Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00054-84

Combined Assessment Program Review of the Alexandria VA Medical Center Pineville, Louisiana

February 27, 2008

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 December 10–14, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Alexandria VA Medical Center (the medical center), Pineville, LA. 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 143 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 16.

Results of the Review

The CAP review covered four operational activities. We made eight recommendations related to the activities reviewed. For these four activities, the medical center needed to:

- Improve root cause analysis (RCA) processes.
- Ensure timely completion of mortality reviews.
- Ensure that identified safety risks on the locked mental health unit are tracked and reported.
- Complete interim corrective actions for safety risks that cannot be immediately corrected.
- Ensure that all staff assigned to the locked mental health unit and all members of the Multidisciplinary Safety Inspection Team (MSIT) receive training on identifying and correcting environmental hazards.
- Ensure that electronic medical record (EMR) business rules are in compliance with VHA regulations.
- Implement a comprehensive patient satisfaction program.
- Ensure that Customer Service Council (CSC) minutes include all appropriate elements.

This report was prepared under the direction of Victoria H. 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 implementation plans. (See Appendixes A and B, pages 13–19, 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, a primary and secondary care facility located in Pineville, LA, provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics (CBOCs) in Lafayette and Jennings, LA. The medical center is part of VISN 16 and serves a veteran population of more than 100,000 throughout Mississippi, Louisiana, Arkansas, Oklahoma, southeast Texas, and northwest Florida.

Programs. The medical center provides comprehensive medical, surgical, mental health, nursing home, physical medicine and rehabilitation, neurology, oncology, and dental services. It has 114 hospital beds and 156 nursing home beds. The medical center is one of three specialty referral facilities in the VISN for acute and intermediate mental health services.

Affiliations and Research. The medical center is affiliated with Tulane University's School of Medicine and Louisiana State University's School of Medicine. It also has affiliations to train allied health professionals in nursing; dentistry; pharmacy; physical, occupational, and recreational therapy; audiology; speech pathology; psychology; social work; dietetics; and biomedical engineering. Currently, no research is conducted at this facility.

Resources. In fiscal year (FY) 2007, medical care expenditures totaled $137 million. At the time of our review, the FY 2008 medical care budget was projected to be $132 million. FY 2007 staffing was 1,067 full-time employee equivalents (FTE), including 50 physician and 367 nursing FTE.

Workload. In FY 2007, the medical center treated 29,147 unique patients and provided 24,603 inpatient days in the hospital and 44,770 inpatient days in the nursing home. The inpatient care workload totaled 2,616 discharges, and the average daily census, including nursing home patients, was 190. Outpatient workload totaled 200,315 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 four activities:

- EMR Business Rules.
- Environment of Care (EOC).
- Patient Satisfaction.
- QM.

The review covered medical center operations for FY 2007 and FY 2008 through December 14, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the medical center (*Combined Assessment Program Review of the Alexandria VA Medical Center, Pineville, Louisiana,* Report No. 06-01521-229, September 28, 2006). 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 to 143 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.

Results

Review Activities With Recommendations

Quality Management

The purposes of this review were to determine if: (a) the medical center had a comprehensive, effective QM program designed to monitor patient care activities and coordinate improvement efforts; (b) senior managers actively supported QM efforts and appropriately responded to QM results; and (c) the medical center was in compliance with VHA directives, appropriate accreditation standards, and Federal and local regulations. To evaluate QM processes, we interviewed senior managers and reviewed the self-assessment completed by QM staff regarding compliance with QM requirements. We also evaluated relevant QM documents and committee minutes.

The QM program was generally effective in providing oversight of the quality of patient care in the medical center, and managers were supportive of QM efforts. Performance improvement (PI) efforts, credentialing and privileging, peer review, adverse event disclosure, patient complaints, medication reconciliation, utilization management, blood products usage, operative and other procedure reviews, resuscitation outcomes, restraint and seclusion, medical record reviews, and system redesign/patient flow were monitored effectively. However, we identified two areas that needed strengthening.

