Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Eastern Colorado Health Care System Denver, Colorado

Report No. 06-02819-145 **June 18, 2007**

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 and benefits 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 January 8–12, 2007, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Eastern Colorado Health Care System (the system). The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we provided fraud and integrity awareness training to 76 employees. In addition, we followed up on recommendations from the previous CAP review. The system is part of Veterans Integrated Service Network (VISN) 19.

Results of Review

The CAP focused on seven areas. The system complied with selected standards in the following three areas:

- Community Based Outpatient Clinics (CBOCs).
- Environment of Care (EOC).
- Survey of Healthcare Experiences of Patients (SHEP).

The following organizational strengths were identified:

- The Performance Improvement (PI) Council had developed a link on the system's intranet to communicate PI activities to employees.
- The Nursing Home Care Unit (NHCU) had improved food service by expanding breakfast hours and adding cooked-to-order selections.

We identified four areas that needed additional management attention. To improve operations, we made the following recommendations:

- Improve the cardiac catheterization laboratory informed consent process.
- Strengthen the contract community nursing home (CNH) oversight process by conducting and documenting monthly patient visits.
- Improve diabetes screening for patients on atypical antipsychotic medications, and monitor patients diagnosed with diabetes.
- Strengthen the QM Program by meeting all Veterans Health Administration (VHA) requirements for peer review and documenting the disclosure of adverse events.

This report was prepared under the direction of Ms. Virginia Solana, Director, and Ms. Dorothy Duncan, Associate Director, Kansas City Regional Office of Healthcare Inspections.

Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–15, 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

System Profile

Organization. The system includes the tertiary care referral medical center in Denver, Colorado, and seven outpatient clinics located in Aurora, Lakewood, Colorado Springs, Pueblo, La Junta, Lamar, and Alamosa, Colorado. The system includes two NHCUs located in Denver and Pueblo, Colorado. The system is part of VISN 19 and serves approximately 50,000 unique veteran patients.

Programs. The system provides comprehensive health care through primary care, tertiary care, and long-term care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care.

Affiliations and Research. The system is affiliated with the medical, pharmacy, and nursing schools of the University of Colorado Health Sciences Center and has other affiliations with local colleges and universities to train nursing, paraprofessional, and allied health students. The system supports 120 resident positions in internal medicine and its subspecialties, surgery and its subspecialties, psychiatry, neurology, physical medicine and rehabilitation, anesthesia, pathology, radiology, and dentistry.

The system has a large research and development program with major areas of biomedical laboratory and clinical sciences research that include oncology, pulmonology, cardiology, substance abuse, and diabetes/endocrinology. During fiscal year (FY) 2006, there were 579 active studies involving 168 VA and non-VA scientists. VA-funded research support for FY 2006 totaled $6,202,599. The total research funding for FY 2006 was $18,579,858.

The system's Schizophrenia Research Center is one of three in the entire VA system. Funding for the Schizophrenia Research Center was renewed October 1, 2006, for an additional 4 years for a total of $1.3 million. At the same time, the Health Services Research and Development Research Enhancement Award Program (REAP) entitled "The Colorado REAP to Improve Care Coordination for Veterans" was funded for $200,000 per year for 5 years. A Mental Illness Research, Education, and Clinical Center was awarded to the system in 2003.

Resources. In FY 2006, the system's medical care budget was $294 million. In FY 2006, the system had 1,566 full-time employee equivalents (FTE), including 250 physician and dentist FTE and 357 nursing FTE.

Workload. During FY 2006, the system treated over 52,000 unique patients. The Denver medical center has 128 hospital beds and 60 NHCU beds. The Pueblo NHCU has 40 beds. The average inpatient daily census was 100, and the average NHCU daily census was 95. The outpatient workload was approximately 481,000 visits.

Objectives and Scope of the Combined Assessment Program 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 services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

Cardiac Catheterization Laboratory Standards	Diabetes and Atypical Antipsychotic Medications
CBOCs	EOC
CNHs	QM
	SHEP

The review covered facility operations for FYs 2005, 2006, and 2007 through December 31, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on the recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado,* Report No. 04-01805-55, December 27, 2004).

During this review, we also presented fraud and integrity awareness briefings for 76 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report we summarize selected focused inspections and make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Activities in the section entitled "Other Review Topics" have no reportable conditions.

Results of Review

Organizational Strengths

Nursing Home Care Unit Improved Food Services

The system implemented a new short order cook program and expanded breakfast hours as part of the Denver NHCU cultural transformation program. Residents had identified problems with the quality, quantity, and promptness of food delivery on satisfaction surveys. When an interdisciplinary team met with residents to determine how to improve satisfaction, the residents stated that they wanted a variety of breakfast foods served and dining hours expanded.

