



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 09-03350-55

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



December 30, 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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Table of Contents

	Page
Executive Summary	i
Introduction	1
Profile.....	1
Objectives and Scope	2
Organizational Strengths	3
Results	4
Review Activities With Recommendations	4
Magnetic Resonance Imaging Safety	4
Quality Management	8
Coordination of Care	9
Environment of Care.....	11
Review Activities Without Recommendations	13
Medication Management	13
Physician Privileging.....	14
VHA Satisfaction Surveys	14
Appendixes	
A. VISN Director Comments	17
B. Medical Center Director Comments.....	18
C. OIG Contact and Staff Acknowledgments	24
D. Report Distribution.....	25

Executive Summary

Introduction

During the week of September 28–October 2, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the Louis Stokes Cleveland VA Medical Center (the medical center), Cleveland, OH. 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 644 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 10.

Results of the Review

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

- Patient Transfer Center (PTC).
- Prosthetic/Orthotic Laboratory.
- Inpatient Diabetes Care.

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

- Require providers to comply with medical center policy regarding informed consent.
- Conduct a comprehensive risk assessment of the magnetic resonance imaging (MRI) suites and correct identified vulnerabilities.
- Ensure that personnel who have access to the MRI suites complete appropriate safety training.
- Ensure that MRI patient safety screening questionnaires, which identify potentially dangerous metabolic or physical conditions, are scanned into the electronic medical record.
- Update Radiology Service policy to reflect current practices.
- Ensure that physician advisors receive Veterans Health Administration (VHA) utilization management (UM) training and review variance data.
- Fully implement the mechanism to track cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) training compliance and ensure that employees

complete the training in accordance with medical center policy.

- Complete discharge documentation in accordance with VHA policy.
- Ensure that all patients discharged from inpatient mental health (MH) care receive follow-up care in accordance with VHA policy.
- Implement a comprehensive respiratory protection program.
- Address identified MH and infection control training deficiencies.
- Install call buttons in all patient bathrooms on the locked behavioral health units.

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

- Medication Management.
- Physician Privileging.

This report was prepared under the direction of Nelson Miranda, Director, Baltimore Office of Healthcare Inspections.

Comments

The VISN and Medical Center Directors agreed with the CAP review findings and recommendations and submitted acceptable improvement plans. (See Appendixes A and B, pages 17–23, 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 has two divisions—Wade Park and Brecksville—that provide a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 13 community based outpatient clinics in Akron, Calcutta, Canton, Cleveland, Lorain, Mansfield, New Philadelphia, Painesville, Ravenna, Sandusky, Warren, Wooster, and Youngstown, OH. The medical center is part of VISN 10 and serves a veteran population of about 365,000 throughout northeast and north central Ohio.

Programs. The medical center provides a full range of primary, secondary, and complex tertiary care. Eight of its programs have been designated as Clinical Programs of Excellence by the Under Secretary for Health. The programs are Serious Mental Illness, Substance Abuse Care, Health Care for the Homeless, Domiciliary Care for the Homeless Veteran, Cardiac Surgery, Spinal Cord Injury, and Geriatrics Evaluation and Management.

The medical center is a referral center for cardiac surgery, gambling disorders, invasive cardiology, post-traumatic stress disorder, spinal cord injury, and substance abuse and has a comprehensive reference clinical laboratory. It has 262 hospital beds, 160 community living center (CLC) beds, and 225 domiciliary beds.

Affiliations and Research. The medical center is affiliated with Case Western Reserve University and provides training for 600 residents and for students of other disciplines, including audiology, dietetics, occupational therapy, optometry, pharmacy, physician assistant, podiatry, psychology, social work, and nursing. In fiscal year (FY) 2009, the medical center research program had 250 projects and a budget of \$13.4 million. Important areas of research included infectious diseases, neurology, health services, and stroke and spinal cord injury rehabilitation.

Resources. In FY 2008, medical care expenditures totaled \$496 million. The FY 2009 medical care budget was \$529 million. FY 2008 staffing was 3,708 full-time employee equivalents (FTE), including 351 physician and 1,067 nursing FTE.

Workload. In FY 2008, the medical center treated 92,260 unique patients and provided 85,264 inpatient days

in the hospital and 63,944 inpatient days in the CLC units. The inpatient care workload totaled 11,109 discharges, and the average daily census, including CLC and domiciliary patients, was 567. Outpatient workload totaled 1,017,138 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 six activities:

- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- MRI Safety.
- Physician Privileging.
- QM.

