Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00925-299

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Wilkes-Barre VA Medical Center Wilkes-Barre, Pennsylvania

October 7, 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
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 site visits during the week of August 4, 2014, at the following CBOCs which are under the oversight of the Wilkes-Barre VA Medical Center and Veterans Integrated Service Network 4:

- Northampton County CBOC, Bangor, PA
- Williamsport CBOC, Williamsport, PA

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. Ensure that:

- The parent facility includes staff at the Northampton County and Williamsport CBOCs in required education, training, planning, and participation in annual disaster exercises.
- The parent facility documents Emergency Management Preparedness-specific training completed for the clinical providers at the Northampton County and Williamsport CBOCs.
- The parent facility's Emergency Management Committee evaluates the Northampton County and Williamsport CBOCs' emergency preparedness activities, participation in annual disaster exercises, and staff training/education relating to emergency preparedness requirements.

Alcohol Use Disorder. Ensure that CBOC/PCC 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.
- Consistently provide written medication information that includes the fluoroquinolone.
- Provide medication counseling/education as required.

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 15–19, 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
Healthcare Inspections

Objectives, Scope, and Methodology

Objectives

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

[1] 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[2] 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.

[2] 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.[a]

We reviewed relevant documents and conducted physical inspections of the Northampton County and Williamsport CBOCs. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

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., mental health clinic).	
	Alcohol hand wash or soap dispenser and sink are available in the examination rooms.	
	Sharps containers are secured.	
	Safety needle devices are available.	
NA	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.	

NM	Areas Reviewed (continued)	Findings
	All medications are secured from unauthorized access.	
	Personally 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 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.	
	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.	
	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.	
	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 Northampton County and Williamsport CBOCs in required education, training, planning, and participation leading up to the annual disaster exercises. • Document Emergency Management Preparedness-specific training for the Northampton County and Williamsport CBOCs' clinical providers.
X	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.	The parent facility's Emergency Management Committee did not evaluate the Northampton County and Williamsport CBOCs' emergency preparedness activities, participation in annual disaster exercise, and staff training/education relating to emergency preparedness requirements.

Recommendations

1. We recommended that the parent facility includes staff at the Northampton County and Williamsport CBOCs in required education, training, planning, and participation in annual disaster exercises.

2. We recommended that the parent facility documents Emergency Management Preparedness-specific training completed for the Northampton County and Williamsport CBOCs' clinical providers.

3. We recommended that the parent facility's Emergency Management Committee evaluates the Northampton County and Williamsport CBOCs' emergency preparedness activities, participation in annual disaster exercises, and staff training/education relating to emergency preparedness requirements.

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.[b]

We reviewed relevant documents. We also reviewed 36 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 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 any of the five 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 motivational interviewing 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

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.[c]

We reviewed relevant documents. We also reviewed 32 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 5 (16 percent) of 32 patient EHRs.
X	Written information on the patient's prescribed medications was provided at the end of the outpatient encounter.	We did not find documentation that 22 (69 percent) of 32 patients received written information that included the fluoroquinolone.
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 4 (13 percent) of 32 patients' EHRs.
	Clinicians documented the evaluation of each patient's level of understanding for the education provided.	
	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 consistently provide written medication information that includes the fluoroquinolone.

7. We recommended that staff provide medication counseling/education as required.

DWHP Proficiency

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

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.[3] The table below provides information relative to each of the CBOCs.

					Uniques[4]				Encounters[4]			
Location	**State**	**Station #**	**Locality[5]**	**CBOC Size[6]**	**MH[7]**	**PC[8]**	**Other[9]**	**All**	**MH[7]**	**PC[8]**	**Other[9]**	**All**
Allentown	PA	693B4	Urban	Very Large	2,903	8,719	8,803	10,422	20,594	18,812	45,128	84,534
Williamsport	PA	693GB	Urban	Mid-Size	800	3,849	1,576	4,179	3,915	7,823	4,390	16,128
Sayre	PA	693GA	Rural	Mid-Size	332	2,902	2,815	3,130	1,700	8,169	13,598	23,467
Berwick (Columbia County)	PA	693GF	Urban	Small	179	1,437	87	1,493	1,003	3,115	118	4,236
Bangor (Northampton County)	PA	693GG	Urban	Small	89	1,318	503	1,361	241	3,282	1,630	5,153
Tobyhanna	PA	693GC	Rural	Small	42	606	181	629	118	1,137	268	1,523

