Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 08-00988-181

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

August 13, 2008

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 fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

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

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Executive Summary

Introduction

During the week of June 9–13, 2008, the OIG conducted a Combined Assessment Program (CAP) review of the VA Southern Oregon Rehabilitation Center and Clinics (the facility), White City, OR. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also provided fraud and integrity awareness training to 254 facility employees. The facility is part of Veterans Integrated Service Network (VISN) 20.

Results of the Review

The CAP review covered four operational activities. We identified the following organizational strengths and reported accomplishments:

- Environment of Care (EOC).
- Root Cause Analysis (RCA) Timeliness.

We made recommendations in two of the activities reviewed. For these activities, the facility needed to:

- Consistently trend, analyze, and routinely report QM data to the appropriate oversight group.
- Define the role of the Executive Committee of the Medical Staff (ECMS) in the performance improvement (PI) plan and ensure that clinical reviews are reported to that committee.
- Trend, analyze, and report peer review data in accordance with Veterans Health Administration (VHA) policy.
- Complete mortality case reviews in a timely manner and implement standardized trending, analysis, and reporting of this data in accordance with VHA policy.
- Ensure that required annual training for controlled substances inspectors is conducted and documented.

The facility complied with selected standards in the following two activities:

- EOC.
- Survey of Healthcare Experiences of Patients (SHEP).

This report was prepared under the direction of Virginia L. Solana, Director, and Reba B. Ransom, Healthcare Inspector, Kansas City Office of Healthcare Inspections.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations. (See Appendixes A and B, pages 10–14, for the full text of the Directors' comments.) 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

Introduction

Profile

Organization. Located in White City, OR, the facility is unique in that it is the only residential rehabilitation center within the VA that is not affiliated with any VA medical center. Primary outpatient medical and mental health care is provided at the facility and at a community based outpatient clinic in Klamath Falls, OR. There is an outreach clinic in Lakeview, OR. The facility is part of VISN 20 and serves a veteran population of about 40,000 throughout southern Oregon and northern California.

Programs. The facility has 600 beds and primarily provides residential rehabilitation, focusing on mental health services, day treatment, experiential learning, substance abuse treatment, and vocational employment services. There is a 15-bed infirmary onsite.

Affiliations. The facility is primarily affiliated with the Oregon Health Sciences University, the Oregon Institute of Technology, Portland State University, and the University of Portland to provide training opportunities for students in nursing, social work, psychology, dentistry, dietetics, and pastoral care.

Resources. In fiscal year (FY) 2007, facility expenditures totaled approximately $39 million. The FY 2008 facility budget is about $46 million. FY 2007 staffing was 486 full-time employee equivalents (FTE), including 18 physician and 66 nursing FTE.

Workload. In FY 2007, the facility treated 13,453 unique patients and provided 159,684 residential days in the facility and 3,003 inpatient days in the infirmary. The residential care workload totaled 603 discharges, and the average daily census was 445. Outpatient workload totaled 51,527 visits.

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 fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following four activities:

- EOC.
- Pharmacy Operations.
- QM.
- SHEP.

The review covered facility operations for FY 2007 and FY 2008 through May 31, 2008, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on select recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon,* Report No. 03-02850-66, January 28, 2004). The facility had corrected all findings related to health care from our prior CAP review.

During this review, we also presented fraud and integrity awareness briefings for 254 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. Activities in the “Review Activities Without Recommendations” section have no reportable findings.

Organizational Strengths

Environment of Care

Built in 1949, the facility houses 58 buildings on 823,000 square feet of land. Despite the age of the facility and the antiquated infrastructure, Facilities Management Services (FMS) and the incentive therapy (IT) veterans maintain an exceptionally clean, safe, and therapeutic environment. The IT program is a work therapy service that assists veterans seeking employment by developing or reestablishing skills, work behavior, and functional capacities. Facility leaders stated that hiring IT veterans contributes to ongoing EOC success.

Root Cause Analysis Timeliness

To improve RCA completion times, facility leaders initiated a system for hand delivery of team charters and memorandums. The Patient Safety Manager (PSM) delivers the charters and memorandums to each team member. Bypassing the mail system prevents potential delivery delays and provides a proactive contact between the PSM and RCA teams. The PSM's daily contact with each team leader conveys the significance of the team's duties and builds rapport. Therefore, team meetings are not cancelled. When the team completes the RCA report, it is hand delivered to the Director's office for review. As a result, completion times have decreased from an average of 72 days in FY 2006 to 32 days in FY 2008.

