Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Boise Medical Center Boise, Idaho

Report No. 06-02002-233 **September 29, 2006**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- 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 10–14, 2006, the Office of Inspector General conducted a Combined Assessment Program (CAP) review of the VA Boise Medical Center (the medical center). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management. During the review, we also provided fraud and integrity awareness training to 359 medical center employees. The medical center is part of Veterans Integrated Service Network (VISN) 20.

Results of Review

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

- Employees reported high satisfaction with their work environment.

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

- Secure patient information and ensure storage areas comply with fire safety codes.
- Ensure patients are informed about adverse events, fully analyze utilization management data, and address results that do not meet performance goals.
- Improve administrative and clinical oversight of the Contract Community Nursing Home program.
- Meet the breast cancer screening performance measure.

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

- Monitoring patients on atypical antipsychotic medications.
- Patient satisfaction survey results action plans.

This report was prepared under the direction of Ms. Julie Watrous, Director of the Los Angeles Healthcare Inspections Division.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the CAP findings and provided acceptable improvement plans. (See Appendixes A and B, pages 11–16, 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

Medical Center Profile

Organization. The Boise VA Medical Center (VAMC or the medical center) is an acute care facility that provides inpatient and outpatient health care services. Outpatient care is also provided at two community based outpatient clinics in Twin Falls, ID, and Ontario, OR. The medical center is part of Veterans Integrated Service Network (VISN) 20 and serves a veteran population of about 85,000 in a primary service area that includes 27 counties in Idaho and Oregon.

Programs. The medical center provides acute medical, surgical, and psychiatric inpatient services and has a total of 46 acute care beds. Programs include primary and specialty care, ambulatory surgery, and women's health. The medical center also has 41 extended care beds.

Affiliations and Research. The medical center is affiliated with the University of Washington School of Medicine and supports 20 residents in 2 medical specialties. Other affiliations include the Idaho State University College of Pharmacy and the Boise State University School of Nursing. In fiscal year (FY) 2005, the medical center research program had 56 projects and a budget of $1 million.

Resources. In FY 2005, the medical center's expenditures totaled $91.2 million. The FY 2006 medical care budget is $91.7 million. Staffing in FY 2005 was 729 full-time equivalent employees (FTE), including 41 physician and 175 nursing FTE.

Workload. In FY 2005, the medical center treated 19,015 unique patients and provided 15,021 inpatient days in the hospital and 8,282 inpatient days in the Nursing Home Care Unit. In FY 2005, the average daily census, including nursing home patients, was 64. Outpatient workload totaled 171,950 visits.

Objectives and Scope of the Combined Assessment Program Review

Objectives. CAP reviews are one element of the Office of Inspector General's (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 quality management (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 clinical areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following six activities:

- Breast Cancer Management
- Contract Community Nursing Home (CNH) Evaluations
- Environment of Care
- Monitoring of Patients on Atypical Antipsychotic Medications
- Patient Satisfaction
- QM

The review covered facility operations for FYs 2004, 2005, and 2006 through June 30, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews.

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 of Review

Organizational Strength and Reported Accomplishment

Employees Reported High Overall Satisfaction

Medical center employees rated their work environment very high in the FY 2006 Veterans Health Administration (VHA) All Employee Survey. In the Job Satisfaction Index (JSI) portion of the survey, the medical center scored higher than both VISN and national averages in all categories. The JSI is designed to examine employees' satisfaction with their current VA job. It explores 13 different aspects of job satisfaction. The medical center scored significantly higher in the following areas:

- Work type
- Promotion opportunity
- Praise/Feedback
- Satisfaction

In the Organizational Assessment Inventory (OAI) portion of the survey, the medical center scored higher than both VISN 20 and VHA averages in all 20 survey categories. The OAI is designed to assess how effectively the medical center operates. The medical center scored significantly higher in the following categories:

- Coworker support
- Employee development
- Job control
- Retention

Opportunities for Improvement

Environment of Care

The purpose of the evaluation was to determine if the medical center maintained a safe and clean patient care environment. We inspected clinical and non-clinical areas for cleanliness, safety, infection control, and general maintenance. The medical center generally maintained a clean and well-maintained environment. However, we identified deficiencies in the following areas:

- Security of Patient Information – In two inpatient units, we found numerous clipboards hanging on hallways with patient names and social security numbers. We also found unattended computer terminals with accessible patient information and patient files left on the check-in desk in a specialty clinic. Federal law and VHA policy require that patient information be secured.

