Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 09-03073-177

Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center Walla Walla, Washington

June 21, 2010

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
CBOC	community based outpatient clinic
CD	chemical dependency
CLC	community living center
CRD	chronic renal disease
EOC	environment of care
ESA	Erythropoiesis-Stimulating Agent
facility	Jonathan M. Wainwright Memorial VA Medical Center
FPPE	Focused Professional Practice Evaluation
FTE	full-time employee equivalents
FY	fiscal year
g/dL	grams per deciliter
HCHV	Healthcare for Homeless Veterans
HUD-VASH	Housing and Urban Development-Veterans Affairs Supportive Housing
JC	Joint Commission
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PI	performance improvement
QM	quality management
RME	reusable medical equipment
SOP	standard operating procedure
SPD	Supply, Processing, and Distribution
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington

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 May 3, 2010.

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

- Coordination of Care
- Environment of Care

The facility's reported accomplishment was that it successfully used 70 Housing and Urban Development-Veterans Affairs Supportive Housing vouchers to assist homeless veterans. The facility forged a close working relationship with the Walla Walla Housing Authority and implemented a fairly liberal screening approach that included veterans with recognizable barriers to case management participation.

Recommendations: We made recommendations in the following five activities:

Reusable Medical Equipment: A training program for reusable medical equipment standard operating procedures needs to be implemented and competencies should be evaluated annually for staff who process reusable medical equipment.

Suicide Prevention Safety Plans: Clinicians need to develop safety plans in a timely manner for all patients assessed as being at high risk for suicide.

Quality Management: Peer reviews should be completed within 120 days or appropriate extensions should be granted.

Medication Management: Clinicians should consistently take and document appropriate actions when chronic renal disease patients' hemoglobin levels exceed 12 grams per deciliter.

Physician Credentialing and Privileging: Focused Professional Practice Evaluation review processes need to be developed for all newly hired physicians.

Comments

The Veterans Integrated Service Network and 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

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

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 seven activities:

- Coordination of Care
- EOC
- Medication Management
- Physician C&P
- QM
- RME
- Suicide Prevention Safety Plans

The review covered facility operations for FY 2009 and FY 2010 through May 5, 2010, and was done in accordance with OIG SOPs for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the*

Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington, Report No. 07-00990-172, July 19, 2007). The facility had corrected all findings from our previous review.

During this review, we also presented crime awareness briefings for 83 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

HUD-VASH Program Implementation Success

The facility was granted 70 HUD-VASH vouchers in a 2009 program expansion. This was a large number of vouchers for such a small community. The facility was successful in using these vouchers to assist homeless veterans and meet the VA targets of success. Several factors contributed to this success, including receiving support from the HCHV programs and forging a close working relationship with the Walla Walla Housing Authority. All HCHV staff, as well as MH/CD staff, began providing care before the permanent case managers came on board. The facility also implemented a fairly liberal screening approach. It included veterans with recognizable barriers to case management participation and took referrals directly from other stake holders in the VA and the community.

The Yakima CBOC was granted 35 vouchers in the 2010 program expansion. Case managers from Walla Walla managed Yakima's program until a new HUD-VASH case manager was hired. Case managers worked 2 days per week in Yakima and initiated care with 34 clients prior to the start of the permanent case manager. In addition, meetings were initiated with the Yakima Housing Authority prior to the dates of voucher availability. The facility took referrals directly from many community sources, including Yakima HCHV staff.

Results

Review Activities With Recommendations

RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. VHA facilities are responsible for minimizing patient risk and maintaining an environment that is safe. The facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, and JC standards.

We inspected the SPD and gastrointestinal areas. We determined that the facility had established appropriate guidelines and monitored compliance with those guidelines.

We reviewed the reprocessing SOPs of seven pieces of RME. In general, we found that SOPs were current and consistent with the manufacturers' instructions. Also, employees were able to either demonstrate the cleaning procedures in the SOPs or verbalize the steps. We reviewed the competency folders and training records of the employees who performed, observed, or verbalized the cleaning procedures and found that training was current and consistently documented. However, we identified the following areas that needed improvement.

SOPs. VHA requires[1] a training program for RME SOPs that includes a plan for implementing any changes to a given SOP and includes a method for annual review of a given SOP. Prior to our site visit, we were told that the facility did not have this training program. While we were onsite, the facility developed a training program and a plan for its implementation.