Results

Review Activities With Recommendations

Quality Management

The purpose of this review was to evaluate whether the facility's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the facility's senior management team and QM personnel. We evaluated plans, policies, and other relevant documents.

The QM program was generally effective in providing oversight of the facility's quality of care, and senior managers supported the program. Appropriate review structures were in place for 7 of the 10 program activities reviewed. We identified three areas that needed improvement.

Data Trending, Analysis, and Reporting. The facility implemented several quality improvement initiatives.

However, managers did not consistently trend and analyze data in all areas required by VHA and The Joint Commission.

The PI plan included a table of important monitors for ongoing data collection and analysis. Indicators were clearly defined with justification for monitoring, but the reporting frequency and oversight committees were not designated. Because of this, we were unable to determine if facility leaders were monitoring and reporting data as intended. Additionally, the facility did not consistently trend and analyze all QM data over periods of time, making it difficult to determine effectiveness of PI initiatives. Committee minutes frequently reflected only 1 month of data without notation of required action.

Quality Management Program Structure. The facility's PI plan did not include the role of the ECMS in QM. The PI plan designated the Executive Leadership Team (ELT) as the group to set priorities for PI. The Performance Enhancement Team was responsible for coordinating and implementing recommendations and for monitoring follow-up of planned PI activities. The Clinical Operations Council was responsible for monitoring clinical services.

It was unclear how PI information flowed to and from the medical staff. We did not find any clinical reports in ECMS meeting minutes. Medical staff leadership is critical in clinical PI, and The Joint Commission requires that organized medical staff participate in organization-wide PI activities.

Peer Reviews. The peer review process did not include all components required by VHA or the facility. Peer reviews were completed in the required timeframes, and the committee met as required. However, aggregate peer review data were not reported on a quarterly basis to the ECMS. Also, data by outcome level and by changes from one level to another were not captured.

VHA defines peer review as a protected, non-punitive, facility process to evaluate the quality of care at the provider level. The peer review process includes an initial review by a peer of the same discipline to determine if most experienced, competent practitioners would have managed care in a similar fashion or if most experienced, competent providers would have managed one or more aspects of care

differently. The facility's peer review policy requires that results of these reviews be forwarded to the ECMS quarterly for final level assignments, data aggregation, and analysis. Trended data and analysis are required to identify variations and opportunities for improvement. Peer reviews can result in both immediate and long-term improvements in patient care by impacting individual provider's practices.

Mortality Review. The facility did not complete clinical reviews of all deaths in a timely manner. VHA mandates trending of mortality data by unit, shift, day of the week, and provider in order to identify any trends that may lead to opportunities to improve patient care. Data were not trended over time by unit, shift, or provider. The facility presented mortality data by individual cases in table format. Absence of trended data impedes the ability to analyze data and identify possible suspicious trends.

Although the facility completed clinical reviews of all deaths and utilized criteria to determine the need for peer review, clinicians did not complete reviews in a timely manner. We reviewed seven patient deaths, and all seven reviews were performed between 4 and 8 months after the patient expired. Delay in reviewing deaths fails to provide timely quality of care information to clinical staff and leadership.

Recommendation 1 We recommended that the VISN Director ensure that the Facility Director requires that QM data are consistently trended, analyzed, and routinely reported to the appropriate oversight group.

The VISN and Facility Directors concurred with our findings and recommendation. The facility will restructure committee minutes to include necessary information to trend results of actions over time. QM will monitor oversight committee minutes to ensure routine reporting. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 2 We recommended that the VISN Director ensure that the Facility Director requires that the PI plan include the role of the ECMS in QM and that clinical reviews be reported to that committee.

The VISN and Facility Directors concurred with our finding and recommendation. The Facility Director formed a workgroup, which will define committee roles. This group will

make recommendations for change to the ELT. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 3 We recommended that the VISN Director ensure that the Facility Director implements a process to trend and analyze peer review findings and report aggregated results quarterly to the ECMS.

The VISN and Facility Directors concurred with our findings and recommendation. QM is developing a spreadsheet for use in trending and analyzing peer review data. Starting in the 4th quarter of FY 2008, QM will report this information quarterly to the ECMS. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Recommendation 4 We recommended that the VISN Director ensure that the Facility Director requires timely completion of mortality case reviews and implements standardized trending, analysis, and reporting of this data in accordance with VHA policy.