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, specifies that 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 to indicate concurrence with the findings and recommendations of the RCA team. Additionally, the handbook requires that appropriate action

plans be implemented to prevent future occurrences of similar events and that outcomes be measured to ensure that corrective actions have the desired effect.

We found deficiencies in all nine of the RCAs chartered or completed in FY 2007. Some of the RCAs did not have a charter memorandum, and some were not signed by the Medical Center Director. In addition, for seven of the nine RCAs, action plan elements were incomplete and outcomes had not been evaluated for effectiveness.

Without completion of the RCA process, managers could not be assured of the effectiveness of the patient safety process and the impact of corrective actions.

Mortality Reviews. We found deficiencies in the mortality review process that could delay identification of adverse events. The PI Manager told us that the clinical services conduct initial death reviews and refer cases to PI if additional review is required. However, we found that this is not occurring on a consistent basis. We identified two deaths evaluated at the service level that required further review, but PI staff were unaware of them. In addition, PI staff alternate responsibility for occurrence screening mortality reviews. As this is a collateral duty, staff might not be able to conduct the reviews within a reasonable timeframe. Should a patient death require further investigation, it is critical to collect data and conduct interviews promptly so that important information is not lost. Failure to appropriately refer and conduct timely mortality reviews can result in missed opportunities to improve patient care.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that the RCA process is completed in accordance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation and reported that the Patient Safety Manager has developed an RCA checklist, an RCA action item tracking log, and an RCA record system. These new systems should assure that RCAs are completed and followed up according to guidelines. 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 all deaths are timely reviewed to identify issues that may require follow-up.

The VISN and Medical Center Directors concurred with the findings and recommendation and reported that medical center managers have implemented actions to improve the timeliness of death reviews, which include (1) establishing occurrence screen menu options in the Veterans Health Information Systems and Technology Architecture (VistA) system to track death reviews to completion; (2) automatically generating a list of deaths from the occurrence screen package in VistA that prints daily in PI; and (3) delegating administrative support staff to obtain the list of deaths each day and assign to PI staff. The Chief of PI will monitor review activities to ensure the timely completion of secondary mortality reviews. 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 medical centers maintain safe and clean health care environments. Medical centers are required to provide comprehensive EOC programs that fully meet VHA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission[1] standards.

We inspected acute care units 7B and 7BN; nursing home care units 45A, 45B, and 45C; mental health units 9A and 9B; the post-anesthesia care unit; the emergency room; the dental clinic; and mental health clinics. The medical center was generally clean and well maintained. The infection control program monitored and reported data to clinicians for implementation of quality improvements. However, we identified safety issues on the locked inpatient mental health unit that needed improvement.

Although the medical center's MSIT conducted EOC rounds on the locked mental health unit (9A) and used the "Mental Health Environment of Care Checklist" (MHEOCC),[2] we determined that managers did not adequately follow up on findings or communicate results to senior managers. On

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

[2] This was developed by VHA's Center for Engineering and Occupational Safety and Health (CEOSH) and includes a list of references regarding mental health EOC.

August 27, 2007, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) issued a memorandum requiring that findings from rounds on locked mental health units be tracked and reported monthly to medical center Directors. The medical center's most recent (2007) MHEOCC identified multiple deficiencies. During our inspection of Unit 9A, we found that many of those deficiencies still existed. (See details below.)

Potential Patient and/or Staff Injury Hazards

- Laundry hampers not secured.
- Desks in patient rooms not secured.
- Panic buttons not installed in interview rooms and staff offices.
- Seclusion room door swings inward.
- Seclusion room cameras not flush mounted and not in use.
- Hallway light fixtures easily breakable.
- Ceiling tiles (rather than a solid surface ceiling) in common areas and hallway.