The review covered medical center operations for FY 2008, FY 2009, and FY 2010 through October 2, 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 Louis Stokes VA Medical Center, Cleveland, Ohio, Report No. 07-00268-110, March 29, 2007*). The medical center had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 644 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 Strengths

Patient Transfer Center

The PTC is a redesign of several systems to improve inpatient flow and patient care coordination. Facilitating patient flow and care management requires extensive coordination through an interdisciplinary approach and spans the course of a hospital stay from pre-admission to discharge. The PTC is a centralized department consisting of clinical staff with the authority to make decisions that are in the best interest of the patient and the medical center. This authority has eliminated fragmentation in patient flow and care coordination, which has improved the occupancy timeliness of some of the busiest wards.

The PTC uses an electronic tracking system so that providers can follow the progress of their patients as they are case managed by nurses. The tracking system allows data to be tracked, aggregated, sorted, and used to make system improvements. The system documents clinical care, progress, tests, and procedures for veterans treated at VA and non-VA facilities. Non-VA fee consults are electronically routed for approval and case management, streamlining coordination of care with non-VA facilities and informing medical center staff of the veteran’s needs once he or she is returned to VA care. The PTC’s efforts have resulted in an increase of 130 transfers per month from other VA and non-VA facilities and an estimated savings of \$12 million in FY 2009.

The PTC has expedited care for veterans, improved communication between clinicians, and increased patient satisfaction while decreasing clinic wait times and billable claims from non-VA facilities.

Prosthetic/Orthotic Laboratory

The medical center's Prosthetic/Orthotic Laboratory has been in full operation for 5 months and is equipped with the most current technology, including a CAD/CAM Carver¹ with digital hand scanner and a Myoelectronic upper extremity artificial limb trainer (Myo-boy). Also, the laboratory is certified in the use of computer processor knee componentry (C-leg and Rheo), which enhances a patient's walk or gait. The laboratory is staffed with two prosthetists, one orthotist, two fabrication technicians, four soft good fitters, and two purchasing agents. Since the laboratory opened, the medical center has saved an estimated \$500,000 dollars in fabrication costs. The consistency in procedures and policies has greatly improved the quality of care for amputees and orthotics patients throughout VISN 10.

Inpatient Diabetes Care

The medical center is the first VHA facility to receive The Joint Commission's (the JC's) Disease-Specific Care Certification in inpatient diabetes. This certification was granted after an onsite review that looked at organizational commitment to excellence in providing diabetes-specific services in a comprehensive manner. Recognizing that glucose control is crucial to avoid further complications for hospital patients who are admitted with an existing diagnosis of diabetes, certification for inpatient diabetes is designed to address management of patients with diabetes across all hospital inpatient departments, regardless of admission diagnosis. The certification program uses inpatient clinical guidelines developed by the American Diabetes Association. Successful certification was the result of a multidisciplinary, collaborative effort.

Results
Review Activities With Recommendations

Magnetic Resonance Imaging Safety

The purpose of this review was to evaluate whether the medical center maintained a safe environment and safe practices in the MRI suites. Safe MRI procedures minimize

¹ The CAD/CAM (computer-aided design/computer-aided manufacturing) Carver is a system to design and fabricate orthotic and prosthetic devices.

risk to patients, visitors, and staff and are essential to quality patient care.

We inspected the MRI area, examined medical and training records, reviewed relevant policies, and interviewed key personnel. Patients in the magnet room are directly observed at all times, and two-way communication is available between the patient and the MRI technologist. In addition, the patient has access to a push-button call system while in the scanner. Also, we found that MRI safety equipment was readily available. However, we identified the following areas that needed improvement.

Informed Consent. For minimal risk procedures, like x-ray and MRI without contrast, medical center policy requires providers to discuss the treatment plan and note the patient's consent in the medical record. Patients undergoing an MRI exam with gadolinium (a contrast media that is used to enhance the image quality of the scan) and who have compromised renal functions (high risk) are required by VHA policy to have signed informed consent forms. The Radiology Service has developed a notice in the electronic medical record for radiologists approving a requested MRI. The notice provides laboratory values to assess whether a patient is high risk. This allows for intervention before an MRI to ensure the patient's fitness for the procedure. We analyzed the medical records of 10 minimal-risk patients for whom medical center policy required an informed consent note to be entered in the medical record and found only one record with the required progress note.

Risk Assessment. In February 2009, the JC issued a sentinel event alert for facilities with MRIs, advising them of recently reported adverse events and setting the standard for conducting a risk assessment. We determined that Radiology Service had not conducted a risk assessment of the environment, as required by the JC and the American College of Radiology (ACR).

Training. Personnel who have daily or periodic access to the MRI area are required to receive appropriate MRI safety training. We reviewed the training records of six MRI technicians and six non-MRI personnel with access to the MRI suite and found that two of the non-MRI personnel did not have the required MRI Level II safety training. In addition, we reviewed relevant VA police training records and found no evidence of ongoing annual MRI safety

training. Prior to our visit, radiology managers identified these issues and have been working to provide needed training and to establish ongoing training programs for police officers who are required to respond to emergencies in the MRI suites.