The system remodeled the dining room and included a work station and grill for a short order cook. The atmosphere is warm and homelike with new dining room tables and chairs. Residents may now order from a menu containing a variety of breakfast foods, which are cooked to order by a chef. Open dining hours are from 7:00 a.m. until 8:30 a.m. This allows residents to eat when they awaken rather than at routine times. Response has been overwhelmingly positive, and the December 2006 resident satisfaction survey reflects 100 percent satisfaction with the new program.

Performance Improvement Intranet Site

The PI Council implemented a site on the system's intranet to facilitate communication of PI activities to employees. The site is accessible to all employees and contains PI policies; agendas and minutes of PI Council meetings; PI team charters, progress reports, and successes; minutes of committees that report to the PI Council; and patient safety reports. Education and PI training activities are also available on the site. The site has resulted in improved communication and awareness and has reduced paper usage.

Opportunities for Improvement

Cardiac Catheterization Laboratory Standards – All Elements of Informed Consents Needed To Be Completed

Condition Needing Improvement. Informed consents needed to consistently include the name of the procedure performed, the name of the clinicians performing the procedure, and dates of signature.

The purpose of this review was to evaluate if cardiac catheterization laboratory processes were consistent with American College of Cardiology (ACC)/Society for Cardiac Angiography and Interventions standards. Cardiac catheterization is a specialty procedure used to diagnose defects in the heart chambers, valves, and blood vessels. If clinicians identify a blockage, they may perform a procedure to open it in the cardiac catheterization laboratory, or they may send the patient for a surgical procedure. The ACC has reported a direct correlation between complications and volume of procedures performed.

System clinicians performed a moderate to high volume of procedures with low complication rates. Cardiac surgery was readily available for patients requiring it, although no emergency surgery has been needed for any cardiac catheterization patient in the past 2 years. Cardiac catheterization laboratory managers trended and analyzed complication rates by individual providers.

We reviewed the medical records of 10 randomly selected patients to determine the quality of the informed consent process, outcomes of the cardiac catheterization procedures, and, if applicable, availability of surgery. None of the 10 patients had complications or required surgery. However, improvements were needed in the informed consent process.

VHA requires that all clinicians who participate in a cardiac catheterization procedure must be identified on the informed consent. In addition, the consent must contain the procedure name, a description of the procedure and possible risks in layman's terms, and the alternatives. The consent is to be signed, dated, and witnessed. We reviewed procedure notes and informed consents to determine if the clinicians who performed the procedures were the same as those noted on the consents. Two of the 10 consents had deficiencies. Deficiencies included the incorrect name of the procedure being performed and missing provider names, procedure dates, and signature dates.

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that clinicians complete all elements of informed consents.

The VISN and System Directors agreed with the findings and recommendation. The System has implemented a process to monitor completion of consents. The improvement

actions are acceptable, and we will follow up on reported implementation actions to ensure that they have been completed.

Contract Community Nursing Homes – Monthly Visits Needed To Be Conducted and Documented

Condition Needing Improvement. The CNH Review Team needed to conduct monthly visits to patients residing in contract nursing homes in order to evaluate the quality of care provided and to assess patients' ongoing needs.

VHA policy requires that every patient placed in a CNH under VA contract must be visited by a social worker or registered nurse at least every 30 days, unless otherwise indicated on the patient's care plan. We reviewed a sample of 10 medical records, and 5 of the 10 records lacked documentation of monthly visits. The CNH Coordinator stated that the social worker was on extended leave at the time of the deficiencies. The nurse contacted many of the patients by telephone but did not document those contacts.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that the CNH social worker and registered nurse conduct and document the required monthly visits for all contract CNH patients.

The VISN and System Directors agreed with the findings and recommendation. The supervisory social worker developed a form to track visits, and this information will be monitored by the QM office. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure that they have been completed.

Diabetes and Atypical Antipsychotic Medications – Screening and Monitoring of High-Risk Patients Needed To Be Improved

Conditions Needing Improvement. Clinicians needed to screen patients at high risk for developing diabetes and perform follow-up laboratory testing, as required by VHA and local policy.

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).

VHA clinical practice guidelines for screening those at risk for the development of diabetes suggest that fasting blood glucose (FBG) is the preferred screening test, and it should be performed every 1–3 years. Additionally, the guidelines suggest that: (a) diabetic patients' hemoglobin A1C (HbA1c)[1] should be less than 9 percent, (b) blood

[1] HbA1c reflects the average blood glucose level over a period of time and should remain in control to prevent complications.

pressure should be 140/90 millimeters of mercury (mmHg) or less, and (c) low density lipoprotein cholesterol (LDL-C) should be less than 120 milligrams per deciliter (mg/dl).

