Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-01875-249

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

August 14, 2012

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

CAP	Combined Assessment Program
COC	continuity of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	Jonathan M. Wainwright Memorial VA Medical Center
FY	fiscal year
MEC	Medical Executive Committee
MH	mental health
MM	medication management
MRC	Medical Records Committee
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
TBI	traumatic brain injury
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, WA

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 June 11, 2012.

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

- Continuity of Care
- Environment of Care

The facility's reported accomplishment was the development of a tobacco cessation and telehealth program.

Recommendations: We made recommendations in the following five activities:

Colorectal Cancer Screening: Notify patients of positive screening test results within the required timeframe, and document notification. Develop follow-up plans or document that no follow-up is indicated within the required timeframe. Ensure patients with positive screening test results receive diagnostic testing within the required timeframe. Notify patients of diagnostic test results within the required timeframe, and document notification.

Quality Management: Ensure the Medical Executive Committee reviews aggregated peer review data quarterly and documents the reviews. Document ethics consultations in ECWeb. Ensure that the Medical Records Committee provides consistent oversight and ensures that monitoring of electronic health record quality and unsigned and/or un-cosigned notes takes place. Monitor the copy and paste functions.

Medication Management: Adhere to local policy for quarterly monitoring of liver function for patients in buprenorphine maintenance treatment.

Polytrauma: Ensure patients with positive traumatic brain injury screening results receive a comprehensive evaluation as outlined in Veterans Health Administration policy.

Moderate Sedation: Include all required elements in pre-sedation assessment documentation.

Comments

The Acting 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.

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 seven activities:

- COC
- CRC Screening
- EOC
- MM
- Moderate Sedation
- Polytrauma
- QM

We have listed the general information reviewed for each of these activities. Some of the items listed might not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011 and FY 2012 through June 11, 2012, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide us with their current status on the recommendations we made in our previous CAP report (*Combined Assessment*

Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington, Report No. 09-03073-177, June 21, 2010).

During this review, we presented crime 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.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 80 responded. We shared survey results with facility managers.

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

Tobacco Cessation and Telehealth Program

The facility implemented a tobacco cessation and telehealth program in response to VHA's T21 Preventative Care Program initiative. The facility's program uses evidence-based clinical interventions, such as comprehensive health education and clinical services, to engage veteran patients by phone or webcam and helps them achieve a tobacco free lifestyle.

Results

Review Activities With Recommendations

CRC Screening

The purpose of this review was to follow up on a report, *Healthcare Inspection – Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (Report No. 05-00784-76, February 2, 2006) and to assess the effectiveness of the facility's CRC screening.

We reviewed the EHRs of 20 patients who had positive CRC screening tests and interviewed key employees involved in CRC management. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
X	Patients were notified of positive CRC screening test results within the required timeframe.
X	Clinicians responsible for initiating follow-up either developed plans or documented no follow-up was indicated within the required timeframe.
X	Patients received a diagnostic test within the required timeframe.
X	Patients were notified of the diagnostic test results within the required timeframe.
	Patients who had biopsies were notified within the required timeframe.
	Patients were seen in surgery clinic within the required timeframe.
	The facility complied with any additional elements required by local policy.

Positive CRC Screening Test Result Notification. VHA requires that patients receive notification of CRC screening test results within 14 days of the laboratory receipt date for fecal occult blood tests or the test date for sigmoidoscopy or double contrast barium enema and that clinicians document notification.[1] Four patients' EHRs did not contain documented evidence of timely notification.

Follow-Up in Response to Positive CRC Screening Test. For any positive CRC screening test, VHA requires responsible clinicians to either document a follow-up plan or document that no follow-up is indicated within 14 days of the screening test.[2] Five patients did not have a documented follow-up plan within the required timeframe.

Diagnostic Testing Timeliness. VHA requires that patients receive diagnostic testing within 60 days of positive CRC screening test results unless contraindicated.[3] Five of the 14 patients who received diagnostic testing did not receive that testing within the required timeframe.

