Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-03417-34

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Portland VA Medical Center Portland, Oregon

January 17, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Glossary

AUD	alcohol use disorder
CBOC	community based outpatient clinic
DWHP	designated women's health provider
EHR	electronic health record
EOC	environment of care
FY	fiscal year
IT	information technology
MH	mental health
MI	motivational interviewing
MM	medication management
NA	not applicable
NM	not met
OIG	Office of Inspector General
PACT	Patient Aligned Care Teams
PCC	primary care clinic
PCMM	primary care management module
PCP	primary care provider
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH	women's health

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected patient care activities to determine whether the community based outpatient clinics (CBOCs) and primary care clinics (PCCs) provide safe, consistent, and high-quality health care for our veterans. We conducted site visits during the week of November 4, 2013, at the following randomly selected CBOCs which are under the oversight of the Portland VA Medical Center and Veterans Integrated Service Network 20:

- North Coast CBOC, Warrenton, OR
- Salem CBOC, Salem, OR

Review Results: We conducted four focused reviews and made recommendations in all of the review areas:

Environment of Care. Ensure that:

- A separate room is provided to store medical (infectious) waste at the Salem CBOC.
- Signage identifying the location of fire extinguishers is installed at the North Coast CBOC.
- Information Technology (IT) server closet at the North Coast CBOC is maintained according to IT safety and security standards.

Alcohol Use Disorder. Ensure that CBOC/PCC:

- Staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
- Registered Nurse Care Managers receive motivational interviewing and health coaching training within 12 months of appointment to Patient Aligned Care Team.

Medication Management. Ensure that CBOC/PCC staff:

- Document medication reconciliation that includes the newly prescribed fluoroquinolone in the electronic health record.
- Provide medication counseling/education that includes the fluoroquinolone.
- Document the evaluation of patient's level of understanding for the medication education.

Designated Women's Health Providers' Proficiency. Ensure that:

- All designated women's health providers are identified with the women's health indicator in the Primary Care Management Module.

Comments

The VISN and Facility Directors agreed with the CBOC and PCC review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 16–21, for the full text of the Directors' comments.) We consider recommendations 1, 2, and 3 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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Objectives, Scope, and Methodology

Objectives

The CBOC and PCC reviews are an element of the OIG's efforts to ensure that our Nation's veterans receive high-quality VA health care services. As such, the CBOC and PCC reviews are recurring evaluations of selected primary care operations that focus on patient care quality and the EOC. In general, our objectives are to:

- Determine whether the CBOCs are compliant with EOC requirements.
- Determine whether CBOCs/PCCs are compliant with VHA requirements in the care of patients with AUD.
- Determine compliance with requirements for the clinical oversight and patient education of fluoroquinolones for outpatients.
- Evaluate if processes are in place for DWHPs to maintain proficiency in WH.

Scope

To evaluate for compliance with requirements related to patient care quality and the EOC, we conducted onsite inspections, reviewed clinical and administrative records, and discussed processes and validated findings with managers and employees. The review covered the following four activities:

- EOC
- AUD
- MM
- DWHP Proficiency

The scope of the review is limited to the established objectives. Issues and concerns that come to our attention that are outside the scope of this standardized inspection will be reviewed and referred accordingly.

Methodology

The onsite EOC inspections were only conducted at randomly selected CBOCs that had not been previously inspected.[a] Details of the targeted study populations for the AUD, MM, and DWHP Proficiency focused reviews are noted in Table 1.

[a] Includes 93 CBOCs in operation before March 31, 2013.

Table 1. CBOC/PCCs Focused Reviews and Study Populations

Review Topic	Study Population
AUD	All CBOC and PCC patients screened within the study period of July 1, 2012, through June 30, 2013, and who had a positive AUDIT-C score[b] and all providers and RN Care managers assigned to PACT prior to October 1, 2012.
MM	All outpatients with an original prescription ordered for one of the three selected fluoroquinolones from July 1, 2012, through June 30, 2013.
DWHP Proficiencies	All WH PCPs designated as DWHPs as of October 1, 2012, and who remained as DWHPs until September 30, 2013.

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.

The review was done in accordance with OIG standard operating procedures for CBOC and PCC reviews.

[b] The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders. Scores range from 0-12.

Results and Recommendations

EOC

The purpose of this review was to evaluate whether CBOC managers have established and maintained a safe and clean EOC as required.[1]

We reviewed relevant documents and conducted physical inspections of the North Coast and Salem CBOCs. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 2. EOC

NM	Areas Reviewed	Findings
	The CBOC's location is clearly identifiable from the street as a VA CBOC.	
	The CBOC has interior signage available that clearly identifies the route to and location of the clinic entrance.	
	The CBOC is Americans with Disabilities Act accessible.	
	The furnishings are clean and in good repair.	
	The CBOC is clean.	
	The CBOC maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates.	
	An alarm system and/or panic buttons are installed in high-risk areas (e.g., MH clinic).	
	Alcohol hand wash or soap dispenser and sink are available in the examination rooms.	
	Sharps containers are secured.	
	Safety needle devices are available.	
X	The CBOC has a separate storage room for storing medical (infectious) waste.	The Salem CBOC did not have a separate storage room for storing medical (infectious), and clean supplies were kept in the dirty utility room.
	The CBOC conducts fire drills (at least every 12 months.)	
	Means of egress from the building are unobstructed.	
	Access to fire alarm pull stations is unobstructed.	