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

- HbA1c greater than 9 percent – 15 percent or lower.
- Blood pressure less than or equal to 140/90mmHg – 72 percent or higher.
- Cholesterol (LDL-C) less than 120mg/dl – 75 percent or higher.

The system generally met VHA performance measures for blood pressure control and LDL-C levels. The performance measures for HbA1c did not meet established performance criteria; however, the system had performance improvement plans in place to address deficiencies.

We reviewed the medical records of 13 patients receiving atypical antipsychotic medications for at least 90 days in FY 2005. Three of the 13 patients had diabetes. Two diabetic patients had HbA1c results greater than 9 percent, but they received appropriate clinical intervention. We found one diabetic patient who did not have a LDL-C completed during the past 24 months, as required by local policy. One non-diabetic patient did not have an FBG completed within the required timeframe.

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with blood pressure less than 140/90mm/Hg	Diabetic patients with LDL-C less than 120mg/dl	Non-diabetic patients appropriately screened	Non-diabetic patients who received diabetes prevention counseling
2/3	3/3	2/3	9/10	9/10

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires clinicians to screen and monitor high-risk patients utilizing established VHA clinical practice guidelines.

The VISN and System Directors agreed with the findings and recommendation. Mental Health Service developed a screening process for patients on antipsychotic medications. These patients will be added to the clinical reminder system to ensure appropriate yearly laboratory monitoring. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure that they have been completed.

Quality Management – Peer Review and Disclosure of Adverse Events Needed To Be Improved

Conditions Needing Improvement. The QM Program was generally effective and provided appropriate oversight of PI activities. Senior managers were supportive of the QM Program, and the structure had been improved since the prior CAP visit. However, the peer review process and disclosure of adverse events needed to be improved.

Peer Review. VHA requires that medical staff have a Peer Review Committee that meets at least quarterly to review the quality of medical care and trend results of peer reviews. This trended data is to be reported to the Medical Staff Executive Committee for recommendations to improve care. The Peer Review Committee only met 3 of 4 quarters in FY 2006 and had not submitted quarterly reports of trended peer review results to the designated oversight committee. In addition, not all peer reviews were completed within the VHA required timeframe of 120 days. The peer reviews that were completed were detailed and provided recommendations for improvement actions. A trend report had been implemented during the last quarter of FY 2006.

Adverse Event Disclosure. When serious adverse events occur as a result of patient care, VHA and local policies require staff to discuss the events with patients and, with input from Regional Counsel, inform them of their right to file tort or benefit claims. These discussions must be documented. The system had two adverse events in the last year. Although they had discussed events with patients and documented those discussions, they had not documented that the patients had been informed of their right to file tort or benefit claims.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that medical staff complete the required peer reviews and report them to the designated oversight committee and that patients are informed of their right to file tort or benefit claims, and those discussions are documented in the medical record.

The VISN and System Directors agreed with the findings and recommendations. The Peer Review Committee is meeting at least quarterly. The Risk Manager is monitoring peer review completions and tracking and trending data. The Chief of Staff will report results to the Clinical Executive Board quarterly. Regional Counsel has assisted in developing a mechanism to ensure that medical staff inform patients or their families of the right to file tort or benefit claims. These discussions will be documented in the medical record. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure that they have been completed.

Other Review Topics

Community Based Outpatient Clinics

The purposes of this review were to assess the effectiveness of CBOC operations and to determine whether CBOCs are in compliance with selected standards of operation.

We selected the Fitzsimons Outpatient Clinic for review. We interviewed key staff at the Denver medical center and the CBOC; reviewed documentation and self-assessment tools; and reviewed credentialing, education, and background checks for five selected clinicians. Three medical provider and two nurse files were randomly selected for review. All files contained documentation of licensure, credentialing, mandatory education, and background checks.

We interviewed seven patients who were being treated at the CBOC on the day of our inspection. Six of the seven patients reported a high level of satisfaction with their providers and the care they receive at the CBOC. One patient rated his experience as fair. We reviewed the CBOC Warfarin Clinic and found evidence that the same standards of care provided to patients at the Denver medical center are in effect at the CBOC. A clinical pharmacist manages the warfarin patients at both facilities. Mental health patients are treated at the CBOC by a social worker and a psychiatrist.

We also inspected the CBOC EOC. The facility was clean and safe with current emergency preparedness plans and training documentation. Staff were educated in and knowledgeable about rendering emergency care.

