Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-00032-213

Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics White City, Oregon

July 7, 2011

Washington, DC 20420

Why We Did This Review

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 crime awareness briefings 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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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
COC	continuity of care
ECMS	Executive Committee of the Medical Staff
EOC	environment of care
facility	VA Southern Oregon Rehabilitation Center and Clinics
FY	fiscal year
MCM	medical center memorandum
MEC	Medical Executive Committee
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PCP	primary care provider
PI	performance improvement
PR	peer review
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, OR

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of March 7, 2011.

Review Results: The review covered five activities. We made no recommendations in the following activity:

- Continuity of Care

The facility's reported accomplishment was an extensive veteran Native American program.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure that peer review findings are reported to the Medical Executive Committee quarterly and that medical record quality reviews include monitoring of unauthenticated documentation.

Management of Test Results: Ensure diagnostic clinicians consistently document the time critical results were communicated to ordering providers. Communicate normal test results to residents within the specified timeframe, and document communication in the medical record.

Physician Credentialing and Privileging: Ensure Ongoing Professional Practice Evaluations contain specific measurable performance data to support physician reprivileging.

Environment of Care: Implement and document daily inspections for unsecured medications.

Comments

The Veterans Integrated Service Network and Acting Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. 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

Objectives and Scope

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 crime awareness briefings 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 selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following five activities:

- COC
- EOC
- Management of Test Results
- Physician C&P
- QM

The review covered facility operations for FY 2010 and FY 2011 through March 7, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon,* Report No. 08-00988-181, August 13, 2008). (See Appendix B for further details.) The facility had one repeat QM finding.

During this review, we also presented crime awareness briefings for 297 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 make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

Veteran Native American Program

The facility provides veterans the opportunity to pursue an understanding of Native American spirituality and culture. Minority veteran volunteers and Native American elders share tribal knowledge and direct the culturally diverse programs.

Results

Review Activities With Recommendations

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following areas that needed improvement.

PR. VHA requires that PR results be reported to the MEC on a quarterly basis.[1] We found that results were discussed at the MEC in only 2 of the past 4 quarters. This was a repeat finding from the previous CAP review.

Medical Records Quality Review. VHA requires that health record reviews include monitoring of unauthenticated documentation.[2] We found that these reviews did not include the monitoring of unsigned progress notes, discharge summaries, and histories and physical exams.

[1] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

Recommendations

1. We recommended that PR findings be reported to the MEC quarterly.

2. We recommended that medical record quality reviews include the monitoring of unauthenticated documentation.

Management of Test Results

The purpose of this review was to follow up on a previous review that identified improvement opportunities related to documentation of notification of abnormal test results and follow-up actions taken.[3]

We reviewed the facility's policies and procedures and we reviewed medical records. We identified the following areas that needed improvement.

Documentation of Ordering Provider Notification. VHA requires that diagnostic laboratory and radiology clinicians document in the medical record the time and means of critical test result communication and the name of the ordering provider contacted.[4] We reviewed the medical records of 20 residents who had critical results and found that diagnostic clinicians did not document the time the ordering provider was notified in 11 of the 20 records.

Communication of Normal Results. VHA requires facilities to communicate normal results to residents no later than 14 calendar days from the date that the results were available to the ordering provider.[5] We reviewed the medical records of 20 residents who had normal results and found that 8 of the 20 records did not contain documentation that the facility had communicated the results to the residents. In addition, we found that of the 12 residents who were notified, three notifications did not occur within the required 14-day timeframe.

Recommendations

3. We recommended that diagnostic clinicians consistently document the time critical results were communicated to ordering providers.

4. We recommended that normal test results be consistently communicated to residents within the specified timeframe and documented in the medical record.

[3] *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results*, Report No. 01-01965-24, November 25, 2002.
[4] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[5] VHA Directive 2009-019.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed four physicians' C&P files and profiles and found that licenses were current and that primary source verification had been obtained. However, we identified the following area that needed improvement.

OPPE. VHA policy requires specific competency criteria in OPPEs for all privileged physicians.[6] We did not find specific measurable performance data to support reprivileging in three of the four C&P files and profiles reviewed.

Recommendation

5. We recommended that OPPEs contain specific measurable performance data to support physician reprivileging.

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements.

We inspected the infirmary and residential care units, including women residents' rooms, for safety and security. We evaluated the infirmary and the residents' rooms for compliance with VHA's MH RRTP policy for safe medication management. The facility maintained a generally clean and safe environment. However, we identified the following area that needed improvement.

