Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Roseburg Healthcare System Roseburg, Oregon

Report No. 06-02817-42 **December 13, 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.
- 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 September 11–15, 2006, the Office of Inspector General conducted a Combined Assessment Program (CAP) review of the VA Roseburg Healthcare System (the healthcare system). 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 209 healthcare system employees. The healthcare system is part of Veterans Integrated Service Network (VISN) 20.

Results of Review

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

- An innovative suggestion program improved services across the healthcare system.

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

- Secure patient information and ensure oxygen and other storage areas comply with fire safety codes.
- Ensure that all patient safety reports are completed within required timeframes and that utilization management results are acted upon.
- Meet the breast cancer screening performance measure, document patient notification of abnormal test results, and ensure timely biopsy evaluations.
- Improve administrative and clinical oversight of the Contract Community Nursing Home program.

The healthcare system complied with selected standards in the following two activities:

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

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

VISN and Healthcare System Directors' Comments

The VISN and Health Care System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 11–17, 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

Healthcare System Profile

Organization. The Roseburg VA Healthcare System (the healthcare system) is a tertiary care facility that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics in Eugene, Bandon, and Brookings, OR. The healthcare system is part of Veterans Integrated Service Network (VISN) 20 and serves a veteran population of about 62,000 in a primary service area that includes 4 counties in Oregon and 1 in northern California.

Programs. The healthcare system provides primary care, medical, surgical, mental health, geriatric, and rehabilitation services and has a sharing agreement with Madigan Medical Center for physiatry services. The healthcare system has 68 hospital beds and 55 nursing home beds.

Affiliations and Research. The healthcare system is affiliated with Umpqua and Mt. Hood Community Colleges, Graceland College, Gonzaga University, the University of Portland, Oregon Health and Science University, and the University of Washington. The healthcare system does not have a research program.

Resources. In fiscal year (FY) 2005, the healthcare system's expenditures totaled $81.6 million. The FY 2006 medical care budget was $84.4 million. Staffing in FY 2005 was 690 full-time equivalent employees (FTE), including 27 physician and 232 nursing FTE.

Workload. In FY 2005, the healthcare system treated 24,377 unique patients and provided 21,790 inpatient days in the hospital and 17,240 inpatient days in the Nursing Home Care Unit. The inpatient care workload totaled 2,383 discharges, and the average daily census, including nursing home patients, was 82. Outpatient workload totaled 283,031 visits.

Objectives and Scope of the Combined Assessment Program Review

Objectives. Combined Assessment Program (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
- Community Nursing Home (CNH) Program
- Environment of Care
- Monitoring Patients on Atypical Antipsychotic Medications
- Patient Satisfaction Survey Results Action Plans
- QM

The review covered facility operations for FYs 2004, 2005, and 2006 through August 31, 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 Accomplishment

Innovative Suggestion Program Improved Services

The healthcare system implemented an innovative suggestion program, Fresh Ideas Start Here (FISH), which allows employees, patients, patients' family members, and others to submit ideas to improve customer service. Colorful submission posters and boxes are located throughout the healthcare system. Senior managers review the suggestions and acknowledge each in writing. Since its inception in 2003, the FISH program has generated over 735 suggestions. Some of the suggestions implemented include:

- Designating additional handicap parking spaces.
- Including information requested by employees on the local website.
- Improving the hours of operation in the pharmacy.
- Improving vending services in the Canteen.

Opportunities for Improvement

Environment of Care

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

Security of Patient Information. In patient examination rooms in the clinic, we found open boxes in plain view that contained patient information that was waiting to be shredded. Federal law and Veterans Health Administration (VHA) policy require that patient information be secured.

Oxygen Storage. In the Transitional Care Unit (TCU), the oxygen storage room contained twice the number of large portable oxygen cylinders that the room was constructed to store safely, according to the National Fire Protection Association requirements[1] (NFPA-99).

[1] National Fire Protection Association, NFPA-99 *Standard for Health Care Facilities*, 2005.

Fire Safety. Supply areas had materials stored less than 18 inches from the ceiling. This is 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.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the Healthcare System Director requires that: (a) patient information waiting to be shredded be secured, (b) oxygen storage in the TCU be in compliance with NFPA-99, and (c) storage areas comply with fire safety requirements.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they immediately removed some of the oxygen stored in the area noted. They also plan to take actions, which will include obtaining locked shred containers, modifying the TCU oxygen storage area, and reviewing all storage areas for code compliance. The target date for completion is November 30, 2006. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

QM

The purpose of this review was to evaluate whether the healthcare system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the Healthcare System 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 healthcare system. Appropriate review structures were in place for 12 of the 14 program activities reviewed. However, we identified two program areas that needed improvement.

