpose of this review was to evaluate whether the medical center had adequate medication management practices. A safe medication management system includes medication ordering, administering, and monitoring.

We reviewed selected medication management processes in the CLC and on the medical/surgical, intensive care, and locked mental health units. We found adequate management of medications brought into the facility by patients or their families. Nurses appropriately scanned patient armbands and used personal identifiers to identify patients prior to medication administration. We found that reconciliation of controlled substances discrepancies at the unit level was adequate. We also found that documentation of PRN (as needed) pain medication effectiveness was

generally in compliance with local policy. We made no recommendations.

Suicide Prevention Program

The purpose of this review was to determine whether the medical center had implemented a suicide prevention program that complied with VHA regulations. We assessed whether senior managers had appointed Suicide Prevention Coordinators (SPCs), and we evaluated whether SPCs fulfilled all required functions. We verified whether medical records of patients determined to be at high risk for suicide contained Category II Patient Record Flags,[10] documented safety plans that addressed suicidality, and documented collaboration between mental health providers and SPCs.

We interviewed the medical center's SPC and mental health providers, evaluated pertinent policies, and reviewed the medical records of eight medical center patients and two CBOC patients determined to be at risk for suicide. Our review showed that senior managers exceeded the requirements by appointing a full-time SPC, a full-time Suicide Prevention Case Manager, and a program assistant. We found that the SPC fulfilled the required functions of the position. We also found that documentation was complete in all medical records reviewed. We made no recommendations.

Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that the medical center used SHEP data to improve patient care, treatment, and services. The SHEP is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA relies on the Office of Quality and Performance's analysis of the survey data to improve the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that at least 76 percent of inpatients discharged during a specified date range and 77 percent of outpatients treated will report the overall quality of their experiences as "very good" or "excellent." Facilities are expected to address areas in which they are underperforming.

The graphs on the next page show the medical center's performance in relation to national and VISN performance. Figure 1 shows the medical center's SHEP performance measure (PM) results for inpatients. Figure 2 shows the medical center's SHEP PM results for outpatients.

[10] A Category II Patient Record Flag is an alert mechanism that is displayed prominently in CPRS.

Figure 1:

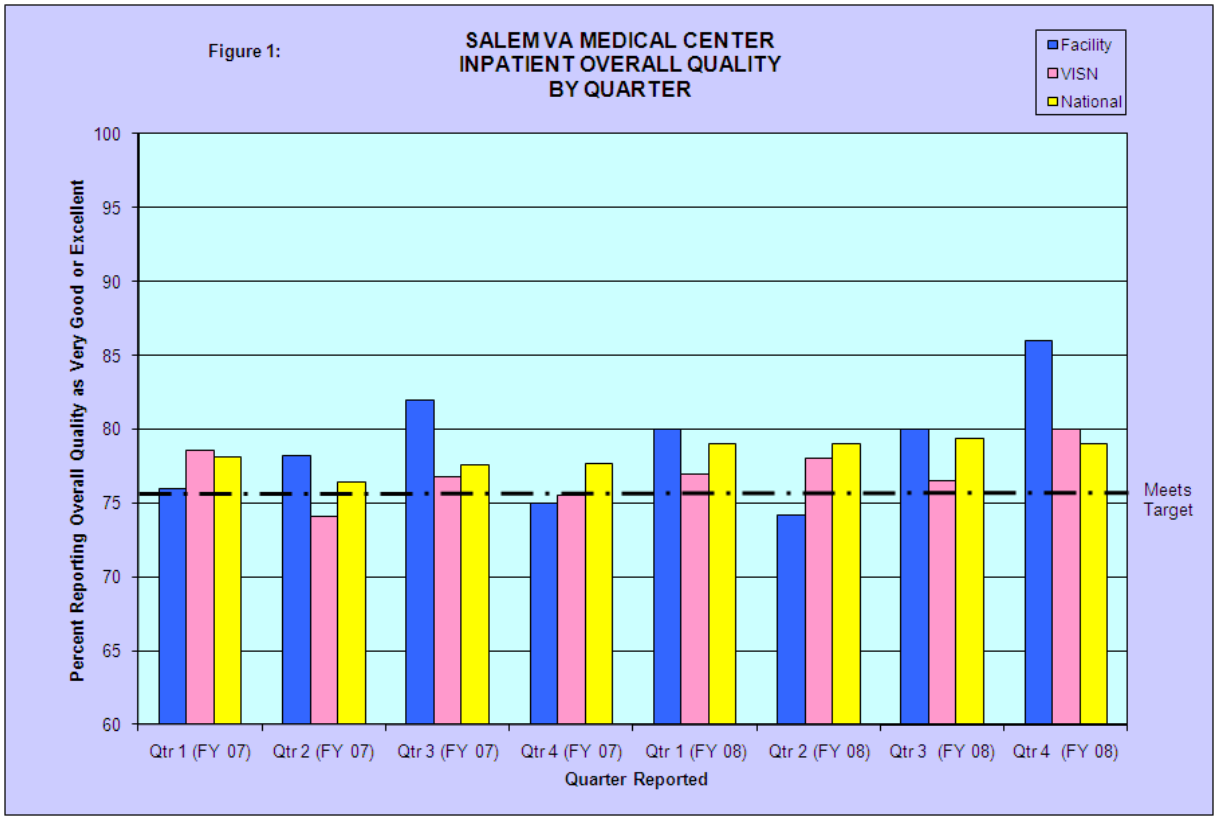
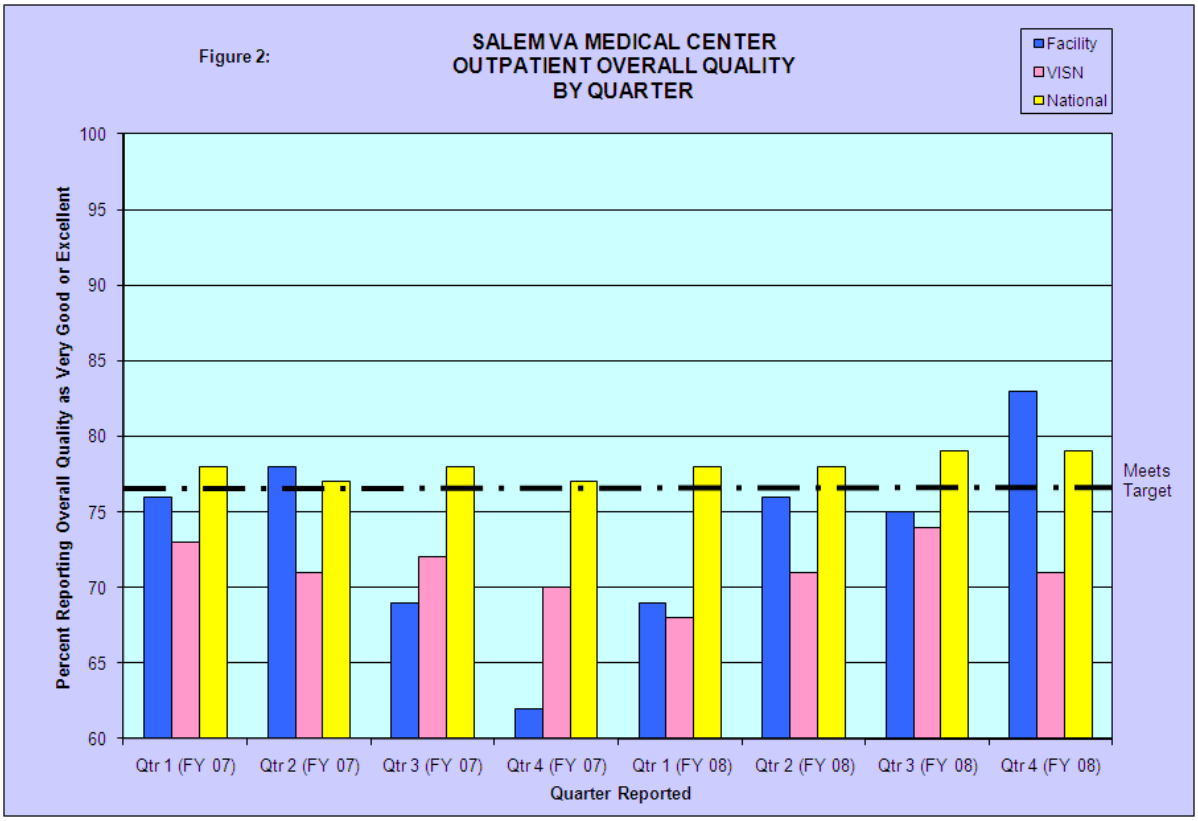


