Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 07-02081-17

Combined Assessment Program Review of the Portland VA Medical Center Portland, Oregon

October 30, 2007

Washington, DC 20420

Why We Did This Review

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

During the week of July 30–August 2, 2007, the OIG conducted a Combined Assessment Program (CAP) review of the Portland VA Medical Center (the medical center). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 135 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 20.

Results of the Review

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

- Nursing Program Magnet Status Recognition.
- Innovative Electronic Patient Check-In and Medication Reconciliation System.
- Effective Tool to Manage Patients on Anticoagulant Medications.
- Environmental Excellence Award.

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

- Identify and disclose adverse events, as appropriate, and revise local policy.
- Take appropriate actions on recommendations from patient complaints trend analyses.
- Develop plans that define provider-specific QM and performance data that will be continuously reviewed and maintain profiles that are consistent with the plans.
- Conduct the annual alarm verification of the oxygen systems and require staff to document oversight of the oxygen refilling procedures.
- Replace existing shower curtains to comply with breakaway regulations in areas where high-risk patients are assigned.
- Secure dirty utility rooms and post hazardous waste signs on the doors.

- Update local policy and review health information business rules to ensure compliance with Veterans Health Administration (VHA) policy.
- Develop a policy for handling medical and/or mental health emergencies for each community based outpatient clinic (CBOC).

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

- Surgical Care Improvement Project (SCIP).
- Research – Unlicensed Physicians.
- Patient Satisfaction Survey Scores.

This report was prepared under the direction of Julie Watrous, Director, Los Angeles 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 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 is a two-division tertiary, teaching, and research facility located in Portland, OR, and Vancouver, WA. It provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at four CBOCs located in Bend, Portland, Salem, and Warrenton, OR. The medical center is part of VISN 20 and serves a veteran population of about 280,000 in a primary service area that includes 27 counties in Oregon and southwest Washington.

Programs. The medical center provides medical, surgical, behavioral, geriatric, and rehabilitation services. It has 149 hospital beds and 72 nursing home beds.

Affiliations and Research. The medical center is affiliated with the Oregon Health and Science University and provides training for 140 residents in 33 training programs, as well as training for other disciplines, including nursing. In fiscal year (FY) 2006, the medical center's research program had 110 projects and a budget of $30 million. Important areas of research included cancer, mental illness, and multiple sclerosis.

Resources. In FY 2006, medical care expenditures totaled more than $351.7 million. The FY 2007 medical care budget is approximately $367.2 million. FY 2006 staffing was 2,159 full-time employee equivalents (FTE), including 164.1 physician and 563.3 nursing FTE.

Workload. In FY 2006, the medical center treated 60,366 unique patients. The inpatient care workload totaled 7,867 discharges, and the average daily census, including nursing home patients, was 160. Outpatient workload totaled 551,272 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 patients, managers, and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

- Business Rules for Veterans Health Information Systems.
- CBOC.
- Environment of Care (EOC).
- Patient Satisfaction Survey Scores.
- QM.
- Research – Unlicensed Physicians.
- SCIP.

The review covered medical center operations for FY 2006 and FY 2007 through July 27, 2007, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on select suggested improvement actions from the prior CAP review of the medical center (*Combined Assessment Program Review of the Portland VA Medical Center, Portland, Oregon,* Report No. 04-01128-201, September 7, 2004). We found that managers had implemented all improvement actions.

We also followed up on recommendations from a report by VHA's Office of the Medical Inspector (OMI) (*Final Report: Review of a Patient Suicide*, *VA Medical Center, Portland, Oregon,* October 12, 2005). In that report, the OMI made recommendations to improve suicide risk assessments and to reduce waiting lists for elective surgery. We reviewed the documentation of the medical center's follow-up and found that a comprehensive suicide risk assessment process had

been implemented. Waiting lists for some surgeries are still long due to difficulty hiring and retaining specialty staff and to limited operating room capacity. We reviewed the plans to address both of these issues and found them to be acceptable. We consider the OMI recommendations closed.

During this review, we also presented fraud and integrity awareness briefings for 135 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

Nursing Program Magnet Status Recognition

In 2006, the medical center's nursing program received Magnet® status recognition from the American Nurses Credentialing Center. Magnet status is awarded to organizations that provide the very best in nursing care and uphold the tradition of professional nursing practice. Of the more than 7,000 hospitals and medical centers nationwide, slightly more than 200 (3 in VHA) have achieved this recognition.