The VISN and Facility Directors concurred with our findings and recommendation. The facility is implementing a process to trend mortality data to meet VHA requirements. All deaths will be reviewed within 30 days after a patient expires. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Pharmacy Operations

The purpose of this review was to evaluate whether the facility had adequate controls to ensure the security and proper management of controlled substances and the pharmacy's internal physical environment. We also determined whether clinical pharmacists had processes in place to monitor patients prescribed multiple medications to avoid polypharmacy, especially in vulnerable populations.

We reviewed VHA regulations governing pharmacy and controlled substances security, and we assessed whether the facility's policies and practices were consistent with VHA regulations.[1] We inspected the pharmacy for security, EOC, and infection control (IC) issues. We interviewed the

[1] VHA Handbook 1108.1, *Controlled Substances (Pharmacy Stock)*, October 4, 2004; VHA Handbook 1108.2, *Inspection of Controlled Substances*, August 29, 2003; VHA Handbook 1108.5, *Outpatient Pharmacy*, May 30, 2006; VHA Handbook 1108.6, *Inpatient Pharmacy*, June 27, 2006.

Controlled Substances Coordinator, appropriate Pharmacy Service staff, and Police and Security Service managers.

Pharmacological regimens involving multiple medications are often necessary to prevent and maintain disease states; however, excessive use of medications can result in adverse reactions and increased risks of complications. Polypharmacy is more complex than just the number of drugs that patients are prescribed. The clinical criteria to identify polypharmacy are the use of: (a) medications that have no apparent indication, (b) therapeutic equivalents to treat the same illness, (c) medications that interact with other prescribed drugs, (d) inappropriate medication dosages, and (e) medications to treat adverse drug reactions.[2] Some literature suggests that elderly patients and mental health patients are among the most vulnerable populations for polypharmacy.[3]

Managers had developed effective processes to ensure that clinical pharmacists identified patients who were prescribed multiple medications, reviewed their medication regimens to avoid polypharmacy, and advised providers as appropriate.

The facility had appropriate policies and procedures to ensure the security of the pharmacy and controlled substances. Controlled substances inspections were conducted according to VHA regulations, and managers reported all controlled substances diversions or suspected diversions to the OIG. The pharmacy's physical environment was clean and well maintained.

We identified one area that would improve controls over the facility's pharmacy operations.

Training. Annual training for inspectors was not completed, as required by VHA. We reviewed the training records for all of the controlled substances inspectors and the Controlled Substances Coordinator. None of the records documented the required annual training.

[2] Yvette C. Terrie, BSPharm, RPh, "Understanding and Managing Polypharmacy in the Elderly," *Pharmacy Times,* December 2004.
[3] Terrie, *Pharmacy Times*, December 2004, Vijayalakshmy Patrick, M.D., et al., "Best Practices: An Initiative to Curtail the Use of Antipsychotic Polypharmacy in a State Psychiatric Hospital," *Psychiatric Services*, 57:21–23, January 2006.

Recommendation 5 We recommended that the VISN Director ensure that the Facility Director requires that annual training for controlled substances inspectors is conducted and documented.

The VISN and Facility Directors concurred with our finding and recommendation. Controlled substances inspectors will complete annual training each September. The Chief of Staff will maintain documentation of training for each inspector. We find this action plan appropriate and will follow up on reported implementation actions to ensure completion.

Review Activities Without Recommendations

Environment of Care

The purpose of this review was to determine whether the facility complied with selected IC standards and maintained a clean and safe health care environment. Facilities are required to provide a comprehensive EOC program that fully meets VHA National Center for Patient Safety, Occupational Safety and Health Administration, and Joint Commission standards.

We evaluated the IC program to determine compliance with VHA directives that require management to collect and analyze data to improve performance. IC staff appropriately monitored, trended, analyzed, and reported infection data to clinicians for implementation of quality improvements to reduce infection risks for residents and staff.

We conducted onsite inspections of ambulatory care areas; waiting rooms; the laboratory; the pharmacy; the dental clinic; supply, processing, and distribution; some residential quarters; the infirmary; activity centers; and other clinical and administrative areas.

FMS maintained a safe and clean environment. Staff expressed high satisfaction with the responsiveness of housekeeping. We made no recommendations.