Patient Safety. Patient incidents were reported and analyzed. However, aggregate reviews for FY 2006 were not completed within the required timeframes. VHA's requirement is for aggregate reports to be completed within 45 days after the end of the quarter.

Utilization Management (UM). Although admission and continued stay reviews were performed, actions were not implemented when the percent of cases meeting criteria was below acceptable levels. For example, in the 2nd quarter of FY 2006, the percent of cases that met criteria was as low as 50 percent, yet no action plans were implemented.

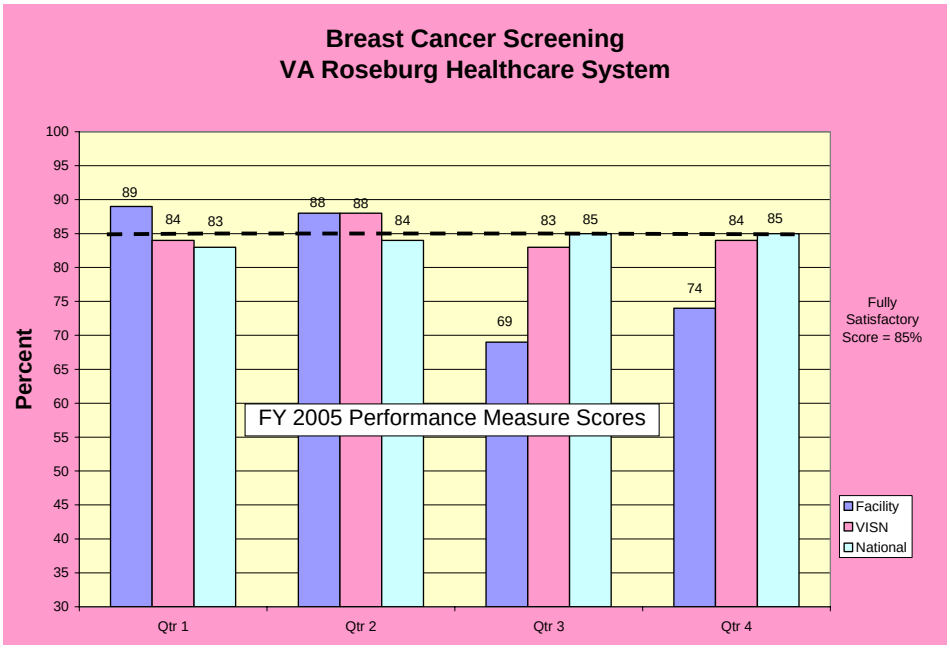
Recommended Improvement Action 2. We recommended that the VISN Director ensure that the Healthcare System Director requires that (a) the Patient Safety Coordinator completes all reports within specified timelines and (b) the Chief of Staff acts on UM results that do not meet goals.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will take actions, which will include completing all required reports, involving physician advisors in continued stay reviews, and addressing results that do not meet goals. The target date for completion is January 31, 2007. The improvement plan is 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 the management of abnormal mammogram results. We evaluated the healthcare system's scores for the breast cancer screening performance measure in FY 2005, interviewed program managers, reviewed medical records, and analyzed relevant documents.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The target goal for satisfactory performance is 85 percent. The healthcare system did not meet the VHA performance measure for breast cancer screening in 2 of the 4 quarters for FY 2005, as indicated in the graph below.



Program managers informed us that they have taken corrective actions to improve performance, including updating the women's health computer system to monitor compliance, sending reminder letters, and educating patients about the importance of mammogram screening. We suggested that program managers monitor the effectiveness of the implemented actions until a satisfactory performance measure score is achieved.

For patients with abnormal or highly suspicious mammograms, timely diagnosis, communication, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We assessed these items in a review of 10 patients who were either newly diagnosed with breast cancer or had abnormal mammograms during FYs 2004 and 2005. Three patients with malignant breast cancer received timely and coordinated consultative and treatment services. The remaining seven patients had benign diagnoses. We identified improvement opportunities in the following areas.

Communication of Abnormal Mammograms. In 3 of the 10 patients with abnormal mammograms, clinicians did not document in the medical records when they notified patients of the results, as required by VHA policy.