Innovative Electronic Patient Check-In and Medication Reconciliation System

The medical center's information technology team developed an airline style kiosk (known as the Automated Patient History Intake Device system) for patients to use to check-in for their medical visits in the outpatient clinics. It is anticipated that these kiosks will be available throughout the medical center by the end of 2007. In addition to the check-in kiosk, the team is developing an automated system that will allow clinicians to reconcile patients' medications. Medication reconciliation allows clinicians to have a complete list of medications a patient is taking (VA and non-VA prescribed). In early 2007, VA announced that the medical center will receive funding over the next 2 years to establish a Patient Safety Center of Inquiry to develop, implement, and disseminate the medication reconciliation system to improve patient safety.

Effective Tool to Manage Patients on Anticoagulant Medications

Medical center pharmacists developed an effective tool called *Anticoagulator* to help simplify the time-consuming processes required to manage patients on anticoagulant (blood thinner) medications. The *Anticoagulator* provides clinicians with easily retrievable electronic information in one location, allowing clinicians to view a patient's anticoagulation blood level and compliance with scheduled blood draws. Any abnormal laboratory values are recorded in "red" to prompt clinicians to take appropriate follow-up actions.

Environmental Excellence Award

The medical center received the 2007 VA Environmental Excellence Award in recognition of its long-term work to collaboratively implement an Environmental Management System (EMS). Efforts included the creation of an EMS website and newsletter and the initiation of a battery recycling program.

Results

Review Activities With Recommendations

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, Chief of Staff, Chief Nurse Executive, and Chief of QM. We also interviewed QM personnel and several other service chiefs. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the medical center's quality of care. Appropriate review structures were in place for 11 of the 14 program activities reviewed. However, we identified three areas that needed improvement.

Adverse Event Disclosure Process. When serious adverse events occur as a result of patient care, VHA policy[1] requires that staff discuss the events with the patients and, with input from VA Regional Counsel, inform them of their right to file tort or benefits claims. During the period June 2006–June 2007, two patients experienced serious adverse events, and the situations were appropriately disclosed and documented. However, we identified at least seven other cases of adverse events that had not been considered for disclosure. Medical

[1] VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*, October 27, 2005.

center managers need to determine a mechanism to discuss all cases where review processes might identify adverse events so that the cases can be considered for disclosure. In addition, the medical center's local policy is more restrictive than the VHA directive and needs to be revised.

Patient Complaints. Quarterly patient complaints reports included data analysis, trend identification, and recommendations. However, we could not find any evidence that recommendations were addressed and actions taken.

Provider Profiles. As of January 1, 2007, accreditation standards require that clinical managers continuously review QM and performance improvement (PI) data and results for all privileged providers. We did not find any evidence that clinical service chiefs had developed plans that define the provider-specific QM/PI results that will be reviewed or the frequency of review.

Prior to January 1, clinical managers were required to consider all available QM/PI results every 2 years when providers were reprivileged. We reviewed provider profiles for five physicians who had been reprivileged since December 2006. One provider's profile had no applicable QM/PI data, and the four other profiles had minimal data. The medical center has robust databases that are available for this purpose.

Recommendation 1 We recommended that the VISN Director ensure that the Medical Center Director requires that adverse events are identified and disclosed, as appropriate, and that Medical Center Memorandum, *Disclosure of Adverse Events*, be revised to be consistent with VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Chief of Staff will determine the appropriate review mechanism for disclosure of adverse events, and the local policy will be revised by February 1, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 2 We recommended that the VISN Director ensure that the Medical Center Director requires that recommendations from patient complaints trend analyses are acted upon appropriately.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Chair of the Patient and Staff Satisfaction Committee will charge the appropriate managers to take the actions identified in patient complaints trend reports. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

Recommendation 3 We recommended that the VISN Director ensure that the Medical Center Director requires clinical service chiefs to develop plans for continuous review of provider-specific QM/PI results and to use provider profiles that demonstrate that the plans are being followed.