We found that the CBOC was in compliance with all expected regulations and standards. Therefore, we made no recommendations.

Environment of Care

The purposes of the evaluation were to determine whether the system had established a comprehensive EOC program that met selected VHA, Occupational Safety and Health Administration, and Joint Commission on Accreditation of Healthcare Organizations standards and to follow up on issues identified during the 2004 CAP review.

To evaluate EOC, we inspected selected clinical and non-clinical areas throughout the system, paying particular attention to those issues noted in the 2004 CAP report. We inspected units for cleanliness, safety, infection control, and general maintenance. Overall, we found system facilities to be clean, safe, and well maintained. Management has a comprehensive plan to update and modernize the aesthetics of the building.

We found that all previously identified EOC issues had been resolved with the exception of the Aspergillosis[2] issue,[3] which is still pending. At the time of our inspection, immunocompromised patients were still being diverted to other facilities pending the results of a final tracer gas test that was scheduled for January 19, 2007. All air flow and ventilation work had been completed. Senior management will be working with the Under Secretary for Health to determine the timeframe for readmission of immunocompromised patients.

Managers provided excellent documentation of EOC rounds and timely abatement of identified conditions. Nurse managers reported that housekeeping staff assigned to their units were conscientious and that the centralized telephone number established for reporting problems was effective. We made no recommendations.

Survey of Healthcare Experiences of Patients

SHEP is aimed at capturing patient perceptions of care in 12 service areas, including access to care, coordination of care, and courtesy. VHA relies on the analyses, interpretations, and delivery of the survey data for making administrative and clinical decisions to improve the quality of care delivered to patients. VHA's Executive Career Field Performance Plan states that in FY 2006, at least 77 percent of ambulatory care patients treated and 76 percent of inpatients discharged during a specified date range will report their experiences as Very Good or Excellent. Health care systems are expected to address areas in which they are underperforming. The following tables show the system's performance in relation to national and VISN performance.

VA Eastern Colorado Health Care System
Inpatient SHEP Results 1st and 2nd Quarters FY 2006

Facility Name	Access	Coordination of Care	Courtesy	Education & Information	Emotional Support	Family Involvement	Physical Comfort	Preferences	Transition
National	81.31	78.63	89.95	68.02	65.80	75.85	83.41	74.49	70.03
VISN	85.6+	83+	92.9+	71.7+	69+	78.5+	86.6+	78.1+	72.9+
Medical Center	81.50	77.50	90.70	67.20	64.20	75.30	84.30	73.00	70.50

+ Significantly better than national average

[2] "A disease condition caused by species of [the fungus] Aspergillus and marked by inflammatory granulomatous lesions in the skin, ear, orbit, nasal sinuses, [and] lungs." *Dorlands Illustrated Medical Dictionary*, 27th ed. (Philadelphia, W. B. Saunders Company, 1988).
[3] See *Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado,* Report No. 04-01805-55, December 27, 2004.

VA Eastern Colorado Health Care System
Outpatient SHEP Results 3rd Quarter FY 2006

	Access	Continuity of Care	Courtesy	Education & Information	Emotional Support	Overall Coordination	Pharmacy Mailed	Pharmacy Pick-up	Preferences	Specialist Care	Visit Coordination
National	80.9	77	94.6	72	83	75.1	81.1	64.4	81.3	80.5	84.1
VISN	82.2	74.2	95.8	71.4	85.8	75.3	83.7	73.8	82.9	83.4	84.9
Outpatient Clinics - Overall	81.5	73.7	95.8	71.7	84.4	75.4	83.8	71.8	84.7	85.1	85.2
Denver	78.1	69.3	94.8	70.7	83.5	72	82.2	*	85.3	85.4	83.7
Fitzsimons	84.8	84.1	97.1	74.6	85.8	79.9	79.5	*	82.5	76.7	88.3
Lakewood	85.5	76.2	98.4 +	82.4	86	75.3	88.1	*	79.7	81.8	90.6
Pueblo	82.3	80	97.6	67.7	85.5	78.8	82.3	*	85.2	81.9	86.1
Colorado Springs	89.6 +	82.6	96.9	74.3	85.8	82.6	*	*	84.2	89.3	87.3
Alamosa	88.2 +	70.5	97	77.4	83.1	85.8 +	88.5	*	85.8	*	92.5 +
La Junta	85.7	57.5 -	95.9	71	85.5	69.7	77.7	*	79	*	78.8
Lamar	90.7 +	60.7 -	94.9	75.2 +	85.3 +	71.2 -	79	*	83.2 +	*	90.5 +

* Less than 30 respondents
\+ Significantly better than national average
\- Significantly worse than national average

The system had a designated SHEP Coordinator who completed a sophisticated analysis of SHEP results and reported this data to top management and service chiefs. In addition, the system's Customer Service Council was active and engaged in initiatives, including Quick Cards (feedback cards) and Service Recovery.[4] Action plans were developed for those areas needing improvement. System managers have included patient satisfaction data in employee annual evaluations. SHEP scores and performance improvement initiatives were adequately communicated and documented, and the effectiveness of corrective actions was evaluated.

