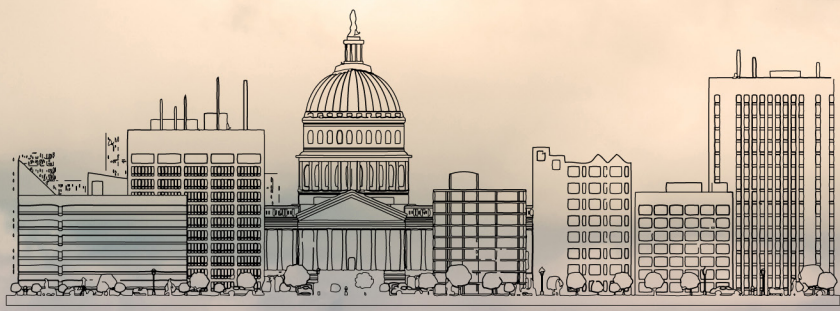


THE BOISE FRONT



DECEMBER 2023

The official newsletter of the Boise VA Medical Center





For this month's compliance corner, I'd like to present to you four examples of ethical failure stories that were compiled from the OIG newsfeed. These are stories that we can learn from and keep a vigilant eye out for.

Ethical Failure: Embezzlement. A former VA Medical Center Cashier pleaded guilty to four counts of embezzlement and one count of mail fraud. The cashier's responsibilities included

helping patients deposit benefits checks and withdraw funds. In January 2021, the sister of a deceased veteran called the VA Police after reviewing the balance in her brother's patient account. Subsequently, the VA Police opened an investigation into the account activity and questioned the cashier who had accessed the account. He later confessed to fraudulently taking approximately \$17,000 from the accounts of three veterans.

Ethical Failure: Extortion, Bribery, and Witness Tampering. A VA benefits service representative located in Providence, Rhode Island, was charged with three counts of bribery and one count each of extortion, gratuity received by a public official, and witness tampering. It is alleged that the employee solicited and accepted bribes from veterans and the family member of a veteran to approve requested dependent care benefits and/or disability benefits. It is further alleged that the employee claimed that some of the money he sought from his victims would be used to purchase gift cards for other purported VA employees who he claimed either could or did assist him in expediting and approving benefits claims. After becoming aware of the government's investigation into his conduct, he allegedly attempted to persuade a witness not to cooperate with the investigation and to lie about the nature of payments made to him.

Ethical Failure: Theft. A dental technician was sentenced to one year of probation for his theft of government property. As part of his guilty plea, he admitted that while employed as a dental technician at the Albany Stratton VA Medical Center between October 2017 and May 2021, he stole and converted to his own use precious metals and noble alloys that were intended to be recycled and used to manufacture crowns, bridges, and other dental prostheses. He then sold those precious metals to a third-party refinery for a profit. He was also ordered to pay approximately \$13,500 in restitution, which he paid at sentencing.

Ethical Failure: Wire fraud. A former procurement supervisor at the Jesse Brown VA Medical Center in Chicago, Illinois, pleaded guilty to one count of wire fraud. He admitted, that between 2012 and 2019, he received thousands of dollars from the president of a Chicago-area medical supply company, for fraudulently initiating and approving purchases of products from their company, knowing that many of the products would not actually be delivered to the VA. The checks were made payable to Helping Hands Properties LLC, a third-party entity managed by the employee that he used to conceal the kickbacks. In 2018, after he became aware that the VA OIG was investigating his conduct, he created fake invoices from Helping Hands claiming to document work performed for the supply company.

Stay vigilant and report suspected criminal activity through appropriate channels. Not sure who to contact? Call Steven Waltari, your ICO, at 208-422-1267.

COMPLIANCE CORNER



VA | Boise VA Medical Center



BOISE is HIGHLY RELIABLE

HRO PRINCIPLES & VALUES

THEME OF THE MONTH
Clear Communications

December 2023 | National Safety Poster

Self-Reporting Enables Clear Communications

C

CONTEXT

When Ricky Reyna, a nurse on the Medical-Surgical Unit at Amarillo VA HCS (Amarillo, TX), realized he had mistakenly given medication through injection rather than an oral syringe, he immediately self-reported the error and entered a Patient Safety Event into the Joint Patient Safety Reporting (JPSR) system. Because the Veteran was unharmed, this error would have remained undiscovered without Mr. Reyna's communication.