- Fire Safety – Supply areas had materials stored close to the ceiling in violation of fire safety codes that require materials to be stored no less than 18 inches from the ceiling to allow water sprinkler systems to operate effectively.

Managers took appropriate steps to address the deficiencies. However, the need to safeguard patient information and compliance with fire safety codes should be emphasized to all medical center employees.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Medical Center Director requires that (a) patient information, hard copy or visible on computer screens, be secured and (b) storage areas comply with fire safety requirements.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they will take actions, which will include purchasing lockable desk-side containers, securing clipboards containing patient identifiers, and reviewing the need to secure information with employees. In addition, the VISN and Medical Center Directors reported that they have taken actions, including ensuring proper storage, providing fire safety training, and monitoring compliance with fire safety codes. The target date for completion is November 30, 2006. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

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 Director,

Chief of Staff, Chief Nurse Executive, and QM personnel; and we evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the quality of care in the medical center. Appropriate review structures were in place for 12 of the 14 program activities reviewed. However, we identified two program areas that needed improvement and one area that we suggested could benefit from attention.

Disclosure Process. When serious adverse events occur as a result of patient care, VHA policy requires staff to discuss the events with the patients and, with input from Regional Counsel, inform them of their right to file tort or benefits claims. For two patients who experienced adverse events from June 2005 through July 2006, we found that clinicians had documented the adverse event discussion with one of the patients in the progress notes. However, staff had not documented that they had advised either patient about their right to file claims.

Utilization Management. Although admission and continued stay reviews were performed, no analyses of the reasons for not meeting criteria were provided, and no actions were documented when the percent of cases meeting criteria were below acceptable levels. For example, in the 2nd quarter of FY 2006, the percent of cases that met criteria ranged from 61–72 percent, yet no specific problems were identified, and no action plans were documented.

Approval, Implementation, and Follow-Up of Action Items. Medical center senior managers need to fully understand the Root Cause Analysis (RCA) team recommendations before giving approval. In one case, RCA recommendations appeared to be approved by senior managers. However, the actions were not implemented within reasonable timeframes. Discussion with the Chief of Staff indicated that he had serious concerns about the recommendations. In addition, we suggested that senior managers needed to take a more active role in several review areas to ensure that specific action items are identified when performance does not meet goals or benchmarks, actions are fully implemented, and results are evaluated.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Medical Center Director requires that: (a) responsible staff members fully inform patients who experience adverse events and document the discussions, (b) the Utilization Management (UM) Coordinator provides detailed analyses of UM data, and (c) senior managers act on results that do not meet goals.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they will take actions, which include reinforcing the disclosure requirements with the Medical Executive Committee and monitoring cases requiring disclosure; developing a local UM data analysis plan; and establishing a forum for discussion and agreement on actions resulting from workgroups. The target date for

completion is December 31, 2006. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Contract Community Nursing Home Program

The purpose of this review was to assess if the medical center complied with requirements regarding the selection, placement, and monitoring of patients in CNHs. VHA's CNH Program has two important tenets: (1) patient choice in selecting a nursing home and (2) local VHA facility oversight of CNHs. Oversight consists of monthly patient visits and annual reviews. To assess the medical center's CNH Program oversight, we reviewed medical records of 10 randomly selected patients, conducted site visits at 2 CNHs, reviewed relevant documents, and interviewed program managers, patients, family members, and nursing home administrators.

We found that the CNH Coordinator provided the required monitoring of patients in the program by involving patients and family members in the placement process, conducting monthly visits, and ensuring CNHs are evaluated annually before renewing contracts. However, we identified five improvement opportunities that could strengthen the program.

Follow-Up Visits Plan. Medical records did not contain individualized follow-up plans prior to placement of the patients in nursing homes. VHA policy requires that a plan be developed that addresses each patient's needs, as well as follow-up visits that will be provided by the medical center. The CNH Coordinator stated that all future CNH discharge orders will contain a description of the total care needs of the patient and a schedule of follow-up visits by the coordinator and the registered nurse (RN).

Nursing Visits. Medical records contained documentation of monthly visits by social workers. However, we did not find evidence of RN involvement in the monthly visits. The medical center is required to provide oversight visits by both a social worker and RN to every patient in a CNH, as indicated by the patients' follow-up plans. Program managers agreed to develop a plan to comply with the required RN visits.

Quality Monitors. VHA policy requires each facility to integrate the CNH program into its QM program. The intent is for employees to use the results of improvement activities to strengthen the program. We did not find evidence that CNH quality data were collected, analyzed, and integrated into the medical center's QM program. Program managers plan to monitor incidence of patient falls and urinary tract infections with quarterly reports to the CNH Oversight Committee.