Patient Screening. For patient safety, MRI technologists need to ensure that all patients undergoing an MRI are screened using a standard questionnaire. Any positive response to the questionnaire must be addressed before a patient is scanned. Radiology staff were unable to provide the questionnaires for the 10 patients we selected for review. The completed questionnaires were not filed or scanned into the electronic medical record.

Medical Center Policy. Radiology Service policy required illumination of a red light in Zone III of the MRI suites at all times. The ACR recommends that Zone IV of the MRI suites have a sign stating “The Magnet is On” and that the sign remain illuminated 24 hours a day and have a backup battery in the event of a power failure. On our tour of the MRI suites, we did not find any illuminated sign or red light.

Recommendation 1

We recommended that the VISN Director ensure that the Medical Center Director requires providers to comply with medical center policy regarding informed consent.

The VISN and Medical Center Directors concurred with the finding and recommendation. They will revise the electronic ordering process for low-risk MRIs and add a step to prompt providers to confirm that the appropriate discussion took place regarding the risk associated with the procedure. The medical center has revised their informed consent policy, expanding documentation options in the electronic medical record. 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 radiology staff to conduct a comprehensive risk assessment of the MRI suites and correct identified vulnerabilities.

The VISN and Medical Center Directors concurred with the finding and recommendation. They have documented completion of the risk assessment and have taken corrective

action for the one vulnerability identified. The corrective actions are acceptable, and we consider this recommendation closed.

Recommendation 3

We recommended that the VISN Director ensure that the Medical Center Director requires personnel who have access to the MRI area to complete appropriate safety training.

The VISN and Medical Center Directors concurred with the findings and recommendation and have identified all staff requiring Level I and Level II training. Training has commenced and is scheduled to be completed by December 31, 2009. Safety training will become part of each relevant employee's annual mandatory training. Training will be monitored, and results will be reported to the Performance Improvement Council (PIC) at least quarterly. 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 MRI patient safety screening questionnaires, which identify potentially dangerous metabolic or physical conditions, are scanned into the electronic medical record.

The VISN and Medical Center Directors concurred with the finding and recommendation. They will incorporate the elements of the hard copy screening form into the electronic medical record. In the interim, hard copy forms are being scanned into the electronic medical record. 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 requires that Radiology Service policy be updated to reflect current practices.

The VISN and Medical Center Directors concurred with the finding and recommendation and have updated the policy. MRI suites have red, illuminated lights with emergency power, which meets the intent of the ACR's recommendations. The corrective actions are acceptable, and we consider this recommendation closed.

Quality Management

The purpose of this review was to evaluate whether the medical center's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the medical center's Director and Chief of Staff, and we interviewed QM personnel. We evaluated plans, policies, performance improvement data, and other relevant documents.

The medical center's QM program was generally effective, and senior managers supported the program through participation in and evaluation of performance improvement initiatives and through allocation of resources to the program. Meaningful data were analyzed, trended, and utilized to improve patient care. Appropriate review structures were in place for 12 out of the 14 program activities reviewed; however, we identified the following QM and risk management areas that needed improvement.

UM. UM is the process of evaluating and determining the coverage and the appropriateness of medical care services across the patient health care continuum to ensure the proper use of resources. Utilization review is a formal evaluation (prospective, concurrent, or retrospective) of the coverage, medical necessity, efficiency, or appropriateness of health care services and treatment plans for an individual patient and uses standardized criteria. Nurses were trained in the use of standardized UM criteria, inter-rater reliability was performed as required, and UM was integrated into patient flow initiatives.

VHA policy² requires the medical center to appoint and train physician advisors to review all cases not meeting UM criteria after they are reviewed by UM staff. We found that the medical center had appointed physician advisors for each service. However, none of the physician advisors attended the required training. In addition, not all of the physician advisors reviewed variances, as required by VHA policy.

CPR and ACLS Training. VHA policy³ requires each medical facility to have a local policy governing CPR and ACLS training and a mechanism for monitoring the

² VHA Directive 2005-040, *Utilization Management Policy*, September 22, 2005.

³ VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

maintenance of this training. The medical center had a new policy addressing the requirements for Basic Life Support (BLS) and ACLS training and a plan for monitoring compliance with the policy. In a sample of 148 individuals who were required to have either BLS or ACLS training, we found that only 120 (81 percent) had current certification.

