Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the El Paso VA Health Care System El Paso, Texas

Report No. 06-01721-32 **November 27, 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 services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

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

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

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Executive Summary

Introduction

During the week of June 12–16, 2006, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the El Paso VA Health Care System (referred to as the system). The purpose of the review was to evaluate selected system operations, focusing on quality management (QM) and selected areas of patient care. During the review, we also provided fraud and integrity awareness training to 115 employees. The system is under the jurisdiction of Veterans Integrated Service Network (VISN) 18.

Results of Review

The CAP review focused on four healthcare areas. We made recommendations for improvement in all four of the activities:

- Breast cancer screening and management
- Diabetes and atypical antipsychotic medication screening, monitoring, and treatment
- Environment of care (EOC) safety and cleanliness
- Quality management program effectiveness

This report was prepared under the direction of Ms. Linda G. DeLong, Director and CAP Review Coordinator, Dallas Regional Office of Healthcare Inspections.

VISN and System Director Comments

The VISN 18 and System Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See Appendixes A and B, pages 9–17 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Introduction

System Profile

Organization. The system includes the main health care facility located adjacent to William Beaumont Army Medical Center (WBAMC) on Ft. Bliss, Texas, and a VA-staffed community based outpatient clinic in Las Cruces, New Mexico. The system provides care to over 23,865 unique veterans and serves a catchment area with over 81,000 veterans. El Paso is the clinic of jurisdiction for contract hospitalization, fee medical services, and fee dental services within a six county area—two in southern New Mexico and four in southwest Texas. Care is managed through interdisciplinary primary care teams.

Programs. The system provides primary and specialized ambulatory care services to veterans in El Paso and surrounding counties. Consultants and fee-basis specialists supplement the medical staff. Services include general medicine, women's health clinic, psychiatry, post-traumatic stress disorder, substance abuse, prosthetics, dental, cardiology, ambulatory surgery, Visual Impairment Service Team, and multiple specialty clinics.

Inpatient services for acute medical, surgical, and psychiatric conditions are primarily provided through a joint venture with Department of Defense partner, WBAMC, and through referrals to community and other VA medical facilities.

Affiliations and Research. The system is affiliated with WBAMC's Graduate Medical Education training program for internal medicine residents and with Texas Tech Health Sciences Center for psychiatry residents and students. Other active affiliations exist with various institutions for such allied health programs as social work interns, doctoral pharmacy interns, and undergraduate and graduate nursing students.

Resources.

	FY 2003	FY 2004	FY 2005
Budget (medical care)	$57.0 M	$62.8 M	$66.6M
MCCR[1]	$ 3.9 M	$ 5.1 M	$9.4M
Total Medical Care Facility FTE[2]	352.7	376.4	400.7

Workload.

	FY 2003	FY 2004	FY 2005
Outpatient Visits	202,183	220,518	222,151
Inpatients Treated	0	0	0
Unique Patients	21,093	22,490	23,865

[1]MCCR is Medical Care Cost Recovery.
[2] FTE is full-time employee equivalent.

Objectives and Scope of the CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care. The objectives are to:

- Conduct recurring evaluations of selected health care facility operations focusing on patient care and quality management.
- 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 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, employees, and patients; and reviewed clinical records. The review covered the following four activities:

Breast Cancer	Environment of Care
Diabetes and Atypical Antipsychotic Medication	Quality Management

Activities needing improvement are discussed in the Opportunities for Improvement section (page 3). Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

During this review, we also presented fraud and integrity awareness briefings for 115 employees, 28 percent of the current employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

Follow-Up on Prior CAP Review Recommendations

The prior review (*Combined Assessment Program Review of the El Paso VA Health Care System, El Paso, Texas*, 04-00230-191, August 27, 2004) made the following recommendations: (a) critically analyze QM data to identify opportunities to improve patient satisfaction, (b) appoint a Process Action Team (PAT) that uses the performance improvement process to address patient satisfaction, and (c) ensure that the Leadership Quality Board (LQB) provides effective oversight for all quality activities. This CAP review has identified that action plans to resolve issues identified in the 2004 CAP have not been implemented consistently and that leadership oversight of QM remains a concern.