Potential Hanging Hazards

- Call bell cords without plastic breakaway bead-type pull cords.
- Dayroom television, videocassette recorder, and cable cords exceed acceptable length.
- Grab bar open in one bathtub.
- Fire exit doors with internally mounted self-closures.
- Fire exit doors with open push-bar devices.
- Handrails open in hallways.
- Piping exposed under sinks.
- Faucets with three anchor points.
- Chain attached to community bathtub exceeds acceptable length.

Medical center staff secured the laundry hampers, removed the chain from the bathtub in the communal bathroom, and installed panic buttons in the interview rooms and staff offices while we were onsite. However, we were told that the

remaining conditions could not be addressed until the medical center secured the necessary resources to complete the projects. While interim measures were initiated, documentation provided showed that not all measures were completed according to the plan. Managers must implement effective processes to ensure that identified environmental safety concerns are resolved in a timely manner or that interim measures are appropriately implemented to mitigate hazards that cannot be addressed immediately.

Additionally, we found that some staff members working on the locked mental health unit and some members of the MSIT did not receive training on identifying and correcting environmental hazards. The DUSHOM memorandum outlined the training requirements; however, medical center documentation revealed that only 15 of the required 47 staff members had been trained. Managers must ensure that staff receive training in accordance with requirements.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires that all findings, actions, and outcomes from safety rounds on the locked mental health unit are tracked and reported on a monthly basis.

The VISN and Medical Center Directors concurred with the findings and recommendation and reported that medical center managers have implemented actions to more specifically track the correction of any outstanding deficiencies. The "Risk Assessment and Abatement Tracking Form" and the MHEOCC will be presented as separate agenda items at the monthly EOC Committee (EOCC) meetings. The EOCC and B-9 Risk Assessment Team meeting minutes will be routed through the Quadrad and signed by the medical center's Director. 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 completion of an interim corrective action plan to address environmental safety concerns on the locked mental health unit that pose a risk but cannot be immediately corrected.

The VISN and Medical Center Directors concurred with the findings and recommendation and reported that staff have been reeducated to complete the interim measures outlined in the interim corrective action plan. A tracking mechanism

has been put in place to ensure compliance. 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 all staff assigned to the locked mental health unit and all members of the MSIT receive training on identifying and correcting environmental hazards.

The VISN and Medical Center Directors concurred with the finding and recommendation and reported that training of all members of the MSIT and all staff assigned to the locked mental health unit was completed in January 2008. The corrective action is acceptable, and we consider this recommendation closed.

Electronic Medical Record Business Rules

Business rules define which groups or individuals are allowed to edit or delete documentation in EMRs. The health record, as defined in VHA Handbook 1907.01, *Health Information Management and Health Records,* issued August 25, 2006, includes 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 guidance to all medical centers 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 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 guidance sent in October 2004.

During our review, we found that the medical center had eight business rules that allowed the editing, amendment, or deletion of a note by someone other than the author. Staff took action to remove the business rules while we were onsite.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires continued compliance with

VHA Handbook 1907.01 and the October 2004 OI guidance related to EMRs.

The VISN and Medical Center Directors concurred with the finding and recommendation and reported that all business rules in question were removed to comply with VHA guidelines. The corrective action is acceptable, and we consider this recommendation closed.

Patient Satisfaction

The Survey of Healthcare Experiences of Patients (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 make decisions 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." Medical centers are expected to address areas in which they are underperforming. The purpose of this review was to assess the extent that VHA medical centers use SHEP data to improve patient care and services.

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 results for inpatients. Figure 2 shows the medical center's SHEP performance measure results for outpatients.