Recommendation 6

We recommended that the VISN Director ensure that the Medical Center Director requires that physician advisors receive the required VHA UM training and that variance data is reviewed. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

The VISN and Medical Center Directors concurred with the findings and recommendation. They have assigned UM physician advisors for all pertinent areas and established policies for reviewing variances. Also, physician advisors have completed the Physician Training Module in the Learning Management System. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7

We recommended that the VISN Director ensure that the Medical Center Director requires that managers fully implement the mechanism established to track CPR and ACLS training compliance and that employees complete the training in accordance with medical center policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. They are currently training all staff who are delinquent. The target completion date is December 31, 2009. Compliance with training requirements will be tracked, and results will be reported to the PIC at least quarterly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Coordination of Care

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

We reviewed the medical records of 44 patients who were transferred to other units within the medical center. We determined that clinicians appropriately managed all 44 transfers. We found transfer notes from sending to receiving units and documentation that nursing assessments were performed by the receiving units in accordance with established timeframes. However, we identified the following areas that needed improvement.

Patient Discharges. We reviewed the medical records of 47 patients who were discharged from inpatient care. Congruency of patient discharge instructions and discharge summaries facilitates continuity of care. To determine consistency, we compared the information on the discharge summaries with the information contained in the corresponding patient discharge instructions. However, only 23 (49 percent) of the discharge summaries and the corresponding discharge instructions were congruent, as required by VHA policy⁴.

Post-Discharge MH Care. VHA policy has specific requirements for post-discharge MH care.⁵ We reviewed the medical records of 10 patients recently discharged from the acute MH unit and found that four of the records lacked required documentation. In two records, there was no documentation that the patients were given follow-up MH appointments at the time of discharge, as required. In the other two records, there was no documentation that the patients had face-to-face evaluations within 14 days or that they refused to be seen.

Recommendation 8

We recommended that the VISN Director ensure that the Medical Center Director requires that discharge documentation be completed in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the finding and recommendation. Clinical Application Coordinators have created electronic links from the discharge instructions to the discharge summary for diagnosis, diet, and activity level to ensure consistency. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

⁴ VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

⁵ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

Recommendation 9

We recommended that the VISN Director ensure that the Medical Center Director requires that all patients discharged from inpatient MH care receive follow-up MH care in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. They have developed a standard operating procedure to ensure that follow-up MH care is provided in accordance with VHA policy. A SharePoint site tracks the process, and results are reported to Psychiatry Service leadership every 2 weeks and to the PIC at least quarterly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment of Care

The purpose of this review was to determine if VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, JC, National Center for Patient Safety, Occupational Safety and Health Administration (OSHA), and National Fire Protection Association standards.

At the Brecksville division, we inspected two locked behavioral health units, two CLC units, and primary care clinics. At the Wade Park division, we inspected the Emergency Department; the Psychiatric Emergency Department; the Supply, Processing, and Distribution Department; the Prosthetics Department; the hemodialysis unit; and all inpatient units. Overall, we found the areas we inspected to be clean and well maintained.

We identified several concerns that required managers' attention, such as inconsistent signage identifying locations of fire extinguishers, inconsistent maintenance of negative airflow logs for isolation rooms, and general maintenance issues related to construction and resulting rainwater leakage. Managers took immediate actions to correct these deficiencies. Therefore, we did not make any recommendations related to these findings. However, we identified the following conditions that needed improvement.

Respirator Fit Testing. OSHA policy for respirator fit testing directs that individuals identified to wear an N95 respirator must undergo initial and annual fit testing, training, and initial medical evaluation. The respirator will be provided to each

employee when it is necessary to protect the health of the employee. The H1N1 flu pandemic enhances the need for the medical center to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use.

We reviewed the fit testing training records for employees from four clinical areas for compliance. Four (17 percent) of the 24 employees had current training. Six (25 percent) of the 24 employees had completed annual fit testing.

Training. VHA policy⁶ requires employees on locked behavioral health units and members of the Multidisciplinary Safety Inspection Team (MSIT) to complete training on environmental hazards that represent a threat to suicidal patients. All behavioral health unit staff and 77 percent of the MSIT have received training on identifying and correcting environmental hazards specific to these units.

In addition, we examined the infection control training records of 27 employees from one inpatient unit and one outpatient unit and found that 12 (44 percent) employees had not completed the required training.

Call Buttons. The congregate bathroom on one of the locked behavioral health units did not have call buttons. Patients have no way to summon help in the case of a fall or other adverse event.

Recommendation 10

We recommended that the VISN Director ensure that the Medical Center Director requires that a comprehensive respiratory protection program be implemented.

The VISN and Medical Center Directors concurred with the findings and recommendation. A comprehensive respiratory protection program has been implemented. The status of respirator fit testing is reported to leadership weekly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11

We recommended that the VISN Director ensure that the Medical Center Director addresses the identified MH and infection control training deficiencies.

⁶ Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

The VISN and Medical Center Directors concurred with the findings and recommendation, and all staff identified as noncompliant with MH training have completed the training. All staff identified as noncompliant with infection control training will complete the training by December 2, 2009. Routine monitoring will be performed, and results will be reported to the PIC at least quarterly. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12

We recommended that the VISN Director ensure that the Medical Center Director requires that call buttons be installed in all patient bathrooms on the locked behavioral health units.