Results of Review

Opportunities for Improvement

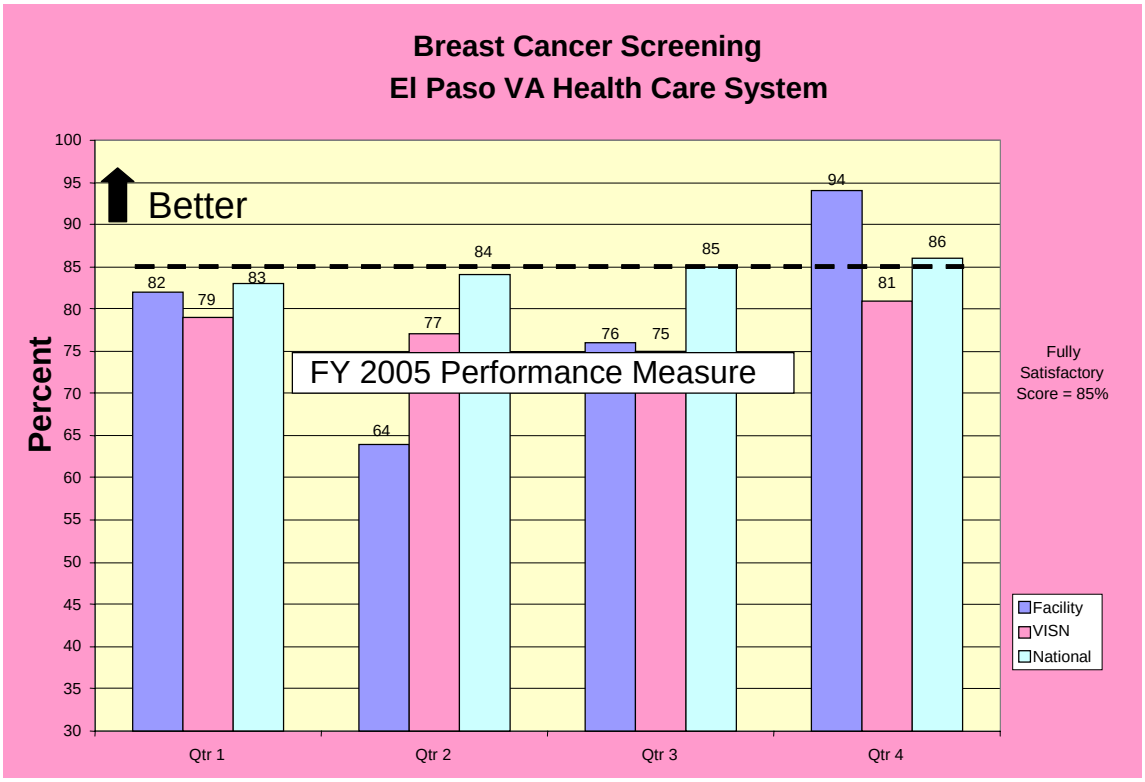
Breast Cancer Management – Mammography Processes Need Strengthening and Management Oversight

Condition Needing Improvement. The purpose of this review was to determine the effectiveness of breast cancer screening and management at VHA facilities. The system needs to develop a policy for clinical oversight of fee-basis services and the consult referral program. Medical staff need training on consult order and entry, as well as tracking procedures. The system refers all patients to community facilities for mammography procedures. All mammogram consults are coordinated and prioritized by the managed care department in the absence of dedicated clinical staff. The appropriateness of care must be determined by clinical staff. The system needs to ensure that mammogram appointments are scheduled in a timely manner and patients receive adequate notification. The system needs to improve compliance with: reporting mammogram results in a timely manner, the process for scanning results within a reasonable timeframe, and documentation of patient notification. The mammography process needs to comply with local policies and establish patient privacy in women's health exam rooms. The system needs to trend and track patient complaints and incidents relating to mammography services.