The VISN and Medical Center Directors concurred with the findings and recommendation. Clinical service chiefs will identify the appropriate provider-specific data to review, and the Chief of Staff or Medical Staff Coordinator will incorporate that data into the medical center's current privileging process. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Environment of Care

The purpose of this review was to determine if the medical center complied with selected standards related to (a) infection control (IC), (b) the drinking water system, (c) radiation safety, (d) the bulk oxygen program, and (e) a safe and clean patient care environment.

The IC program was comprehensive. We reviewed policies and examined 10 medical records of patients with multi-drug resistant organisms. IC policies and procedures for managing these patients were satisfactory.

We reviewed documents related to the oversight of the drinking water systems (for both the Portland and Vancouver divisions) to ensure compliance with the required safety and security standards. Water quality data were current, and managers had appropriately conducted vulnerability assessments of the water systems and had addressed identified vulnerabilities.

We reviewed radiation safety documents and policies and interviewed the Radiation Safety Officer (RSO) to verify proper use, storage, and disposal of tritium, a radioactive substance. In 2006, the RSO had reported an incident involving improper disposal of empty tritium containers by a housekeeper. The RSO, in conjunction with Radiation Safety

Committee members, took immediate actions to avoid similar incidents in the future. We found that management of and practices related to tritium complied with VHA and other accreditation standards.

Overall, the patient care areas we inspected were generally clean and well maintained. We identified three areas that needed management attention.

Bulk Oxygen Systems. VHA policy requires managers to conduct annual alarm-set point verification through the use of a qualified third party expert. The medical center did not meet this requirement in 2006. In addition, medical center staff are required to oversee and monitor bulk oxygen refilling procedures. We did not find documented evidence of this oversight.

Shower Curtains. On the inpatient locked mental health unit (5C), we found that shower curtains did not meet breakaway regulations. This presents a hazard and potential safety risk for patients considered to be high risk for suicide. We encouraged managers to assess the environment for similar safety concerns.

Utility Rooms. Dirty utility rooms on the inpatient units at the medical center were used to store biohazardous materials. Stored materials included medical sharps (used needles), cleaning products, and other items that have the potential to transmit infection or cause injury if accessed by unauthorized individuals. Medical waste regulations require that these areas be secured; however, we found only one room locked, and none had signage that restricted access or enforced security.

Recommendation 4 We recommended that the VISN Director ensure that the Medical Center Director requires compliance with the annual alarm-set verification of all oxygen distribution systems by an external expert and directs responsible staff to document monitoring of the oxygen refilling procedures.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Facilities Management Service Chief has been designated to take appropriate actions to ensure compliance with the annual alarm verification and provide oversight of the oxygen refilling

procedures. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Recommendation 5 We recommended that the VISN Director ensure that the Medical Center Director requires managers to replace existing shower curtains to comply with safety regulations.

The VISN and Medical Center Directors concurred with the findings and recommendation and reported that breakaway shower curtains will be installed by December 1, 2007. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

Recommendation 6 We recommended that the VISN Director ensure that the Medical Center Director requires responsible managers to secure dirty utility rooms and post hazardous waste signs.

The VISN and Medical Center Directors concurred with the findings and recommendation and reported that they will take actions, which will include posting hazardous waste signs and installing punch locks on all dirty utility rooms. The target date for completion is February 1, 2008. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Business Rules for Veterans Health Information Systems

The purpose of this review was to determine whether business rules governing the patient health record (electronic and paper) complied with VHA policy. The health record includes entries, such as physician orders, progress notes, and test reports. Once entries are signed, they must be maintained in unaltered form. New information or corrections may be added to the record as addenda to the original notes or as new notes. Business rules define what functions certain groups or individuals are allowed to perform in the health record.

In October 2004, VHA's Office of Information (OI) provided guidance that advised VHA facility managers to review their business rules and delete any rules that allowed editing of signed medical records. The OI also recommended that the ability to edit signed records be limited to the facility's Privacy Officer. On June 7, 2006, VHA instructed all facilities to comply with the OI guidance.

We reviewed VHA and local policies and examined over 600 business rules. The medical center had a written

procedure for correcting erroneous patient information. However, the local policy did not delineate who is authorized to alter signed notes and view unsigned notes. Viewing of unsigned notes poses a risk of clinical decision making based on information that may be changed or deleted.