[1] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy).
[2] VHA Directive 2007-004.
[3] VHA Directive 2007-004.

Diagnostic Test Result Notification. VHA requires that test results be communicated to patients no later than 14 days from the date on which the results are available to the ordering practitioner and that clinicians document notification.[4] Three of the 14 patients who received diagnostic testing did not have documented evidence of timely notification in their EHRs.

Recommendations

1. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinicians document notification.

2. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

3. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

4. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

[4] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.

We interviewed senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The areas marked as noncompliant in the table below needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	There was a senior-level committee/group responsible for QM/performance improvement, and it included all required members.
	There was evidence that inpatient evaluation data were discussed by senior managers.
X	The protected peer review process complied with selected requirements.
	Licensed independent practitioners' clinical privileges from other institutions were properly verified.
	Focused Professional Practice Evaluations for newly hired licensed independent practitioners complied with selected requirements.
	Staff who performed utilization management reviews met requirements and participated in daily interdisciplinary discussions.
	If cases were referred to a physician utilization management advisor for review, recommendations made were documented and followed.
	There was an integrated ethics policy, and an appropriate annual evaluation and staff survey were completed.
X	If ethics consultations were initiated, they were completed and appropriately documented.
	There was a cardiopulmonary resuscitation review policy and process that complied with selected requirements.
	Data regarding resuscitation episodes were collected and analyzed, and actions taken to address identified problems were evaluated for effectiveness.
	If Medical Officers of the Day were responsible for responding to resuscitation codes during non-administrative hours, they had current Advanced Cardiac Life Support certification.
X	There was an EHR quality review committee, and the review process complied with selected requirements.
	If the evaluation/management coding compliance report contained failures/negative trends, actions taken to address identified problems were evaluated for effectiveness.
X	Copy and paste function monitoring complied with selected requirements.
	The patient safety reporting mechanisms and incident analysis complied with policy.
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.

Noncompliant	Areas Reviewed
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.
	The facility complied with any additional elements required by local policy.

Peer Review. VHA requires that the MEC review a summary of the Peer Review Committee's analysis quarterly.[5] There was no evidence that the MEC had reviewed aggregated peer review data over the past 12 months.

Ethics Consultations Documentation. VHA requires that ethics consultations be documented in the ECWeb database.[6] Although ethics consultations had been initiated and completed, they had not been documented in ECWeb.

EHR Review. VHA requires facilities to have an EHR Committee that provides oversight and monitoring of EHR quality and unauthenticated documentation, such as unsigned and un-cosigned notes.[7] The facility did not conduct either of these reviews over the past 12 months.

Copy and Paste Monitoring. VHA requires facilities to monitor the copy and paste functions in the EHR.[8] There was no evidence that the MRC had discussed copy and paste data over the past 12 months.

Recommendations

5. We recommended that processes be strengthened to ensure that the MEC reviews aggregated peer review data quarterly and documents the reviews.

6. We recommended that processes be strengthened to ensure that ethics consultations are documented in ECWeb.

7. We recommended that processes be strengthened to ensure that the MRC provides consistent oversight and ensures that monitoring of EHR quality and unsigned and/or un-cosigned notes takes place.

8. We recommended that processes be strengthened to ensure that the MRC monitors the copy and paste functions.

[5] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[6] VHA Handbook 1004.06, *Integrated Ethics*, June 16, 2009.
[7] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[8] VHA Handbook 1907.01.

MM

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[9] therapy with methadone and buprenorphine and handling of methadone.

We reviewed 10 EHRs of patients receiving methadone or buprenorphine for evidence of compliance with program requirements. We also reviewed relevant documents, interviewed key employees, and inspected the methadone storage area (if any). The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Opioid dependence treatment was available to all patients for whom it was indicated and for whom there were no medical contraindications.
	If applicable, clinicians prescribed the appropriate formulation of buprenorphine.
	Clinicians appropriately monitored patients started on methadone or buprenorphine.
	Program compliance was monitored through periodic urine drug screenings.
	Patients participated in expected psychosocial support activities.
	Physicians who prescribed buprenorphine adhered to Drug Enforcement Agency requirements.
	Methadone was properly ordered, stored, and packaged for home use.
X	The facility complied with any additional elements required by local policy.

