Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00228-94

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Overton Brooks VA Medical Center Shreveport, Louisiana

March 14, 2014

Washington, DC 20420

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

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
MH	mental health
MI	motivational interviewing
MM	medication management
NM	not met
OIG	Office of Inspector General
PACT	Patient Aligned Care Teams
PCC	primary care clinic
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 a site visit during the week of January 27, 2014, at the Monroe, LA, CBOC which is under the oversight of the Overton Brooks VA Medical Center and Veterans Integrated Service Network 16.

Review Results: We conducted four focused reviews and had no findings for the Designated Women's Health Providers' Proficiency review. However, we made recommendations in the following three review areas:

Environment of Care (EOC). Ensure that:

- All identified EOC deficiencies at the Monroe CBOC are reported to and tracked by the parent facility Executive Safety Committee until resolution.
- The parent facility include staff at the Monroe CBOC in required education, training, planning, and participation in annual disaster exercises.

Alcohol Use Disorder. Ensure that CBOC/PCC:

- Staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
- Staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.

Medication Management. Ensure that CBOC/PCC staff:

- Document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.
- Document the evaluation of patient's level of understanding for the medication education.

Comments

The VISN and Interim Center Directors agreed with the CBOC and PCC review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 15–19, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives, 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 an onsite inspection, 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 this 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 inspection was only conducted at a randomly selected CBOC 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/PCC 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 AUDs. 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 a physical inspection of the Monroe CBOC. 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 and tested 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.	
	The CBOC has a separate storage room for storing medical (infectious) waste.	
	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.	
	Access to fire extinguishers is unobstructed.	
	The CBOC has signs identifying the locations of fire extinguishers.	
	Exit signs are visible from any direction.	
	No expired medications were noted during the onsite visit.	
	All medications are secured from unauthorized access.	

NM	Areas Reviewed (continued)	Findings
	Patient-identifiable information 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 laying 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.	
	The Information Technology network room/server closet is locked.	
	All computer screens are locked when not in use.	
	Staff use privacy screens on monitors to prevent unauthorized viewing in high-traffic areas.	
X	EOC rounds are conducted semi-annually (at least twice in a 12-month period) and deficiencies are reported to and tracked by the EOC Committee until resolution.	EOC deficiencies at the Monroe CBOC were not reported to and tracked by the parent facility Executive Safety Committee until resolution.
	The CBOC has an automated external defibrillator.	
	Safety inspections are performed on the CBOC medical equipment in accordance with Joint Commission standards.	
X	The parent facility includes the CBOC in required education, training, planning, and participation leading up to the annual disaster exercise.	The parent facility did not include the Monroe CBOC in required education, training, planning, and participation leading up to the annual disaster exercises.
	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.	

Recommendations

1. We recommended that all identified environment of care deficiencies at the Monroe CBOC are reported to and tracked by the parent facility Executive Safety Committee until resolution.

2. We recommended that the parent facility include staff at the Monroe CBOC in required education, training, planning, and participation in annual disaster exercises.

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.	
X	Diagnostic assessments are completed for patients with a positive alcohol screen.	Staff did not complete diagnostic assessments for 5 (13 percent) of 40 patients who had positive alcohol use screens.
	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 of Alcohol Abuse and Alcoholism guidelines.	
X	Documentation reflects 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 13 patients diagnosed with alcohol dependence.
	For patients with AUD who decline referral to specialty care, CBOC/PCC staff monitored them and their alcohol use.	
	Counseling, education, and brief treatments for AUD are provided within 2 weeks of positive screening.	
	CBOC/PCC RN Care Managers have received MI training within 12 months of appointment to PACT.	
	CBOC/PCC RN Care Managers have received VHA National Center for Health Promotion and Disease Prevention-approved health coaching training (most likely TEACH for Success) within 12 months of appointment to PACT.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

3. We recommended that CBOC/Primary Care Clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.

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

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 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 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 13 (33 percent) of 40 patient EHRs.
	Written information on the patient's prescribed medications was provided at the end of the outpatient encounter.	
	Medication counseling/education for the fluoroquinolone was documented in the 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 7 (18 percent) of 40 patients.
	The facility complied with local policy.	

