Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Eastern Kansas Health Care System Leavenworth, Kansas

Report No. 06-02820-141 **June 15, 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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Contents

Executive Summary

Introduction

The Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Eastern Kansas Health Care System (the system) during the week of November 27–December 1, 2006. 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 105 system employees. The system is part of Veterans Integrated Service Network (VISN) 15.

Results of Review

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

- Breast Cancer Management.
- Diabetes and Atypical Antipsychotic Medications.
- Survey of Healthcare Experiences of Patients (SHEP).

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

- Enhance community based outpatient clinic (CBOC) operations by completing peer recommendations at the time of medical provider reprivileging, developing a written policy for management of health emergencies, and placing signage for the location of fire extinguishers.
- Strengthen the contract community nursing home (CNH) oversight process by completing initial evaluations on all new contract homes.
- Improve environment of care (EOC) and patient safety by conducting mandatory scheduled checks of crash carts.
- Strengthen the QM Program by documenting peer review discussions and completing the reviews within the required timeframe, documenting disclosure of adverse events, consistently analyzing data, and documenting follow-up actions.

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

Comments

The VISN 15 and System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 12–15, for the full text of the Directors' comments.) We will follow upon 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 is comprised of two divisions located in Leavenworth and Topeka, KS. The system provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at 13 CBOCs located in Abilene, Emporia, Garnett, Kansas City, Junction City, Salina, Chanute, Fort Scott, Holton, Lawrence, Russell, and Seneca, KS; and in St. Joseph, MO. The system is part of VISN 15 and serves a veteran population of about 104,000 in a primary service area that includes 49 counties in Kansas and Missouri.

Programs. The system provides medical, surgical, mental health, geriatric, and rehabilitation services and has 213 hospital beds, 138 nursing home beds, and 202 domiciliary beds. The system has sharing agreements with two military bases, the State of Kansas, and two community hospitals.

Affiliations and Research. The system is affiliated with the University of Kansas Medical Center and the University of Missouri Medical School and supports 29 medical resident positions in seven training programs. In fiscal year (FY) 2005, the system's research program had six projects and a budget of $25,000.

Resources. In FY 2005, medical care expenditures totaled $176 million. The FY 2006 medical care budget was $187 million. FY 2006 staffing totaled 1,513 full-time employee equivalents (FTE), including 75 physician and 445 nursing FTE.

Workload. In FY 2006, the system treated 34,217 unique patients. The average daily census, including nursing home patients, was 228. The outpatient workload was 349,548 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 and benefits 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:

Breast Cancer Management	EOC
CBOCs	QM
CNHs	SHEP
Diabetes and Atypical Antipsychotic Medications	

The review covered system operations for FYs 2005 and 2006 through October 31, 2006, and was done in accordance with OIG standard operating procedures for CAP reviews. We followed up on the recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Eastern Kansas Health Care System, Leavenworth, Kansas*, Report No. 04-02331-112, March 25, 2005). The system had corrected all findings related to health care from our prior CAP review. We also followed up on recommendations from a report by the Veterans Health Administration's (VHA's) Office of the Medical Inspector (OMI) (*Final Report: Site Visit, Dwight D. Eisenhower Veterans Affairs Medical Center, Leavenworth, Kansas*, December 15, 2006). In that report, the OMI made recommendations to improve the clinical privileging and credentialing of physicians and the peer review process. We reviewed the documentation of the follow-up from the system and found everything to be acceptable. We consider the OMI recommendations closed.

During this review, we also presented fraud and integrity awareness briefings for 105 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 Other Review Topics section have no reportable conditions.

Results of Review

Organizational Strength

Performance Measures Plus

The system's senior leadership launched "Performance Measures Plus" in FY 2004 to improve the scores on VHA performance measures. "Performance Measures Plus" is a weekly meeting to review VHA performance measures, current performance scores, target performance levels, and strategies for improvement. This performance improvement workgroup is comprised of all service line managers, key staff, and clinical process owners. Each performance measure has an assigned team leader and team members. Teams focus on opportunities for improvement and report on their progress and initiatives using a standardized template. To increase accessibility and enhance staff awareness, performance measure scores are available to all staff on a color-coded dashboard on the local website. The system's monthly newsletter also documents progress on performance measures.