Criteria. The VHA breast cancer screening performance measure assesses the percentage of patients screened according to prescribed timeframes. Timely screening, diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. VHA mammography standards require normal findings to be documented in the medical record within 30 days of the procedure. Abnormal results must be communicated to the ordering provider within 3 working days. Timely results need to be available and accessible to guide patient care and treatment. The system was below the fully satisfactory level for 3 quarters in fiscal year (FY) 2005. The 4th quarter demonstrates a percentage above the fully satisfactory score. However, an analysis of the performance measure did not accurately reflect the 4th quarter score and the problems associated with this program. A consult tracking list from September 2004–March 2006 was obtained which showed 194 cancelled consults; 169 of these were documented as a "no show." WBAMC identified a system failure to document patient notification of an appointment. A careful review has verified that all patients who missed appointments have since been seen or are scheduled for an appointment. To date, no adverse outcomes have been noted. The system will continue to follow the status of the remaining few patients until all cases have been verified and reported to OHI.

In March 2006, the system implemented the Mammogram PAT, which examines the mammogram process from ordering to receiving the results and identifies needed changes within the current system. The effectiveness of this PAT has not yet been demonstrated due to its recent implementation.

Findings. Five patients diagnosed with breast cancer during FY 2005 were reviewed. The mammography results were not documented or scanned in the computerized patient record system as required in VHA Handbook 1104.1. Consultations and referrals were requested in a timely manner although the coordination of inter-facility treatment plans, including communication of findings and documentation of patient notification, needs improvement. The 2005 VHA Breast Cancer Screening performance measure for the 4th quarter did not accurately reflect medical record review results and onsite inspection by this team.



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
5/5	5/5	5/5	5/5	5/5

Recommended Improvement Action 1. We recommend the VISN Director ensure the System Director takes action to: (a) develop a policy for clinical oversight of fee-basis mammography services and consult referral program based on requirements outlined in VHA Handbook 1104.1; (b) provide medical staff training on consult order entry and tracking procedures; (c) ensure all mammography consults are reviewed for care determinations, coordinated, and prioritized by clinical staff dedicated to the managed care department; (d) ensure that mammogram appointments, patient notification, results reporting, and report scanning complies with local policies and VHA Handbook 1104.1; (e) establish patient privacy in women's health exam rooms; and (f) require the Leadership Quality Board (LQB) to provide oversight of patient complaints and incidents in the Women Veterans Health Program to trend and track improvements.

Diabetes and Atypical Antipsychotic Medications – Improve Monitoring and Managing Hemoglobin A1c, Document Diabetes Risk Factors, and Utilize the Diabetic Nurse Educator

Condition Needing Improvement. The purpose of this review was to determine the effectiveness of diabetes screening, monitoring, and treatment of mental health patients receiving atypical antipsychotic medications (medications that cause fewer neurological side effects but increase the patient's risk for the development of diabetes). Clinicians needed to improve monitoring and strategic intervention for elevated hemoglobin A1c (HbA1c) for patients with diabetes, document risk factors for diabetes in the medical record, and utilize the diabetic nurse educator for diabetic patients.

Criteria. VHA clinical practice guidelines for the management of diabetes suggests that: diabetic patients' HbA1c, which reflects the average blood glucose level over a period of time, should be less than 9 percent to avoid symptoms of hyperglycemia; blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg); and low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl).