NM	Areas Reviewed	Findings
	Access to fire extinguishers is unobstructed.	
X	The CBOC has signs identifying the locations of fire extinguishers.	There were no signs identifying the location of fire extinguishers at the North Coast CBOC.
	Exit signs are visible from any direction.	
	No expired medications were noted during the onsite visit.	
	All medications are secured from unauthorized access.	
	PII is protected on laboratory specimens during transport so that patient privacy is maintained.	
	Adequate privacy is provided to patients in examination rooms.	
	Documents containing patient-identifiable information are not lying around, visible, or unsecured.	
	Window coverings provide privacy.	
	The CBOC has a designated examination room for women veterans.	
	Adequate privacy is provided to women veterans in the examination room.	
X	The IT network room/server closet is locked.	Access to the IT network room/server closet at the North Coast CBOC was not documented or restricted to personnel authorized by Office of IT.
	All computer screens are locked when not in use.	
	Staff use privacy screens on monitors to prevent unauthorized viewing in high-traffic areas.	
	EOC rounds are conducted semi-annually (at least twice in a 12-month period).	
	The CBOC has an AED.	
	AED batteries are current (within the manufacturer's posted expiration date).	
	Safety inspections are performed on the CBOC medical equipment in accordance with VA and Joint Commission standards.	
	The parent facility includes the CBOC in required education, training, planning, and participation leading up to the annual disaster exercise.	

NM	Areas Reviewed	Findings
	The parent facility's Emergency Management Committee evaluates CBOC emergency preparedness activities, participation in annual disaster exercise, and staff training/education relating to emergency preparedness requirements.	

1. We recommended that a separate room is provided to store medical (infectious) waste at the Salem CBOC.

2. We recommended that signage is installed at the North Coast CBOC to clearly identify the location of fire extinguishers.

3. We recommended that the IT server closet at the North Coast CBOC is maintained according to IT safety and security standards.

AUD

The purpose of this review was to determine whether the facility's CBOCs and PCCs complied with selected alcohol use screening and treatment requirements.[2]

We reviewed relevant documents. We also reviewed 40 EHRs and validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 3. AUD

NM	Areas Reviewed	Findings
	Alcohol use screenings are completed during new patient encounters, and at least annually.	
	Diagnostic assessments are completed for patients with a positive alcohol screen.	
	Education and counseling about drinking levels and adverse consequences of heavy drinking are provided for patients with positive alcohol screens and drinking levels above National Institute on Alcohol and Alcoholism guidelines.	
X	Documentation reflects the care provided and the offer of further treatment for patients diagnosed with alcohol dependence.	We did not find documentation of the offer of further treatment for 2 of 6 patients diagnosed with alcohol dependence.
	For patients with AUD who decline referral to specialty care, CBOC/PCC staff monitor them and their alcohol use condition.	
	Counseling, education, and brief treatments for AUD are provided within 2 weeks of positive screening.	
X	CBOC/PCC RN Care Managers have received MI training within 12 months of appointment to PACT.	We found that 29 (69 percent) of 42 RN Care Managers did not receive MI training within 12 months of appointment to PACT.
X	CBOC/PCC RN Care Managers have received National Center for Health Promotion and Disease Prevention approved health coaching training (most likely TEACH for Success) within 12 months of appointment to PACT.	We found that 13 (31 percent) of 42 RN Care Managers did not receive health coaching training within 12 months of appointment to PACT.
	The facility complied with any additional elements required by VHA or local policy.	

4. We recommended that CBOC/PCC staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.

5. We recommended that CBOC/PCC RN Care Managers receive MI and health coaching training within 12 months of appointment to PACT.

MM

The purpose of this review was to determine whether appropriate clinical oversight and education were provided to outpatients prescribed oral fluoroquinolone antibiotics.[3]

We reviewed relevant documents. We also reviewed 39 EHRs and validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 4. Fluoroquinolones

NM	Areas Reviewed	Findings
X	Clinicians documented the medication reconciliation process that included the fluoroquinolone.	We did not find documentation that medication reconciliation included the newly prescribed fluoroquinolone in 15 (38 percent) of 39 patients' EHRs.
	Written information on the patient's prescribed medications was provided at the end of the outpatient encounter.	
X	Medication counseling/education for the fluoroquinolone was documented in the patients' EHRs.	We did not find documentation of medication counseling that included the fluoroquinolone in 7 (18 percent) of 39 patients' EHRs.
X	Clinicians documented the evaluation of each patient's level of understanding for the education provided.	Clinicians did not document the level of understanding for 6 (19 percent) of 32 patients.
	The facility complied with local policy.	

6. We recommended that CBOC/PCC staff document medication reconciliation that includes the newly prescribed fluoroquinolone in the EHR.

7. We recommended that CBOC/PCC staff provide and document medication counseling/education that includes the fluoroquinolone.

8. We recommended that CBOC/PCC staff document the evaluation of patient's level of understanding for the medication education.

DWHP Proficiency

The purpose of this review was to determine whether the facility's CBOCs and PCCs complied with selected DWHP proficiency requirements.[4]

We reviewed the facility self-assessment, VHA and local policies, PCMM data, and supporting documentation for DWHP proficiencies. The table below shows the area reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 5. DWHP Proficiency

NM	Areas Reviewed	Findings
	CBOC and PCC DWHPs maintained proficiency requirements.	
X	CBOC and PCC DWHPs were designated with the WH indicator in the PCMM.	Four of 19 DWHPs were not designated with the WH indicator in the PCMM.

9. We recommended that the Chief of Staff consistently ensure that all DWHPs are designated with the WH indicator in the PCMM.

CBOC Profiles

This review evaluates the quality of care provided to veterans at all of the CBOCs under the parent facility's oversight.[c] The table below provides information relative to each of the CBOCs.