Oversight Committee. We found that the medical center had not established a CNH Oversight Committee, as required. The function of the CNH Oversight Committee is to assess program completeness and conduct program reviews. This committee must

include multidisciplinary management-level representatives from various disciplines, as delineated in the policy. The CNH Coordinator stated that a subcommittee will be created under the Extended Care Committee.

Collaboration with State Ombudsman. The CNH Coordinator had contacted the appropriate Veterans Benefits Office staff to discuss issues related to the program. However, contact had not been made with the State Ombudsman's office to discuss subjects of mutual interest or concerns, as required. The CNH Coordinator stated that annual contact with the appropriate Ombudsman's office will occur.

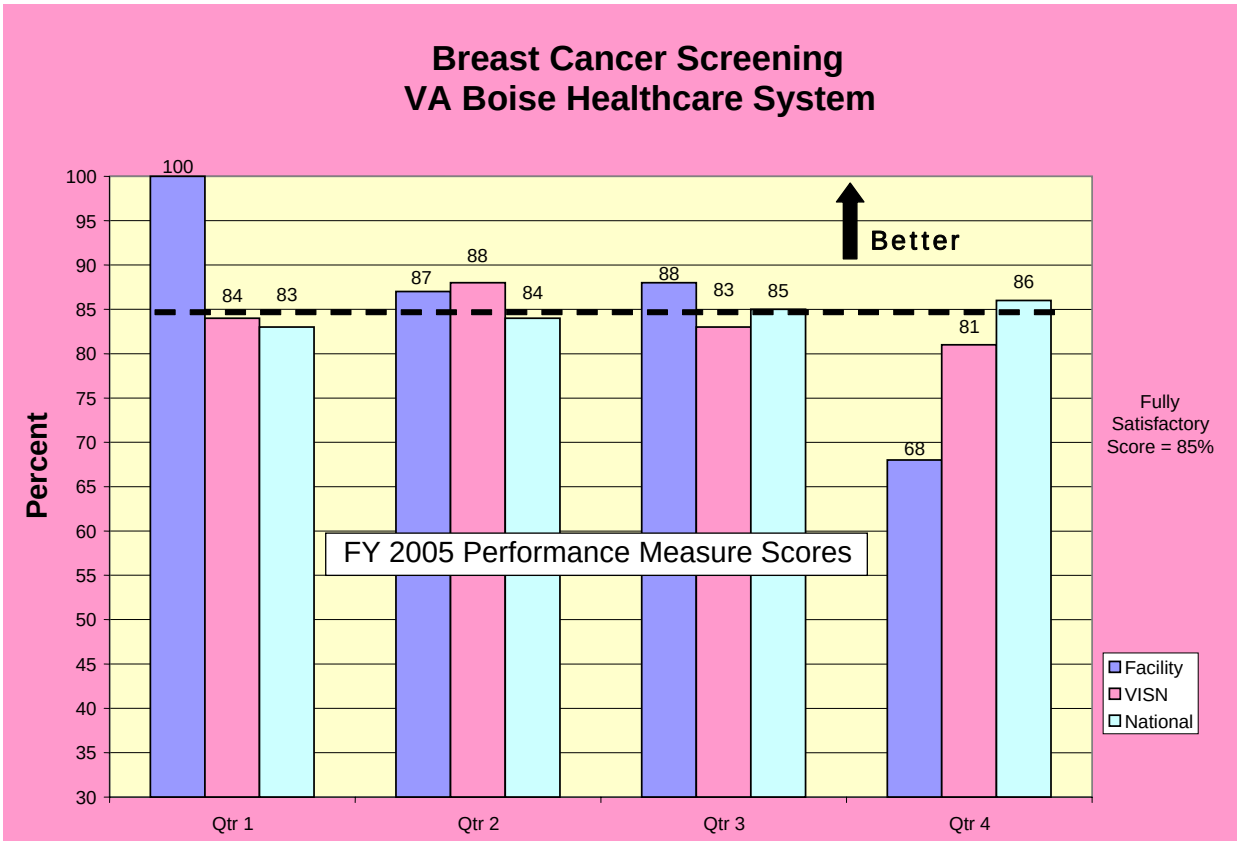
Recommended Improvement Action 3: We recommended that the VISN Director ensure that the Medical Center Director takes action to make certain that: (a) the CNH Coordinator develops individualized plans for follow-up visits prior to placement of patients in CNHs, (b) RNs provide the required visits, (c) the CNH program is integrated into the QM program, (d) a CNH Oversight Committee is created with the appropriate membership, and (e) the CNH Coordinator contacts the State Ombudsman's office annually to discuss issues relevant to the CNH program.