The system has significantly improved its performance measure scores. In FY 2004, the system was meeting 42 percent of the targets. In FY 2005, the system improved to 73 percent of the targets. In FY 2006, the system was meeting 76 percent of VHA performance measures. This accomplishment was due to the collaborative efforts of staff and senior leadership working together to improve patient outcomes.

Opportunities for Improvement

Community Based Outpatient Clinics – Reprivileging Process, Health Emergency Management Policy, and Fire Extinguishers Signage Needed To Be Improved

The purpose of this review was to assess the effectiveness of CBOC operations and to determine whether CBOCs are in compliance with selected standards of operations. We selected one CBOC for review, the Wyandotte CBOC in Kansas City, KS. We interviewed system and CBOC staff and reviewed documentation and self-assessment tools. We randomly selected three medical providers and two registered nurses and reviewed documentation pertaining to credentialing and privileging, education, and background checks. All clinicians had appropriate documentation of licensure, mandatory education, and background checks.

We interviewed six patients who were being treated at the Kansas City CBOC the day of our inspection. All patients reported a high level of satisfaction with their providers and the care they receive at the CBOC.

Conditions Needing Improvement. The CBOC that we reviewed met most standards, and the environment was generally clean and safe. However, the system needed to improve the process for completing peer recommendations for the reprivileging of practitioners, develop and implement a written policy for the management of health emergencies, and place signage that identifies the location of fire extinguishers.

Reprivileging Process. Reprivileging is the process of granting privileges to a practitioner who currently holds privileges within the facility. According to VHA policy and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), this process must be conducted at least every 2 years and must include a minimum of two peer recommendations. The definition of a peer is someone from the same discipline with essentially equal qualifications. One of the three medical providers we reviewed did not have the appropriate peer recommendations for reprivileging.

Health Emergency Management Policy. VHA policy requires CBOCs to have a written procedure defining how health emergencies are handled. We interviewed three staff who verbalized correct procedures for handling health emergencies; however, the CBOC did not have a written procedure.

Fire Extinguisher Signage. The National Fire Protection Association Life Safety Code requires signage identifying the location of fire extinguishers. Neither of the two fire extinguishers had the required identification. The Safety Officer immediately installed identifying signage.

Recommendation 1. We recommended that the VISN Director ensure that the System Director requires that appropriate peer recommendations are present for medical providers reprivileging, a written CBOC health emergency management procedure be developed, and all fire extinguishers are properly identified with signage.

The VISN and System Directors agreed with the findings and recommendations. The system is developing a check sheet to ensure all elements are present prior to reprivileging. A health emergency policy will be developed for the CBOC, and signage for fire extinguishers has been installed. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Contract Community Nursing Homes – Program Oversight Needed Strengthening

According to VHA policy, the CNH Review Team must evaluate community nursing homes prior to awarding an initial contract. The CNH Review Team must obtain and analyze quality data, state survey findings, inspection reports, and the Center for Medicare and Medicaid Services quality indicators. This data provides comparative information on state nursing homes' compliance with quality standards and designates areas of deficiency, as well as actions taken to resolve problems. After the CNH Review Team analyzes the data, they make recommendations to the system contracting officer regarding the contract award.

We reviewed five contracted nursing homes and 10 patient records. We interviewed staff, reviewed policies, conducted a site visit at one CNH, and interviewed veterans.

Condition Needing Improvement. The CNH Review Team needed to evaluate nursing homes prior to the award of initial contracts and subsequent placement of veterans in those homes. Although oversight of the CNHs was available on an ongoing basis for the last 5 years, the initial evaluation prior to contract and placement of patients was missing in four of the five CNHs. Initial inspections done on CNHs contracted prior to FY 2003 were not available. Staff reported that the inadequate documentation was likely due to staff turnover within the program. New CNH Program management personnel were appointed in FY 2004 and have complied with the initial inspection requirement since that time.