The VISN and Medical Center Directors concurred with the findings and recommendation. Call buttons appropriate for use on locked behavioral health units have been ordered and will be installed no later than December 1, 2009. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

Review Activities Without Recommendations

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes on the inpatient medicine/surgery, MH, and CLC units.

We found that the medical center had a designated Bar Code Medication Administration Program coordinator who had appropriately identified and addressed existing problems. In general, nursing staff documented PRN (as needed) pain medication effectiveness within the timeframe specified by local policy, and pharmacy staff completed monthly medication reviews for CLC patients. In addition, although the pharmacy is closed from 6:00 p.m. to 6:00 a.m. daily, we found that the medical center had appropriately provided a qualified pharmacist to answer questions during those hours. We made no recommendations.

Physician Privileging

The purpose of this review was to determine whether VHA facilities have consistent processes for credentialing and privileging (C&P) physicians. We reviewed selected VHA required elements in C&P files and physician profiles.⁷ We also reviewed meeting minutes during which discussions about the physicians took place.

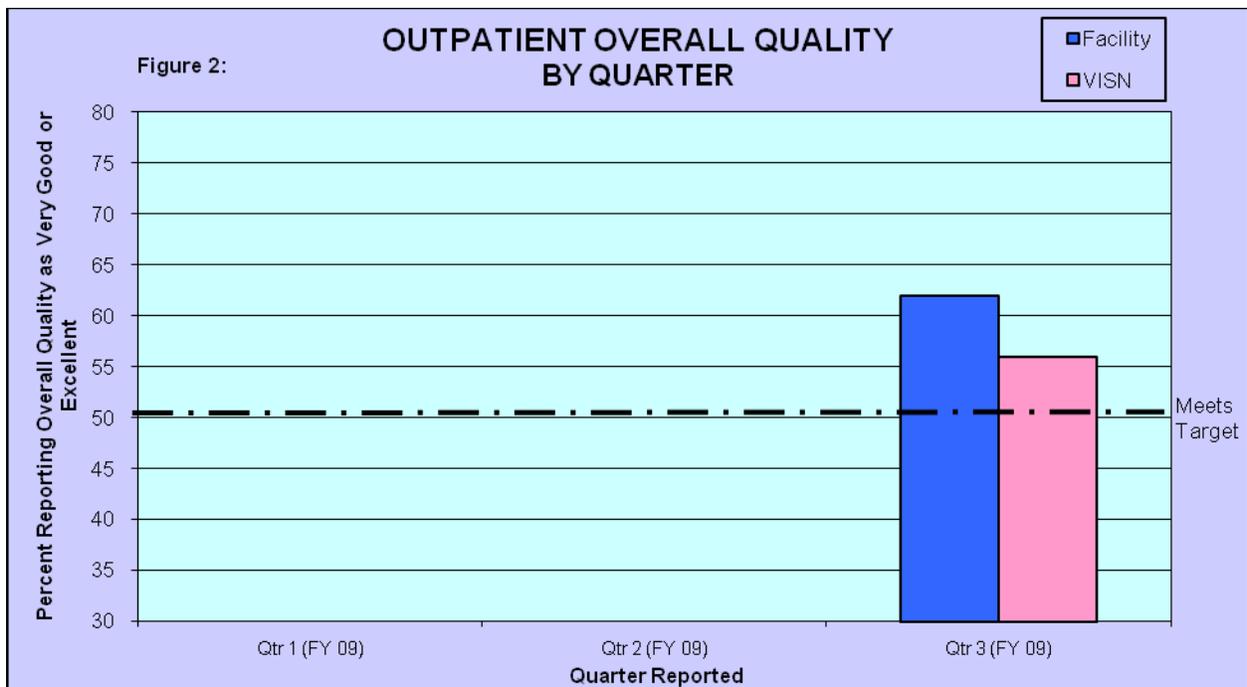
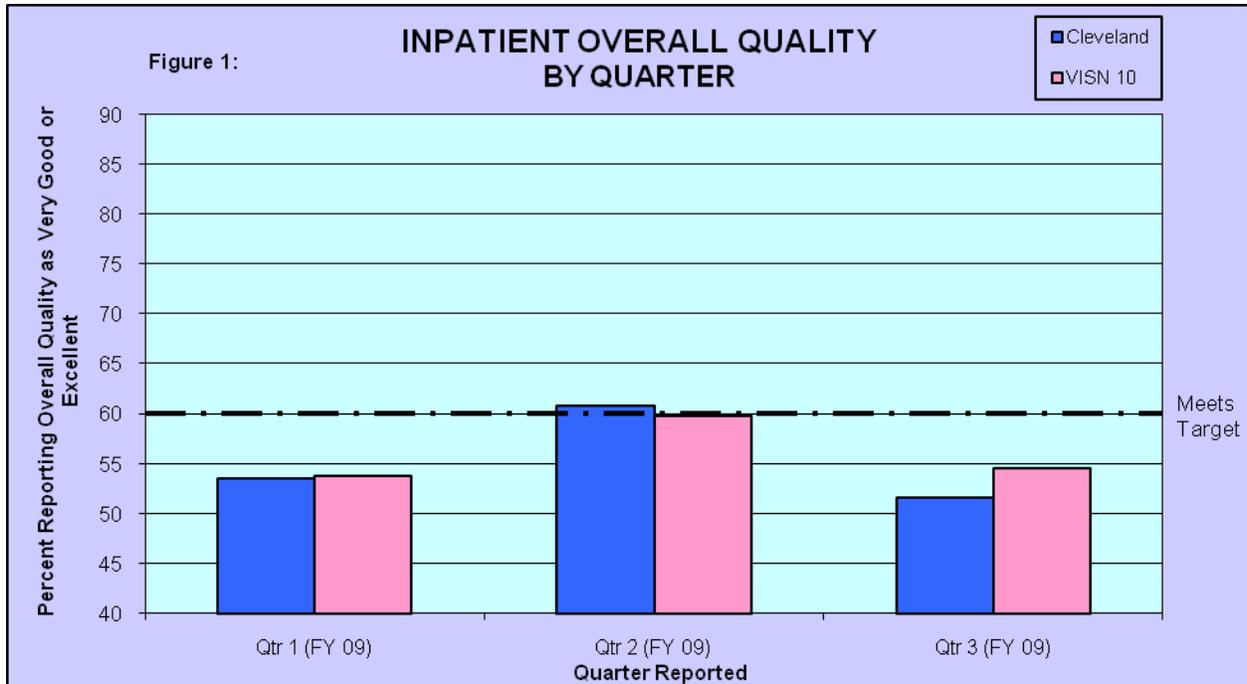
We reviewed 10 C&P files and profiles and found that licenses were current and that primary source verification had been obtained. Focused Professional Practice Evaluation was appropriately implemented for newly hired physicians. Service-specific criteria for Ongoing Professional Practice Evaluation had been developed and approved. We found sufficient performance data to meet current requirements. Meeting minutes consistently documented thorough discussions of the physicians' privileges and performance data prior to recommending renewal of or initial requested privileges. We made no recommendations.