Competencies. VHA requires[2] that all employees involved in the use and reprocessing of RME have documented initial competencies and validation of those competencies on an annual basis. We reviewed the competency folders and training records of seven SPD employees assigned to process RME and found that the staff person assigned to

[1] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.
[2] VHA Directive 2009-004.

process the biopsy probe did not have a documented competency to process that piece of RME.

Recommendations

1. We recommended that the training program for RME SOPs is implemented.

2. We recommended that competencies are evaluated annually for staff who process RME.

Suicide Prevention Safety Plans

The purpose of this review was to determine whether clinicians had developed safety plans that provided strategies to mitigate or avert suicidal crises for patients assessed to be at high risk for suicide. Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[3]

A previous OIG review[4] of suicide prevention programs in VHA facilities found a 74 percent compliance rate with safety plan development. The safety plan issues identified in that review were that plans were not comprehensive (did not contain the above elements), were not developed timely, or were not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings. We reviewed the medical records of 10 patients assessed to be at high risk for suicide and identified the following area that needed improvement.

Safety Plan Development. We found that clinicians did not develop safety plans in a timely manner for any of the 10 patients assessed as being at high risk for suicide.

Recommendation

3. We recommended that clinicians develop safety plans in a timely manner for all patients assessed as being at high risk for suicide.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program designed to

[3] Deputy Under Secretary for Health for Operations and Management, "Patients at High-Risk for Suicide," memorandum, April 24, 2008.
[4] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009*; Report No. 09-00326-223; September 22, 2009.

monitor patient care quality and whether senior managers actively supported the program's activities. We evaluated policies, PI data, and other relevant documents. We also interviewed appropriate senior managers and the QM Coordinator.

The QM program was generally effective, and senior managers supported the program through participation in and evaluation of PI initiatives and through allocation of resources to the program. Appropriate review structures were in place for eight of the nine program activities reviewed. However, we identified the following condition that needed improvement.

Peer Review Process. Once the need for a peer review is determined, VHA policy[5] requires facilities to complete the peer review within 120 days. Any exception or extension beyond 120 days must be requested in writing and approved by the Director, who is responsible for monitoring and reviewing the number of extensions twice a year.

We found that 9 (36 percent) of 25 peer reviews did not meet the 120-day deadline. No extensions were requested.

Recommendation

4. We recommended that peer reviews are either completed within 120 days or that appropriate extensions are granted.

Medication Management

The purpose of this review was to evaluate whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes for outpatients.

Although the pharmacy is closed during the evening and night, we found that the facility had a qualified pharmacist to answer questions and had an adequate retrospective review process. We identified the following area that needed improvement.

Management of ESAs. In November 2007, the U.S. Food and Drug Administration issued a safety alert stating that for CRD patients, ESAs[6] should be used to maintain hemoglobin levels between 10 and 12g/dL. Hemoglobin levels greater than 12g/dL increase the risk of serious conditions and death. We reviewed the medical records of six outpatients with CRD who had hemoglobin levels greater than 12g/dL.

[5] VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.
[6] These are drugs that stimulate the bone marrow to make red blood cells. They are used to treat anemia.

Clinicians documented an action to address the hemoglobin level in four of the six cases.

Recommendation

5. We recommended that clinicians consistently take and document appropriate actions when CRD patients' hemoglobin levels exceed 12g/dL.

Physician C&P

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.[7] We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 physicians' C&P files and profiles and found that licenses were current and that primary source verification had been appropriately obtained. OPPE was appropriately implemented. However, we identified the following area that needed improvement.

FPPE. VHA policy requires a time-limited FPPE review process to ensure the competence of newly hired physicians. Three of the five new providers whose files we reviewed did not have FPPE review processes developed.

Recommendation

6. We recommended that FPPE review processes are developed for all newly hired physicians.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether discharges were coordinated appropriately over the continuum of care and met VHA and JC requirements.[8] Coordinated discharges are essential to an integrated, ongoing care process and optimal patient outcomes.

VHA policy[9] and JC standards require that providers include information regarding medications, diet, activity level, and follow-up appointments in written patient discharge instructions. We reviewed the medical records of 10 discharged patients and determined that clinicians had generally documented the required elements. Also, we

[7] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[8] Because the facility is a free standing ambulatory care facility with a substance abuse residential treatment program and does not transfer patients, the inter-facility transfer portion of this review was not applicable. Therefore, we only evaluated discharges.
[9] VHA Handbook 1907.01, *Health Information Management and Heath Records*, August 25, 2006.

found that follow-up appointments occurred within the timeframes specified. We made no recommendations.