The medical center had no business rules that allowed alteration of a signed note by unauthorized individuals. However, we identified several rules that were inactive and needed to be deleted.

Recommendation 7 We recommended that the VISN Director ensure that the Medical Center Director requires program managers to update local policy, delete rules no longer in use, and conduct a periodic review of business rules to ensure full compliance with VHA policy.

The VISN and Medical Center Directors concurred with the findings and recommendation. The Chief Information Officer has been designated to update the local policy, delete inactive rules, and establish an annual review process of business rules by December 31, 2007. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Community Based Outpatient Clinic

The purposes of this review were to determine if the Salem CBOC complied with selected VHA standards, improved patient access, and maintained the same standards of care as the medical center for providing mental health services and anticoagulation therapy. We interviewed key personnel and patients, and we evaluated policies, procedures, and other relevant documents.

We found that the CBOC provided quality care and was compliant with the VHA standards of operation reviewed. The clinic had improved access, timeliness, and convenience of services, and patients were satisfied with all aspects of care. Mental health treatment was provided by clinicians at the CBOC, and the standards of care for providing anticoagulation therapy were the same throughout the medical center.

Documentation for physician and nurse licenses, background checks, and provider privileging was current and complete. Although CBOC personnel appeared to be knowledgeable of how to respond to medical emergencies, we did not find a specific emergency response policy for each individual

CBOC. VHA policy requires that each CBOC have standard operating procedures or a local policy defining how medical emergencies are handled, including mental health emergencies.

Recommendation 8 We recommended that the VISN Director ensure that the Medical Center Director requires that each CBOC have a policy for handling medical and/or mental health emergencies relevant to the specific needs and community resources of that CBOC.

The VISN and Medical Center Directors concurred with the findings and recommendation and reported that a specific policy for each CBOC will be developed by December 1, 2007. The improvement plan is acceptable, and we will follow up on the completion of the planned action.

Review Activities Without Recommendations

Surgical Care Improvement Project

The purpose of this review was to determine if clinical managers implemented strategies to prevent or reduce the incidence of infections for patients having major surgical procedures. Surgical infections present significant patient safety risks and contribute to increased post-operative complications, mortality rates, and health care costs.

We evaluated the following VHA performance measures for FY 2006 and the 1st and 2nd quarters of FY 2007:

- Administration of prophylactic antibiotics within 1–2 hours prior to the first surgical incision. The VHA target score was 90 percent.
- Discontinuation of prophylactic antibiotics within 24–48 hours after surgery. The VHA target score was 87 percent.
- Control blood glucose levels for cardiac surgery below 200 milligrams/deciliter for the first 2 days post-operative. The VHA target score was 90 percent.
- Control core body temperature for colorectal surgery at greater than or equal to 96.8 degrees Fahrenheit in the immediate post-operative period. The VHA target score was 70 percent.

The medical center did not meet the established target score for the discontinuation of prophylactic antibiotics. To improve

performance, program managers provided an acceptable action plan to ensure that antibiotics are discontinued according to established timeframes.

We examined the medical records of 30 patients who had cardiac, colorectal, vascular, or orthopedic surgeries performed during the first 2 quarters of FY 2007. The results of our review are displayed in the table below.

Antibiotic administered timely	Antibiotic stopped timely	Blood glucose monitored (cardiac surgery)	Body temperature controlled (colorectal surgery)
100 percent (30/30)	100 percent (30/30)	100 percent (6/6)	100 percent (6/6)

We found that in all 30 cases, clinicians appropriately administered and discontinued antibiotics. Clinicians appropriately monitored blood glucose for the first 2 days post-operative for six patients who had cardiac surgery and controlled immediate post-operative body temperature for six patients who had colorectal surgery. We made no recommendations.

Research – Unlicensed Physicians

The purpose of this review was to determine whether research activities performed by unlicensed physicians were consistent with their scopes of practice and did not constitute the practice of medicine.

VHA policy requires that the medical center Director ensure that researchers conduct research studies in accordance with ethical standards and all applicable regulations. Unlicensed physicians are expected to operate under a "scope of practice," which is a term used to describe activities that may be performed by health care workers, regardless of whether they are licensed independent health care providers. If engaged in research activities, these individuals may function in roles such as study coordinators or research assistants, but they cannot practice medicine.