Recommendation 2. We recommended that the VISN Director ensure that the System Director takes actions to implement a monitoring process for completion of initial CNH evaluations prior to awarding the contract.

The VISN and System Directors agreed with the findings and recommendations. Since the system has been evaluating CNHs prior to initial contracts since FY 2004, we consider this recommendation closed.

Environment of Care – Crash Cart Checks Needed To Be Completed

VHA and JCAHO require that the hospital environment present minimal risk to patients, employees, and visitors and that infection control practices are employed to reduce the risk of hospital-acquired infections. We conducted EOC inspections at both divisions. We inspected bathrooms, medication and utility rooms, occupied and unoccupied patient rooms, and outpatient areas.

We randomly selected 16 pieces of equipment to evaluate cleanliness, safety, and maintenance. All equipment was clean and maintained appropriately. All alarms were functioning properly. Preventative maintenance checks were current and followed VHA policies.

Condition Needing Improvement. The system's EOC was generally clean and safe. However, Intensive Care Unit (ICU) and Emergency Room (ER) staff needed to complete emergency crash cart checks. Crash carts in the ICU and ER were not checked according to system policy. The policy states that crash carts will be checked a minimum of one time per day. We reviewed the crash cart checks for October and November 2006. ICU and ER staff should have completed 59 crash cart checks in their areas. In the ICU, 10 (17 percent) of the 59 were not completed. In the ER, 4 (7 percent) of the 59 were not completed. Critical medical equipment must be maintained and checked to ensure proper functioning in emergency situations.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that ICU and ER staff complete required crash cart checks.

The VISN and System Directors agreed with the findings and recommendations. ICU and ER staff have been re-educated on the emergency cart policy, and nurse managers will verify compliance daily. The improvement actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Quality Management – Peer Review Documentation, Adverse Event Disclosure, and Critical Analysis of Data Needed Strengthening

To evaluate the QM Program, we reviewed policies, plans, committee minutes, reports, credentialing and privileging files, performance improvement data, and other pertinent documents. We also interviewed key managers.

Conditions Needing Improvement. We concluded that the program was generally effective and provided appropriate oversight of patient care. However, managers needed to document peer review discussions, complete peer reviews within 120 days, document adverse event disclosures, consistently analyze data, and develop action plans for improvement. The following areas needed specific improvements:

Peer Review Committee Minutes. The Peer Review Committee minutes did not adequately document committee members' case discussions. Peer reviews evaluate the care provided by individual medical practitioners for the purpose of improving quality of care or resource utilization.

The committee reconsiders all peer reviews that are initially determined to be Level 2 or Level 3.[1] Two of five sets of minutes we reviewed documented these case discussions. However, due to legal advice stating that too much information was included in the minutes, the process was changed for the last three sets of minutes, which did not include documentation of discussions. VHA Directive 2004-054 requires that formal discussions occurring during Peer Review Committee meetings be recorded in confidential meeting minutes. Without proper documentation, managers could not be assured that peer review severity levels were changed for justifiable reasons. In addition, peer reviews were not completed within the 120 days required by the directive.

Adverse Event Disclosure. VHA and JCAHO require disclosure of adverse events to patients who have been harmed in the course of their care. The disclosure must be documented in the medical record using the disclosure of adverse event note template. We reviewed four medical records that should have included adverse event disclosure, and none contained a disclosure note. The Quality Manager reported that all patients had been informed and that the template was now being used.

Data Analysis and Follow-Up Actions. Program managers needed to trend and analyze pertinent data in all areas required by VHA policy and JCAHO. JCAHO requires hospitals to analyze data for trends and make recommendations to improve care. Although program managers collected data, it was not consistently analyzed and trended. In addition, responsibility for follow-up actions was not always assigned. One factor that contributed to this was the lack of a standardized format for minutes.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that the Peer Review Committee minutes document discussions and that peer reviews are completed within 120 days; adverse event disclosures are documented, as required; data is consistently analyzed; and follow-up actions are documented.

