Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-02601-07

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

October 17, 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 use the knowledge and skills of the OIG's Office of Healthcare Inspections to provide collaborative assessments of VA medical facilities on a cyclical basis. The purpose of the CAP review is to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/hotline/default.asp)

Glossary

CAP	Combined Assessment Program
COC	continuity of care
CRC	colorectal cancer
EHR	electronic health record
EOC	environment of care
facility	VA Southern Oregon Rehabilitation Center and Clinics
FY	fiscal year
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
OIG	Office of Inspector General
POCT	point-of-care testing
QM	quality management
SCI	spinal cord injury
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

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. We conducted the review the week of August 13, 2012.

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

- Continuity of Care
- Environment of Care
- Medication Management
- Point-of-Care Testing

The facility's reported accomplishment was the success of its Voluntary Service Program.

Recommendations: We made recommendations in the following three activities:

Colorectal Cancer Screening: Notify patients of positive screening test, diagnostic test, and biopsy results within the required timeframe, and document notification. Either develop follow-up plans or document that no follow-up plan is indicated within the required timeframe. Implement an effective fee basis referral process to ensure patients receive diagnostic testing within the required timeframe, and monitor compliance with the new process.

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

Quality Management: Establish an Electronic Health Record Committee that meets Veterans Health Administration requirements, and clearly define the responsibilities of the committee.

Comments

The Acting Veterans Integrated Service Network Director and Acting Facility Director 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

Objective and Scope

Objective

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 objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.

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
- Medication Management
- POCT
- 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 August 16, 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 VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon,* Report No. 11-00032-213, July 7, 2011).

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 138 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

Voluntary Service Program

The facility's Voluntary Service Program, in existence since 1949, serves as a broad spectrum networking system fostering community partnerships, influencing stakeholder perceptions and behaviors, and shaping facility image. The program has more than 500 regularly scheduled volunteers who contribute roughly 73,000 hours of service at the facility and its branch rural health care clinics. These hours equate to 34.8 full-time employee equivalents and approximately $1.5 million in salary costs. In FY 2011, the facility yielded a total of more than $1.1 million in monetary, in-kind, activity, equipment, and comfort items through the donation program. The Voluntary Service Program and the facility work in tandem on therapeutic initiatives such as the Vocational Rehabilitation's Program's Turf Management Program. Other volunteer programs include pet therapy, Project Hobby, Camp White Military Museum, a clothing room, and the Volunteer Transportation Network.

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 19 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.
X	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] Six 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] Four 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] All eight patients who required diagnostic testing were referred to community providers on a fee basis. Three of these eight patients did not receive diagnostic testing within the

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

required timeframe because the facility had not established an effective process for fee basis.

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] Four of the eight patients who received diagnostic testing did not have documented evidence of timely notification in their EHRs.

Biopsy Result Notification. VHA requires that patients who have a biopsy receive notification within 14 days of the date the biopsy results were confirmed and that clinicians document notification.[5] Of the three patients who had a biopsy, two EHRs did not contain documented evidence of timely notification.

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 the facility implement an effective fee basis referral process to ensure patients receive diagnostic testing within the required timeframe and that compliance with the new process be monitored.

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.

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

[4] VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.
[5] VHA Directive 2007-004.

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.[6] 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.

Five 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. However, on August 15, 2012, the facility submitted a request for an alternate plan.

[6] 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

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

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 area marked as noncompliant in the table below needed improvement. Details regarding the finding 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.
	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.
	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.
	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 (continued)
	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.

EHR Review. VHA requires facilities to have an EHR Committee that provides oversight of various EHR reviews.[7] We found that the facility did not have an EHR Committee to provide oversight and coordination of EHR reviews.

Recommendation

7. We recommended that the facility establish an EHR Committee that meets VHA requirements and clearly define the responsibilities of the committee.

[7] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 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 in the community 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 August 2011 to April 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. 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 domiciliary and Domiciliary Care for Homeless Veterans Program were in compliance with selected MH RRTP requirements.

We inspected the infirmary, the primary care and dental clinics, the general domiciliary, and the Domiciliary Care for Homeless Veterans Program. 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 medication management, 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.

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for opioid dependence treatment, specifically, opioid agonist[8] 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 table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

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.
	The facility complied with any additional elements required by local policy.

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

POCT

The purpose of this review was to evaluate whether the facility's inpatient blood glucose POCT program complied with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.

We reviewed the EHRs of 30 patients who had glucose testing, 12 employee training and competency records, and relevant documents. We also performed a physical inspection of the infirmary where glucose POCT was performed, and we interviewed key employees involved in POCT management. The table below details the areas reviewed. The facility generally met requirements. We made no recommendations.

Noncompliant	Areas Reviewed
	The facility had a current policy delineating testing requirements and oversight responsibility by the Chief of Pathology and Laboratory Medicine Service.
	Procedure manuals were readily available to staff.
	Employees received training prior to being authorized to perform glucose testing.
	Employees who performed glucose testing had ongoing competency assessment at the required intervals.
	Test results were documented in the EHR.
	Facility policy included follow-up actions required in response to critical test results.
	Critical test results were appropriately managed.
	Testing reagents and supplies were current and stored according to manufacturers' recommendations.
	Quality control was performed according to the manufacturer's recommendations.
	Routine glucometer cleaning and maintenance was performed according to the manufacturer's recommendations.
	The facility complied with any additional elements required by local policy.