[3] Includes all CBOCs in operation before March 31, 2013.
[4] Unique patients and Total Encounters – Source: MedSAS outpatient files; completed outpatient appointments indicated by a valid stop code during the October 1, 2012, through September 30, 2013, timeframe at the specified CBOC.
[5] http://vaww.pssg.med.va.gov/PSSG/DVDC/FY2013_Q1_VAST.xlsx
[6] 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).
[7] Mental Health includes stop codes in the 500 series, excluding 531 and 563, in the primary position.
[8] 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.
[9] All other non-Primary Care and non-MH stop codes in the primary position.

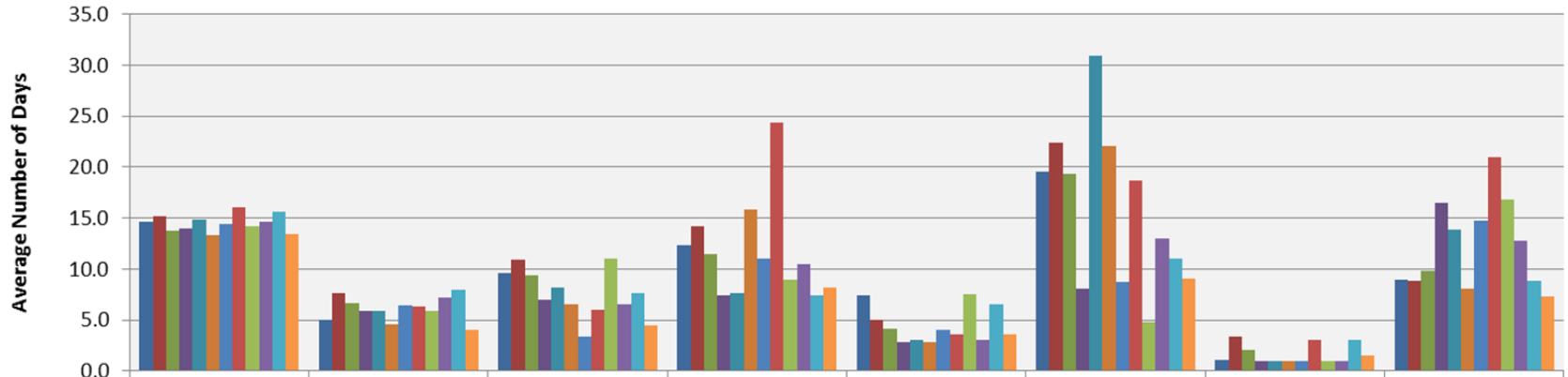
CBOC Services Provided

In addition to primary care integrated with WH and mental health care, the CBOCs provide various specialty care, ancillary, and tele-health services. The following table lists the services provided at each CBOC.[10]

CBOC	Specialty Care Services[11]	Ancillary Services[12]	Tele-Health Services[13]
Allentown	Optometry Dental Podiatry Ophthalmology Dermatology Orthopedics Rheumatology General Surgery	Laboratory Pharmacy Audiology Radiology Electrocardiography Diabetes Care MOVE! Program[14] Diabetic Retinal Screening Nutrition VIST[15] Prosthetics/Orthotics	Tele Primary Care
Williamsport	Anti-Coagulation Clinic Social Work		Tele Primary Care
Sayre	Podiatry Anti-Coagulation Clinic Optometry	Laboratory Radiology Prosthetics/Orthotics Nutrition Electrocardiography	Tele Primary Care
Berwick (Columbia Co.)	---		Tele Primary Care
Northampton County	Anti-Coagulation Clinic		Tele Primary Care
Tobyhanna	---		Tele Primary Care