The VISN and System Directors agreed with the findings and recommendations. Peer Review Committee minutes will detail discussions, and clinicians will complete peer reviews within 120 days. Medical staff will be educated regarding the use of the adverse event disclosure template. A policy is being developed to standardize the format of committee minutes to ensure required elements are documented. The improvement

[1] VHA Directive 2004-054, *Peer Review for Quality Management*, September 29, 2004, designates Level 2 as most experienced, competent practitioners might have managed the case differently in one or more aspects listed in the directive and Level 3 as most experienced, competent practitioners would have managed the case differently in one or more aspects listed in the directive.

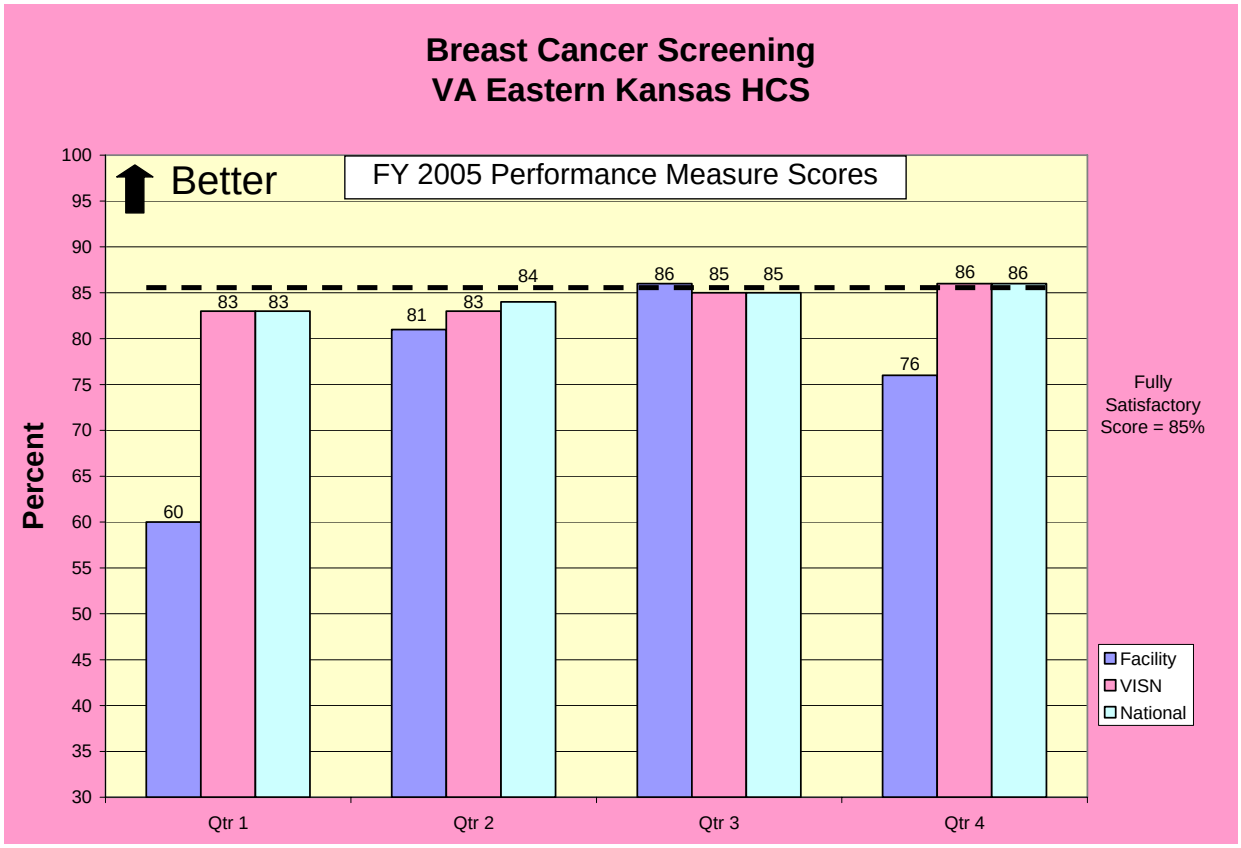
actions are acceptable, and we will follow up on reported implementation actions to ensure they have been completed.