VHA Satisfaction Surveys

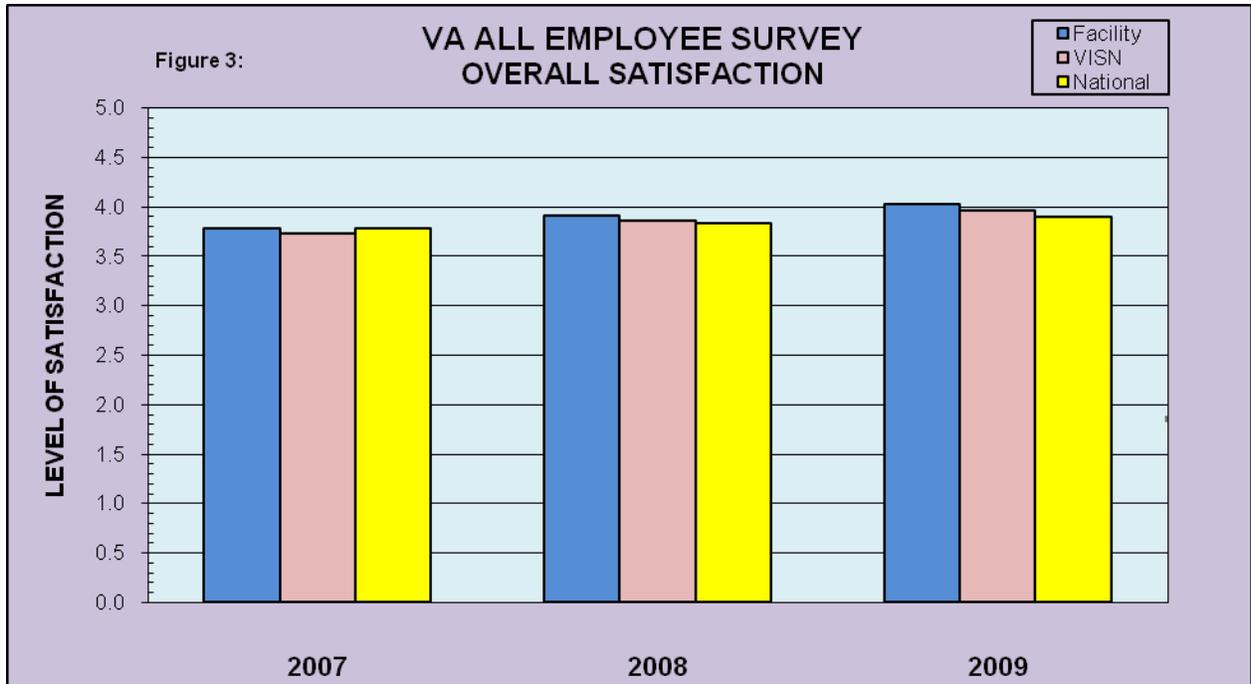
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 on the next page shows the medical center's and VISN's overall inpatient satisfaction scores for quarters 1, 2, and 3 of FY 2009. Figure 2 on the next page shows the medical center's and VISN's overall outpatient satisfaction scores for quarter 3 of FY 2009.⁸ The target scores are noted on the graphs.