The medical center identified a total of six unlicensed physicians. Two of these physicians functioned as research assistants in two studies involving 127 veteran patients. We reviewed the medical records of 20 patients enrolled in these studies. We did not find evidence that the two unlicensed physicians performed research activities outside their scopes of practice. We made no recommendations.

Patient Satisfaction Survey Scores

The purpose of this review was to assess the extent to which the medical center used the results of VHA's patient satisfaction survey to improve care and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. The table below shows the national, VISN 20, and the medical center's Survey of Healthcare Experiences of Patients (SHEP) results.

Portland VA Medical Center

INPATIENT SHEP RESULTS

FY 2007 Quarters 1 and 2	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	80.1	77.8	89.4	67.1	64.9	75.4	82.8	74.1	69.2
VISN	84+	81.1+	91.9+	69.6+	68.9+	77.6+	86.2+	76.6+	73.2+
Medical Center	84.9+	82.2+	93.3+	68.7	69.3+	78.0	86.2+	78.2+	73.6+

OUTPATIENT SHEP RESULTS

FY 2007 Quarter 2	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-Up	Preferences	Specialist Care	Visit Coordination
National	80.2	77.8	94.3	72.1	82.3	75	81.2	65.1	81.1	80.9	84.1
VISN	80.5	84.0 +	94.8	73.6	84.9	73.3	77.9	58.5	81.7	81.5	84.8
Medical Center Clinics	78.7	82.4	91.9	70.1	82.6	71.3	61.2	30.5 -	79.1	78.9	81.9

Legend: "+" indicates results that are significantly better than the VHA average
"-" indicates results that are significantly worse than the VHA average

The medical center's scores exceeded the national average in all inpatient areas. Managers had implemented action plans to improve satisfaction with outpatient care. We found the action plans acceptable, and we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 12, 2007

From: VISN Director (10N20)

Subject: **Combined Assessment Program Review of the Portland VA Medical Center, Portland, Oregon**

To: Director Los Angeles Healthcare Inspections Division (54LA)

Director, Management Review Office (10B5)

1. Attached is the status report for the Office of Inspector General (OIG) Combined Assessment Program survey comments and implementation plan from the VA Medical Center, Portland, OR.

2. If you have any questions regarding this report, please contact Nancy Benton, Chief, Quality & Performance Service, at (503) 273-5267.

(original signed by:)

Dennis M. Lewis, FACHE

Attachments

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 12, 2007

From: Medical Center Director (648/00)

Subject: **Combined Assessment Program Review of the Portland VA Medical Center, Portland, Oregon**

To: VISN Director (10N20)

I have reviewed the attached actions plans for the areas of improvement recommended by the Office of Inspector General Combined Assessment Program, and I concur with all recommended improvement actions.

(original signed by:)

JAMES TUCHSCHMIDT, MD, MM

IMPLEMENTATION PLAN
Portland VA Medical Center
Response to the Office of Inspector General
Combined Assessment Report

Comments and Implementation Plan

1. Quality Management

Recommendation 1: We recommended that the VISN Director ensure that the Medical Center Director requires that adverse events are identified and disclosed, as appropriate, and that Medical Center Memorandum, *Disclosure of Adverse Events*, be revised to be consistent with VHA Directive 2005-049, *Disclosure of Adverse Events to Patients*.

Concur with recommendation. Target Date of Completion: see below

Planned Action:

Action Plan:	Timeline:	Responsible Person
1. Policy to be revised to delete specific language, which allows for non-disclosure if the adverse event was a known complication.	To be completed by February 1, 2008.	Chief of Staff/ Risk Manager
2. Chief of Staff to determine appropriate venues of review to determine if adverse events have been disclosed, e.g., M&M reviews, etc.	To be completed by December 15, 2007.	Chief of Staff or designee

Recommendation 2: We recommended that the VISN Director ensure that the Medical Center Director requires that recommendations from patient complaints trend analyses are acted upon appropriately.