Daily Medication Inspections. VHA requires that resident rooms be inspected daily for unsecured medications.[7] The facility was not conducting these inspections.

Recommendation

6. We recommended that daily inspections for unsecured medications be implemented and documented.

Review Activity Without Recommendations

COC

The purpose of this review was to determine whether communication between community hospitals and the facility occurred when facility residents were hospitalized in the community. Such communication is essential to continuity of care and optimal resident outcomes. In addition, we looked

[6] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[7] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, May 26, 2009.

for evidence to determine whether PCPs acknowledged and documented resident hospitalizations.

We reviewed the medical records of 13 residents who were hospitalized at VA expense in the local community from February 2010 to December 2010. We determined that the facility generally met requirements in these areas. We made no recommendations.

Comments

The VISN and Acting Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 9–14, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[8]		
Type of Organization	Residential rehabilitation center and outpatient clinics	
Complexity Level	3	
VISN	20	
Community Based Outpatient Clinic	Klamath Falls, OR	
Veteran Population in Catchment Area	46,140	
Type and Number of Total Operating Beds: • **Domiciliary Residential Rehabilitation Treatment Program** • **Domiciliary Care Homeless Veterans**	 546 54	
• **CLC/Nursing Home Care Unit**	0	
• **Other**	0	
Medical School Affiliation(s)	Eastern Washington University, Spokane, WA Oregon Health and Science University, Portland, OR Others	
• **Number of Residents**	0 (No residency program)	
	Current FY (through January 2011)	**FY 2010**
Resources (in millions):		
• **Total Medical Care Budget**	$85.8	$88.5
• **Medical Care Expenditures**	$28.6	$87.5
Total Medical Care Full-Time Employee Equivalents	566.10	559.57
Workload:		
• **Number of Station Level Unique Patients**	10,737	16,250
• **Inpatient Days of Care:**		
o **Acute Care**	0	0
o **CLC/Nursing Home Care Unit**	0	0
MH RRTP Discharges	181 (Community)	758 (Community)
Total Average Daily Census (including all bed types)	398.42	425.58
Cumulative Occupancy Rate (in percent)	82.49	88.11
Outpatient Visits	36,479	189,814

[8] All data provided by facility management.

Follow-Up on Previous Recommendations			
Recommendations	**Current Status of Corrective Actions Taken**	**In Compliance Y/N**	**Repeat Recommendation? Y/N**
QM			
1. Consistently trend, analyze, and routinely report QM data to the appropriate oversight group.	Committee minutes have been restructured. In-service training was completed September 22–23, 2008. The MCM was uploaded for staff on October 10, 2008.	Y	N
2. Ensure that the PI plan includes the role of the ECMS in QM and that clinical reviews are reported to that committee.	The committee developed an MCM for the new MEC and sent it out for 10-day concurrence. The MCM was implemented by October 1, 2008.	Y	N
3. Implement a process to trend and analyze PR findings, and report aggregated results quarterly to the ECMS.	A spreadsheet for trending and analyzing PR data was implemented July 25, 2008. However, the ECMS/MEC is not reviewing aggregated reports quarterly.	N	Y (see pages 2–3)
4. Require timely completion of mortality case reviews, and implement standardized trending, analysis, and reporting of this data in accordance with VHA policy.	A spreadsheet for trending and tracking mortality data was implemented July 26, 2008. This information is reported quarterly to MEC.	Y	N
Pharmacy Operations			
5. Implement a requirement that annual training for controlled substances inspectors be conducted and documented**.**	Controlled substance inspectors' training records contain documentation of annual training.	Y	N