Figure 1:

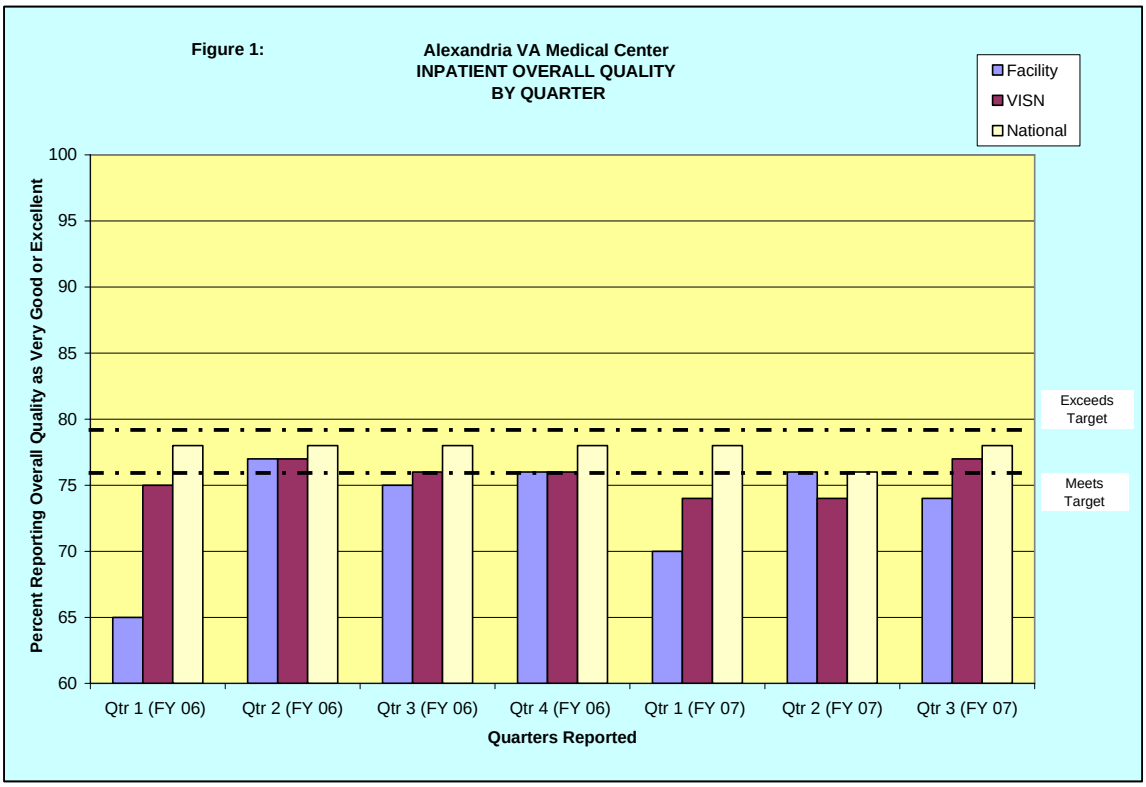
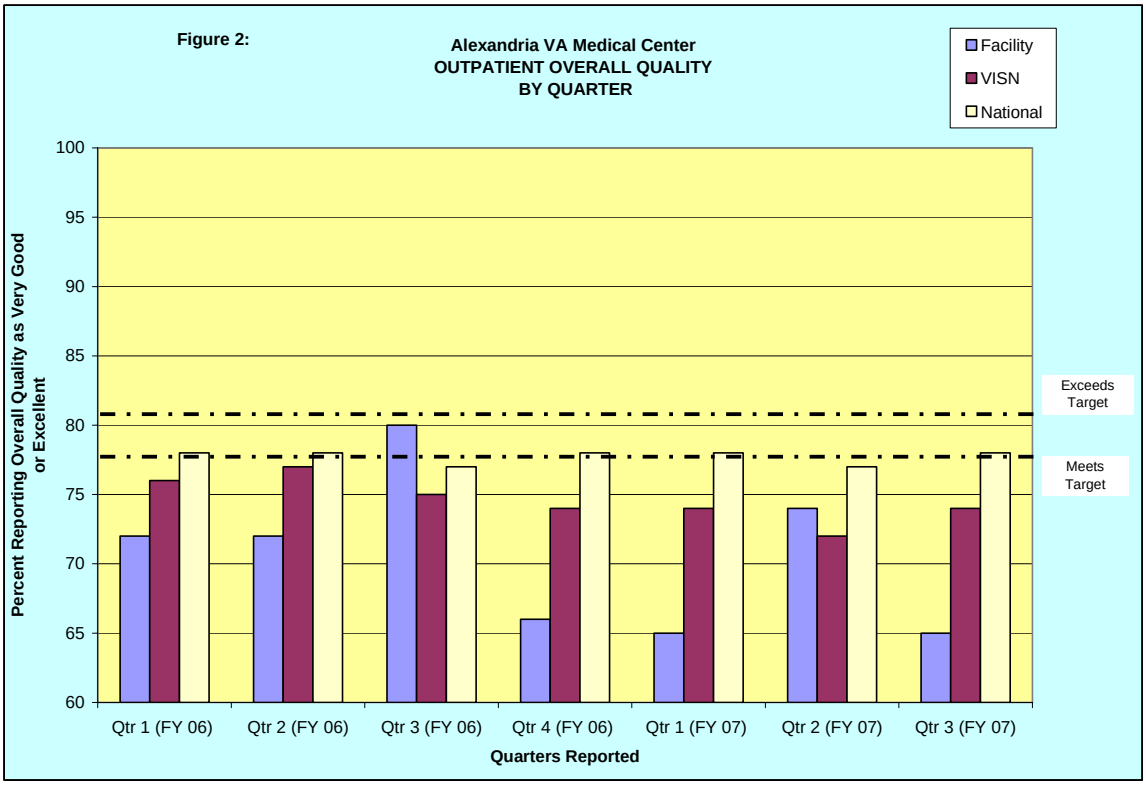