Figure 2:



For FYs 2007 and 2008, the medical center met or exceeded the established target for inpatient overall quality in 6 of the 8 quarters. However, the medical center only met or exceeded the established target for outpatient overall quality in 2 of those 8 quarters. The medical center has dubbed the outpatient areas of weakness as "The Four Ps"—pain, parking, phones, and pharmacy.

The medical center had a Customer Service Coordinator who worked with designated service level patient advocates (called STARs) to analyze and address patient satisfaction issues. Patient satisfaction data were reported to the Executive Leadership Board. Managers had initiated improvement actions, which included implementation of a pain committee, valet parking, telephone call scripting and callback options, and educational sessions for staff and patients. In addition, a process action team evaluated pharmacy-related patient satisfaction and made recommendations for improvement. As a result, outpatient prescription waiting times decreased from about 1 hour (last 2 quarters of FY 2008) to less than 30 minutes (as of May 2009). Since the medical center had already taken appropriate actions, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: **September 10, 2009**

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **Combined Assessment Program Review of the Salem VA Medical Center, Salem, Virginia**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (10B5)

I concur with the findings of the OIG-CAP team and the responses by the Medical Center Director to correct the findings and implement appropriate changes to meet the VHA policies for each of the findings.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 9, 2009

From: Director, Salem VA Medical Center (658/00)

Subject: **Combined Assessment Program Review of the Salem VA Medical Center, Salem, Virginia**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

I concur with the findings of the OIG-CAP team and submit the responses to correct the findings, implementing appropriate changes to meet the VHA policies for each of the findings.

(original signed by:)

JOHN E. PATRICK

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 ED staff document discharge instructions and evaluate patient and/or caregiver understanding of the discharge instructions provided.

Concur Target Completion Date: November 1, 2009

Prior to the OIG-CAP review in June 2009, our facility had recognized that we were not compliant with discharge instructions being documented. We had adopted an emergency department template for discharge from the Richmond VAMC. This discharge template in CPRS has mandated fields to indicate that discharge instructions were provided, the addition of the specific instructions provided from the Krames-On-Demand software, identification of future scheduled appointments, and signature and date of the nurse providing the instructions. The form is then printed so that the patient/family can sign the form indicating that they have been provided an opportunity to ask questions and that they understand the instructions. The signed Discharge Instruction form is then scanned into the patient's medical record and is available in VISTA Imaging as part of the patient's medical record. In early June 2009, super-users had been identified and the implementation was in progress with two systems utilized at the time of our OIG-CAP visit. Therefore, not all patient records had the information documented regarding discharge instructions. All staff members had completed education regarding the template by June 18, 2009. Full implementation of the template occurred on June 22, 2009. The Nurse Manager began review of records monthly during July 2009 to ensure that the template is being utilized. Results of reviews are planned to be discussed at monthly staff meetings beginning in September 2009. Reports of findings will be sent to the Medicine Service Line monthly meeting and to the Clinical Executive Board. The Chief of Staff reports adverse findings from the Clinical Executive Board presently to the Executive Leadership Board in a quarterly report and, in the future, after revision of our reporting structure, will report to the newly formed Executive Quality Council.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that the process for requesting and granting ED staff privileges complies with VHA regulations.