Other Review Topics

Breast Cancer Management

The system provided timely breast cancer screening and follow-up. Patients were promptly notified of results of diagnostic testing and biopsies. Mammography is done by an offsite facility, and reports from that facility to the system were timely.

The VHA breast cancer screening performance measure assesses the percent of patients screened according to prescribed timeframes. The system did not achieve the fully satisfactory level in 3 of 4 quarters in FY 2005 (see chart below). A system breast cancer management group instituted process improvements in the fee-basis mammography program, which included follow-up of pending exams, close tracking of all female veterans, and consult monitoring. As a result, the system surpassed the fully satisfactory level in FY 2006.



Timely diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. We reviewed these items for FY 2005 in a random sample of three patients with suspicious or highly suggestive mammography results and one newly diagnosed breast cancer case. Services were timely (see table below).

Patients appropriately screened	Mammography results reported to patients within 30 days	Patients appropriately notified of their diagnoses	Patients received timely consultations	Patients received timely biopsy procedure
4/4	4/4	4/4	2/2	4/4

Diabetes and Atypical Antipsychotic Medications

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). We found that system clinicians appropriately screened and managed mental health patients receiving atypical antipsychotic medications.

VHA clinical practice guidelines for the management of diabetes suggests that: (1) a diabetic patient's hemoglobin A1c (HbA1c)[2] should be maintained at less than 9 percent to avoid symptoms of hyperglycemia, (2) blood pressure should be less than or equal to 140/90 millimeters of mercury (mmHg), and (3) 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:

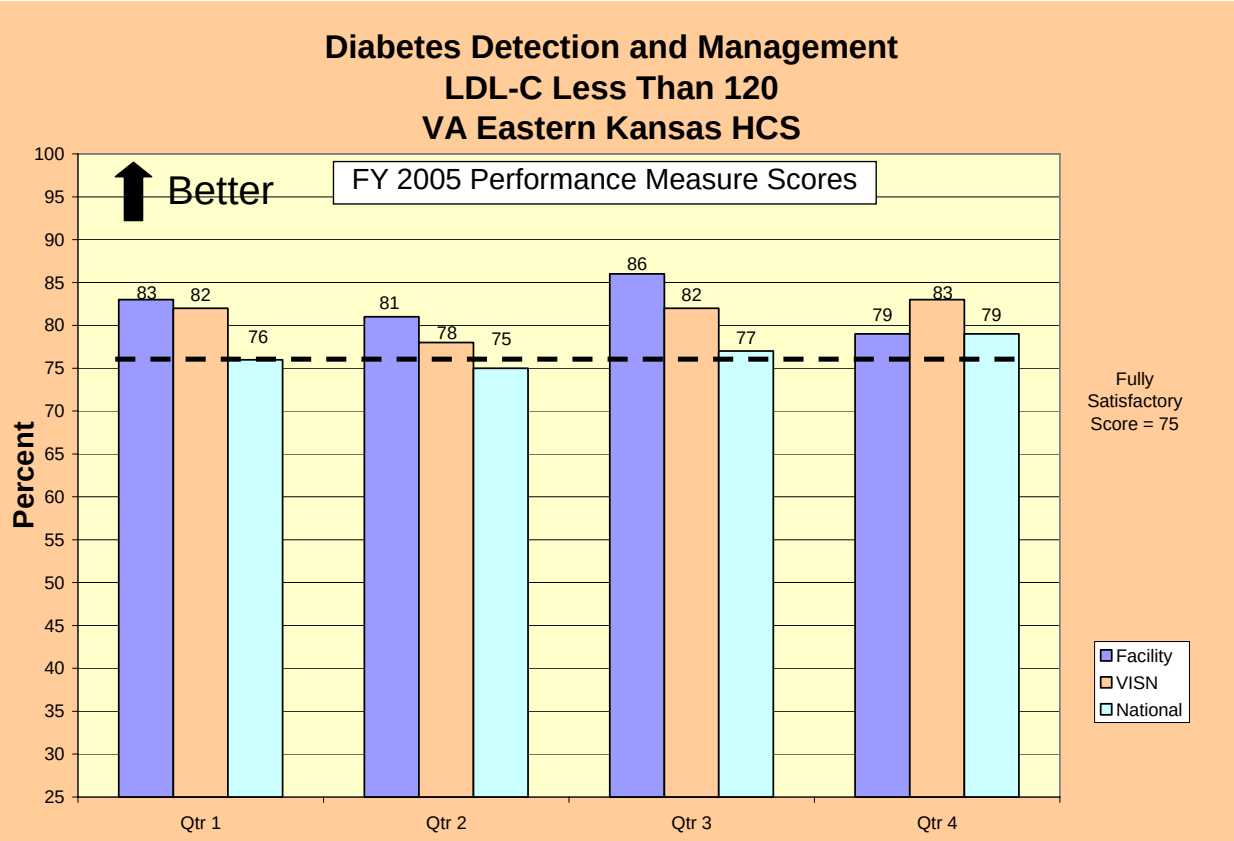
- HbA1c greater than 9 percent – 15 percent or lower
- Blood pressure less than or equal to 140/90mmHg – 72 percent or higher
- LDL-C less than 120mg/dl – 75 percent or higher