Recommendations

5. We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.

6. We recommended that 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, Primary Care Management Module data, and supporting documentation for DWHPs' proficiencies. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Table 5. DWHP Proficiency

NM	Areas Reviewed	Findings
	CBOC and PCC DWHPs maintained proficiency requirements.	
	CBOC and PCC DWHPs were designated with the WH indicator in the Primary Care Management Module.	

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**
Longview	TX	667GC	Urban	Large	797	5,301	3,307	5,872	4,202	11,639	8,849	24,690
Monroe	LA	667GB	Urban	Large	627	4,834	2,959	5,052	2,016	11,142	6,846	20,004
Texarkana	AR	667GA	Urban	Mid-Size	746	4,457	2,648	4,776	3,820	12,812	8,036	24,668

[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] Mental Health 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

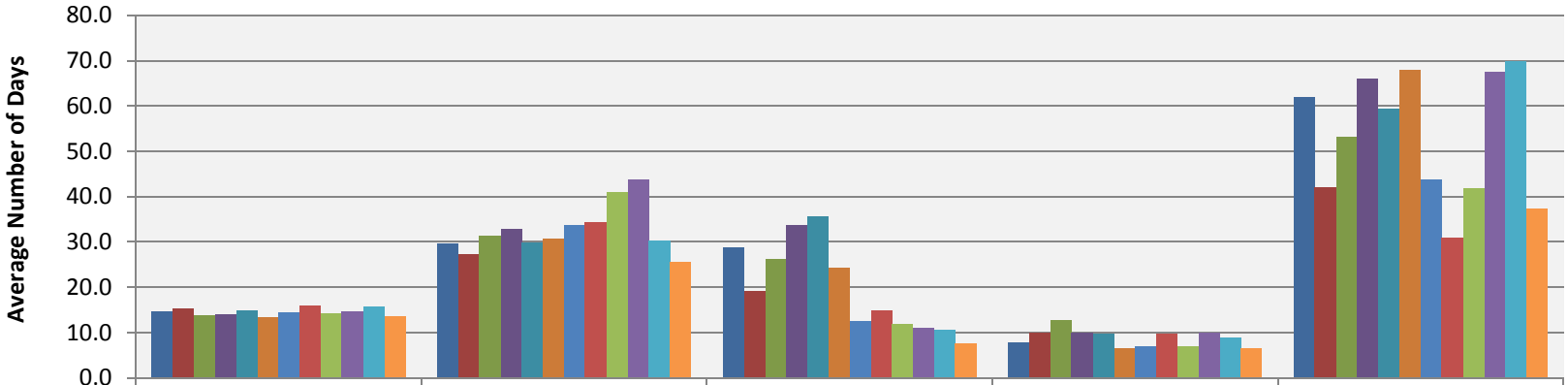
In addition to primary care integrated with WH and MH care, the CBOCs provide various specialty care, ancillary, and tele-health services. The following table lists the services provided at each CBOC.[j]

CBOC	Specialty Care Services[k]	Ancillary Services[l]	Tele-Health Services[m]
Longview	---	Audiology Diabetic Retinal Screening Nutrition MOVE! Program[n]	Tele Primary Care
Monroe	---	Diabetic Retinal Screening Nutrition MOVE! Program	Tele Primary Care
Texarkana	---	Nutrition Diabetic Retinal Screening MOVE! Program	Tele Primary Care

[j]Source: MedSAS outpatient files; the denoted Specialty Care and Ancillary Services are limited to Primary Clinic Stops with a count ≥ 100 encounters during the July 1, 2012, through June 30, 2013, timeframe at the specified CBOC.
[k] Specialty Care Services refer to non-Primary Care and non-Mental Health services provided by a physician.
[l] Ancillary Services refer to non-Primary Care and non-Mental Health services that are not provided by a physician.
[m] Tele-Health Services refer to services provided under the VA Telehealth program (http://www.telehealth.va.gov/)
[n] VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.