To receive fully satisfactory ratings for these diabetes performance measures, the system must achieve the following scores:

- HbA1c greater than 9 percent (poor glycemic control) – 15 percent (lower percent is better)
- Blood Pressure less than or equal to 140/90mmHg – 72 percent (higher percent is better)
- Cholesterol (LDL-C) less than 120mg/dl – 75 percent (higher percent is better)

VHA clinical practice guidelines for screening patients who are at risk for the development of diabetes suggests that fasting blood glucose (FBG) is the preferred screening test and should be performed every 1 to 3 years. A normal FBG is less than or

equal to 110 mg/dl. Patients with FBG values greater than 110 mg/dl but less than 126 mg/dL should be counseled about prevention strategies (calorie-restricted diets and exercise). A FBG value that is greater than or equal to 126 mg/dL on at least two occasions is diagnostic for diabetes mellitus.

Findings. We reviewed a sample of 12 diabetic patients who were on 1 or more atypical antipsychotic medications for at least 90 days. Seven of the 12 records reviewed had elevated HbA1c with little or no intervention. The current performance measures reflected the lack of monitoring HbA1c. The medical record reviews revealed a lack of documentation of diabetes risk factors for 10 of the 12 diabetic patients. The documentation also failed to support referrals to the diabetic nurse educator.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with B/P less than 140/90 mm/Hg	Diabetic patients with LDL-C less than 120mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
58 percent (7/12)	83 percent (10/12)	83 percent (10/12)	None	None

Recommended Improvement Action 2. We recommend the VISN Director ensure the System Director requires clinicians to: (a) monitor and provide intervention for elevated HbA1c in all patients with diabetes who are receiving atypical antipsychotic medications, (b) document risk factors for diabetes in the medical record, and (c) make appropriate referrals to utilize the diabetic nurse educator.

Environment of Care – Work Order Tracking Needed To Be Improved

Condition Needing Improvement. The purposes of this review were to determine if managers have established a comprehensive EOC program that results in a safe and clean environment, to assess whether staffing resources are a barrier to maintaining the EOC, and to determine if biomedical equipment is clean and maintained. The system must establish a comprehensive EOC program that fully meets all VHA, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. To evaluate EOC, clinical and non-clinical areas are inspected for cleanliness, safety, infection control, and general maintenance. The system maintained a clean and sanitary environment. However, work orders showed an 18-month backlog dating back to 2004.

Timeliness of work orders. Local policy outlines classification of priority for work orders.

- Emergency work requests are the highest priority and will receive immediate attention.
- High Priority work requests will receive attention at the earliest possible time.
- Average work requests, under normal circumstances, will be acted on within 10 working days.
- Low work requests, under normal circumstances, will be acted on within 60 days.

The backlog consisted of work orders as follows: 24 classified as emergency dating back to February 2005; 74 classified as high priority dating back to January 2005; 150 classified as average dating back to December of 2004; and 6 classified as low dating back to February 2005. While inspectors were on site, management took immediate steps to verify work orders completeness and implement a tracking mechanism.

Recommended Improvement Action 3. We recommend the VISN Director ensure the System Director requires: (a) outstanding work orders and tracking are completed and (b) prioritization of work orders accurately reflect the needs of the system.

Quality Management

Condition Needing Improvement. The purposes of this review were to determine whether: (1) VHA facilities have comprehensive, effective QM programs designed to monitor patient care activities and coordinate improvement efforts and (2) VHA facility senior managers actively support and appropriately respond to QM efforts.

Leadership Oversight of the Quality Management Program. The LQB does not provide effective oversight for all quality activities conducted within the system. Criteria established in June 2004 by the LQB to prioritize performance measures and identify the need for focused reviews has not been followed or reviewed. Implementation and monitoring of performance improvement recommendations from the Process Action Team (PAT) and Root Cause Analysis (RCA) team are not tracked consistently by the LQB as required in Center Policy Memorandum (CPM) 00-07, *Quality Management Program*. Committee minutes do not routinely reflect referrals, decisions, or follow-up by leadership. Performance measures/dashboard reviews do not include dates for completing action plans but consider them to be "ongoing." Expectations that a timeline for improvement exists is not understood due to the repeatedly "deferred" or "not available" reports as documented in the LQB minutes.