EOC

The purpose of this review was to determine whether VHA facilities maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association, and JC standards.

We inspected the MH residential treatment unit, the outpatient primary care clinics, the sleep clinic, the gastroenterology clinic, the dental clinic, the eye clinic, the laboratory, the radiology department, and the outpatient rehabilitation unit. The facility maintained a generally clean and safe environment. The infection control program monitored data and appropriately reported that data to relevant committees. Safety guidelines were generally met, and risk assessments were in compliance with VHA standards. We made no recommendations.

Comments

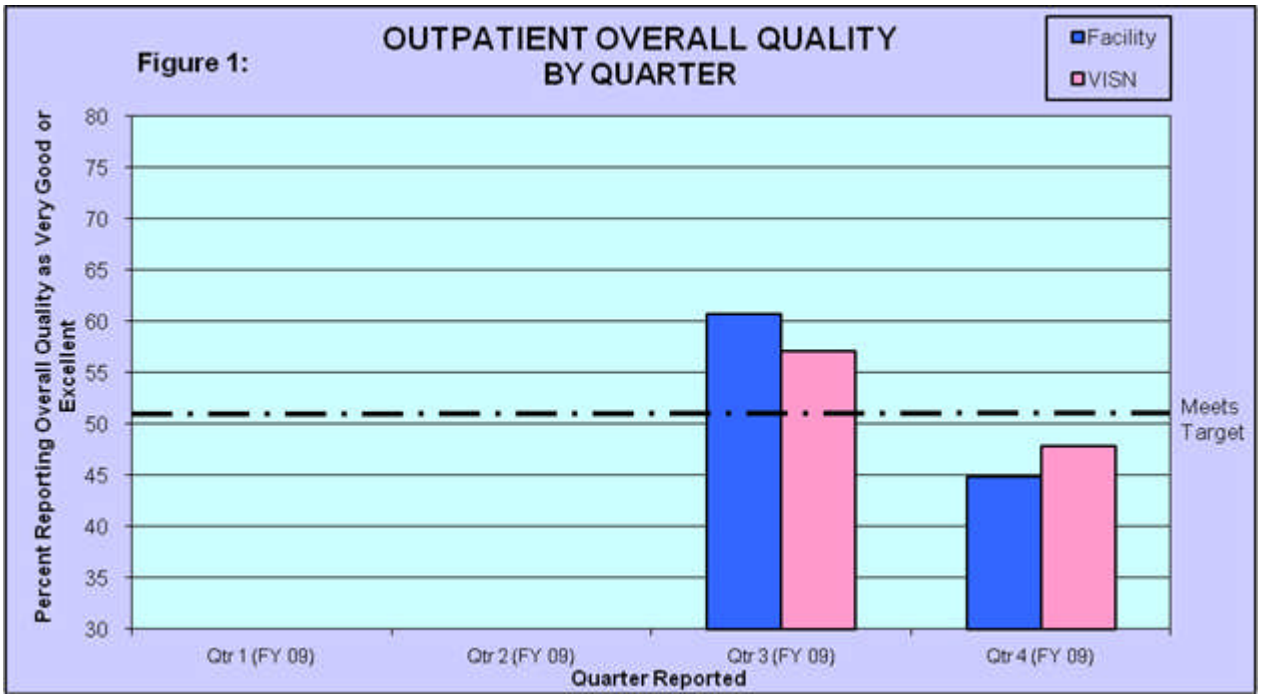
The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 11–15, for the full text of the Directors' comments.) We consider Recommendation 5 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile[10]		
Type of Organization	Free-standing ambulatory care facility with a substance abuse residential treatment program	
Complexity Level	3	
VISN	20	
CBOCs	Yakima, WA Richland, WA Lewiston, ID La Grande, OR	
Veteran Population in Catchment Area	Approximately 60,000	
Type and Number of Operating Beds: • **Acute care**	None	
• **CLC**	None	
• **Other**	31 residential rehabilitation treatment	
Affiliation(s)	Walla Walla Community College Walla Walla University University of Washington Illinois College of Optometry Washington State University Pacific University College of Optometry University of Utah Gonzaga University Wenatchee Valley College Lewis-Clark State College	
• **Number of Residents**	1 optometry resident	
	Current FY	**Prior FY**
Resources (in millions):		
• **Budget**	$77,735,558 (Projected)	$78,837,519 (Actual)
• **Medical Care Expenditures**		$70.3 million
FTE	401.4	379.5
Workload:		
• **Number of Unique Patients**		17,817
• **Inpatient Days of Care:**		
o **Acute Care**		0
o **CLC**		0
Hospital Discharges		0
Cumulative Average Daily Census (including CLC patients)		0
Cumulative Occupancy Rate		0
Outpatient Visits		135,592