Concur with recommendation. Target Date of Completion: see below

Planned Action:

Action Plan:	Timeline:	Responsible Person
1. Patient advocates to trend data and explicitly identify recommended actions. Report to the Executive Leadership Board (ELB) quarterly through the Patient and Staff Satisfaction Committee.	First report with trended data to be completed by October 31, 2007 for FY 07 data. Reports to be made quarterly thereafter.	DDAF/ Chair-Patient and Staff Satisfaction Committee
2. Chair of Patient and Staff Satisfaction Committee to charge appropriate medical center managers with actions identified in trend report. Chair to report to ELB on progress and barriers quarterly.	First report on FY 07 data by November 15, 2007. Reporting quarterly to ELB thereafter.	DDAF/ Chair-Patient and Staff Satisfaction Committee

Recommendation 3: We recommended that the VISN Director ensure that the Medical Center Director requires clinical service chiefs to develop plans for continuous review of provider-specific QM/PI results and to use provider profiles that demonstrate that the plans are being followed.

Concur with recommendation. Target Date of Completion: see below

Planned Action:

Action Plan:	Timeline:	Responsible Person
1. Clinical Service Chiefs to meet and discuss appropriate quality data to be reviewed.	Meet and discuss by November 15, 2007.	Chief of Staff
2. Data streams and processes for collection and distribution of pertinent quality data for re-privileging to be incorporated into current privileging process.	To be completed and in place by January 15, 2008.	Chief of Staff/ Medical Staff Coordinator

2. Environment of Care

Recommendation 4: We recommended that the VISN Director ensure that the Medical Center Director requires compliance with the annual alarm-set verification of all oxygen distribution systems by an external expert and directs responsible staff to document monitoring of the oxygen refilling procedures.

Concur with recommendation. Target Date of Completion: see below

Planned Action:

Action Plan:	Timeline:	Responsible Person
1. Facilities management to develop a process to conduct annual alarm verification by third party and report to Executive Leadership Board when completed.	To be completed by October 1, 2007.	DDAF/ Chief FMS
2. Facilities management to develop a process and designate responsible person to oversee bulk oxygen refill process.	To be completed by October 1, 2007.	DDAF/ Chief FMS

Recommendation 5: We recommended that the VISN Director ensure that the Medical Center Director requires managers to replace existing shower curtains to comply with safety regulations.

Concur with recommendation. Target Date of Completion: December 1, 2007

Planned Action:

Action Plan:	Timeline:	Responsible Person
1. Facilities management to replace shower curtains. Report to Executive Leadership Board when completed.	To be completed by December 1, 2007.	DDAF/ Chief FMS

Recommendation 6: We recommended that the VISN Director ensure that the Medical Center Director requires responsible managers to secure dirty utility rooms and post hazardous waste signs.

Concur with recommendation. Target Date of Completion: February 1, 2008

Planned Action:

Action Plan:	Timeline:	Responsible Person
1. Facilities Management to install signs and place punch locks on all dirty utility doors and report to Executive Leadership Board when completed.	Signs to be installed by December 1, 2007. Punch locks to be completed February 1, 2008.	DDAF/ Chief FMS

3. Business Rules for Veterans Health Information Systems

Recommendation 7: We recommended that the VISN Director ensure that the Medical Center Director requires program managers to update local policy, delete rules no longer in use, and conduct a periodic review of business rules to ensure full compliance with VHA policy.

Concur with recommendation. Target Date of Completion: December 31, 2007

Planned Action:

Action Plan:	Timeline:	Responsible Person
1. Update local policy to indicate who is authorized to alter signed notes and view unsigned notes. All inactive Patient Health Record business rules will be deleted. These business rules will be reviewed annually (during the 1st quarter of the fiscal year) by the Medical Records Committee, which reports to the Executive Leadership Board.	To be completed by December 31, 2007.	DDAF/ Chief information Officer

4. Community Based Outpatient Clinic

Recommendation 8: We recommended that the VISN Director ensure that the Medical Center Director requires that each CBOC have a policy for handling medical and/or mental health emergencies relevant to the specific needs and community resources of that CBOC.

Concur with recommendation. Target Date of Completion: December 1, 2007

Planned Action:

Action Plan:	Timeline:	Responsible Person
1. Develop specific policy for each CBOC and reported to Executive Leadership Board when completed.	To be completed by December 1, 2007.	COS/ Administrative Director Primary Care

OIG Contact and Staff Acknowledgments

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