Credentials and Privileging. The provisions of VHA Handbook 1100.19, *Credentialing and Privileging*, specifically require that a facility attempt to obtain malpractice information from sources other than the National Practitioners Database for use during the credentialing, privileging, and reappointment processes. The system did not document

attempts to obtain primary verification from insurance companies, courts, or attorneys of circumstances surrounding malpractice claims disclosed on initial or reappointment applications for privileges.

Peer Review. Initial peer review and RCAs are not consistently completed in the 45 days required by VHA Directive 2004-054, *Peer Review for Quality Management*; CPM 11-109, *Peer Review for Quality Management*; CPM 00-25, *Integrated Patient Safety Improvement Program*; and CPM 00-02, *Chapter 1, Leadership and Quality Board*. Additionally, all deaths must be screened against death review criteria and exceptions to the death review criteria. Cases that meet the criteria must be referred for protected peer review for quality improvement. Mortalities and major morbidities associated with any surgical procedure (elective or not) or any mortality related to readmission for the same condition (within 30 days) need to undergo morbidity and mortality peer review. A 12-month list of veterans seen in the clinic within 72 hours prior to their death included two or more who met criteria for at least a medical record review, but these were not performed.

Recommended Improvement Action 4. We recommend the VISN Director ensure the System Director requires that: (a) the LQB implement, monitor, and track performance improvement recommendations from PATs and RCAs; (b) tracking and reporting processes include anticipated completion dates which are followed and documented; (c) credentialing and privileging files contain documentation attempts to obtain primary verification from insurance companies, courts, or attorneys of circumstances surrounding malpractice claims disclosed on initial or reappointment applications for privileges; (d) initial peer reviews and RCAs are completed in 45 days; and (e) mortality assessments are conducted in accordance with VHA Directive 2005-056, *Mortality Assessment*.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 2, 2006

From: Network Director, VISN 18 (10N18)

Subject: **CAP Review of El Paso VA Health Care System**

To: Director, Dallas Audit Operations Division (52DA)

I concur with the attached facility draft responses to the recommendations for improvement contained in the Combined Assessment Program review at the El Paso VA Health Care System. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2692.

Patricia A. McKlem

Attachment

cc: Margaret Seleski, Director, Management Review Service (10B5)

VISN Director's Comments to Office of Inspector General's Report

The following VISN Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

Recommended Improvement Action 1. We recommend the VISN Director ensure the System Director takes action to: (a) develop a policy for clinical oversight of fee-basis mammography services and consult referral program based on requirements outlined in VHA Handbook 1104.1; (b) provide medical staff training on consult order entry and tracking procedures; (c) ensure all mammography consults are reviewed for care determinations, coordinated, and prioritized by clinical staff dedicated to the managed care department; (d) ensure that mammogram appointments, patient notification, results reporting, and report scanning complies with local policies and VHA Handbook 1104.1; (e) establish patient privacy in women's health exam rooms; and (f) require the LQB to provide oversight of patient complaints and incidents in the Women Veterans Health Program to trend and track improvements.

Concur **Target Completion Date:** November 1, 2006

See Facility Director comments.

Recommended Improvement Action 2. We recommend the VISN Director ensure the System Director requires clinicians to: (a) monitor and provide intervention for elevated HbA1c in all patients with diabetes who are receiving atypical antipsychotic medications, (b) document risk factors for diabetes in the medical record, and (c) make appropriate referrals to utilize the diabetic nurse educator.

Concur **Target Completion Date:** Completed

See Facility Director comments.

Recommended Improvement Action 3. We recommend the VISN Director ensure the System Director requires: (a) outstanding work orders and tracking are completed and (b) prioritization of work orders accurately reflect the needs of the system.

Concur **Target Completion Date:** Completed

See Facility Director comments.