VHA Satisfaction Surveys

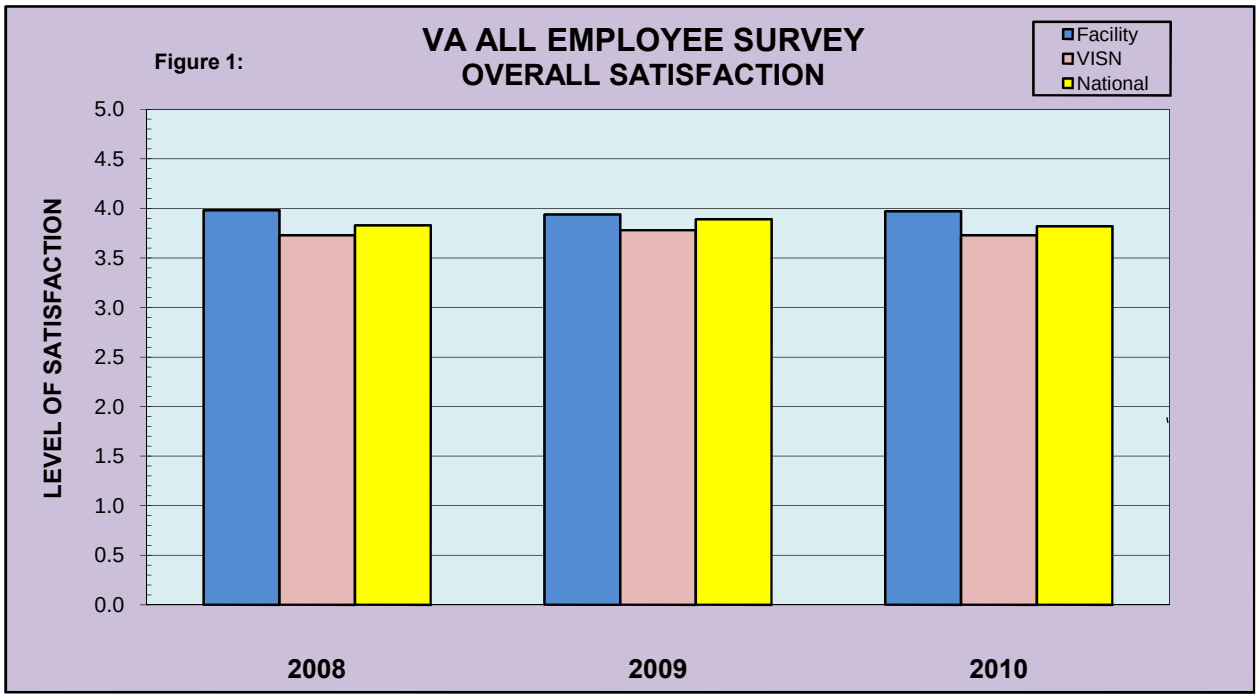
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for FY 2010.

Table 1

	FY 2010 (inpatient target = 64, outpatient target = 56)							
	Inpatient Score Quarter 1	Inpatient Score Quarter 2	Inpatient Score Quarter 3	Inpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	NA	NA	NA	NA	55.2	45.8	50.2	51.3
VISN	61.2	65.7	68.8	65.5	49.6	49.7	50.0	50.1
VHA	63.3	63.9	64.5	63.8	54.7	55.2	54.8	54.4

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2008, 2009, and 2010. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: 06/10/2011

From: Network Director, VISN 20 (10N20)

Subject: **CAP Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, OR**

To: Director, Seattle Office of Healthcare Inspections (54SE)

Director, Management Review Service (VHA CO 10B5 Staff)

1. Thank you for the opportunity to provide a status report on the draft findings from the Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon.

2. Attached please find the facility concurrences and responses to each of the findings from the review.

3. If you have additional questions or need further information, please contact Susan Gilbert, Survey Coordinator, VISN 20 at (360) 567-4678.

(*original signed by:)*
Susan Pendergrass, DrPH

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 06/07/2011

From: Acting Director (692/00), SORCC

Subject: **CAP Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, OR**

To: Director, Northwest Network (10N20)

1. On behalf of the VA Southern Oregon Rehabilitation Center & Clinics (SORCC), I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and Comprehensive Assessment Program (CAP) review conducted March 7–10, 2011.

2. The findings from the report we have reviewed and updated and SORCC's responses addressing each recommendation are attached. The responses include actions that are in progress and those that have already been implemented.

3. We appreciate the opportunity for the review as a continuing process to improve the care we provide for our Veterans.

David Donnelly, MD

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 PR findings be reported to the MEC quarterly.

Concur

Target date for completion: Peer Review Reports will be reported at the first of each quarter to MEC. If the meeting is cancelled the report will be forwarded to the agenda for the next month. The process will begin immediately.

Facility's response:

1. Before FY2009 we did not have a process to aggregate and analyze Peer Review Data. The aggregation of data and analysis is a continuous process, which has been in place since October 1, 2008.

2. In FY 09 the data was reported to the MEC quarterly, however due to meeting cancellations the data was not reported quarterly to the MEC in FY2010. The same data was reported to the Quality Leadership Committee (QLC). The Chief of Staff and senior executives are members to this committee and they did review and analyze the data on a quarterly basis.

3. Adjustments have been made to identify reports that must be reported quarterly to the MEC, and this particular report will be presented at the beginning of each quarter. This will allow time to report the data within the quarter, if the first meeting is cancelled.