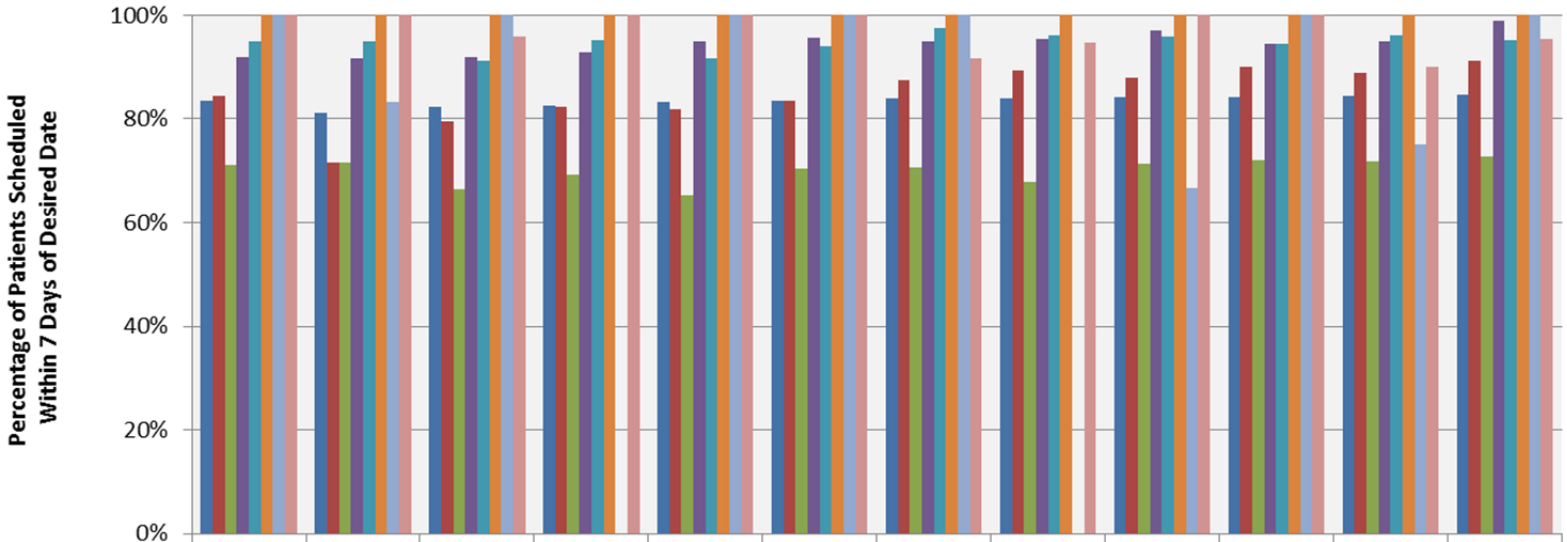
[10] Source: MedSAS outpatient files; the denoted Specialty Care and Ancillary Services are limited to Primary Clinic Stops with a count ≥ 100 encounters during the October 1, 2012, through September 30, 2013, timeframe at the specified CBOC.
[11] Specialty Care Services refer to non-Primary Care and non-MH services provided by a physician.
[12] Ancillary Services refer to non-Primary Care and non-MH services that are not provided by a physician.
[13] Tele-Health Services refer to services provided under the VA Telehealth program (http://www.telehealth.va.gov/)
[14] VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.
[15] The Visual Impairment Services Team (VIST) is a group of case managers that coordinate services for severely disabled and visually impaired Veterans and active duty service members.

PACT Compass Metrics



	VHA Total	Wilkes Barre (693)	Allentown (693B4)	Sayre (693GA)	Williamsport (693GB)	Tobyhanna (693GC)	Berwick (693GF)	Northampton County (693GG)
OCT FY13	14.6	5.0	9.6	12.4	7.4	19.5	1.0	8.9
NOV FY13	15.2	7.6	10.9	14.2	5.0	22.4	3.4	8.8
DEC FY13	13.8	6.7	9.4	11.5	4.2	19.4	2.1	9.8
JAN FY13	14.0	5.9	7.0	7.4	2.8	8.1	1.0	16.5
FEB FY13	14.8	5.9	8.2	7.7	3.0	31.0	1.0	13.8
MAR FY13	13.3	4.6	6.5	15.9	2.9	22.0	1.0	8.1
APR FY13	14.4	6.4	3.3	11.0	4.0	8.7	1.0	14.8
MAY FY13	16.0	6.3	5.9	24.4	3.6	18.7	3.0	21.0
JUN FY13	14.2	5.9	11.0	8.9	7.5	4.8	1.0	16.8
JUL FY13	14.6	7.2	6.6	10.5	3.1	13.0	1.0	12.7
AUG FY13	15.7	7.9	7.6	7.4	6.6	11.0	3.0	8.8
SEP FY13	13.4	4.0	4.4	8.1	3.5	9.0	1.5	7.3