⁷ VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

⁸ Due to technical difficulties with VHA's outpatient survey data, no outpatient satisfaction scores are available for quarters 1 and 2 of FY 2009.



Employees are surveyed annually. Figure 3 on the next page shows the medical center’s overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



VISN Director Comments

Department of
Veterans Affairs

Memorandum

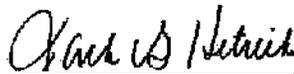
Date: November 20, 2009

From: Director, VA Healthcare System of Ohio (10N10)

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

To: Director, Baltimore, MD, Healthcare Inspections Division (54BA)
Director, Management Review Service (10B5)

I concur with the recommendations from the OIG CAP visit conducted September 28–October 2, 2009.



JACK G. HETRICK, FACHE
Network Director
VA Healthcare System of Ohio
VISN 10

Medical Center Director Comments

Department of
Veterans Affairs

Memorandum

Date: November 20, 2009

From: Director, Louis Stokes Cleveland VA Medical Center (541/00)

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

To: Director, VA Healthcare System of Ohio (10N10)

I concur with the recommendations from the OIG CAP visit conducted September 28–October 2, 2009. The attached responses outline our plan for each recommendation. We look forward to your feedback.



WILLIAM D. MONTAGUE
MEDICAL CENTER DIRECTOR

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 providers to comply with medical center policy regarding informed consent.

Concur

Completion Date: 12/18/2009

A workgroup was established to revise the electronic ordering process for low risk MRIs. A step to the ordering process will be added so providers will confirm the appropriate discussion took place regarding the risk associated with the procedure and will document the patient's understanding and agreement. The local Informed Consent Policy has been amended to expand documentation options for informed consent in the electronic health record.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires radiology staff to conduct a comprehensive risk assessment of the MRI suites and correct identified vulnerabilities.

Concur

Completion Date: 11/9/2009

A comprehensive risk assessment was in fact completed prior to the OIG CAP survey in accordance with the ten assessment categories outlined in the Joint Commission Sentinel Event Alert on MRI Safety, but the results of the assessment were not adequately documented. Documentation is now complete, and corrective action has been taken for the one vulnerability identified as a result of the risk assessment.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires personnel who have access to the MRI area to complete appropriate safety training.

Concur

Completion Date: 12/31/2009

All staff requiring Level 1 and Level 2 training has been identified; training has commenced and will be completed by December 31, 2009. Staff who has not completed level 2 training will be precluded from entering zone 4 until training is complete. In addition, the long-range plan has

been developed whereby the training will be assigned to the relevant staff identified as part of their annual mandatory training. Routine monitoring will be done in order to assist in maintaining full compliance. Results will be reported to Performance Improvement Council (PIC) at least quarterly.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires that MRI patient safety screening questionnaires, which identify potentially dangerous metabolic or physical conditions, are scanned into the electronic medical record.

Concur

Completion Date: 11/30/2009

A hard copy screening form is completed for each patient. However, the process of scanning the results of that hard-copy screen into the electronic medical record was not in place. A proposal was presented to the facility Clinical Informatics Committee to incorporate the elements of the screening form into the electronic medical record. The final action plan will be presented and approved at the November Clinical Informatics Committee and implemented by November 30, 2009. In the interim, the hard copy forms are being scanned into the electronic health record.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that Radiology Service policy be updated to reflect current practices.

Concur

Completion Date: 11/17/2009

The radiology service policy has been updated to reflect current practices. Both the MRI suite at the Wade Park campus and the Brecksville campus have red illuminated lights, on emergency power, that meet the intent of the American College of Radiology recommendations.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires that physician advisors to receive the required VHA UM training and that variance data is reviewed.