Figure 2:



The medical center's inpatient satisfaction scores did not meet established targets in 4 of the last 7 quarters of available data. Outpatient scores have remained below the established target for 6 of the last 7 quarters.

The medical center did not have a full-time SHEP coordinator; rather, SHEP activities were managed by the multidisciplinary CSC. The CSC developed several initiatives to improve patient satisfaction, including expedited resolution of complaints and improved staff and patient education. However, scores have remained below expectations. We identified the following issues requiring management attention:

- The CSC lacked authority to mandate service-level corrective action plans and follow-up activities. As a result, service chiefs did not submit action plans to improve scores in their areas.
- The CSC minutes did not always include discussion of SHEP scores and related issues, recommendations, responsible parties, corrective actions, or evaluation of action effectiveness. In addition, the minutes did not reflect that CSC action items were followed up at subsequent meetings.

At the time of our visit, the medical center had already initiated action to hire a customer service/SHEP coordinator. Without a coordinated effort, medical center managers could miss opportunities to improve patient satisfaction.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director develops a comprehensive SHEP program that includes specific service-level action planning and follow-up.

The VISN and Medical Center Directors concurred with the findings and recommendation and reported that the CSC has taken action to develop a comprehensive SHEP program. They will (1) present and analyze current SHEP data at all CSC meetings, (2) forward all current available service-specific SHEP data to the services and CBOCs and track service-specific actions on the "Action Item Log," and (3) display unit-specific SHEP data in all patient care areas. Medical center managers will establish a Customer Service Program Manager position and have already implemented senior management rounds. The implementation plans are

acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires the CSC minutes to include all appropriate elements and show continuity of process from month to month.

The VISN and Medical Center Directors concurred with the findings and recommendation and reported that the CSC implemented actions to improve the documentation of the minutes, which include (1) presenting and analyzing all current SHEP data at every meeting and documenting the data in the CSC minutes, (2) requiring service-specific action plans and documenting these plans in the CSC minutes, and (3) establishing an "Action Item Log" for the CSC to monitor service-specific actions. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 11, 2008

From: Network Director, South Central VA Health Care Network (10N16)

Subject: **Combined Assessment Program Review of the Alexandria VA Medical Center, Pineville, Louisiana**

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

Director, Management Review Service (10B5)

1. The response to the Combined Assessment Program Review of the Alexandria VA Medical Center is provided as requested.

2. If you should have any questions regarding the response for the Alexandria VA Medical Center, please contact me at (601) 364-7901. Thank you.