Timeliness of Biopsy Evaluations. Of the 10 patients, 8 required follow-up biopsy procedures. Clinicians had referred all cases to the Portland VA Medical Center (PVAMC) surgery clinic for evaluation. In two cases, timeliness of biopsy evaluations exceeded the facility goal of 10 business days from the initial referral. The delays appeared to be related to scheduling issues at PVAMC, and managers told us that they had recently implemented a procedure to provide biopsy evaluations locally to ensure prompt diagnosis.

Patients appropriately screened.	**Patients notified of mammography results, and notification was documented in the medical records.**	**Patients received timely biopsy evaluations.**	**Patients received timely interventions and/or follow-up treatments.**
10/10	**7/10**	**6/8**	**3/3**

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the Healthcare System Director takes action to: (a) improve compliance with VHA's breast cancer screening performance measure, (b) consistently document patient notification of abnormal test results in the medical records, and (c) ensure timely biopsy evaluations.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will take actions, which will include mammogram scheduling changes, increased use of software and clinical reminders, and improved tracking processes. The target date for completion is November 1, 2007. The improvement plan is 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 healthcare system 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 healthcare system'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 contract CNH administrators.

We found that the CNH review team performed annual evaluations of all contracted nursing homes before renewing contracts. However, we identified four improvement opportunities.

Follow-Up Visits Plans. 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 healthcare system.

Nursing Visits. We did not find evidence of registered nurse (RN) involvement in the monthly visits. The healthcare system 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.

Quality Monitors. VHA policy requires all facilities to integrate the CNH program into its QM program. We found evidence that the CNH oversight committee monitors the annual evaluation of contracted homes. However, CNH quality review data had not been integrated into the healthcare system's QM program.

Collaboration with State Ombudsman and Veterans Benefits Staff. The CNH Coordinator had not established contacts with the appropriate Veterans Benefits and State Ombudsman offices' staff to discuss subjects of mutual interest or concerns on an annual basis, as required.

Recommended Improvement Action 4: We recommended that the VISN Director ensure that the Healthcare System Director takes action to make certain that: (a) individualized plans are developed for follow-up visits prior to placement of patients in CNHs, (b) RNs provide the required visits, (c) quality review data from the CNH program is integrated into the QM program, and (d) annual contacts with State Ombudsman and Veteran Benefits offices' staff are established.

The VISN and Healthcare System Directors agreed with the findings and recommendations and reported that they will take actions, which will include developing standardized notes for documenting follow-up visits plans, assuring nurse visits, and implementing a tracking mechanism. The target date for completion is November 30, 2006. The improvement plan is acceptable, and we will follow up on the completion of the planned actions.

Other Review Topics

Patient Satisfaction Survey Results Action Plans

The purpose of this review was to assess the extent to which the healthcare system 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 satisfaction scores of very good or excellent in 76 percent of inpatients and 77 percent of outpatients surveyed as the FY 2006 targets for the results of its Survey of the Health Experiences of Patients (SHEP). The table below shows the national, VISN 20, and healthcare system's survey results.

VA Roseburg Healthcare System

INPATIENT SHEP RESULTS

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+**
Healthcare System	85.8+	83.3+	90.8	71.3+	71+	76.7	87.1+	80.4+	72.3

OUTPATIENT SHEP RESULTS

FY 2006 Quarter 2	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	**80.7**	**78.1**	**94.8**	**72.6**	**83.3**	**75.8**	**81.5**	**65.5**	**81.7**	**80.8**	**84.7**
VISN	**82.3**	**80.1**	**95.6**	**72.5**	**84.9**	**74.7**	**78.1**	**62.8**	**82.7**	**79.6**	**84.2**
Healthcare System Clinics	80.8	78.9	96.8	69.7	86	76.9	68.8	44.2	83.1	80.1	81

Legend: "+" Indicates Results that are Significantly Better than the National Average

The healthcare system's managers shared the results with employees, as expected. Managers had implemented action plans to improve patient satisfaction with education and information, pharmacy mailed, and pharmacy pick-up. We found the action plans acceptable and did not make any recommendations.

Monitoring 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.

We reviewed the medical records of 13 randomly selected patients who were receiving 1 or more atypical antipsychotic medications for at least 90 days in FY 2005. Two of the 13 patients had diabetes. We found that all of the 11 non-diabetic patients were screened for diabetes and appropriately counseled about prevention strategies. In June 2006, the healthcare system implemented the use of a progress note template that included baseline monitoring parameters for all patients receiving atypical antipsychotic medications. We did not make any recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 16, 2006

From: Network Director, VISN 20 (10N20)

Subj: VISN 20 Response to Suspense Due 10/16/06 – Roseburg CAP Draft Report

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 Roseburg VA Medical Center, Roseburg, Oregon.