Concur

Completion Date: 11/20/2009

UM physician advisors have been assigned for all pertinent areas, the standard operating procedure for reviewing variances has been defined, and process has been implemented. The assigned physician advisors have also completed the Physician Training Module in the Learning Management System (LMS) developed by the National Utilization Management Advisory Council (NUMAC).

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director requires that managers fully implement the mechanism established to track CPR and ACLS training compliance

and that employees complete the training in accordance with medical center policy.

Concur

Completion Date: 6/30/2010

The staff identified as delinquent in BLS and/or ACLS training have completed the training (90%) or are currently enrolled in a December training session (10%). Therefore 100% of staff identified as delinquent during the OIG CAP survey will be fully compliant with training by December 31, 2009. A long-range plan has been developed for training oversight whereby the training will be electronically assigned to the relevant staff as part of their mandatory training. Full implementation of the long-range plan is expected by June 30, 2010. In the interim, the CPR Committee and clinical service chiefs will work together to develop a staff compliance list, and supervisors will ensure compliance in accordance with medical center policy. In addition to traditional recertification classes, the CPR Committee has added alternatives to classroom training in order to facilitate compliance and decrease the time needed to complete the training. Routine monitoring will be done in order to assist in maintaining full compliance. Results of the monitor will be reported to PIC at least quarterly.

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires that discharge documentation be completed in accordance with VHA policy.

Concur

Completion Date: 11/17/2009

Prior to the OIG CAP survey, the Clinical Application Coordinators (CACs) created electronic objects that electronically linked the follow-up appointments and discharge medications from the discharge instructions to the discharge summary. Medicine Service reviewed and tested this for one week and determined there was a 100% compliance rate with the follow-up appointment and medications being the same in both the discharge summary and discharge instructions. After the OIG CAP survey, Medicine Service, Quality Management, and Clinical Application Coordinators worked together, to identify the remaining core elements that should be consistent 100% of the time in both the discharge summary and discharge instructions given to patients. The CACs then created objects for the remaining three core elements, diagnosis, diet, and activity level, which were finalized and implemented.

Recommendation 9. We recommended that the VISN Director ensure that the Medical Center Director requires that all patients discharged from inpatient MH care receive follow-up MH care in accordance with VHA policy.

Concur

Completion Date: 12/31/2009

A standard operating procedure (SOP) was developed to include a process to ensure follow-up mental health care according to VHA policy. The patient's follow-up number is obtained, as well as the centralized scheduling of two discharge appointments; one within 5 days of discharge and the second within 14 days with an assigned community mental health care provider. The patients all receive a reminder phone call prior to their scheduled appointment. If the patient does not keep their first scheduled follow-up appointment, a "no show" progress note is entered into their medical record with an inpatient social worker as an additional signer. The social worker then places a follow-up call to the patient and documents the outcome of this phone call using the designated progress note title and stop codes. The same process is completed if the patient does not keep their 14-day follow-up appointment. A SharePoint site has been implemented to track progress, and results are reported to Psychiatry Service leadership every two weeks and PIC Exec at least quarterly.

Recommendation 10. We recommended that the VISN Director ensure that the Medical Center Director requires that a comprehensive respiratory protection program be implemented.

Concur

Completion Date: 12/4/2009

A comprehensive respiratory protection program has been implemented and is outlined within Medical Center Policy 138-033: Respiratory Protection. A respirator training module has been developed and is now assigned to the appropriate staff in SynQuest. Personnel Health maintains medical documentation for respirator qualification and provides Occupational Health and Safety a list of employees qualified for fit testing. Fit testing is conducted using a priority system developed by Infection Prevention and Control through a risk assessment. The status of respirator fit testing, including the high risk areas, is reported to leadership weekly during the H1N1 emergency.

Recommendation 11. We recommended that the VISN Director ensure that the Medical Center Director addresses the identified MH and infection control training deficiencies.

Concur

Completion Date: 12/1/2009

All staff identified as noncompliant during the OIG CAP survey have completed the assigned mental health training. All staff identified as noncompliant during the OIG CAP survey will complete the assigned infection control training by December 2, 2009. Routine monitoring will be

done in order to assist in maintaining full compliance. Results will be reported to PIC at least quarterly.

Recommendation 12. We recommended that the VISN Director ensure that the Medical Center Director requires that call buttons be installed in all patient bathrooms on the locked behavioral health units.

Concur

Completion Date: 12/1/2009

Call lights located in the patient bathrooms were identified as a risk in the July 2007 mental health risk assessment and were removed in August 2007 in accordance with requirements associated with the Mental Health EOC checklist. Subsequent to call light removal, clinical practice included close monitoring (e.g., wait outside the bathroom door) of patients by staff while in the restrooms to ensure safety. Based on the OIG recommendations, call buttons appropriate for use in locked behavioral health units have been ordered and will be installed upon receipt but no later than December 1, 2009.

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