Recommendation 2. We recommended that medical record quality reviews include the monitoring of unauthenticated documentation.

Concur

Target date for completion: Per VHA Directive 1907.01 (Health Information Management and Health Records), and MCM 136-005 (Medical Record Documentation), a quality review monitor will be officially established June 1, 2011.

Facility's response: We have a process in place that monitors daily discharge summaries and history & physical exams. The results are reported monthly to our Performance Enhancement Team (PET) Committee. We have been deficient in a process to report audited unsigned progress notes. The new process will address unsigned progress notes by providers and will be reported at the beginning of each

month and sent to the PET. The report will provide unsigned notes by the number of days delinquent; i.e. for the Month of January: 5 notes were 1 to 3 days delinquent; 65 notes were 4 to 7 days delinquent; 58 notes were 8 to 14 days delinquent and so on. Additionally, trends (by provider) that are noted will be addressed to the PET for review. In conducting this review each provider (on a monthly basis) will be sent via encrypted Outlook message, a list of their unsigned progress notes in order to allow the provider(s) a chance to sign them at the time the quality review is conducted.

Recommendation 3. We recommended that diagnostic clinicians consistently document the time critical results were communicated to ordering providers.

Concur

Target date for completion: June 1, 2011

Facility's response:

1. Critical lab results are entered into the Veteran's medical record through a laboratory template for critical results. The template entries include the date and time when the critical results are communicated, by what means the results were communicated, who was contacted and received the results (i.e. ordering provider) and the initials of the laboratory technologist that made the notification/communication.

2. At the time of the OIG CAP survey, Radiology did not have a system in place that documented that time critical results were conveyed to the ordering provider. SORCC has since implemented a new process whereby an entry is made into the Veteran's electronic medical record that will include the name of the provider who receives the notification, date, time and means of communication of the critical test result as part of the reporting process.

3. In addition to the data and analysis Laboratory and Radiology submit quarterly to the MEC, they will include audits that demonstrate compliance in documentation concerning critical results were communicated and documented in the Veteran's electronic medical record. This additional information will be reported by the FY2011 fourth quarter.

Recommendation 4. We recommended that normal test results be consistently communicated to residents within the specified timeframe and documented in the medical record.

Concur

Target date for completion: An Improvement Team is currently in progress. A system will be in place to report normal test results to the residents by August 1, 2011 and the data collection and analyze to be reported in the new fiscal year, starting Oct. 1, 2011.

Facility's response: A performance improvement work group consisting of stakeholders has been implemented to develop a means to communicate posted

normal lab results to our residents within 14 days. The processes this team develops will be implemented by August 1, 2011. In our facility quarterly medical record chart reviews will include audits to identify if these normal test results are consistently communicated and documented with the specified time frame. The data collected will be presented to Performance Enhancement Team (PET) quarterly beginning in the new fiscal year, October 1, 2011.

Recommendation 5. We recommended that OPPEs contain specific measurable performance data to support physician reprivileging.

Concur

Target date for completion: Process was completed and implemented April 1, 2011

Facility's response: During the OIG visit the new process for OPPEs had been developed but not implemented. Subsequently the process has been fully implemented. Risk Management does 10% spot checks per quarter for Dental and Pharmacy Services and bi-annual spot checks for Medicine and Psychiatry. OPPE is reviewed prior to re-privileging.

Recommendation 6. We recommended that the daily inspections for unsecured medications be implemented and documented.

Concur

Target date for completion: June 1, 2011

Facility's response:

1. SORCC has included a process to look for unsecured medications in the twice daily bed checks at 6 a.m. and 10 p.m. The process is documented on the Bed Check Roster Spreadsheet and a column specifically for unsecure medication is provided for documentation. This data will be aggregated and reported quarterly to the Rehabilitation Executive Committee (REC).

2. Currently, 10% of the residential rooms are randomly inspected on a weekly basis. These inspections will include unsecure medication checks and will be documented in the report.

3. Inspections will be completed when a resident's status changes (admitted to the Infirmary; transferred to another facility; lodged out of the facility or unaccounted for) and any unsecure medication will be noted and documented.

4. We will add a column for unsecure medications during weekly medication and locker inspections. All unsecure medications found will be reported to the residential program coordinators. This information will be included in the Bed Check Roster Spreadsheet that is reported quarterly to the REC.

5. Weekly Environmental Rounds includes a process to check unsecure medication. This data will be included in the Environmental Rounds Report. This report is presented to Quality Leadership Committee (QLC) at least quarterly.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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