[10] All data provided by facility management.

VHA Satisfaction Surveys

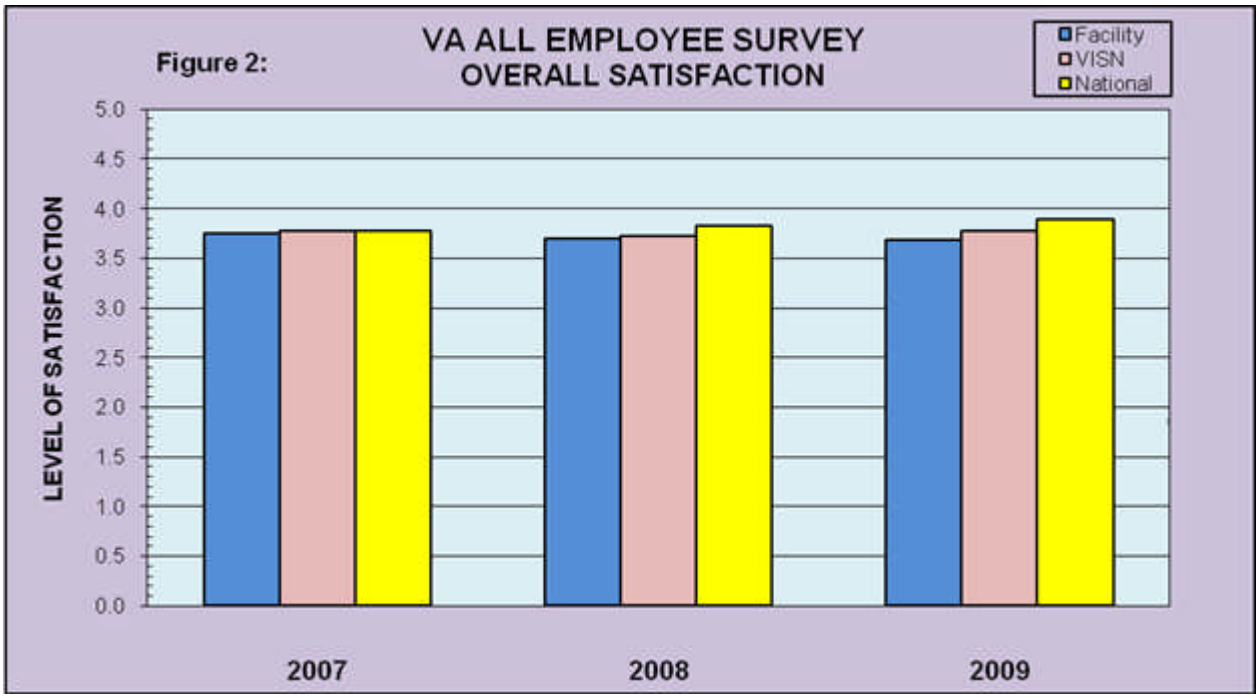
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figure 1 below shows the facility's and VISN's overall outpatient[11] satisfaction scores for quarters 3 and 4 of FY 2009.[12] The target score is noted on the graph.



[11] Inpatient overall quality is not included because this facility does not provide inpatient services.
[12] Due to technical difficulties with VHA's outpatient survey data, outpatient satisfaction scores for quarters 1 and 2 of FY 2009 are not included.

Employees are surveyed annually. Figure 2 below shows the facility's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 2:



Appendix C

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 3, 2010

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

1. Thank you for the opportunity to provide a status report on the follow-up to the findings from the Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington.

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 Nancy Benton, Quality Management Officer, VISN 20 at (360) 619-5949.