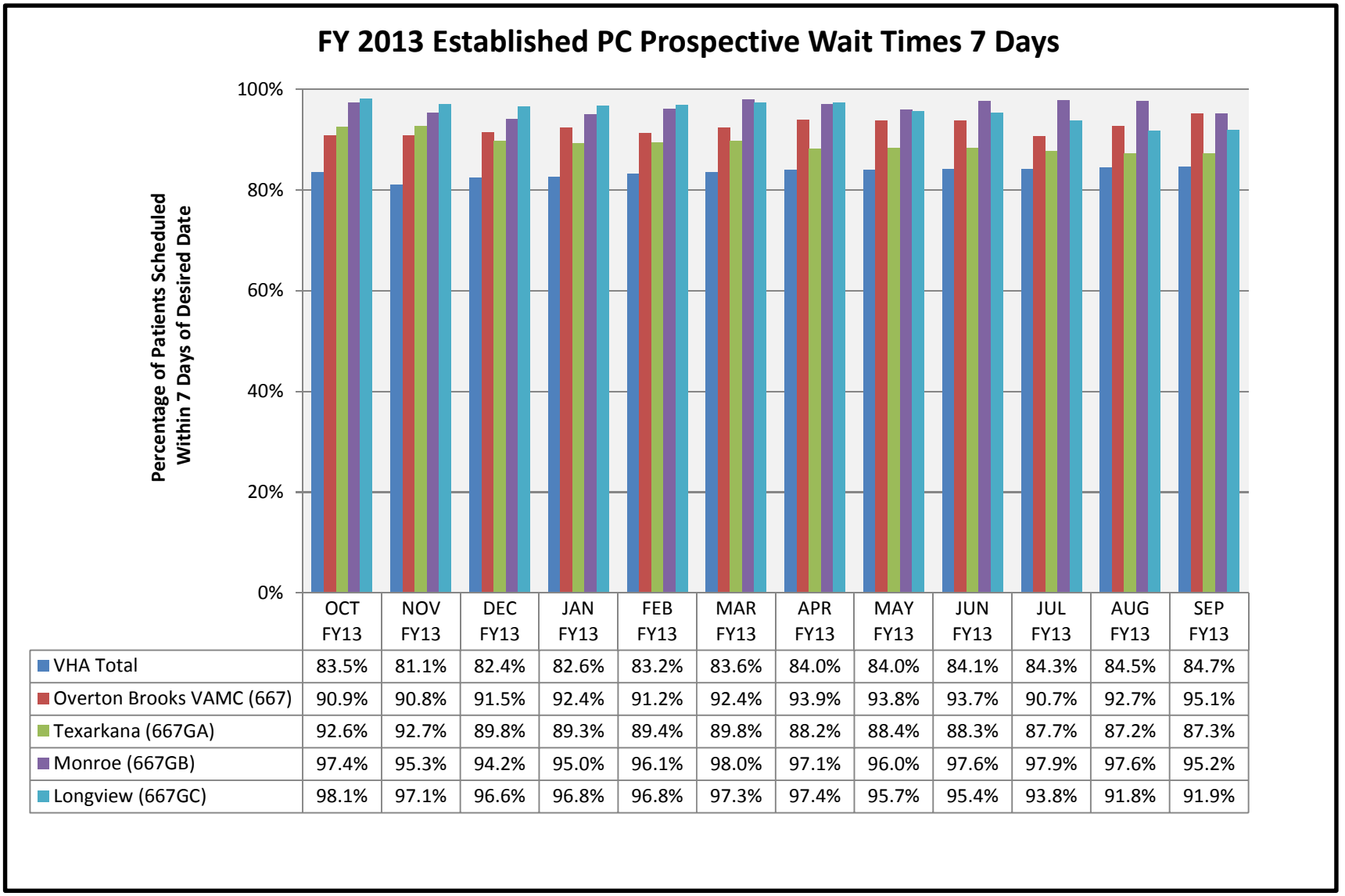
PACT Compass Metrics

FY 2013 Average 3rd Next Available in PC Clinics



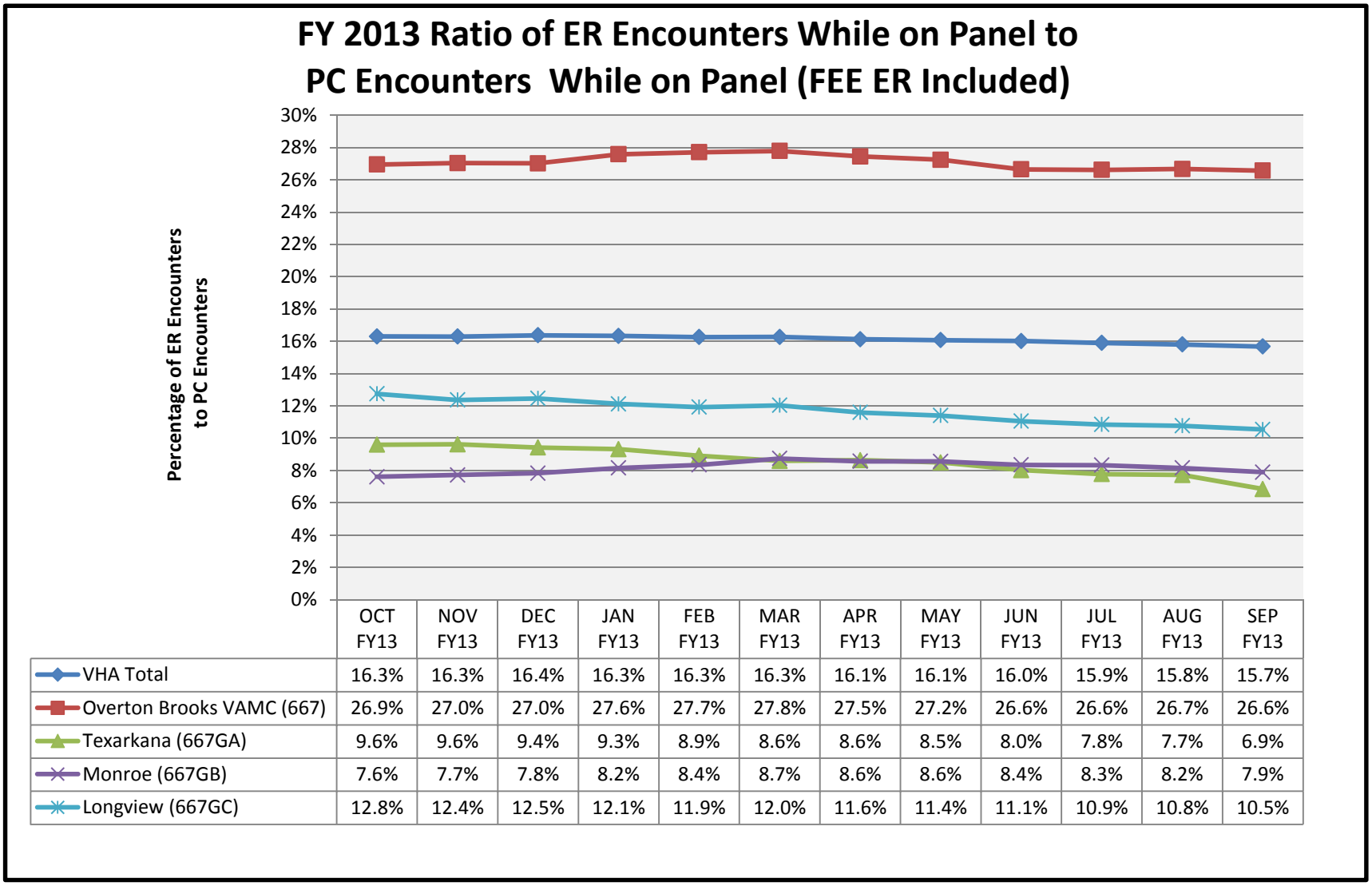
	VHA Total	Overton Brooks VAMC (667)	Texarkana (667GA)	Monroe (667GB)	Longview (667GC)
OCT FY13	14.6	29.7	28.6	7.8	61.8
NOV FY13	15.2	27.2	19.1	9.9	41.9
DEC FY13	13.8	31.3	26.1	12.6	53.0
JAN FY13	14.0	32.8	33.6	9.9	66.0
FEB FY13	14.8	29.8	35.5	9.7	59.3
MAR FY13	13.3	30.6	24.2	6.5	67.8
APR FY13	14.4	33.6	12.4	6.9	43.7
MAY FY13	16.0	34.4	14.9	9.8	31.0
JUN FY13	14.2	40.8	11.9	7.0	41.7
JUL FY13	14.6	43.8	11.0	9.8	67.5
AUG FY13	15.7	30.3	10.6	8.9	69.7
SEP FY13	13.4	25.5	7.5	6.4	37.4