Comments

The Acting VISN and Acting Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. See Appendixes C and D, pages 17–21, for the full text of the Directors' comments. We will follow up on the planned actions until they are completed.

Facility Profile[9]		
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	54,660	
Type and Number of Total Operating Beds: • **Hospital, including Psychosocial Residential Rehabilitation Treatment Program**	441	
• **Community Living Center/Nursing Home Care Unit**	0	
• **Domiciliary Care for Homeless Veterans**	54	
Medical School Affiliation(s)	Pacific University	
• **Number of Residents**	1 optometry	
	Current FY (through May 2012)	**Prior FY (2011)**
Resources (in millions):		
• **Total Medical Care Budget**	$91.6	$90.0
• **Medical Care Expenditures**	$49.8	$89.0
Total Medical Care Full-Time Employee Equivalents	562.7	555.0
Workload:		
• **Number of Station Level Unique Patients**	14,232	16,567
• **Inpatient Days of Care:**		
o **Acute Care**	0	0
o **Community Living Center/Nursing Home Care Unit**	0	0
Hospital Discharges	0	0
Total Average Daily Census (including all bed types)	373	391
Cumulative Occupancy Rate (in percent)	85.6	88.7
Outpatient Visits	108,968	174,210

[9] All data provided by facility management.

VHA Satisfaction Surveys

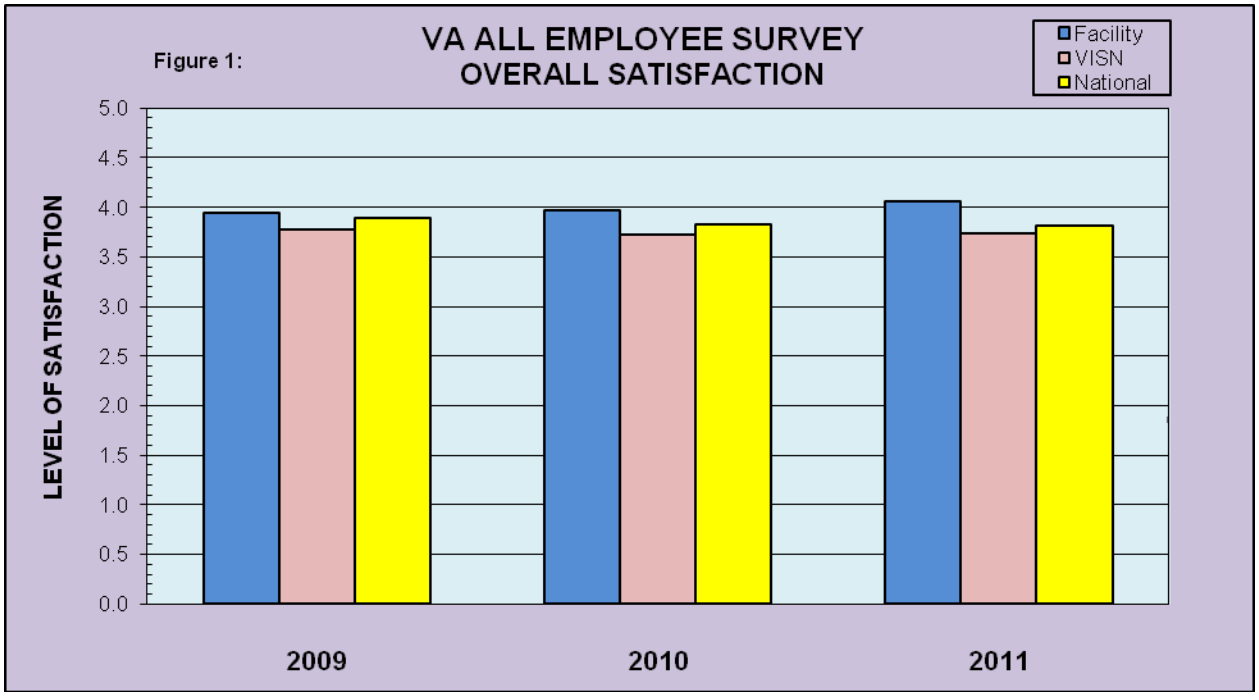
VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for quarters 3 and 4 of FY 2011 and quarters 1 and 2 of FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2011	FY 2012	FY 2011		FY 2012	
	Inpatient Score Quarters 3–4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	*	*	45.1	47.9	43.0	37.6
VISN	65.5	65.3	46.4	49.8	51.5	49.3
VHA	64.1	63.9	54.2	54.5	55.0	54.7

* The facility has no 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.



Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 21, 2012

From: Acting Director, Northwest Network (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 10AR MRS)

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:)
Michael W. Fisher

Acting Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 21, 2012

From: Acting Director, VA Southern Oregon Rehabilitation Center and Clinics (692/00)

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

To: Acting Director, Northwest Network (10N20)

1. On behalf of the VA Southern Oregon Rehabilitation Center & Clinics (SORRC), I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and Combined Assessment Program (CAP) review conducted August 13–17th, 2012.