We reviewed a sample of 13 randomly selected patients who were on one or more atypical antipsychotic medications for at least 90 days. All patients were appropriately screened for diabetes. Four of the 13 patients had diabetes. Providers utilize an electronic clinical reminder to notify clinicians about patients' health maintenance requirement schedules. One patient did not receive diabetes counseling because of missed appointments.

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

Diabetic patients with HbA1c greater than 9 percent	Diabetic patients with blood pressure 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
1/4	4/4	1/4	9/9	8/9

Although three of the four diabetic patients in our sample had LDL-C levels above 120mg/dl, clinical staff had identified areas for improvement and implemented appropriate action plans. The system met or exceeded the VHA performance measure for LDL-C control for FY 2005 (see chart below). Because senior managers had analyzed performance measure results and supported the corrective actions for meeting these measures, we made no recommendations.



Survey of Healthcare Experiences of Patients

SHEP scores either met national targets or the system had initiated improvement plans in areas where targets were not met. Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns, as defined by patients. In 1995, VHA began surveying its patients

using a standardized instrument modeled from the Picker Institute, a non-profit health care surveying group. VHA set FY 2006 SHEP target results of patients reporting overall satisfaction of Very Good or Excellent at 76 percent for inpatients and 77 percent for outpatients. The following tables show the system's inpatient and outpatient SHEP results compared to VISN 15 and national survey results:

VA Eastern Kansas 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	83+	80.3+	90.10	67.80	65.40	75.40	83.50	74.30	68.2-
Medical Center	87.8+	83.5+	92.7+	67.90	66.90	76.10	85.4+	75.80	67.2-

VA Eastern Kansas 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	83.3	76.8	95.2	71.3	80.1	75.1	80.5	66.3	80.8	79.3	86.3
Outpatient Clinics - Overall	80	82.7	91.5	69.2	78.6	72.2	78.9	60	80.3	78.6	84.4
Topeka Outpatient Clinic	77.4	89.6 +	89.5	68.9	75.1	72.7	77.4	60.8	81.4	78.7	85.5
Leavenworth Outpatient Clinic	81.5	75.8	94.1	68.6	80.6	69.5	80	59.8	78.2	78	82.5
Salina CBOC	94.3 +	89.8 +	98.5 +	82.9 +	94 +	80.2 +	81.6	*	89.8 +	*	96.6 +
St. Joseph's VA Outpatient Clinic	81.1	61.5	84.2	65.7	82.2	71.9	75	*	79.7	*	82.1
Wyandotte CBOC	88.8 +	84.3	92.8	74.9	86.5	84.8 +	81	*	82.7	77	88.1
Abilene Outpatient Clinic	*	*	*	*	*	*	*	*	*	*	*
Chanute CBOC	87.2 +	85.8 +	98 +	82.6 +	92.7 +	84.2 +	83.7 +	*	88.2 +	*	95.2 +
Emporia CBOC	*	*	*	*	*	*	*	*	*	*	*
Garnett CBOC	*	*	*	*	*	*	*	*	*	*	*
Holton CBOC	*	*	*	*	*	*	*	*	*	*	*
Junction City CBOC	*	*	*	*	*	*	*	*	*	*	*
Russell CBOC	*	*	*	*	*	*	*	*	*	*	*
Seneca CBOC	*	*	*	*	*	*	*	*	*	*	*
Lawrence CBOC	*	*	*	*	*	*	*	*	*	*	*
Ft. Scott Outreach Clinic	92.1 +	79.7 +	96.5 +	79.8 +	90.8 +	76.8 +	86.8 +	*	86 +	*	91.6 +