(original signed by:)
Susan Pendergrass, DrPH

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 2, 2010

From: Director, Jonathan M. Wainwright Memorial VA Medical Center (687/00)

Subject: **CAP Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA**

To: Director, Northwest Network (10N20)

1. I concur with findings/recommendations presented in this Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center. Actions taken as a result of these findings are attached.

2. I would like to note that the IG Team Leader and Team that conducted the audit did so in a very professional and collegial manner that made the site visit productive and educational for our staff involved.

3. If you have any questions regarding the content of this report, please contact me at (509) 527-3450.

(original signed by:)
Brian W. Westfield, MSN

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 training program for RME SOPs is implemented.

Concur

Target date for completion: July 1, 2010

The Chief of SPD has completed a training program plan for RME and has begun implementing the plan throughout the facility. The plan is designed to include both new and existing equipment SOPs, and responsibility is assigned to the Lead SPD Technician to provide training and evaluate competency of those staff members tasked with the reprocessing of equipment. SOPs will be reviewed on a yearly basis or with recommended changes from the manufacturer. Any changes will be reflected in an updated SOP and any responsible staff will be trained accordingly.

Recommendation 2. We recommended that competencies are evaluated annually for staff who process RME.

Concur

Target date for completion: July 1, 2010

The Chief of SPD will develop a spreadsheet for recording all competencies needed by SPD staff and the date each staff member last completed the competency. This tracking tool will be used to ensure that each member is current with competencies during their annual performance appraisal. Each competency will be based upon the device specific SOP for the individual piece of medical equipment. The Chief of SPD completed training and competency evaluation on May 21, 2010 for staff with reprocessing responsibility for the biopsy probe.

Recommendation 3. We recommended that clinicians develop safety plans in a timely manner for all patients assessed as being at high risk for suicide.

Concur

Target date for completion: Completed

The Chief of Behavioral Health in collaboration with the Associate Chief of Staff for Behavioral Health and the Suicide Prevention Coordinator developed a process to ensure a safety plan is developed in a timely manner.

The Suicide Prevention Coordinator at the time of placing a veteran on the High Risk of Suicide List will track all veterans placed on this list and ensure that a safety plan has been completed or that an appointment to complete the safety plan has been scheduled with an appropriate clinician. The Suicide Prevention Coordinator's tracking will include insuring veterans who are scheduled who no show or cancel are followed up on in accordance with requirements. Veteran's who are identified at high risk and currently receiving inpatient care will be placed on the High Risk of Suicide List at the time of discharge.

Recommendation 4. We recommended that peer reviews are either completed within 120 days or that appropriate extensions are granted.

Concur

Target date for completion: June 21, 2010

The Risk Manager, in support of the Peer Review Committee, has developed a tracking process to display status of peer reviews and will prepare recurring reports to ensure peer reviews are completed with 120 days. These reports will be provided to the Chief of Staff monthly and reviewed in the Peer Review Committee.

Recommendation 5. We recommended that clinicians consistently take and document appropriate actions when CRD patients' hemoglobin levels exceed 12 g/dL.

Concur

Target date for completion: Completed

The Chief of Pharmacy in collaboration with the Pharmacy and Therapeutics Committee directed that beginning in Feb 2010 facility pharmacists begin reviewing patients monthly via the Medication Utilization Evaluation Tracker tool. Pharmacists review lists from this tool documenting interventions and discontinuing, holding, or continuing the ESA. A list of all patients on ESAs will be prepared monthly and distributed to the pharmacists to verify, and take action if necessary to prevent automatic "refills" of ESAs before lab tests are verified.

Report on these actions will be reviewed in the Pharmacy and Therapeutics Committee minutes.

Recommendation 6. We recommended that FPPE review processes are developed for all newly hired physicians.

Concur

Target date for completion: Completed

The facility Management Analyst in collaboration with the Chief of Staff has developed a process for ensuring FPPE reviews are performed in accordance with VHA Handbook

requirements. Initial FPPE reports based on this process have already been prepared and provided for Service Chief review. The Management Analyst is responsible to coordinate and track collection of defined measures and prepare a summary for the Service Chief review. The Management Analyst will monitor a tracking sheet for FPPE due dates, maintained by the Medical Staff Credentialing officer, to ensure that required FPPE summaries are available for Service Chief review in a timely manner.

OIG Contact and Staff Acknowledgments

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