2. We have reviewed and updated the findings from the report, and SORCC's responses addressing each recommendation are attached. The responses include actions that are in progress that will be implemented.

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

Nancy Benton, PhD, RN, CNS, CPHQ

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 clinicians document notification.

Concur

In March 2012 the facility implemented monthly monitoring of all positive FOBT results which tracks if results were conveyed to the Veteran within the required timeframe. This monitor is sent to the Associate Chief of Staff, Primary Care where results are reviewed with the providers not meeting the required timeframe. Positive occult blood testing results have been converted to be a critical value which increases the urgency of the result improving turnaround time of notification to the Veteran.

Target date for completion: December 1, 2012

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

In March 2012 the facility implemented monthly monitoring of all positive FOBT results which tracks if follow up plans were developed and conveyed to the Veteran within the required timeframe. This monitor is sent to the Associate Chief of Staff, Primary Care where results are reviewed with the providers not meeting the required timeframe.

Target date for completion: December 1, 2012

Recommendation 3. We recommended that the facility implement an effective fee basis referral process to ensure patients receive diagnostic testing within the required timeframe and that compliance with the new process be monitored.

Concur

The facility will change the consult for diagnostic colonoscopies to "stat" vs. routine which will ensure a speedier referral to the provider conducting the diagnostic testing. The Associate Chief of Staff, Primary Care will educate providers on the need to place the diagnostic consults stat. The Chief, Business Office Service will educate the employee responsible for initiating this fee process of the change in the diagnostic colonoscopies. The facility has implemented monthly monitoring of colonoscopies

conducted as a result of a positive FOBT to ensure the exam is completed within the required timeframe. This monitor is sent to the Associate Chief of Staff, Primary Care where results are reviewed with the Fee providers not meeting the required timeframe.

Target date for completion: November 1, 2012

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

The Associate Chief of Staff, Primary Care will send letters to all entities providing diagnostic colonoscopies requesting at the time of the procedure the provider review the findings of the colonoscopy with the Veteran and document in their operative report that diagnostic test results were reviewed with the Veteran prior to discharge from the procedure. The facility has implemented monthly monitoring of colonoscopies conducted as a result of a positive FOBT to ensure the colonoscopy results are conveyed to the Veteran at the time the procedure occurs.

Target date for completion: January 1, 2013

Recommendation 5. We recommended that processes be strengthened to ensure that patients are notified of biopsy results within the required timeframe and that clinicians document notification.

Concur

The facility will change the timeframe for scanning pathology reports into the Veteran's record to be completed within two working days of receiving the results. The hard copy reports will be placed in a pickup receptacle in the Business Office where the reports will be retrieved daily from a representative from Primary Care who will deliver reports to the team who ordered the colonoscopy. The facility has implemented monthly monitoring of colonoscopies conducted as a result of a positive FOBT to ensure the pathology results are conveyed to the Veteran within the required timeframe.

Target date for completion: November 30, 2012

Recommendation 6. 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

On August 15, 2012 a Comprehensive Second Level Traumatic Brain Injury (TBI) Evaluation Alternate Plan was submitted to National Director of Physical Medicine and Rehabilitation Service (10P4RC). This letter was signed by VA SORCC's Acting Chief of Staff and VISN 20 Chief Medical Officer (10NX). The VISN 20 Office and VA

SORCC (Station 692) are still awaiting VACO approval for TBI Evaluations to be completed by a specialist with appropriate background and skills to complete the exam. The letter highlights the recommendations made by VA SORCC with the intent of meeting the intent of VHA Directive 2010-12. VA SORCC is a Level IV Polytrauma Facility.

VA SORCC Polytrauma Coordinator will continue to request the status of the letter on a monthly basis with goal of having letter approved no later than January 1, 2013.

Target date for completion: January 1, 2013

Recommendation 7. We recommended that the facility establish an EHR Committee that meets VHA requirements and clearly define the responsibilities of the committee.

Concur

The Chief of Business Office and the Chief of Quality Management will present to the Executive Leadership Team (ELT) on October 17, 2012 a committee charter and proposal requesting approval for the inception of an Electronic Health Record quality review committee. This will provide the coordination and oversight stated in Handbook 1907.01 Health Information Management and Health Records. Upon approval the new Electronic Record Committee will be implemented with the first meeting to occur on November 20, 2012.

Target date for completion: November 30, 2012

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Karen A. Moore, RNC, MSHA, Project Leader Susan Tostenrude, MS, Team Leader Sarah Lutter, RN, JD Sami O'Neill, MA Noel Rees, MPA Marc Lainhart, BS, Management and Program Analyst

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Acting Director, Northwest Network (10N20)
Acting Director, VA Southern Oregon Rehabilitation Center and Clinics (692/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jeff Merkley, Ron Wyden
U.S. House of Representatives: Greg Walden

This report is available at http://www.va.gov/oig/publications/default.asp.