Recommended Improvement Action 4. We recommend the VISN Director ensure the System Director requires that: (a) the LQB implement, monitor, and track performance improvement recommendations from PATs and RCAs; (b) tracking and reporting processes include anticipated completion dates which are followed and documented; (c) credentialing and privileging files contain documentation attempts to obtain primary verification from insurance companies, courts, or attorneys of circumstances surrounding malpractice claims disclosed on initial or reappointment applications for privileges; (d) initial peer reviews and RCAs are completed in 45 days; and (e) mortality assessments are conducted in accordance with VHA Directive 2005-056, *Mortality Assessment*.

Concur **Target Completion Date:** December 29, 2006

See Facility Director comments.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 26, 2006

From: Director, El Paso VA Health Care System (00)

Subject: **Combined Assessment Program Review of the El Paso VA Health Care System – Project Number: 2006-01721-HI-0325.**

To: Director, Veterans Integrated Service Network (10N18)

My staff and I have reviewed the draft Combined Assessment Program Review of the El Paso VA Health Care System – Project Number: 2006-01721-HI-0325 and have attached our comments in the template provided by the OIG.

Should you have questions concerning our response, please contact my Acting Associate Director, Mr. Everett Ray Perdue at (915) 564-7902.

(original signed by:)

Bruce E. Stewart

System Director's Comments to Office of Inspector General's Report

The following System Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendations

Recommended Improvement Action 1. We recommend the VISN Director ensure the System Director takes action to: (a) develop a policy for clinical oversight of fee-basis mammography services and consult referral program based on requirements outlined in VHA Handbook 1104.1; (b) provide medical staff training on consult order entry and tracking procedures; (c) ensure all mammography consults are reviewed for care determinations, coordinated, and prioritized by clinical staff dedicated to the managed care department; (d) ensure that mammogram appointments, patient notification, results reporting, and report scanning complies with local policies and VHA Handbook 1104.1; (e) establish patient privacy in women's health exam rooms; and (f) require the LQB to provide oversight of patient complaints and incidents in the Women Veterans Health Program to trend and track improvements.

Concur **Target Completion Date:** November 1, 2006

a. As noted in the CAP report, we chartered a Mammogram Process Action Team in March 2006 that is developing proposed process changes to address clinical oversight. Notification of abnormal results will be reported promptly to the Women's Veterans Health Care Clinic Chief or the Chief of Medicine in her absence. The Managed Care Department will be reorganized effective October 15, 2006. Three administrative consult clerks will be reassigned from that office to the Coordinated Care Office. The Coordinated

Care Office will have dedicated clinical staff that will review, prioritize and coordinate the consult process on all mammogram consults and all complex care consults.

b. The Clinical Informatics Nurse is scheduled to provide training on consult order entry and tracking procedures for consults in October 2006.

c. The Mammogram Process Action Team which includes William Beaumont Army Medical Center (WBAMC) staff is recommending a process change. Where the results are positive, the referral for a mammogram will be used as pre-authorization for the patient to be seen in other WBAMC clinics, to include surgery if necessary. This process change will be presented at the October 2006 LQB.

d. The Mammogram Process Action Team recommendation for a nurse Mammogram Coordinator will be presented at the October 2006 LQB. The Coordinator will be responsible for ensuring that the process for mammogram appointments, patient notification, results reporting, and report scanning is incorporated in local policy and is in full compliance with VHA Handbook 1104.1

e. Locks have been installed on women's health exam rooms.

f. Patient complaints and incidents from September 2006 in the Women Veteran's Health Program will be reported at the October 2006 LQB and each month thereafter. Data will be tracked and trended and presented as such monthly at the LQB.

Recommended Improvement Action 2. We recommend the VISN Director ensure the System Director requires clinicians to: (a) monitor and provide intervention for elevated HbA1c in all patients with diabetes who are receiving atypical antipsychotic medications, (b) document risk factors for diabetes in the medical record, and (c) make appropriate referrals to utilize the diabetic nurse educator.