The VISN and Medical Center Directors agreed with the findings and recommendations and reported that they will take actions, which include developing a template note that will contain an individualized plan and follow-up visit schedule, requiring a RN to visit veterans within a 50-mile radius, integrating two CNH monitors into the QM program, and creating a CNH Oversight Committee with appropriate membership. The target date for completion is October 31, 2006. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Breast Cancer Management

The purpose of this review was to assess the effectiveness of breast cancer screening and management of abnormal mammogram results. We evaluated the medical center's scores for the breast cancer screening performance measure in FY 2005, interviewed program managers, reviewed medical records, and analyzed relevant documents. In FY 2005, the medical center performed a total of 328 mammograms.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The medical center achieved the fully satisfactory level of 85 percent during the first 3 quarters of FY 2005. However, the 4th quarter score was 68 percent. The Women Veterans Coordinator stated that she will take an active role in the review process to ensure compliance.



Timely diagnosis and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We reviewed these items in all 10 patients who had abnormal mammography findings during FYs 2004 and 2005. All screening and diagnostic mammograms, as well as follow-up interventions, were provided at community facilities on a fee-for-service basis. In all 10 cases, we found that veterans received appropriate screening, timely notifications of test results, and timely follow-up services.

Patients appropriately screened	Mammography results reported to patient within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
10/10	**10/10**	**10/10**	**10/10**	**10/10**

Recommended Improvement Action 4: We recommended that the VISN Director ensure that the Medical Center Director takes action to improve compliance with VHA's breast cancer screening performance measure.

The VISN and Medical Center Directors agreed with the findings and recommendation and reported that the Women Veterans Coordinator will be involved in the review

process and will take corrective actions to enhance compliance. The target date for completion is September 1, 2006. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Other Review Topics

Monitoring of Patients on Atypical Antipsychotic Medications

The purpose of this review was to determine whether clinicians appropriately monitored and managed patients receiving a specific class of medications used to treat psychosis. While these medications cause fewer neurological side effects (such as involuntary tremors) than other classes of antipsychotic medications, they increase the risk of developing diabetes.

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1–3 years. A normal FBG is less than 110 milligrams/deciliter (mg/dL). In patients with slightly higher FBG values (110–126 mg/dL), clinicians should provide counseling about such prevention strategies as calorie-restricted diets, weight control, and exercise. In patients with high FBG values (greater than 126 mg/dL) on at least two occasions, clinicians should diagnose diabetes.

We reviewed the medical records of 13 randomly selected patients who were receiving one or more atypical antipsychotic medications for at least 90 days. None of the 13 patients had diabetes. We found that all of the 13 patients were screened for diabetes and appropriately counseled about prevention strategies. Two patients who had FBG values within the slightly high range had no documentation in the medical records that explained the elevated values. However, the explanations provided by the Chief of Mental Health appeared to be reasonable. We are not making any 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, treatment, and services. In 1995, VHA began surveying its patients using a standardized instrument modeled from the Picker Institute, a non-profit healthcare surveying group. VHA set 76 percent for inpatients and 77 percent for outpatients as the FY 2006 target for the results of its Survey of the Health Experiences of Patients (SHEP). The tables on the next page show the national, VISN 20, and the medical center's survey results.

Boise VA Medical Center

INPATIENT SHEP RESULTS

Reporting period: July 10–14, 2006 FY 2006 Quarters 1 and 2	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	**81.31**	**78.63**	**89.95**	**68.02**	**65.8**	**75.85**	**83.41**	**74.49**	**70.03**
VISN	**84+**	**81.9+**	**91.8+**	**69.6+**	**68.1+**	**77.6+**	**80.1+**	**77.5+**	**72.5+**
Medical Center	85.3+	82.7+	93.3+	71.1+	69.7+	76.8	85.3+	76.6	71.9

OUTPATIENT SHEP RESULTS

FY 2006 Quarter 1	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	**81.5**	**78**	**95.3**	**73.1**	**83.7**	**76.2**	**82.6**	**66.5**	**82.2**	**80.7**	**85.2**
VISN	**83.8**	**80.2**	**95.9**	**74.4**	**86.3**	**76.8**	**85.4**	**67.2**	**83.8**	**83.4**	**84.7**
Medical Center Clinics	80.1	91.2 +	92	72.2	86.9	77.2	92.5 +	68.5	82.6	79	83.4