					Uniques[d]				Encounters[d]			
Location	**State**	**Station #**	**Locality[e]**	**CBOC Size[f]**	**MH[g]**	**PC[h]**	**Other[i]**	**All**	**MH[g]**	**PC[h]**	**Other[i]**	**All**
Vancouver	WA	648A4	Urban	Very Large	5,937	11,504	14,137	20,512	68,815	24,937	75,804	169,556
West Metro Portland	OR	648GF	Urban	Very Large	5,904	6,845	12,521	17,229	10,098	13,504	32,885	56,487
East Metro Portland	OR	648GE	Urban	Large	1,053	9,293	4,316	9,945	3,112	18,938	13,490	35,540
Salem	OR	648GB	Urban	Large	1,420	8,692	3,645	9,272	5,855	17,428	9,335	32,618
Bend	OR	648GA	Urban	Large	965	5,724	4,905	6,830	5,441	11,676	15,906	33,023
West Linn	OR	648GG	Urban	Large	607	4,512	1,948	5,267	1,757	6,206	4,295	12,258
North Coast	OR	648GD	Rural	Mid-Size	221	1,452	646	1,531	1,071	3,649	1,693	6,413

[c] Includes all CBOCs in operation before March 31, 2013.
[d] Unique patients and Total Encounters – Source: MedSAS outpatient files; completed outpatient appointments indicated by a valid stop code during the July 1, 2012, through June 30, 2013, timeframe at the specified CBOC.
[e] http://vaww.pssg.med.va.gov/PSSG/DVDC/FY2013_Q1_VAST.xlsx
[f] Based on the number of unique patients seen as defined by VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, the size of the CBOC facility is categorized as very large (> 10,000), large (5,000-10,000), mid-size (1,500-5,000), or small (< 1,500).
[g] MH includes stop codes in the 500 series, excluding 531 and 563, in the primary position.
[h] Primary Care includes the stop code list in the primary position: 323 – Primary Care; 322 – Women's Clinic; 348 – Primary Care Group; 350 – Geriatric Primary Care; 531 – MH Primary Care Team-Individual; 563 – MH Primary care Team-Group; 170 – Home Based Primary Care (HBPC) Physician.
[i] All other non-Primary Care and non-MH stop codes in the primary position.

CBOC Services Provided

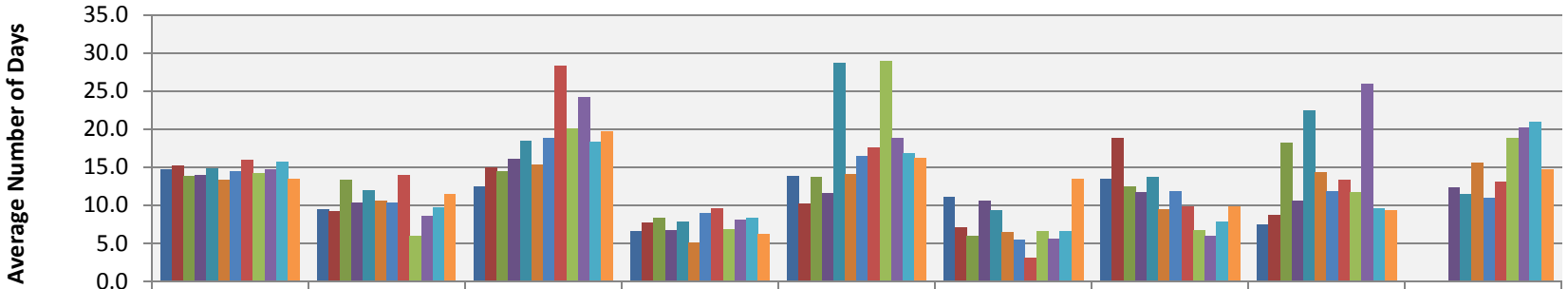
In addition to primary care integrated with WH and MH care, the CBOCs provide various specialty care, ancillary, and tele-health services. The following table lists the services provided at each CBOC.

CBOC	Specialty Care Services[j]	Ancillary Services[k]	Tele-Health Services[l]
Vancouver	Optometry Dental Podiatry Geriatrics Women's Cancer Care	Rehabilitation Radiology Audiology Diabetic Retinal Screening MOVE! Program[m] Social Work Prosthetics/Orthotics Polytrauma Speech Pathology Spinal Cord Injury Pharmacy Nutrition VICTORS & Advanced Low Vision[n] Chaplain	Tele Primary Care
West Metro Portland	Optometry Orthopedics Ophthalmology Neurology Ear, Nose and Throat	Radiology Audiology Diabetic Retinal Screening Social Work Pharmacy MOVE! Program Nutrition	Tele Primary Care
East Metro Portland	---	Social Work Pharmacy Nutrition	Tele Primary Care
Salem	Plastic Surgery	Diabetic Retinal Screening Social Work MOVE! Program	Tele Primary Care
Bend	Optometry Ophthalmology Dermatology Plastic Surgery	Rehabilitation Audiology Diabetic Retinal Screening Social Work MOVE! Program	Tele Primary Care
West Linn	---	Diabetic Retinal Screening Social Work MOVE! Program	Tele Primary Care
North Coast	---	MOVE! Program	Tele Primary Care

[j] Specialty Care Services refer to non-Primary Care and non-MH services provided by a physician.
[k] Ancillary Services refer to non-Primary Care and non-MH services that are not provided by a physician.
[l] Tele-Health Services refer to services provided under the VA Telehealth program (http://www.telehealth.va.gov/)
[m] VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.
[n] The Visual Impairment Centers to Optimize Remaining Sight (VICTORS) concept was developed to complement existing inpatient Blind Rehabilitation Centers to care for Veterans with significant visual impairment.