A

ACTION

The report resulted in a Root Cause Analysis (RCA) to determine how to prevent this error from reoccurring. The Nurse Manager, Terrah Jamandron, and the RCA team discovered that the facility lacked the appropriate syringes. Leadership immediately acquired the needed syringes and educated all nursing teams about the situation through training and updated orientation materials.

R

RESULTS

Michelle Isham, Chief of Inpatient Services, explains how Mr. Reyna's Close Call and Clear Communications positively impacted Amarillo VA HCS. Mr. Reyna notified leadership through proper channels, the team got to the root cause and Amarillo VA HCS addressed the reason for the error, closing the loop with clear, simple instructions. Mr. Reyna's reporting of the near miss was then celebrated to encourage the behavior at other facilities.



Ricky Reyna, RN
Registered Nurse, Medical-Surgical Unit



Terrah Jamandron, BSN, RN
Nurse Manager, Medical-Surgical Unit



Michelle Isham, MSN, RN, SANE
Chief of Inpatient Nursing Services

“By using the standard processes and channels, we clearly communicated and remedied the situation and can now use it to inform others.”

Ricky Reyna, RN
Registered Nurse, Medical-Surgical Unit
Amarillo VA HCS
Amarillo, TX

Congratulations to Our Tai Chi Instructors!

In May 2023, our staff and volunteers completed the Wheelchair/Applied Tai Chi Chuan for Veterans Instructional Training Workshop. Boise VA was accepted for VA Adaptive Sports Grant to host this class. The training was open to VISN 20. 16 staff participated from Boise, Walla Walla, and White City. Staff have incorporated tai chi in their work with Veterans.

6 staff and 2 volunteers represented Boise VA:

Ann Wildman, Recreational Therapist

Kristin Schultz, Occupational Therapist

Emily Malinowski, Occupational Therapist for HBPC

Dr. Lucinda Scott, BHIP Psychologist

Mariia Mosina, CLC RN

Renee Walters, Primary Care Float NP

Volunteers: Patricia Plimmer and James Roethig

A special thanks to Michelle Jones for mentoring our new instructors!





Cara
Newberry

Employee of
the Month
NOVEMBER



VA | Boise VA
Medical Center

Cara consistently demonstrates adherence to our ICARE values when serving our Veterans. She consistently promotes and takes action to prioritize the well-being of our Veterans, aiming to enhance the quality of care that she and her unit deliver. In a recent instance, she came across discrepancies in the documentation of code status while reviewing a patient's chart for a procedure involving anesthesia. While the patient had a "Do Not Resuscitate" (DNR) note on file in Vista Imaging, there was no corresponding documentation in CPRS. This situation could have posed an ethical challenge during a critical moment when the patient's end-of-life wishes were unclear.

Cara took the initiative to collaborate with the procedure's provider, the staff in the Endoscopy department, and the anesthesia provider to ensure that the patient's wishes were known. Additionally, she worked with the Copper Team staff to provide education on thoroughly reviewing advance directives in charts before future procedures. Recognizing the importance of addressing this issue, Cara submitted an ethical consult to review and improve the current process concerning advanced directives, with the aim of eventually implementing a "Code Status" banner in CPRS.

Boise VAMC Office of Systems Redesign & Improvement

Congratulations! In an effort to shed more light onto the HRO pillar of Continuous Process Improvement, the Systems Redesign and Improvement program will be showcasing projects and work from around our Boise VAMC.

We would like to congratulate Wendy Decarvalho, RN for earning her Lean Yellow Belt certification!

Problem Statement: *Following the COVID-19 Pandemic, Primary Care services experienced a sudden increase in face-to-face clinic visits. The increased volume of appointments along with staffing shortages related to recruitment, created concerns over expanded patient wait times in the lobby, exam rooms, and with seeing the provider. In addition, the expansion of the national CPRS clinical reminder list directly increased the nursing check-in times and negatively affected nursing hours by increasing overtime and compensation time leading to staff burnout.*

Wendy and her team created an improved process flow from patient arrival to discharge at the Primary Care Women's Wellness Clinic. By using laminated clinical reminders for patients to complete while waiting to be roomed, this reduced nursing time spent reading each clinical reminder to the Veteran during the check-in process. They also created a patient check-in form to summarize the reason for visit, positive reminders from the Veteran's clinical reminder form, vital signs, and pertinent information to providers. This led to reduced patient wait times, decrease in nursing hours, improved communication to providers, and increased patient and staff satisfaction.