Legend: "+" "-" Indicate Results that are Significantly **Better** "**+**" or **Worse** "**-**" than the National Average

The medical center's managers shared the results with employees, as expected. Managers had formulated plans to reduce waiting times, provide more patient education materials, and address staffing issues. We found the action plans acceptable and are not making any recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 25, 2006

From: Network Director, VISN 20 (10N20)

Subj: VISN 20 Response to Suspense Due 8/25/06 – Combined Assessment Program Review, VA Boise Medical Center, Boise, ID (Project No. 2006-02002-HI-0341)

To: Director, VHA Management Review Service (10B5)

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

2. If you have any questions regarding this report, please contact Jan Gieselman, Quality Manager at (206) 422-1105.

(original signed by:)
Dennis M. Lewis, FACHE

Attachments

Appendix B

Medical Center Director Comments

Boise VAMC
Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Environment of Care – Security of Patient Information and Fire Safety

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) patient information, hard copy or visible on computer screens, be secured and (b) storage areas comply with fire safety requirements.

Concur with recommended improvement actions

a. Patient Information, hard copy or visible on computer screens, be secured:

Planned Action:

- Purchase lockable desk-side security containers to secure patient-identified confidential waste prior to disposal into the larger grey shred containers by **September 1, 2006**, and implement by **November 1, 2006**.
- Remove clipboards with patient identifiers from the hallway by **September 1, 2006**. Clipboards will be moved to the patient bedside and coded to the patient without use of full identifiers. At time of discharge, the clipboard record will be labeled with full identifiers prior to being placed in the patient's medical record.
- Educative screensavers will continue to be utilized as a constant reminder of the need to maintain information security **(completed August 1, 2006)**. All supervisors will review the need to secure information with employees in their work unit by **September 30, 2006**. An Information Security Committee will be formed under the direction of the Medical Center Director or his designee by **October 1, 2006**. The purpose of the Information Security Committee will be to identify and address information security risks and to educate and gain support for implementation of information security policies in the Medical Center. The initial Information Security Committee meeting will take place by **November 30, 2006**, and will continue quarterly and as needed thereafter.
- In addition to reports of the Information Security Committee, the Medical Center will monitor for ongoing compliance with information security via monthly tracer and Environmental Rounds activities beginning

September 1, 2006. Concerns requiring action will be reported to the Medical Center Director.

b. Storage areas comply with fire safety requirements:

Planned Action: All supply areas have been checked and corrections taken so that no materials are stored less than 18 inches from the ceiling. All employees will be re-educated regarding the need to comply with fire safety codes by **September 30, 2006**. We will monitor for ongoing compliance with fire safety code during monthly tracer activities and during Environmental Rounds, effective **September 1, 2006**. Concerns requiring action will be reported to the Medical Center Director.

2. Quality Management

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Medical Center Director requires that: (a) responsible staff members fully inform patients who experience adverse events and document the discussions, (b) the Utilization Management (UM) Coordinator provides detailed analyses of UM data, and (c) senior managers act on results that do not meet goals.

Concur with recommended improvement actions

a. Responsible staff members fully inform patients who experience adverse events and document the discussions:

Planned Action: The Chief of Staff will review the OIG findings surrounding disclosure with the Medical Executive Committee and will reinforce the requirements of the facility Disclosure Directive, including use of the national disclosure template, at their next meeting on **October 12, 2006**. The Patient Safety Coordinator will monitor cases requiring disclosure and track them for documentation of (1) discussion and (2) advisement of right to file claims. Cases that do not meet these two requirements will be reported immediately to the Chief of Staff. A summary of the disclosure monitor findings will be incorporated into the Risk Management Report provided by the Patient Safety Program Coordinator to the Quality Council on a quarterly basis effective **December 31, 2006**.

b. The Utilization Management (UM) Coordinator provides detailed analyses of UM data:

Planned Action: The newly hired UM Coordinator will be educated regarding UM data analysis by arranging a site visit to a successful UM program **(Completed August 15–16, 2006)**. A local UM data analysis plan will be developed to include performance goals, a standard report format, and a process for reporting and taking action on significant findings **(Completed August 22, 2005)**. This plan will be incorporated into the facility UM policy by **September 30, 2006**, and will be implemented by **October 30, 2006**.