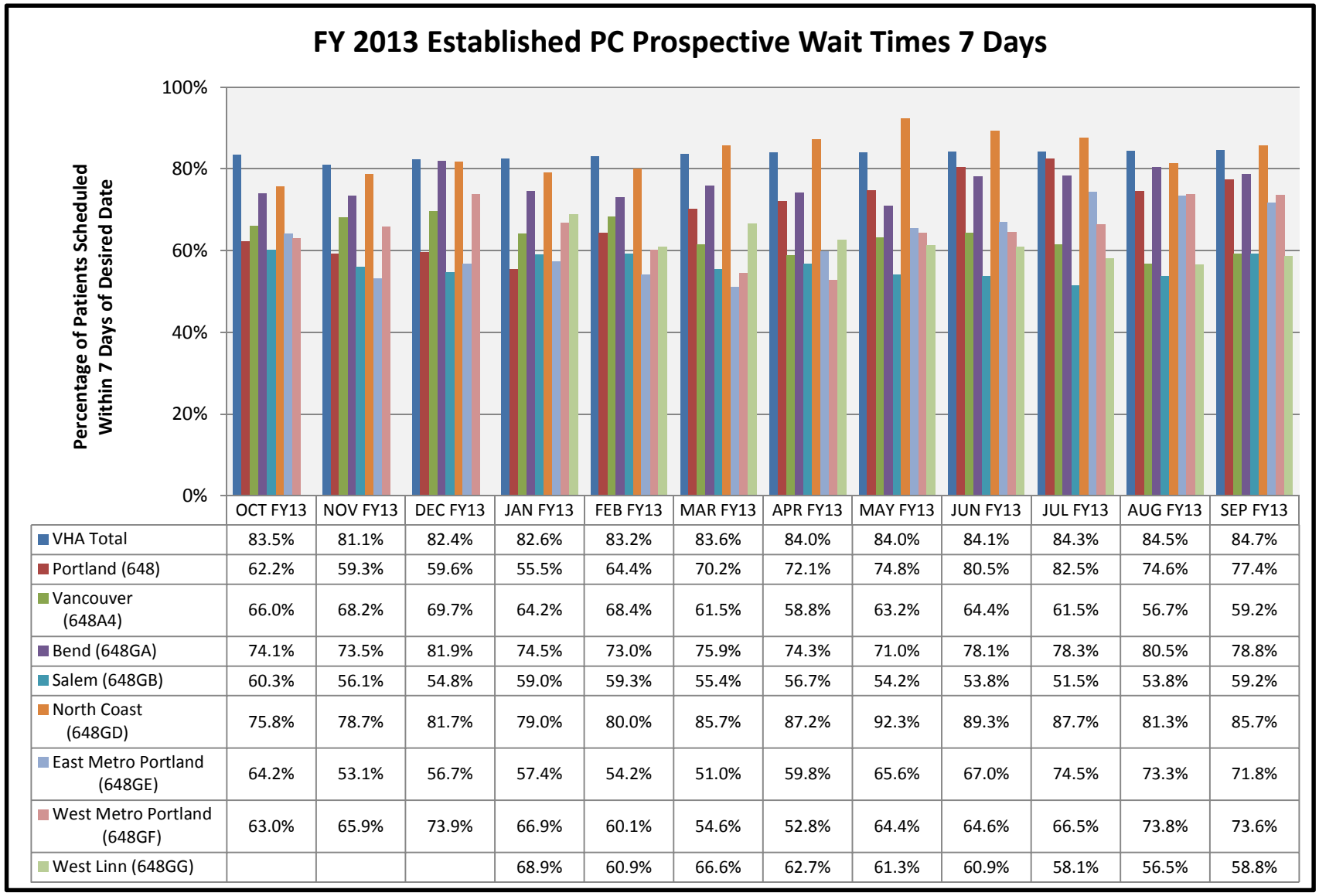
PACT Compass Metrics

FY 2013 Average 3rd Next Available in PC Clinics



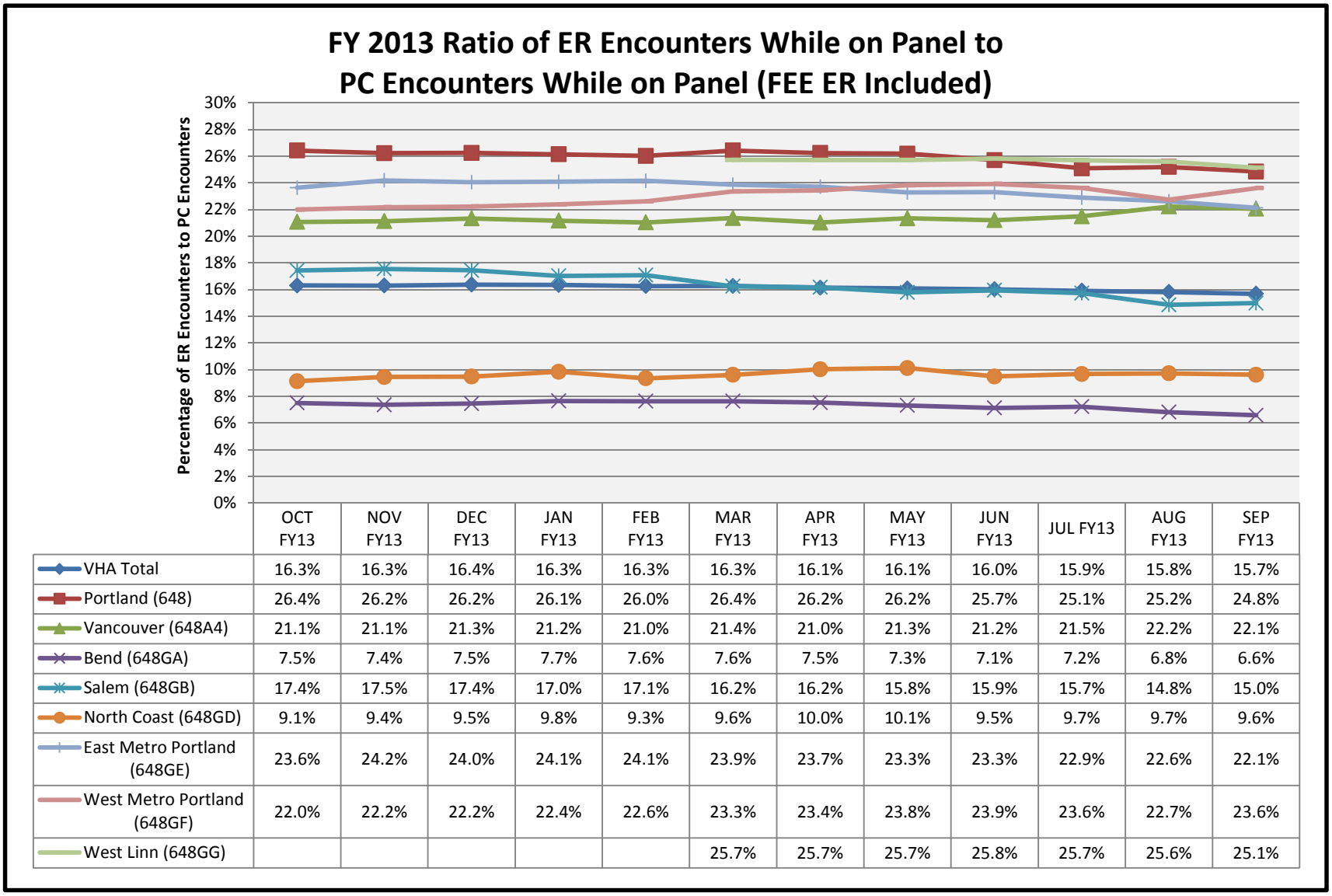
	VHA Total	Portland (648)	Vancouver (648A4)	Bend (648GA)	Salem (648GB)	North Coast (648GD)	East Metro Portland (648GE)	West Metro Portland (648GF)	West Linn (648GG)
OCT FY13	14.6	9.5	12.4	6.6	13.8	11.1	13.4	7.4	
NOV FY13	15.2	9.2	15.0	7.6	10.2	7.1	18.8	8.7	
DEC FY13	13.8	13.3	14.4	8.4	13.7	5.9	12.5	18.2	
JAN FY13	14.0	10.3	16.1	6.7	11.6	10.6	11.6	10.6	12.3
FEB FY13	14.8	11.9	18.4	7.8	28.6	9.3	13.6	22.4	11.4
MAR FY13	13.3	10.6	15.3	5.1	14.1	6.4	9.4	14.3	15.6
APR FY13	14.4	10.3	18.8	9.0	16.4	5.5	11.8	11.8	10.9
MAY FY13	16.0	13.9	28.3	9.6	17.6	3.0	9.8	13.3	13.1
JUN FY13	14.2	6.0	20.1	6.8	28.9	6.6	6.7	11.7	18.8
JUL FY13	14.6	8.6	24.2	8.1	18.8	5.6	5.9	25.9	20.2
AUG FY13	15.7	9.7	18.4	8.3	16.8	6.6	7.8	9.5	20.9
SEP FY13	13.4	11.4	19.6	6.2	16.2	13.5	9.8	9.4	14.7

Data Definition.[5] The average waiting time in days until the next third open appointment slot for completed primary care appointments in stop code 350. Completed appointments in stop code 350 for this metric include completed appointments where a 350 stop code is in the primary position on the appointment or one of the telephone stop codes is in the primary position, and 350 stop code is in the secondary position. The data is averaged from the national to the division level. Blank cells indicate the absence of reported data.