2. If you have any questions regarding this report, please contact Deanna Watson, Quality Manager at (541) 440-1000, x44168.

(original signed by Susan Yeager for)
Dennis M. Lewis, FACHE

Attachments

VA ROSEBURG HEALTHCARE SYSTEM
Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Environment of Care

Recommended Improvement Action 1. We recommend that the VISN Director ensure that the Healthcare System Director requires that: (a) patient information waiting to be shredded be secured, (b) oxygen storage in the TCU be in compliance with NFPA-99, and (c) storage areas comply with fire safety requirements.

Concur with recommended improvement actions

a. Patient information waiting to be shredded be secured.

Planned Action:
VARHS is in the process of developing a vendor contract for shredding. Contract provides for specific located locked collection points; this will eliminate open boxes in Ambulatory Care and SATP.
Target date: 10/31/06.

b. Oxygen storage in the TCU be in compliance with NFPA-99.

Planned Action:
VARHS immediately removed oxygen tanks to comply with NFPA-99. In addition, VARHS is in the process of modifying the oxygen storage room to meet NFPA-99, 5-1.3.3.2, which will allow for increased storage of oxygen tanks. A 2237 has been submitted for contracting necessary duct work.
Target completion: 11/30/06.

c. Storage areas comply with fire safety requirements.

Concur with recommended improvement action

VARHS has already removed items from the shelf in question. In addition, we will remove the shelf to assure that items may not be placed on it in the future. In addition, we will conduct a review of all storage areas to ensure compliance, and we will educate staff who conduct environmental rounds on regulations regarding the appropriate storage of items.
Target date: November 10, 2006.

2. Quality Management

Recommended Improvement Action 2. We recommend that the VISN Director ensure that the Healthcare System Director requires that: (a) the Patient Safety Coordinator completes all reports within specified timelines and (b) the Chief of Staff acts on UM results that do not meet goals.

Concur with recommended improvement actions

a. The Patient Safety Coordinator completes all reports within specified timelines.

Planned Action:
FY 06 Quarter 2 & Quarter 3 reports will be completed **10/16/06**. We are recruiting for additional support staff for the Patient Safety Program and expect that this will prevent future delays.
Target date: 10/16/06.

b. The Chief of Staff acts on UM results that do not meet goals.

Planned Action:
1) Daily concurrent review will be completed on all cases that do not meet continued stay criteria, with a log identifying alternative level of care. Physician advisors will be consulted when UR reviewers and attending physicians do not agree on appropriate level of care.
Target date: 11/1/06.

2) The target ranges that fall out for admissions and continued stay days not meeting criteria data will be reported to the Executive Committee of the Medical Staff (ECMS) quarterly starting with FY 07 1st Qtr data January 2007. The COS will review and identify action plans to address deficiencies when targets are not met.
Target date: 1/31/07.

3. Breast Care Management

Recommended Improvement Action 3. We recommend that the VISN Director ensure that the Healthcare System Director takes action to: (a) improve compliance with VHA's breast cancer screening performance measure, (b) consistently document patient notification of abnormal test results in the medical records, and (c) ensure timely biopsy evaluations.

Concur with recommended improvement actions.

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

Planned Action:

1) Schedule screening mammography either BEFORE or on the day of their visit for gender-specific care in Women's Clinic at all three VARHS sites, if such screening is appropriate.
Target date: Start October 1, 2006; review at end of Quarter 2, FY 07 (April 1, 2007).

2) Emphasize importance of breast cancer screening to female veteran patients with more patient education handouts, personalized Health Diaries, and more in-depth discussion with clinical staff when they come in for their gender-specific care.
Target date: Start October 1, 2006. Procure more patient education handouts and personalized Health Diaries by December 1, 2006. Review end of Quarter 1, FY 07 (January 1, 2007).

3) Use the Women's Health Software AND the double-tiered breast cancer screening Clinical Reminder to proactively identify women who might be due for screening mammography.
Target date: April 1, 2007, for full implementation of Women's Health Software for this purpose. October 1, 2007, for full implementation of double-tiered breast cancer Clinical Reminder (Allows time to procure competent, reliable IT/CAC and implement full extent of Clinical Reminders & be sure such work). Provide quarterly updates on implementation to WVAC and ECMS until Action completed.