(original signed by:)

George H. Gray, Jr.

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 11, 2008

From: Director, Alexandria VA Medical Center (502/00)

Subject: **Combined Assessment Program Review of the Alexandria VA Medical Center, Pineville, Louisiana**

To: Network Director, South Central VA Health Care Network (10N16)

1. Our response to the Combined Assessment Program Review of the Alexandria VA Medical Center is attached.

2. If you should have any questions regarding our response, please contact Portia McDaniel, RN, BSN, Chief, Performance and Improvement, at (318) 473-0010, ext. 1-2370. Thank you.

(original signed by:)

Barbara C. Watkins

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 the RCA process is completed in accordance with VHA policy.

Concur Target Completion Date: 12/18/2007

The Medical Center Director will sign the RCA Charter Memorandum and sign and date the RCA concurrence sheet. Currently, the Medical Center Director approves each RCA prior to the team convening to review the circumstances surrounding an incident or event. The Medical Center Director also meets with the RCA team at the conclusion of their review to discuss the findings and recommended action items. A line item listing of all recommendations is presented at the meeting.

The Patient Safety Manager has implemented an RCA Checklist, RCA Action Item Tracking Log, and RCA Record System. These revised processes and procedures will facilitate a system of checks and balances to ensure that each charter memo is signed, and action plans are followed to completion and evaluated for effectiveness.

The RCA Checklist will be utilized with each RCA to ensure that each step in the process is carried out in accordance with the National Patient Safety Handbook.

The RCA Action Item Tracking Log will be utilized to document and track each approved action to completion and effectiveness evaluation. The status of action items and the effectiveness of outcomes will be included in the quarterly patient safety report. The RCA Record System will provide a standardized 6-part folder that will hold all documents related to the RCA in a centralized location.

Recommendation 2. We recommended that the VISN Director ensure that the Medical Center Director requires that all deaths are timely reviewed to identify issues that may require follow-up.

Concur Target Completion Date: Initiated 12/18/2007

Primary mortality review occurs at the service level. Mortality reviews were being conducted at the time of the site visit by clinicians at the bed service level of deaths. All reviews had been completed within 30 days. At the time of the review, the bed services were and continue to utilize the death review criteria outlined in VHA Directive, *Mortality Assessment*. The reviews at the service level are completed by providers within the service, and when care is provided by two services during the episode of care, each bed service completes a review of the death.

As a result of the finding from this site visit, administrative support has been designated to the risk management program to facilitate timely assignment of death reviews in Performance Improvement. The Chief, Performance Improvement, will monitor review activities to ensure the timely completion of secondary mortality reviews within the Office of Performance Improvement. The occurrence screen menu options in the VISTA system will be used to track completion.

In an effort to make sure that all deaths are captured, IRM has established site-specific parameters that automatically generate a list of deaths from the occurrence screen package in VISTA to a designated printer in Performance Improvement. Administrative support staff checks the printer each administrative day to obtain the list of deaths and assign to staff.

Recommendation 3. We recommended that the VISN Director ensure that the Medical Center Director requires that all findings, actions, and outcomes from safety rounds on the locked mental health unit are tracked and reported on a monthly basis.

Concur Target Completion Date: 01/17/2008

To even more specifically track the correction of any outstanding deficiencies on the mental health locked unit, in the future, the Risk Assessment and Abatement Tracking Form and the MHEOCC will be presented as a separate agenda item at the monthly EOCC meetings. The B-9 Risk Assessment Team meetings already include reviewing these documents. Both the EOCC and B-9 Risk Assessment Team meeting minutes will be routed through the Quadrad and signed by the Medical Center Director.