Wendy's LEAN project, "Primary Care Clinical Reminders" has already been implemented at several CBOCs with success and with future plans to gather feedback and implement elsewhere. This process improvement initiative created a pathway for staff to become involved in providing solutions and input. By including front-line staff, a spirit of camaraderie and shared success was evident. Congratulations, Wendy, on another job well done!

If you would like to see more information on this project, please click on the presentation link below. We are proud to showcase Wendy's work. If you are interested in Lean training or would like more information about how you can participate in process improvement, please email BOISystemsRedesign@va.gov. We'd love to hear from you!



Lean
Yellow Belt
Project
Spotlight:
**Wendy
Decarvalho**



*NO PHOTO
ON FILE*

**Karen
Smith**

**Employee of
the Month
NOVEMBER**

Ms. Karen Smith has been a long time Clinical Applications Coordinator (CAC) at the Boise VAMC during which time she has done amazing work keeping our CPRS charting system up to date and functioning as well as troubleshooting and fixing any problems that individuals have experienced. In early October Ms. Smith ran a periodic fileman report on unprocessed alerts and noted that the dates for the oldest alerts were not as far back as usually reported. Ms. Smith researched this issue with several departments where she discovered that one option available for deletion of alerts was to remove all CPRS alerts greater than 14 days old. Our routine at the Boise VAMC was not to delete alerts less than 180 days old. With further investigation Ms. Smith was able to confirm that this greater than 14 day deletion had occurred. She immediately placed a help ticket as a high priority and patient safety issue. Ms. Smith persisted in inquiring after the ticket and found out it had been elevated to the national level. Ms. Smith continued her investigation and inquiries with national being told that 14 days for deletion was the standard to which Ms. Smith provided documentation that this was not the case for Boise. Ms. Smith's persistence in the face of multiple replies of "cannot do this" had a tremendous impact on patient safety and has ensured at least for now that this would not occur again. Ms. Smith demonstrated the use of all of the HRO principles but to her credit, continued to persist when "deference to expertise" did not provide the answers she knew were critical to the care of our patients.



Ryan
Iffland

Employee of
the Month
NOVEMBER



VA | Boise VA
Medical Center

HAS Supervisor Don Lake would like to nominate Ryan Iffland for the Employee of the Month. Ryan is the facility Print Shop operator.

He is always going above and beyond in everything he does.

Recently the mail room ended up with one of the clerks taking on a new job and the other clerk retiring. This left us with no staff in the mailroom. Ryan, who is a primary backup for mailroom services immediately stepped in to keep mail services running for our facility.

As challenging as that might be, it became even more challenging when one of the mailroom computers failed and had to be replaced and reloaded with specialty mailing software. A failure like that affects critical services needed for the lab and pharmacy. Certain critical items absolutely must ship and cannot wait. Using a network

of acquaintances throughout the facility, Ryan was able to locate a computer with the UPS application to ship some items that could not wait. Because of his quick thinking and dedication to our mission,

some high priority lab boxes were shipped before the contents expired. His flexibility and quick thinking during this time saved the day!

HELLO'S & GOODBYE'S



**The Boise VAMC would
like to welcome our new
employees who joined
the team in December
2023:**

**Andrea Ecsedy, Physical Medicine
Jennifer Anderson, Specialty Care
Lubi Dixon, Specialty Care
Aubriana Toole, Pharmacy
Deanna Smith, Sterile Processing
Gerad House, Primary Care
Kaila Bent, Health Administration
Karrah Miner, Community Care
Laura Coates, Primary Care
Veronica Williams, Health Administration
Taylor Baker, Connected Care
Taylor Oxley, Connected Care
Rachael Harmon, Supply
Gayleen Borden, Facilities Management**

HELLO'S & GOODBYE'S



**The Boise VAMC would
like to say goodbye to the
employees who left the
team in December 2023:**

**Cindy Collis, Health Administration
Daniel Chapman, Mental Health
McKenna Cornforth, Nursing
Brooke Horlocher, Health Administration**