4) Use the Women's Health Software to send reminder letters to patients who are coming due for their screening exams in the next 3 months.
Target date: Start November 1, 2007. Provide quarterly updates on implementation to WVAC and ECMS.

5) Use the Women's Health Software to better track breast cancer screening. Example: when women are due; when exams are done; when follow-up actions have been completed.
Target date: Start November 1, 2006. Provide quarterly updates to WVAC and ECMS.

6) Educate direct care clinicians in "Motivational Interviewing" to help address patient-specific barriers to Refusals (Van Horn, Andrea, et al., "Breast Cancer Screening in the VA," Federal Practitioner, June 2006; 42–48).

Target date: Start October 1, 2006. Provide quarterly updates to WVAC and ECMS. NOTE: In-service provided to Roseburg site Ambulatory Care providers October 11, 2006.

b. Consistently document patient notification of abnormal test results in the medical records.

Planned Action:
Targeting direct care clinicians, emphasize importance of documenting this action in the patient's CPRS record. Clinicians will be notified on an ongoing basis via Women Veterans Advisory Committee meetings, Ambulatory Care meetings, and in-services. NOTE: clinicians have been notifying patients of abnormal results, but the documentation has been poor; thus, clinicians need to be reminded of the importance of documentation.
Target date: October 1, 2006. Provide quarterly Updates to WVAC and ECMS.

c. Ensure timely biopsy evaluations.

Planned Action:
1) If a patient cannot be evaluated within 10 days at the Portland VAMC (the only site in VISN 20 who will perform such diagnostic procedures…on an intermittent basis), then Fee mechanisms will be used to set up diagnostic evaluations with appropriate breast specialists in the communities near VARHS sites.
Target date: Started September 1, 2006. Provide quarterly updates to WVAC and ECMS.

2) Using the two-tiered CPRS Clinical Reminder for breast cancer screening, track the timing between initial study date, date of follow-up diagnostic studies, initial consult date, and actual consult date that patient was evaluated by a designated Breast Specialist. AND

3) The VARHS Women Veterans Program Manager and/or the Women's Health Clinical Director or their designee will track these consults and help ensure services are delivered within the 10 business days specified in our Ambulatory Care Memo 140-100.
Target date: October 1, 2007, for full implementation of Actions 2 and 3. Provide quarterly updates to WVAC and ECMS on progress of implementation.

4. Contract Community Nursing Home Program

Recommended Improvement Action 4: We recommend that the VISN Director ensure that the Healthcare System Director takes action to make certain that: (a) individualized plans are developed for follow-up visits prior to placement of patients in CNHs, (b) RNs provide the required visits, (c) quality review data from the CNH program is integrated into the QM program, and (d) annual contacts with State Ombudsman and Veteran Benefits offices' staff are established.

Concur with recommended improvement actions.

a. Individualized plans are developed for follow-up visits prior to placement of patients in CNHs.

Planned Action:
1) Tracking spreadsheet has been developed and implemented to ensure all CNH placements include individualized plan prior to discharge.
Target date: Accomplished.

2) 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 social worker and nurse.
Target date: 11/30/06.

b. RNs provide the required visits.

Nursing visits have been initiated. Documentation of actual nursing visits will be incorporated in the individualized plan tracking spreadsheet (noted above) and reported quarterly to the CNH Oversight Committee. The CNH Oversight Committee presents its reports to the Continuum of Care Lead Committee on a quarterly basis, which then reports to the Leadership Performance Board.
Target date: 11/30/06, follow-up quarterly.

c. Quality review data from the CNH program is integrated into the QM program.

Planned Action:
Two quality improvement monitors will be in place at all times. The CNH social worker and CNH Program Support Assistant will collect the data for the monitors. The initial two monitors will be (1) patient hospital admissions—to monitor for proper notification by the CNH; and (2)

timeliness of VA Roseburg Healthcare facility staff follow-up visit 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 through reporting to the Continuum of Care Lead Committee, which then reports to the Leadership Performance Board. At least annually, or when the CNH Oversight Committee determines that sufficient information has been gathered, a new monitor will be chosen.
Target date: 11/30/06.

d. Annual contacts with State Ombudsman and Veteran Benefits offices' staff are established.

Planned Action:
First annual meetings with the State Ombudsman Office and Veterans Benefits Office will be held prior to November 30, 2006. The information will be documented in the CNH Oversight Committee minutes annually. The CNH Oversight Committee presents its reports on a quarterly basis to the Continuum of Care Lead Committee, which then reports to the Leadership Performance Board.
Target date: 11/30/06.

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

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