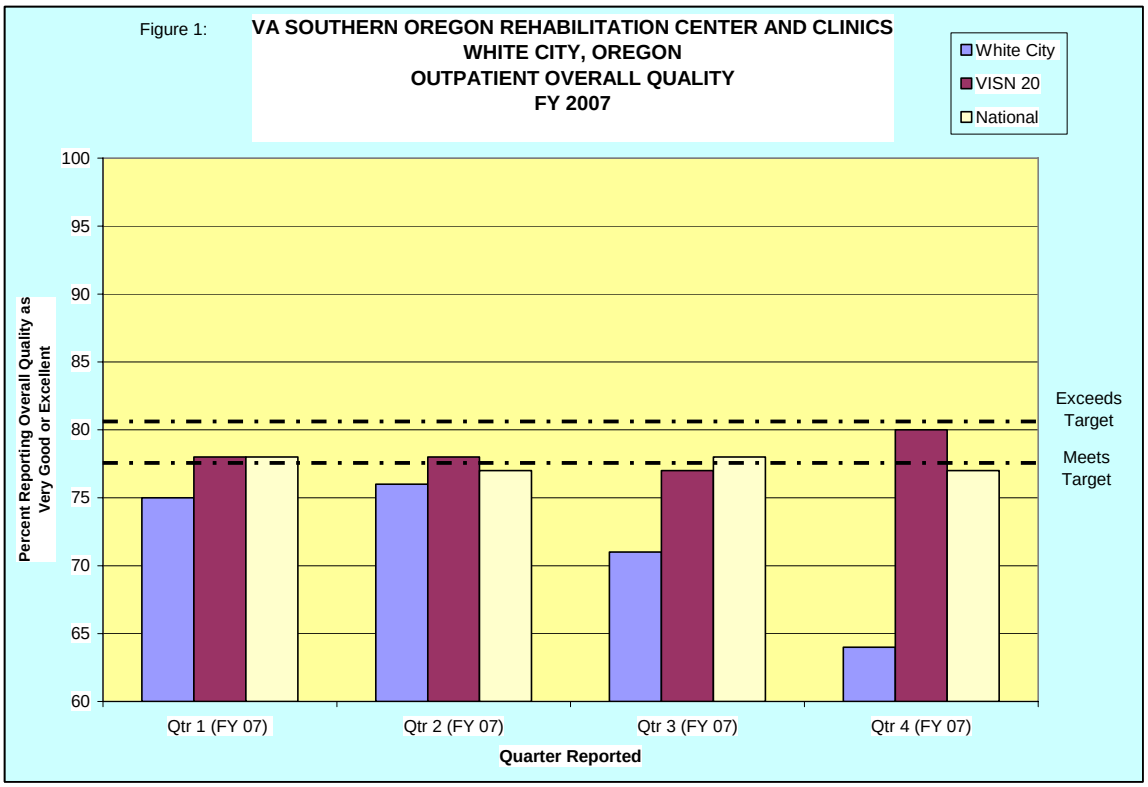
Survey of Healthcare Experiences of Patients

The purpose of this review was to assess the extent that VHA medical facilities use the quarterly/semi-annual survey report results of patients' health care experiences with the VHA system to improve patient care, treatment, and services. The Performance Analysis Center for Excellence of the Office of Quality and Performance within VHA is the analytical, methodological, and reporting staff for SHEP. VHA set performance measure (PM) goals for patients

reporting overall satisfaction of "very good" or "excellent" at 76 percent for inpatients and 77 percent for outpatients.

We reviewed the outpatient survey results for each quarter in FY 2007. Figure 1 shows the facility's SHEP PM results.

Figure 1: **VA SOUTHERN OREGON REHABILITATION CENTER AND CLINICS WHITE CITY, OREGON OUTPATIENT OVERALL QUALITY FY 2007**



The facility did not meet the PM goal in FY 2007. However, managers had identified opportunities for improvement and had developed an action plan targeting specific services and departments. Because the facility implemented an action plan, demonstrated evidence of ongoing activities, and evaluated the plan for effectiveness, we made no recommendations.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 8, 2008

From: Director, Veterans Integrated Service Network (10N20)

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

To: Director, Kansas City Regional Office of Healthcare Inspections (54KC)

Director, Management Review Service (10B5)

1. Attached is the status report for the Office of Inspector General (OIG) Combined Assessment Program survey comments and implementation plan from the VA Southern Oregon Rehabilitation Center and Clinics, White City, OR.