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.



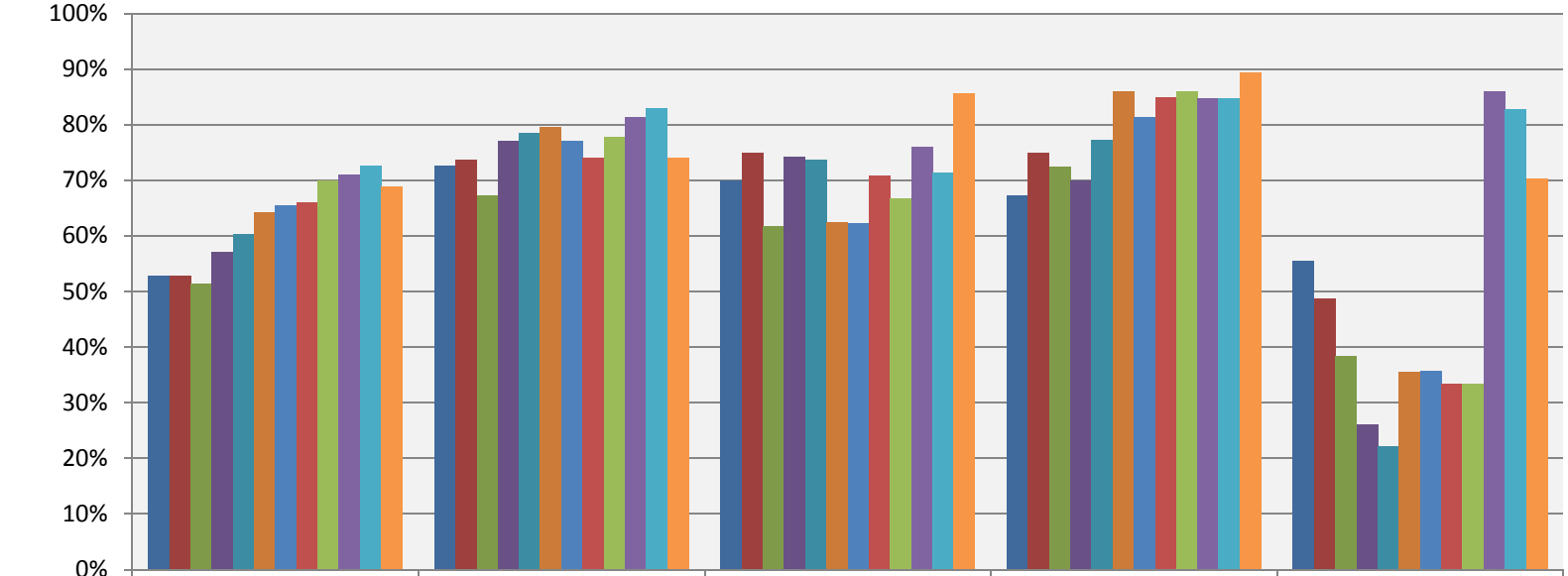
	OCT FY13	NOV FY13	DEC FY13	JAN FY13	FEB FY13	MAR FY13	APR FY13	MAY FY13	JUN FY13	JUL FY13	AUG FY13	SEP FY13
VHA Total	83.5%	81.1%	82.4%	82.6%	83.2%	83.6%	84.0%	84.0%	84.1%	84.3%	84.5%	84.7%
Overton Brooks VAMC (667)	90.9%	90.8%	91.5%	92.4%	91.2%	92.4%	93.9%	93.8%	93.7%	90.7%	92.7%	95.1%
Texarkana (667GA)	92.6%	92.7%	89.8%	89.3%	89.4%	89.8%	88.2%	88.4%	88.3%	87.7%	87.2%	87.3%
Monroe (667GB)	97.4%	95.3%	94.2%	95.0%	96.1%	98.0%	97.1%	96.0%	97.6%	97.9%	97.6%	95.2%
Longview (667GC)	98.1%	97.1%	96.6%	96.8%	96.8%	97.3%	97.4%	95.7%	95.4%	93.8%	91.8%	91.9%