Concur **Target Completion Date:** Completed

a. Following the OIG CAP visit, we did an internal review of all patients with HbA1c >9 with diabetes and who were receiving atypical antipsychotic medications, and took appropriate action. Monitoring is now being done weekly with a pull list of patients meeting these criteria. This list is printed in our Diabetic Care Line for intervention by a diabetic nurse educator.

b. Risk factors for diabetes are documented in patients' medical record obtained during a patient primary care clinical screen and as part of the documented biopsychosocial completed in Behavioral Health Service. Substantiation of documentation is made a part of medical record and peer reviews.

c. Weekly monitoring of HbA1c > 9 and an automatic reminder to physician ordering atypical antipsychotic medication now generate appropriate referral to diabetic nurse educator.

Recommended Improvement Action 3. We recommend the VISN Director ensure the System Director requires: (a) outstanding work orders and tracking are completed and (b) prioritization of work orders accurately reflect the needs of the system.

Concur **Target Completion Date:** Completed

a. Weekly work order reconciliation is now done by the Chief Maintenance and Operations Supervisor. This includes review of all open work orders with an update to the tracking system following the review. Work order priority assignment is also reviewed during the reconciliation. To insure accuracy of the work order reconciliation, the outstanding work order list is reviewed and spot checked as part of the facility's weekly environmental rounds process.

b. Prior to the OIG CAP review, we had 60 individuals who could enter work orders and select the priority. The priority was often incorrectly selected. The number of individuals who have access to input work orders has been reduced to 36. Training has been provided to those individuals on the priority system and the completion time allotted to each work order priority level.

Recommended Improvement Action 4. We recommend the VISN Director ensure the System Director requires that: (a) the LQB implement, monitor, and track performance improvement recommendations from PATs and RCAs; (b) tracking and reporting processes include anticipated completion dates which are followed and documented; (c) credentialing and privileging files contain documentation attempts to obtain primary verification from insurance companies, courts, or attorneys of circumstances surrounding malpractice claims disclosed on initial or reappointment applications for privileges; (d) initial peer reviews and RCAs are completed in 45 days; and (e) mortality assessments are conducted in accordance with VHA Directive 2005-056, *Mortality Assessment*.

Concur Target Completion Date: December 29, 2006

a. At the time of the OIG review, PATs were asked to orally report monthly to the LQB. PATS will now provide a monthly written progress report along with their oral report. The written report will be included as part of the LQB minutes. PAT charters will be revised to include a clearer definition of expectations and intermittent target dates will be set using the "Plan, Do, Check, Act" process as the assessment tool used by the LQB. RCAs will be presented monthly to the LQB to allow the board to assess whether a PAT should be established to correct process issues associated with the RCA report.

b. The LQB will track both PAT and RCA progress and document in the LQB minutes. The LQB will stress adherence to completion dates.

c. Prime source verification on malpractice claims reported in application of initial privileges and reappointment

applications was added to our credentialing and privileging process immediately following the CAP review.

Our practice now includes prime source verification of any individual who reports malpractice claims on their application, and any that appear on the NPDB report. This step has been placed on the checklist that the credentials coordinator uses when preparing the files for the initial and reappointment process.

d. Initial peer reviews and RCAs will require a mid-point written report to the Quality Manager pointing out barriers to the team meeting the 45-day completion deadline if needed. Peer reviews and RCAs not completed on time will be reported to the LQB for discussion and process change if needed.

e. A mortality review program will be developed in conjunction with the clinical service chiefs and Chief of Staff in accordance with the guidelines in VHA Directive 2005-056, Mortality Assessment.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Linda G. DeLong, Director Dallas Regional Office of Healthcare Inspections (214) 253-3331
Acknowledgments	Karen Moore, Associate Director Shirley Carlile Roxanna Osegueda

Appendix D

Report Distribution

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This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.