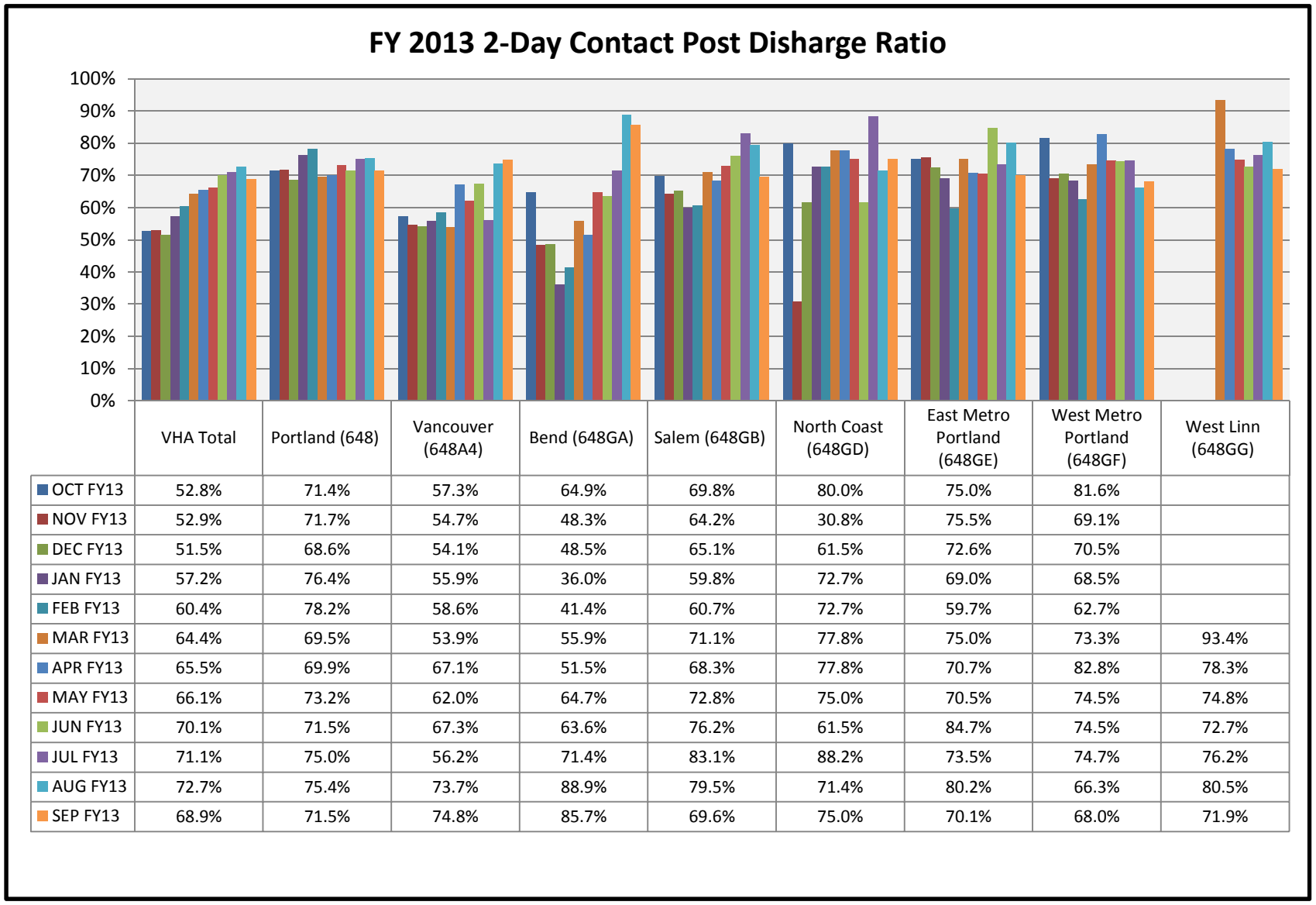
	OCT FY13	NOV FY13	DEC FY13	JAN FY13	FEB FY13	MAR FY13	APR FY13	MAY FY13	JUN FY13	JUL FY13	AUG FY13	SEP FY13
VHA Total	83.5%	81.1%	82.4%	82.6%	83.2%	83.6%	84.0%	84.0%	84.1%	84.3%	84.5%	84.7%
Portland (648)	62.2%	59.3%	59.6%	55.5%	64.4%	70.2%	72.1%	74.8%	80.5%	82.5%	74.6%	77.4%
Vancouver (648A4)	66.0%	68.2%	69.7%	64.2%	68.4%	61.5%	58.8%	63.2%	64.4%	61.5%	56.7%	59.2%
Bend (648GA)	74.1%	73.5%	81.9%	74.5%	73.0%	75.9%	74.3%	71.0%	78.1%	78.3%	80.5%	78.8%
Salem (648GB)	60.3%	56.1%	54.8%	59.0%	59.3%	55.4%	56.7%	54.2%	53.8%	51.5%	53.8%	59.2%
North Coast (648GD)	75.8%	78.7%	81.7%	79.0%	80.0%	85.7%	87.2%	92.3%	89.3%	87.7%	81.3%	85.7%
East Metro Portland (648GE)	64.2%	53.1%	56.7%	57.4%	54.2%	51.0%	59.8%	65.6%	67.0%	74.5%	73.3%	71.8%
West Metro Portland (648GF)	63.0%	65.9%	73.9%	66.9%	60.1%	54.6%	52.8%	64.4%	64.6%	66.5%	73.8%	73.6%
West Linn (648GG)				68.9%	60.9%	66.6%	62.7%	61.3%	60.9%	58.1%	56.5%	58.8%

Data Definition.[5] The percent of patients scheduled within 7 days of the desired date. Data source is the Wait Times Prospective Wait Times measures. The total number of scheduled appointments for primary care-assigned patients in primary care clinics 322, 323 and 350. Data is collected twice a month on the 1st and the 15th. Data reported is for the data pulled on the 15th of the month. There is no FY to date score for this measure. Blank cells indicate the absence of reported data.



	OCT FY13	NOV FY13	DEC FY13	JAN FY13	FEB FY13	MAR FY13	APR FY13	MAY FY13	JUN FY13	JUL FY13	AUG FY13	SEP FY13
VHA Total	16.3%	16.3%	16.4%	16.3%	16.3%	16.3%	16.1%	16.1%	16.0%	15.9%	15.8%	15.7%
Portland (648)	26.4%	26.2%	26.2%	26.1%	26.0%	26.4%	26.2%	26.2%	25.7%	25.1%	25.2%	24.8%
Vancouver (648A4)	21.1%	21.1%	21.3%	21.2%	21.0%	21.4%	21.0%	21.3%	21.2%	21.5%	22.2%	22.1%
Bend (648GA)	7.5%	7.4%	7.5%	7.7%	7.6%	7.6%	7.5%	7.3%	7.1%	7.2%	6.8%	6.6%
Salem (648GB)	17.4%	17.5%	17.4%	17.0%	17.1%	16.2%	16.2%	15.8%	15.9%	15.7%	14.8%	15.0%
North Coast (648GD)	9.1%	9.4%	9.5%	9.8%	9.3%	9.6%	10.0%	10.1%	9.5%	9.7%	9.7%	9.6%
East Metro Portland (648GE)	23.6%	24.2%	24.0%	24.1%	24.1%	23.9%	23.7%	23.3%	23.3%	22.9%	22.6%	22.1%
West Metro Portland (648GF)	22.0%	22.2%	22.2%	22.4%	22.6%	23.3%	23.4%	23.8%	23.9%	23.6%	22.7%	23.6%
West Linn (648GG)						25.7%	25.7%	25.7%	25.8%	25.7%	25.6%	25.1%

Data Definition.[5] This is a measure of where the patient receives his or her primary care and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care/FEE ER Encounters WOP (including FEE ER visits) *divided by* the number of primary care encounters WOP with the patient's assigned primary care (or associate) provider plus the total VHA ER/Urgent Care/FEE ER Encounters (including FEE ER visits) WOP plus the number of primary care encounters WOP with a provider other than the patient's PCP/AP. Blank cells indicate the absence of reported data.