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.



	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%
Overton Brooks VAMC (667)	26.9%	27.0%	27.0%	27.6%	27.7%	27.8%	27.5%	27.2%	26.6%	26.6%	26.7%	26.6%
Texarkana (667GA)	9.6%	9.6%	9.4%	9.3%	8.9%	8.6%	8.6%	8.5%	8.0%	7.8%	7.7%	6.9%
Monroe (667GB)	7.6%	7.7%	7.8%	8.2%	8.4%	8.7%	8.6%	8.6%	8.4%	8.3%	8.2%	7.9%
Longview (667GC)	12.8%	12.4%	12.5%	12.1%	11.9%	12.0%	11.6%	11.4%	11.1%	10.9%	10.8%	10.5%

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.



	VHA Total	Overton Brooks VAMC (667)	Texarkana (667GA)	Monroe (667GB)	Longview (667GC)
OCT FY13	52.8%	72.7%	70.0%	67.3%	55.6%
NOV FY13	52.9%	73.7%	75.0%	75.0%	48.8%
DEC FY13	51.5%	67.3%	61.8%	72.5%	38.5%
JAN FY13	57.2%	77.1%	74.3%	70.0%	26.1%
FEB FY13	60.4%	78.5%	73.7%	77.3%	22.2%
MAR FY13	64.4%	79.5%	62.5%	86.0%	35.6%
APR FY13	65.5%	77.0%	62.2%	81.4%	35.7%
MAY FY13	66.1%	74.0%	70.8%	85.0%	33.3%
JUN FY13	70.1%	77.8%	66.7%	86.0%	33.3%
JUL FY13	71.1%	81.3%	76.0%	84.8%	86.0%
AUG FY13	72.7%	83.0%	71.4%	84.8%	82.9%
SEP FY13	68.9%	74.0%	85.7%	89.4%	70.3%

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.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 24, 2014

From: Director, South Central VA Health Care Network (10N16)

Subject: **CBOC and PCC Reviews of the Overton Brooks VA Medical Center, Shreveport, LA**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the draft Community Based Outpatient Clinic and Primary Care Clinic Report submitted by the Overton Brooks VA Medical Center, Shreveport, LA.

2. If you have questions regarding the information submitted, please contact Reba T. Moore, VISN 16 Accreditation Specialist at (601) 206-7022.

Lynn Ryan
Deputy Network Director
for and in the absence of:

Rica Lewis-Payton, MHA, FACHE
Director, South Central VA Health Care Network (10N16)

Appendix D

Interim Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 24, 2014

From: Interim Center Director, Overton Brooks VA Medical Center (667/00)

Subject: **CBOC and PCC Reviews of the Overton Brooks VA Medical Center, Shreveport, LA**

To: Director, South Central VA Health Care Network (10N16)

1. The Overton Brooks VA Medical Center, Shreveport, LA, concurs with the findings included in the Community Based Outpatient Clinic (CBOC) and Primary Care Clinic Report for the Monroe, LA, CBOC.