Liver Function Testing. Local policy requires that patients in buprenorphine maintenance treatment have their liver function monitored at least quarterly. Eight patients' EHRs did not contain evidence of quarterly monitoring of liver function.

Recommendation

9. We recommended that the facility adhere to local policy for quarterly monitoring of liver function for patients in buprenorphine maintenance treatment.

[9] A drug that has affinity for the cellular receptors of another drug and that produces a physiological effect.

Polytrauma

The purpose of this review was to determine whether the facility complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

We reviewed relevant documents and 10 EHRs of patients with positive TBI results, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Providers communicated the results of the TBI screening to patients and referred patients for comprehensive evaluations within the required timeframe.
X	Providers performed timely, comprehensive evaluations of patients with positive screenings in accordance with VHA policy.
	Case Managers were appropriately assigned to outpatients and provided frequent, timely communication.
	Outpatients who needed interdisciplinary care had treatment plans developed that included all required elements.
	Adequate services and staffing were available for the polytrauma care program.
	Employees involved in polytrauma care were properly trained.
	Case Managers provided frequent, timely communication with hospitalized polytrauma patients.
	The interdisciplinary team coordinated inpatient care planning and discharge planning.
	Patients and their family members received follow-up care instructions at the time of discharge from the inpatient unit.
	Polytrauma-TBI System of Care facilities provided an appropriate care environment.
	The facility complied with any additional elements required by local policy.

Comprehensive Evaluation. VHA requires that patients with positive TBI screening results at a Level IV site be offered further evaluation and treatment by clinicians with expertise in the area of TBI.[10] A higher level Polytrauma System of Care site must complete the comprehensive evaluation or a Level IV site can develop and submit an alternate plan for review by the VISN and the national Director of Physical Medicine and Rehabilitation for approval of alternate arrangements outside of the directive.

Eight patients received a comprehensive evaluation at the facility and were not referred to a higher level Polytrauma System of Care site. Additionally, the facility did not have an alternate plan approved by the VISN and the national Director of Physical Medicine and Rehabilitation.

[10] VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010.

Recommendation

10. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Moderate Sedation

The purpose of this review was to determine whether the facility had developed safe processes for the provision of moderate sedation that complied with applicable requirements.

We reviewed relevant documents, six EHRs, and two training/competency records, and we interviewed key employees. The area marked as noncompliant in the table below needed improvement. Details regarding the finding follow the table.

Noncompliant	Areas Reviewed
	Staff completed competency-based education/training prior to assisting with or providing moderate sedation.
X	Pre-sedation documentation was complete.
	Informed consent was completed appropriately and performed prior to administration of sedation.
	Timeouts were appropriately conducted.
	Monitoring during and after the procedure was appropriate.
	Moderate sedation patients were appropriately discharged.
	The use of reversal agents in moderate sedation was monitored.
	If there were unexpected events/complications from moderate sedation procedures, the numbers were reported to an organization-wide venue.
	If there were complications from moderate sedation, the data was analyzed and benchmarked, and actions taken to address identified problems were implemented and evaluated.
	The facility complied with any additional elements required by local policy.

Pre-Sedation Assessment Documentation. VHA requires that providers document a complete history and physical examination and/or pre-sedation assessment within 30 days prior to a procedure where moderate sedation will be used.[11] None of the EHRs included all required elements of the history and physical examination, such as a review for illicit drug use and specifics regarding time and nature of oral intake.

Recommendation

11. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

[11] VHA Directive 2006-023, *Moderate Sedation by Non-Anesthesia Providers*, May 1, 2006.

Review Activities Without Recommendations

COC

The purpose of this review was to evaluate whether communication between facility primary care and community hospitals occurred when facility patients were hospitalized at VA expense. Such communication is essential to COC and optimal patient outcomes.