	VHA Total	Portland (648)	Vancouver (648A4)	Bend (648GA)	Salem (648GB)	North Coast (648GD)	East Metro Portland (648GE)	West Metro Portland (648GF)	West Linn (648GG)
OCT FY13	52.8%	71.4%	57.3%	64.9%	69.8%	80.0%	75.0%	81.6%	
NOV FY13	52.9%	71.7%	54.7%	48.3%	64.2%	30.8%	75.5%	69.1%	
DEC FY13	51.5%	68.6%	54.1%	48.5%	65.1%	61.5%	72.6%	70.5%	
JAN FY13	57.2%	76.4%	55.9%	36.0%	59.8%	72.7%	69.0%	68.5%	
FEB FY13	60.4%	78.2%	58.6%	41.4%	60.7%	72.7%	59.7%	62.7%	
MAR FY13	64.4%	69.5%	53.9%	55.9%	71.1%	77.8%	75.0%	73.3%	93.4%
APR FY13	65.5%	69.9%	67.1%	51.5%	68.3%	77.8%	70.7%	82.8%	78.3%
MAY FY13	66.1%	73.2%	62.0%	64.7%	72.8%	75.0%	70.5%	74.5%	74.8%
JUN FY13	70.1%	71.5%	67.3%	63.6%	76.2%	61.5%	84.7%	74.5%	72.7%
JUL FY13	71.1%	75.0%	56.2%	71.4%	83.1%	88.2%	73.5%	74.7%	76.2%
AUG FY13	72.7%	75.4%	73.7%	88.9%	79.5%	71.4%	80.2%	66.3%	80.5%
SEP FY13	68.9%	71.5%	74.8%	85.7%	69.6%	75.0%	70.1%	68.0%	71.9%

Data Definition.[5] Total Discharges Included in 2-day Contact Post Discharge Ratio: The total VHA and FEE Inpatient Discharges for assigned primary care patients for the reporting timeframe. Discharges resulting in death and discharges where a patient is readmitted within 2 days of discharge are excluded from this metric. Blank cells indicate the absence of reported data.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 24, 2013

From: Director, VISN 20 (10N20)

Subject: **CBOC and PCC Reviews of the Portland VA Medical Center, Portland, OR**

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

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. Thank you for the opportunity to respond to the proposed recommendations from the Community Based Outpatient Clinic and Primary Care Clinic Reviews at the Portland VA Medical Center, Portland, 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:*)

Lawrence H. Carroll

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 20, 2013

From: Director, Portland VA Medical Center (648/P1DIR)

Subject: **CBOC and PCC Reviews of the Portland VA Medical Center, Portland, OR**

To: Director, VISN 20 (10N20)

I have reviewed the attached action plans for the areas of improvement recommended by the CBOC and PCC Reviews of the Portland VA Medical Center, Portland, OR and I concur with all recommended improvement actions.

(*original signed by:)*

MICHAEL W. FISHER
Interim Medical Center Director

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 a separate room is provided to store medical (infectious) waste at the Salem CBOC.

Concur

Target date for completion: December 14, 2013

Facility response: Additional shelving was installed in the clean utility room. Clean, unopened Kavi wipes, bleach wipes, and Purell hand sanitizer are now stored in the clean utility room (#140). All medical waste is in a separate dedicated room (dirty utility room #139).

Recommendation 2. We recommended that signage is installed at the North Coast CBOC to clearly identify the location of fire extinguishers.

Concur

Target date for completion: November 21, 2013

Facility response: Signage clearly identifying the location of fire extinguishers has been installed as required.

Recommendation 3. We recommended that the IT server closet at the North Coast CBOC is maintained according to IT safety and security standards.

Concur

Target date for completion: November 21, 2013

Facility response: The North Coast server room is now locked and secure based on IT safety and security standards. Access to the server room is restricted to authorized personnel. The key to the server room is in the possession of the lead LPN, or delegate. Only authorized IT personnel are given access to the server room/IT closet. A signature log has been established to track all authorized personnel who enter the IT server closet. Name, date of entry, and reason for entry is recorded in the log and the log entry is signed by both the individual gaining access and the individual granting access.

Recommendation 4. We recommended that CBOC/PCC staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.

Concur

Target date for completion: April 30, 2014

Facility response: A refresher education will be provided to Primary Care Division (PCD) staff physicians, nurse practitioners, contract and locum tenens staff on the importance of offering treatment to Veterans seen in clinic who have a diagnosis of alcohol dependence noted during their yearly AUDIT-C screen. The importance of documenting this discussion will be included in this education. A log will be kept to ensure that 100% of the staff providers receive this education by January 31, 2014.

Ongoing monitoring will occur to assure staff consistency of documenting the offer of further treatment to patients with alcohol dependence. Based on results from this monitor, expect to see treatment offering and documentation at greater than or equal to 90% compliance.

Recommendation 5. We recommended that CBOC/PCC RN Care Managers receive MI and health coaching training within 12 months of appointment to PACT.

Concur

Target date for completion: June 30, 2014

Facility response: CBOC/PCC RN Care Managers (NCMs) within the Primary Care Division not yet trained in MI/TEACH, will be trained by June 30, 2014. A process is in place to ensure all NCM's obtain this training within 12 months of their assignment to PACT. The Health Promotion Disease Prevention (HPDP) Program Manager and Health Behavior Coordinator will work closely with the CBOC Operation Managers to identify NCMs needing training. They will track training to ensure it is completed within the designated 12 month time period and quarterly report the status of this training to Primary Care Leadership.