c. Senior managers act on results that do not meet goals:

Planned Action: The Patient Safety Program Coordinator, Quality Manager, and senior managers will establish a forum in which to discuss and come to full agreement on actions resulting from workgroups (such as Root Cause Analyses and Healthcare Failure and Effects Mode Analyses) by **September 30, 2006**, and will fully implement the process by **October 1, 2006.**

3. Community Nursing Home Program

Recommended Improvement Action 3: We recommend that the VISN Director ensure that the Medical Center Director takes action to make certain that: (a) the CNH Coordinator develops individualized plans for follow-up visits prior to placement of patients in CNHs, (b) RNs provide the required visits, (c) the CNH program is integrated into the QM program, (d) a CNH oversight committee is created with the appropriate membership, and (e) the CNH Coordinator contacts the State Ombudsman office annually to discuss issues relevant to the CNH program.

Concur with recommended improvement actions

a. The CNH Coordinator develops individualized plans for follow-up visits prior to placement of patients in CNHs:

Planned Action: An interdisciplinary workgroup has been charged to develop an electronic discharge template that will include a description of the total care needs of the individual veteran and will designate a follow-up visit schedule for the CNH Coordinator and the CNH Nurse. To be implemented by **October 31, 2006.**

b. RNs provide the required visits:

Planned Action: A Registered Nurse will visit the veterans in the CNH within a 50-mile radius of the BVAMC on a schedule determined by the discharge follow-up plan that will meet the number of nursing visits required by the CNH Handbook. **To be implemented by September 30, 2006.**

c. The CNH program is integrated into the QM program:

Planned Action: Two quality improvement monitors will be in place at all times. The CNH Coordinator and Social Work Program Specialist will collect the data for the monitors. The initial two monitors will be (1) patient falls—to monitor for proper notification by the CNH and (2) timeliness of Boise VAMC staff follow up notes—must be completed within 2 business days of the visit. The results of these monitors will be presented to the CNH oversight committee and will be integrated into the hospital QA Monitoring program **by September 30, 2006**. At least annually, or when the CNH Oversight Committee determines that sufficient information has been gathered, a new monitor will be chosen.

d. A CNH oversight committee is created with the appropriate membership:

Planned Action: A CNH Oversight Committee will be created as directed by the CNH Handbook. The Committee will consist of representatives of Social Work Service, Nursing Service, Medical Service, Quality Management, and Contracting. The CNH Coordinator and Social Work Program Specialist will report quarterly to the CNH Oversight Committee. These reports will include documentation of (1) the annual meeting with the Ombudsman, (2) the annual meeting with the VBA, (3) results of the Exclusion Review and/or on-site CNH Surveys as documented on the CNH Website, (4) reports of any Critical Incidents or Sentinel Events occurring in the CNH, (5) timeliness of the monthly visits, (6) the results of the QA measures for the previous quarter, and any other matter that the CNH Coordinator determines should be presented to the Committee. The first meeting of the Oversight Committee will take place by **August 31, 2006**, and will occur quarterly thereafter.

e. The CNH Coordinator contacts the State Ombudsman office annually to discuss issues relevant to the CNH program:

Planned Action: Annual contact with the Ombudsman and VBA: The BVAMC CNH Coordinator will make annual contact with the Office of

Ombudsman, State of Idaho, and submit a list of the Skilled Nursing Facilities under VA Contract. There will be a request for the Ombudsman to inform the VA of any facilities which have had above average number or unusual types of complaints or issues. To be implemented by **August 31, 2006**. The information will be documented on a form created for that purpose and will be submitted to the CNH Oversight committee annually. The first report will be completed before **September 30, 2006.**

4. Breast Cancer Management

Recommended Improvement Action 4. We recommend that the VISN Director ensure that the Medical Center Director takes action to improve compliance with VHA's breast cancer screening performance measure.

Concur with recommended improvement actions

a. Improve compliance with VHA's breast cancer screening performance measure:

Planned Action: The Women Veterans Coordinator will take an active role in the breast cancer screening performance measure by (1) direct involvement in the EPRP review process to identify barriers to patients being scheduled for annual screening, follow up of individual cases that fall out in the EPRP review beginning **September 1, 2006**; and (2) corrective actions based on EPRP review findings will be taken to enhance compliance with annual mammogram screening beginning **September 1, 2006.**

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, Director Los Angeles Healthcare Inspections Division (213) 253-5134
Acknowledgments	Daisy Arugay Michelle Porter Monty Stokes

Appendix D

Report Distribution

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