We reviewed the EHRs of 10 patients who were hospitalized at VA expense in the local community from June 2011 to January 2012. We assessed whether documentation of community hospitalization was available to the Patient-Aligned Care Team for the clinic visit subsequent to the hospitalization. In addition, we looked for evidence to determine whether the Patient-Aligned Care Team acknowledged and documented the community hospitalization in patient EHRs.

We determined that the facility generally met requirements in these areas. We made no recommendations.

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 and whether the facility's Substance Abuse RRTP was in compliance with selected MH RRTP requirements.

We inspected the audiology, dental, primary care, and gastroenterology/urology clinics and the Substance Abuse RRTP. Additionally, we reviewed relevant documents and training records, and we interviewed key employees and managers. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed for General EOC
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, progress toward resolution, and tracking of items to closure.
	Infection prevention risk assessment and committee minutes reflected identification of high-risk areas, analysis of surveillance activities and data, actions taken, and follow-up.
	Patient care areas were clean.
	Fire safety requirements were met.
	Environmental safety requirements were met.
	Infection prevention requirements were met.
	Medication safety and security requirements were met.
	Sensitive patient information was protected, and patient privacy requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for Dental EOC
	If lasers were used in the dental clinic, staff who performed or assisted with laser procedures received medical laser safety training, and laser safety requirements were met.
	General infection control practice requirements in the dental clinic were met.
	Dental clinic infection control process requirements were met.
	Dental clinic safety requirements were met.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for SCI EOC
	EOC requirements specific to the SCI Center and/or SCI outpatient clinic were met.
	SCI-specific training was provided to staff working in the SCI Center and/or SCI outpatient clinic.
	The facility complied with any additional elements required by local policy.
	Areas Reviewed for MH RRTP
	There was a policy that addressed safe MM, contraband detection, and inspections.
	MH RRTP inspections were conducted, included all required elements, and were documented.
	Actions were initiated when deficiencies were identified in the residential environment.

Noncompliant	Areas Reviewed for MH RRTP (continued)
	Access points had keyless entry and closed circuit television monitoring.
	Female veteran rooms and bathrooms in mixed gender units were equipped with keyless entry or door locks.
	The facility complied with any additional elements required by local policy.

Comments

The Acting VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–22, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

Facility Profile[12]		
Type of Organization	Ambulatory care	
Complexity Level	3	
VISN	20	
Community Based Outpatient Clinics	Richland, WA Lewiston, ID Yakima, WA La Grande, OR	
Veteran Population in Catchment Area	Approximately 60,000	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial RRTP**	28 RRTP	
• **Community Living Center/Nursing Home Care Unit**	N/A	
• **Other**	N/A	
Medical School Affiliation(s)	Pacific University, College of Optometry	
• **Number of Residents**	2	
	Current FY (through March 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$98.1	$92.2
• **Medical Care Expenditures**	$41.9	$91.8
Total Medical Care Full-Time Employee Equivalents	443.23	440.63
Workload:		
• **Number of Station Level Unique Patients**	14,539	17,568
• **Inpatient Days of Care:**		
o **Acute Care**	N/A	N/A
o **Community Living Center/Nursing Home Care Unit**	N/A	N/A
Hospital Discharges (RRTP Only)	146	275
Total Average Daily Census (including all bed types)	23.8	23.6
Cumulative Occupancy Rate (in percent)	85	84
Outpatient Visits	84,195	161,509

[12] 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. Table 1 below shows facility, VISN, and VHA overall inpatient satisfaction scores for FY 2011 and overall outpatient satisfaction scores for quarters 2–4 of FY 2011 and quarter 1 of FY 2012.