Recommendation 4. We recommended that the VISN Director ensure that the Medical Center Director requires completion of an interim corrective action plan to address environmental safety concerns on the locked mental health unit that pose a risk but cannot be immediately corrected.

Concur Target Completion Date: 03/30/2008

Effective June 20, 2007, the following measures were implemented to mitigate the risk of suicide due to the identified environment of care issues on the locked mental health unit:

- Fire Department staff conducts rounds on locked mental health unit three times per day.
- Police officers conduct rounds on locked mental health unit two times per shift.
- Safety Officer conducts rounds on locked mental health unit once daily.
- Nursing Service staff conduct accountability checks every 30 minutes for every patient on the locked mental health unit.

Staff has been reeducated to complete the measures as described above. A tracking mechanism has been put in place to ensure compliance.

Recommendation 5. We recommended that the VISN Director ensure that the Medical Center Director requires that all staff assigned to the locked mental health unit and all members of the MSIT receive training on identifying and correcting environmental hazards.

Concur Target Completion Date: 01/09/2008

The training of all Multidisciplinary Safety Inspection Team (MSIT) was completed on January 07, 2008. All staff assigned to the locked mental health unit completed the training on January 09, 2008.

Recommendation 6. We recommended that the VISN Director ensure that the Medical Center Director requires continued compliance with VHA Handbook 1907.01 and the October 2004 OI guidance related to EMRs.

Concur Target Completion Date: 12/12/2007

The eight business rules mentioned in the report were changed on the spot when notified that they were not in compliance with the intent of VHA Handbook 1907.01. Compliance with the directive is an ongoing, evolving process. A current review of business rules indicates that there are no unauthorized business rules at this time.

Recommendation 7. We recommended that the VISN Director ensure that the Medical Center Director develops a comprehensive SHEP program that includes specific service-level action planning and follow-up.

Concur Target Completion Date: Listed in response

During the December 19, 2007, Customer Service Council meeting, the preliminary OIG CAP Survey findings concerning SHEP were reviewed. The Council developed the following plans:

- All current available SHEP data will be presented and analyzed at every meeting. **COMPLETED December 19, 2007**

- All current available service-specific SHEP data will be forwarded to Medicine, Specialty, Psychiatry, and Nursing Services and the Lafayette and Jennings Community Based Outpatient Clinic's (CBOC's) when available. **COMPLETED December 20, 2007**

- Service-specific actions will be distributed to appropriate services when necessary. Submission dates will be established, and the council will monitor progress through a newly established Action Item Log. Monitoring of this Action Item Log will be a standing agenda item. **COMPLETED December 19, 2007**

- The Medical Center will establish a Customer Service Program Manager position which will be responsible for tracking all aspects of patient satisfaction and making recommendations to improve SHEP results. **Selection to be made by April 1, 2008**

- Senior Management Rounds have been implemented.

- Unit-specific SHEP data will be displayed in all patient care areas. **February 15, 2008**

Recommendation 8. We recommended that the VISN Director ensure that the Medical Center Director requires the CSC minutes to include all appropriate elements and show continuity of process from month to month.

Concur Target Completion Date: 12/19/ 2007

During the December 19, 2007, Customer Service Council meeting, the preliminary OIG CAP Survey findings concerning SHEP were reviewed. The Council developed the following plans:

- All current available SHEP data will be presented and analyzed at every meeting and documented in the minutes. **COMPLETED December 19, 2007**

- Service-specific SHEP action plans will be required from Medicine, Specialty, Psychiatry, and Nursing Services and the Lafayette and Jennings Community Based Outpatient Clinic's (CBOC's). These will

be documented in the Customer Service Council minutes when available. **COMPLETED: Ongoing**

- Service-specific actions will be distributed to appropriate services when necessary. Submission dates will be established, and the council will monitor progress through a newly established Action Item Log. Monitoring of this Action Item Log will be a standing agenda item. **COMPLETED December 19, 2007**

OIG Contact and Staff Acknowledgments

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