Concur Target Completion Date: October 16, 2009

Site specific Out-of-OR Airway Management privileges for Emergency Department physicians will be approved by the Medical Executive Board at the September 11, 2009, meeting. All Emergency Department physicians will receive education regarding the requirements of the Out-of -OR Airway Management Directive, and each physician will be observed in performance of Out-of-OR Airway Management competencies by the Chief, Anesthesia Service, during September 2009. These privileges will be added to each physician's privilege form with privileges granted and documented in the minutes of the Medical Executive Board during their October 9, 2009, meeting.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director conducts a comprehensive review of QM monitoring and the committee reporting structure and updates policies as appropriate to reflect responsibilities for reporting and oversight.

Concur Target Completion Date: January 31, 2010

After review of our reporting of the performance improvement components as identified in VHA Directive 2008-061, Quality Management Program, Dated October 7, 2008, the following changes are planned:

Initiate an Executive Quality Council with monthly meetings and membership to include the Director as chair of the Council, Chief of Staff, Associate Director for Patient/Nursing Services, Associate Director for Operations, Chief, Quality Management, and Patient Safety Manager, as well as, others as appropriate. The Executive Quality Council will review all aspects of performance improvement to include patient safety activities, internal and external reviews, performance management, patient satisfaction and complaints, utilization management, risk management, quality information, system redesign, process action team recommendations for improvement and actions taken, VHA Performance Measure results, and review of findings regarding the medical staff performance improvement findings as reported through the Clinical Executive Board to this body. Analysis of data reviewed will be captured in the minutes of the Executive Quality Council. The Executive Quality Council will report to the Executive Leadership Board regarding performance improvement findings needing organizational actions. The first meeting of the new Executive Quality Council will occur in January 2010;

Change the focus of the present Executive Leadership Board to focus on strategic and budget planning for the organization;

Revise the policies for the Executive Leadership Board, Clinical Executive Board, and the Quality Management Program to reflect the changes in alignment, reporting, and expectations for committee members regarding analysis and reports provided; and

Provide education to key personnel regarding the changes and expectations identified with these changes.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that contract physicians' privileges do not extend beyond the terms of their contracts.

Concur Target Completion Date: November 30, 2009

Starting with the September 11, 2009, meeting of the Medical Executive Board, each contracted physician record coming for appointment and granting of privileges will include the contract with the time period specified. Privileges will only be granted for the time period specified in the contract. Should the contract be extended, the physician privileges will be brought back to the committee for appointment and granting of privileges once again. This process will be reflected in corrections/additions to the Medical Staff Bylaws, dated October 22, 2008, and MCM 658-11-01, Credentialing and Privileging, dated July 19, 2007, which will both be approved no later than November 30, 2009.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director implements a tracking system to ensure that all designated clinically active staff maintain their CPR certifications.

Concur Target Completion Date: October 1, 2009

The employee education department will initiate a process of notification of supervisors and Service Chiefs of all BLS and ACLS expirations starting at three months prior to expiration, with additional notifications at two months and one month. These notifications will begin with the September 2009 notifications. The member of the leadership team (Chief of Staff or Associate Director for Patient/Nursing Services) responsible will closely monitor potential expirations and ensure that all essential personnel as required by policy will obtain recertification. Should anyone allow the certification to expire, 658-05-25 Advanced Cardiac Life Support (ACLS) and Cardio-Pulmonary Resuscitation (CPR), dated May 18, 2005, will be enforced uniformly by placing the person off work and on AWOL status until the certification is complete. Upcoming expirations and actions taken due to expirations will be monitored by the newly formed Executive Quality Council.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that a process to review and evaluate the use of the copy and paste functions in CPRS is established.

Concur Target Completion Date: November 30, 2009

MCM 658-136-02, Copying and Pasting of Medical Record Documentation, dated May 15, 2009, was approved and implemented. Beginning in July 2009, the Health Information Management Committee began monitoring the results of reports regarding the use of the copy and paste mechanism. Reports were also sent to clinical service chiefs. This report of monitoring the process will be reported to Clinical Executive Board for discussion and action as appropriate beginning with the September meeting.

OIG Contact and Staff Acknowledgments

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