Recommendation 6. We recommended that CBOC/PCC staff document medication reconciliation that includes the newly prescribed fluoroquinolone in the EHR.

Concur

Target date for completion: April 30, 2014

Facility response: A refresher education will be provided to Primary Care Division and Pharmacy Division CBOC staff on the need to perform and document medication reconciliation in the EHR (CPRS) which specifically includes newly prescribed flouroquinolones. A log will be kept to ensure that 100% of the identified staff receives this education by January 31, 2014.

Ongoing monitoring will occur to assure staff consistency of performing and documenting medication reconciliation in the EHR. This monitoring will continue until documentation is greater than or equal to 90% compliance.

Recommendation 7. We recommended that CBOC/PCC staff provide and document medication counseling/education that includes the fluoroquinolone.

Concur

Target date for completion: April 30, 2014

Facility response: A refresher education to Primary Care Division (PCD) staff physicians, nurse practitioners, contract and locum tenens staff, Registered Nurse staff, and CBOC-based Pharmacy staff on the need to routinely perform and document medication counseling/education in the EHR (CPRS) that specifically includes newly prescribed flouroquinolones. A log will be kept to ensure that 100% of the identified staff receives this education by January 31, 2014.

Ongoing monitoring will occur to assure staff consistency of performing and documenting medication counseling/education in the EHR. This monitoring will continue until documentation is greater than or equal to 90% compliance.

Recommendation 8. We recommended that CBOC/PCC staff document the evaluation of patient's level of understanding for the medication education.

Concur

Target date for completion: April 30, 2014

Facility response: A refresher education to Primary Care Division (PCD) staff physicians, nurse practitioners, contract and locum tenens staff, Registered Nurse staff, and CBOC-based Pharmacy staff, on the need to routinely perform and document in the EHR (CPRS) an assessment that indicates the Veteran's level of understanding of the medication education for newly prescribed medications (including flouroquinolones). A log will be kept to ensure that 100% of the identified staff receives this education by January 31, 2014.

Ongoing monitoring will occur to assure staff consistency of performing and documenting an assessment indicating the Veteran's level of understanding of the medication education for newly prescribed medications including flouroquinolones in the EHR (CPRS). This monitoring will continue until documentation is greater than or equal to 90% compliance.

Recommendation 9. We recommended that the Chief of Staff consistently ensure that all DWHPs are designated with the WH indicator in the PCMM.

Concur

Target date for completion: March 31, 2014

Facility response: Designation of DWHPs was corrected on November 21, 2013. Beginning in January 2014, the Women Veterans Health Program Manager (WVHPM) will meet with every newly hired PCP during new employee orientation to determine skill set. Based on that interview and assessment, the WVHPM will contact our PCMM Manager to assure that DWHP designation is entered into PCMM. The WVHPM and Primary Care Leadership (PCL) review the list of designated DWHP Primary Care Providers and correct any discrepancies. The PCL is the Chief of Staff designate.

OIG Contact and Staff Acknowledgments

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Endnotes

[1] References used for the EOC review included:
- US Access Board, *Americans with Disabilities Act Accessibility Guidelines (ADAAG)*, September 2, 2002.
- US Department of Health and Human Services, Health Insurance Portability and Accountability Act, *The Privacy Rule*, August 14, 2002.
- US Department of Labor, Occupational Safety and Health Administration, *Laws and Regulations*.
- US Department of Labor, Occupational Safety and Health Administration, *Guidelines for Preventing Workplace Violence*, 2004.
- Joint Commission, *Joint Commission Comprehensive Accreditation and Certification Manua*l, July 1, 2013.
- VA Directive 0324, *Test, Training, Exercise, and Evaluation Program*, April 5, 2012.
- VA Directive 0059, *VA Chemicals Management and Pollution Prevention*, May 25, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information System*, September 20, 2012.
- VHA Center for Engineering, Occupational Safety, and Health, *Emergency Management Program Guidebook*, March 2011.
- VHA Center for Engineering, Occupational Safety, and Health, *Online National Fire Protection Association Codes, Standards, Handbooks, and Annotated Editions of Select Codes and Standards*, July 9, 2013.
- VHA Deputy Under Secretary for Health for Operations and Management, Memorandum: *Environmental Rounds*, March 5, 2007.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults & Other Defined Public Safety Incidents in VHA Facilities*, September 27, 2012.
- VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- VHA Handbook 1850.05, *Interior Design Operations and Signage*, July 1, 2011.

[2] References used for the AUD review included:
- VHA Handbook 1120.02, *Health Promotion Disease Prevention (HPDP) Program*, July 5, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

[3] References used for the Medication Management review included:
- VHA Directive 2011-012, *Medication Reconciliation*, March 9, 2011.
- VHA Directive 2012-011, *Primary Care Standards*, April 11, 2012.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Joint Commission, *Joint Commission Comprehensive Accreditation and Certification Manua*l, July 1, 2013.

[4] References used for the DWHP review included:
- VHA Deputy Under Secretary for Health for Operations and Management, Memorandum: *Health Care Services for Women Veterans*, Veterans Health Administration (VHA) Handbook 1330.01; Women's Health (WH) Primary Care Provider (PCP) Proficiency, July 8, 2013.
- VHA Handbook 1330.01 *Health Care Services for Women Veterans*, May 21, 2010.
- VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

[5] Reference used for PACT Compass data graphs:
- Department of Veterans' Affairs, *Patient Aligned Care Teams Compass Data Definitions*, August 29, 2013.