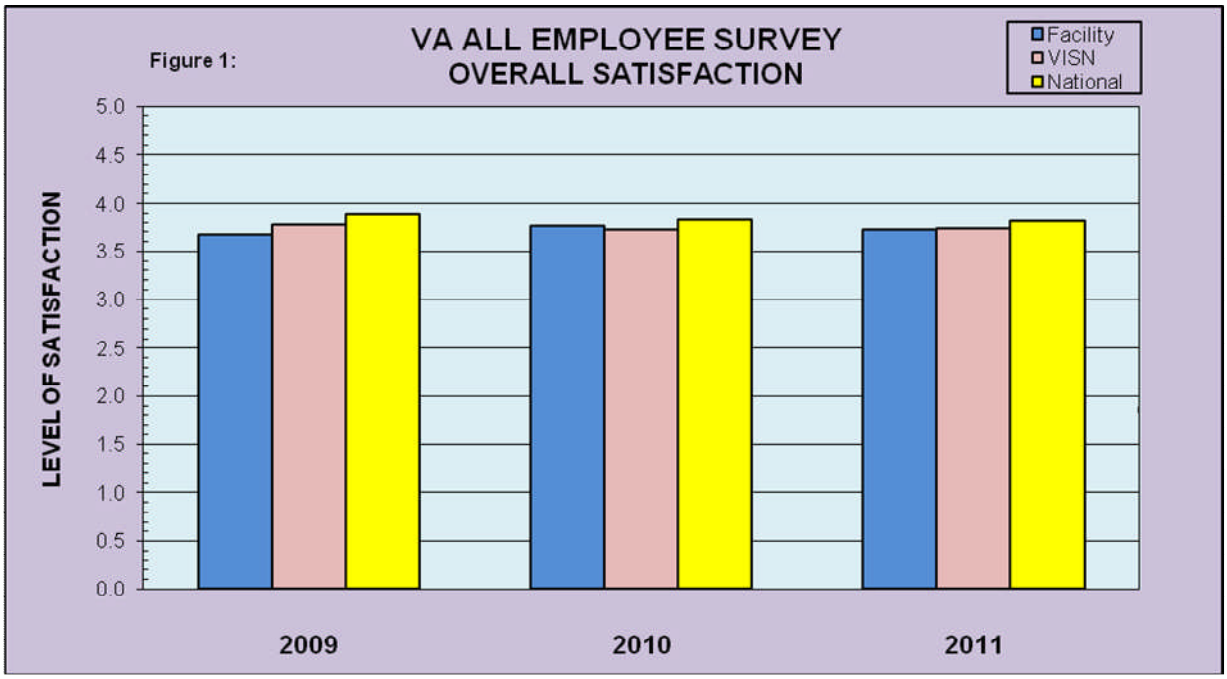
Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011		FY 2011			FY 2012
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1
Facility	*	*	45.1	44.1	46.0	45.7
VISN	61.6	65.5	47.6	46.4	49.8	51.5
VHA	63.9	64.1	55.3	54.2	54.5	55.0

* The facility does not have inpatient beds.

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.

Figure 1:



Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2012

From: Acting Director, Northwest Network (10N20)

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

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

Director, Management Review Service (VHA 10A4A4 Management Review)

Director, OIG Healthcare (54Q)

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

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:)
Michael W. Fisher

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2012

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. The status report on the follow-up to the findings from the Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center (VAMC Walla Walla) is attached. It includes the facility concurrences and responses to each of the findings from the review.

2. If you have additional questions or need further information, please contact Steve Bird, Quality Manager, at (509) 525-5200, extension 26995, or steve.bird@va.gov.

(original signed by:)
BRIAN W. WESTFIELD, MSN
Director

Attachment:

1. OIG Recommendations

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that patients are notified of positive CRC screening test results within the required timeframe and that clinician's document notification.

Concur

Target date for completion: September 15, 2012

Laboratory and Pathology will inform ordering physician via Critical Alert of positive fecal occult blood tests and/or positive pathology findings upon completion of the FIT test.

Within 14 days of receipt of positive fecal occult blood tests, the primary care provider will inform Veterans of the positive result by telephone or letter. A written record of this notification will be present in the electronic medical record.

Recommendation 2. We recommended that processes be strengthened to ensure that responsible clinicians either develop follow-up plans or document that no follow-up is indicated within the required timeframe.