While the system's SHEP scores fell below the established goals in a few areas, we found that appropriate actions were being taken to address patient satisfaction issues. Therefore, we made no recommendations.

[4] A positive approach to handling patient complaints by addressing identified issues to the patient's satisfaction and promoting patient retention.

Appendix A

VISN 19 Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 14, 2007

From: Director, Veterans Integrated Service Network (10N19)

Subject: **VA Eastern Colorado Health Care System**

To: Director, Kansas City Regional Office of Health Care Inspections

1. We are submitting written comments in response to the Combined Assessment Program Review completed January 8–12, 2007, at the VA Eastern Colorado Health Care System (ECHCS) at Denver, Colorado.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. Network 19 concurs with the report.

3. If you have any questions regarding this response, please contact Ms. Marilyn M. Lynn at 303-393-4644.

(original signed by:)

LAWRENCE A. BIRO

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 12, 2007

From: Director, VA Eastern Colorado Health Care System (554/00)

Subject: **VA Eastern Colorado Health Care System**

To: Director, Network 19

1. We are submitting written comments in response to the Combined Assessment Program Review completed January 8–12, 2007, at the VA Eastern Colorado Health Care System (ECHCS) at Denver, Colorado.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. ECHCS concurs with the report.

3. If you have any questions regarding this response, please contact me at 303-393-2800.

(original signed by:)

LYNETTE A. ROFF

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

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

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that clinicians complete all elements of informed consents.

Concur **Target Completion Date:** June 1, 2007

Changes had already occurred between the dates of the consents that were reviewed and our current process. The moderate sedation form in the Catheterization Lab now has a check box where the nurses document that the consent form was properly completed. It is again reviewed during the official "time out." Staff were re-educated on this process in January 2007. The Quality Management office will audit a sample of random charts for 3 months to confirm the current process assures completion of all the required elements on the consent.

Recommendation 2. We recommended that the VISN Director ensure that the System Director requires that the CNH social worker and registered nurse conduct and document the required monthly visits for all contract CNH patients.

Concur **Target Completion Date:** June 1, 2007

The Supervisory Social Worker who manages the Community Nursing Home (CNH) Program developed an Excel tracking sheet of every CNH Veteran by facility name. This is forwarded to through supervisors to the Associate Director for Patient and Nursing (AD/P&N) Services monthly to ensure compliance. The AD/P&N Services will provide monthly data to the Quality Management office for the next 3 months to validate compliance of this new process.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires clinicians to screen and monitor high-risk patients utilizing established VHA clinical practice guidelines.

Concur **Target Completion Date:** June 1, 2007

Mental Health Service (MHS) developed a screening process for patients on antipsychotic medications as an adjunct to the Clinical Guidelines that were written in September 2005. All patients on the atypical medications will be added to the clinical reminder system for appropriate yearly laboratory monitoring. MHS will pilot this process for 3 months with the plan to fully implement by June 1, 2007.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that medical staff complete the required peer reviews and report them to the designated oversight committee and that patients are informed of their right to file tort or benefit claims, and those discussions are documented in the medical record.

Concur **Target Completion Date:** June 1, 2007

As a result of numerous transitions of staff, the Peer Review Board is meeting more regularly than the required quarterly intervals to assure a comprehensive understanding of the VHA Directive and Peer Review Board process. It is managed by the Risk Manager (RM) and will now be chaired by the Chief of Staff (COS). Peer Review completions will be monitored carefully and tracked and trended by the RM. The Peer Reviews and required dates for completion will be discussed at the Peer Review Board, the designated oversight committee; a quarterly report will be discussed by the COS to the Clinical Executive Board (CEB), which she chairs.

Patients requiring full disclosure will have that documented in their medical record using the Disclosure of Adverse Event Note template. The template includes advisement of 1151 claims process and the right to file an administrative tort claim. Regional Counsel was consulted, and additional language has been added to assist the physicians in communicating this item to the patients and/or their families. Continuing education of this item will be documented in the March CEB meeting.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections 816/426-2023
Acknowledgments	Dorothy Duncan Jennifer Kubiak Reba Ransom Randy Rupp James Seitz Marilyn Stones

Appendix D

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