2. If you have questions or need additional information, please contact Myrtle Tate, Quality Management Consultant at (318) 990-5407.

Mark A. Enderle, MD
Interim Center Director, Overton Brooks VA Medical Center (667/00)

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 all identified environment of care deficiencies at the Monroe CBOC are reported to and tracked by the parent facility Executive Safety Committee until resolution.

Concur

Target date for completion: February 25, 2014

Facility response: A representative from the Monroe CBOC was added as a voting member to the Executive Safety Committee (ESC). Environment of Care Rounds Deficiency Report was added to the agenda of the ESC. Per VHA Policy, citations greater than 14 days for all EOC rounds including the Monroe CBOC will be reported to the ESC. Deficiencies greater than 30 days will be elevated to the Medical Center Governing Board for further action, including findings from the Monroe CBOC.

Evaluation method: Rounds will be tracked to completion and deficiencies reported to the ESC. Performance goal for tracking is 100%.

Recommendation 2. We recommended that the parent facility include staff at the Monroe CBOC in required education, training, planning, and participation in annual disaster exercises.

Concur

Target date for completion: March 30, 2014

Facility response: CBOC Administrative Officers are participating in Emergency Management Committee meetings via VANTS telephone line and participation is documented in the minutes. In future exercises, CBOC staff will be asked to participate in support of main campus events. Administrative Officers have been included in scheduled Incident Command Staff training which will be documented on a class roster. Administrative Officers will ensure other CBOC staff are trained in Emergency Management.

Evaluation method: Documentation will reflect 100% participation in Emergency Management training and participation in 90% of Emergency Management Committee meetings.

Recommendation 3. We recommended that CBOC/Primary Care Clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.

Concur

Target date for completion: March 30, 2014

Facility response: Education was completed for CBOC/Primary Care providers on February 19, 2014, to reinforce completion of diagnostic assessment for positive alcohol screen. A process will be developed to assist providers in identification of missed assessment.

Evaluation method: The facility will audit 50% of positive Audit-C cases each quarter, or 30 cases, whichever is greater until 90% compliance is sustained.

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

Concur

Target date for completion: February 19, 2014

Facility response: Education was completed for CBOC/Primary Care providers on February 19, 2014, to reinforce documentation of further treatment offered to patients with alcohol dependence.

Evaluation method: The facility will audit 50% of cases with alcohol dependence diagnosis monthly for documentation of further treatment with a target of 90% compliance.

Recommendation 5. We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.

Concur

Target date for completion: March 31, 2014

Facility response: This finding was reviewed by the Pharmacy and Therapeutics Committee on February 10, 2014. The committee recommended the issue be discussed at the Medical Executive Committee. At the February 20, 2014, Medical Executive Committee meeting providers were reminded they will document that medication reconciliation has occurred when a newly-prescribed Fluoroquinolone is administered, prescribed, or modified. An additional communication was sent to all providers on February 21, 2014.

Evaluation method: Pharmacy Service will prospectively review 30 records or 10% of cases (whichever is greater) for patients receiving a newly-prescribed Fluoroquinolone to ensure medication reconciliation is documented in at least 95% of records reviewed.

Recommendation 6. We recommended that staff document the evaluation of patient's level of understanding for the medication education.

Concur

Target date for completion: March 31, 2014

Facility response: This finding was reviewed by the Pharmacy and Therapeutics Committee on February 10, 2014. The committee recommended the issue be discussed at the Medical Executive Committee. At the February 20, 2014, Medical Executive Committee providers were reminded they will document the patient's level of understanding of medication education provided when a newly-prescribed Fluoroquinolone is administered, prescribed, or modified. An additional communication was sent to all providers on February 21, 2014.

Evaluation method: Pharmacy Service will prospectively review 30 records or 10% of cases (whichever is greater) for patients receiving a newly-prescribed Fluoroquinolone to ensure a patient's level of understanding of education provided is documented in at least 95% of records reviewed.

OIG Contact and Staff Acknowledgments

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Endnotes

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