Concur

Target date for completion: September 15, 2012

Within 14 days of receipt of positive fecal occult blood tests, the Primary Care Provider will record a follow-up plan in the electronic medical record. If no follow-up is indicated this shall be recorded in the record as well.

Veteran declination of follow-up will be documented in the electronic medical record.

Recommendation 3. We recommended that processes be strengthened to ensure that patients with positive CRC screening test results receive diagnostic testing within the required timeframe.

Concur

Target date for completion: September 15, 2012

Specialty Care will perform diagnostic colonoscopies within 60 days of the positive screening test or arrange for the colonoscopy to be provided at a non-VA facility that can complete the colonoscopy within the 60-day timeframe.

Veteran declination of diagnostic testing will be documented in the electronic medical record.

Recommendation 4. We recommended that processes be strengthened to ensure that patients are notified of diagnostic test results within the required timeframe and that clinicians document notification.

Concur

Target date for completion: September 15, 2012

The GI physician will orally convey the initial findings of a screening or diagnostic colonoscopy at the time of the testing. The colonoscopy procedure note will document that the Veteran notification was given.

Recommendation 5. We recommended that processes be strengthened to ensure that the MEC reviews aggregated peer review data quarterly and documents the reviews.

Concur

Target date for completion: August 15, 2012

The Executive Committee of the Medical Staff (ECMS) has included peer review quarterly reports as a standing agenda item. The 1st quarter 2012 peer review aggregated report was presented at the May 2012 ECMS meeting.

Recommendation 6. We recommended that processes be strengthened to ensure that ethics consultations are documented in ECWeb.

Concur

Target date for completion: September 30, 2012

Director will ensure allocation of time for entry of all ethical consults (EC) into ECWeb by the end of the fiscal year. The EC Coordinator will be assigned by the Director to enter all existing consults into ECWeb by the stated timeframe.

Recommendation 7. We recommended that processes be strengthened to ensure that the MRC provides consistent oversight and ensures that monitoring of EHR quality and unsigned and/or un-cosigned notes takes place.

Concur

Target date for completion: October 1, 2012

The Medical Record Committee (MRC) developed monitors that are now approved by the ECMS. Quarterly monitoring of the quality of the medical record and unsigned/un-cosigned notes is reported to the MRC and then to the ECMS.

Recommendation 8. We recommended that processes be strengthened to ensure that the MRC monitors the copy and paste functions.

Concur

Target date for completion: January 1, 2013

The Medical Records Committee (MRC) monitors copy and paste quarterly and reports to the ECMS. This monitor was approved by the ECMS and we have completed two quarterly reports. Monitoring and reporting will continue as defined in the Medical Record Policy.

Recommendation 9. We recommended that the facility adhere to local policy for quarterly monitoring of liver function for patients in buprenorphine maintenance treatment.

Concur

Target date for completion: September 15, 2012

Medical Center Memorandum RX-14 (April 18, 2011), Buprenorphine (Opioid Agonist) Therapy for the Treatment of Opioid Dependence, will be revised to reflect Physicians' Clinical Support System – Buprenorphine (PCSS-B) guidance, and will no longer require quarterly liver function tests, but rather that liver function tests are monitored periodically at physician discretion.

Recommendation 10. We recommended that processes be strengthened to ensure that patients with positive TBI screening results receive a comprehensive evaluation as outlined in VHA policy.

Concur

Target date for completion: November 15, 2012

An exception plan request per Directive has been submitted to allow the facility to provide comprehensive secondary evaluations as outlined in VHA Policy. The plan includes TBI mini residency training of selected primary care providers. Training dates are 10/29/2012 thru 11/01/2012.

Recommendation 11. We recommended that processes be strengthened to ensure that pre-sedation assessment documentation includes all required elements.

Concur

Target date for completion: July 22, 2012

The pre-assessment form was revised to include the nature, date, and time of patient's last oral intake. The revised pre-procedure assessment form was designed while the OIG was on site.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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