2. If you have any questions regarding this report, please contact Virginia Hawker, Health Systems Specialist, VA SORCC, at (541) 826-2111, x3447.

Dennis M. Lewis, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 3, 2008

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

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

To: Director, Veterans Integrated Service Network (10N20)

1. Attached is the response to the OIG CAP site Review and comments from the Network Director, VISN 20.

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

3. We appreciate the courtesy and cooperativeness displayed by you and all of the OIG Team throughout this review process.

(original signed by:)

Max E. McIntosh, PhD, MBA

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the Facility Director requires that QM data are consistently trended, analyzed, and routinely reported to the appropriate oversight group.

Concur

Oversight committees will be monitored by QM to ensure that reporting is completed in a timely manner and trended so analyses and conclusions are easily identified and verified.

SORCC will restructure committee minutes to include action and results from previous months and expectations of future meetings. Minutes will reflect past meeting minutes with new revisions demonstrating that actions were implemented, new actions might be indicated and the outcome from the actions. For new business, the minutes will use graphs to emphasize trending. The minutes will also include discussion, actions to be taken including resolution dates. All committees will be using this new format by October 1, 2008.

Recommendation 2. We recommended that the VISN Director ensure that the Facility Director requires that the PI plan include the role of the ECMS in QM and that clinical reviews be reported to that committee.

Concur

The Facility Director implemented a workgroup on June 17, 2008, to identify VHA's expectation of ECMS; define the current role and responsibility of SORCC's ECMS and COC. The workgroup's findings will include the committees' structural change that will be presented to the ELT on August 20, 2008, and approved recommendations will be implemented beginning October 1, 2008.

Recommendation 3. We recommended that the VISN Director ensure that the Facility Director implements a process to trend and analyze peer review findings and report aggregated results quarterly to the ECMS.

Concur

The QM department is developing an Excel data spreadsheet that will be completed by July 31, 2008. Per quarter, QM will input the following data: total number of cases screened for peer review, the number of initial peer reviews, the timeliness on completing the peer reviews, the initial peer review assigned level, and the peer review final determination. When the data is entered in the Excel program, it will immediately trend the data into bar graphs by the following topics: total number of screens per quarter, total number of peer reviews per quarter, peer review committee final determination of levels per quarter by actual cases and percentages. During the forth quarter of FY 08 the aggregated data will be reported to the ECMS and aggregated data will be reported quarterly thereafter.

Recommendation 4. We recommended that the VISN Director ensure that the Facility Director requires timely completion of mortality case reviews and implements standardized trending, analysis, and reporting of this data in accordance with VHA policy.

Concur

SORCC is trending all data from FY 2007 and FY 2008 to reflect the requirements of VHA Directive 2005-056, which will be completed by July 31, 2008. The following categories will be graphed: deaths per service; death per provider; deaths per DNRs vs. full code; death per shift per quarter; death per each ward per month; and death per shift trended to the previous months.

SORCC's MCM 11-022 Peer Review for Quality Management, Attachment C, is being revised to include the VHA Directive 2005-056, section 4, entitled Action, category (a) through (c). The information concerning surgical procedures in category (d) has been omitted, as SORCC does not perform surgeries; however, category (d) will state that all inpatient deaths will be clinically reviewed and trended within 30 calendar days of the patient's expiration date. The revision of this MCM will be completed on July 31, 2008.

QM will be responsible for tracking compliance and will be reporting the aggregated data for discussion in a formal forum in accordance to VHA Directive 2005-056.

Recommendation 5. We recommended that the VISN Director ensure that the Facility Director requires that annual training for controlled substances inspectors is conducted and documented.

Concur

Annual Training of all CSI Inspectors will be held yearly in September to provide initial training for all new Inspectors and update training for current Inspectors requiring an annual update. The training will consist of the

video on drug diversion, online certification for inspectors, group orientation as to the inspection process, and review with discussion of VHA Handbooks 1108.1 and 1108.2. Target Date: September 30, 2008.

SORCC MCM 11-002 and attachments will be reviewed, which discusses the local Inspection process and areas to be reviewed.

The instructors are Ron Foreman AA/COS and Steve Baker, Pharm D.

Copies of the training will be documented and maintained in the CSI files located in the Chief of Staff office.

OIG Contact and Staff Acknowledgments

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