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

The system continuously strives to improve patient satisfaction and SHEP scores. Managers have shared results with employees at service level meetings and posted information in the system's newsletter. Additionally, program managers have implemented a "mystery shopper" program to identify areas for immediate remedial attention or best practices to improve customer service within the system.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 12, 2007

From: Director, Veterans Integrated Service Network (10N15)

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

To: Department of Veterans Affairs Office of Inspector General

I concur with the responses to the recommendations outlined in this report.

(original signed by:)

PETER L. ALMENOFF, M.D., FCCP

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 12, 2007

From: Director, VA Eastern Kansas Health Care System (589A6/00)

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

To: Department of Veterans Affairs Office of Inspector General

1. Attached please find VA Eastern Kansas Health Care System's response to the draft report of the Combined Assessment Program Review.

2. If you have any questions, please contact Mary Weier, Quality Management and Performance Improvement Coordinator, at (913) 682-2000 ext. 52146.

(original signed by:)

RAJEEV TREHAN, MBBS, MD, MPH

System 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 appropriate peer recommendations are present for medical providers reprivileging, a written CBOC health emergency management procedure be developed, and all fire extinguishers are properly identified with signage.

Concur **Target Completion Date:** March 30, 2007

VA Eastern Kansas Health Care System is developing a check sheet to be used with each file presented to the Professional Standards Board (PSB). This check sheet will be used with each file presented to the PSB to ensure that all elements are present, including two peer references. This will be in place by February 1, 2007.

A written CBOC health emergency policy that defines how health emergencies are handled will be developed and in place by March 1, 2007.

Signage for fire extinguishers was installed on November 29, 2006. This is monitored on environmental organizational readiness rounds.

Recommendation 2. We recommended that the VISN Director ensure that the System Director takes actions to implement a monitoring process for completion of initial CNH evaluations prior to awarding the contract.

Concur **Target Completion Date:** January 16, 2007

Current recordkeeping, as identified in the CAP report, since FY 2004 is adequately documenting the initial CNH evaluation prior to awarding the contract. This current method of monitoring and documenting CNH evaluation will be continued. The CNH Oversight Committee will review all initial and renewal evaluations and document in their minutes.

Recommendation 3. We recommended that the VISN Director ensure that the System Director requires that ICU and ER staff complete required crash cart checks.

Concur **Target Completion Date:** January 4, 2007

All ICU and ER staff have been re-educated on emergency cart policy. The nurse managers will verify compliance daily.

Recommendation 4. We recommended that the VISN Director ensure that the System Director requires that the Peer Review Committee minutes document discussions and that peer reviews are completed within 120 days; adverse event disclosures are documented, as required; data is consistently analyzed; and follow-up actions are documented.

Concur **Target Completion Date:** March 30, 2007

The peer review minutes documenting detailed discussions began at the 12/13/06 Peer Review Committee meeting. Peer reviews will be completed within 120 days in accordance with VHA Directive 2004-054 by March 30, 2007.

Medical staff will be re-educated on the Disclosure of Adverse Events to Patient Health System Policy and Disclosure of Adverse Event Note template by March 30, 2007.

To capture and document data analysis, a health system policy standardizing the format for minutes will be developed noting subject of discussion, conclusion, recommendation, action, and evaluation/follow-up by March 30, 2007.

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, Associate Director Jennifer Kubiak Reba Ransom James Seitz Marilyn Stones James Werner

Appendix D

Report Distribution

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