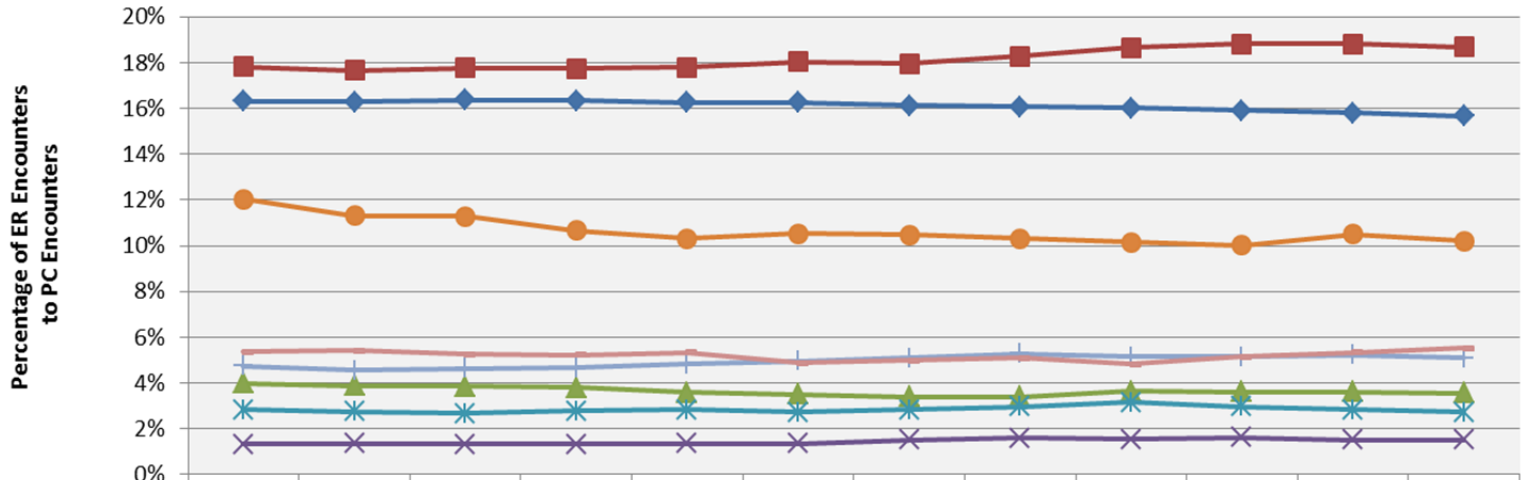
Data Definition.[e] The average waiting time in days until the next third open appointment slot for completed primary care appointments in stop code 350. Completed appointments in stop code 350 for this metric include completed appointments where a 350 stop code is in the primary position on the appointment 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%
Wilkes Barre (693)	84.3%	71.6%	79.5%	82.4%	82.0%	83.4%	87.5%	89.3%	87.9%	90.0%	89.0%	91.2%
Allentown (693B4)	71.0%	71.6%	66.3%	69.2%	65.3%	70.5%	70.7%	67.8%	71.4%	72.0%	71.8%	72.6%
Sayre (693GA)	91.9%	91.8%	91.9%	92.8%	94.8%	95.7%	95.1%	95.4%	97.0%	94.5%	95.0%	98.9%
Williamsport (693GB)	95.0%	95.1%	91.2%	95.2%	91.6%	94.0%	97.6%	96.1%	96.0%	94.4%	96.0%	95.2%
Tobyhanna (693GC)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Berwick (693GF)	100.0%	83.3%	100.0%		100.0%	100.0%	100.0%		66.7%	100.0%	75.0%	100.0%
Northampton County (693GG)	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	91.7%	94.7%	100.0%	100.0%	90.0%	95.5%

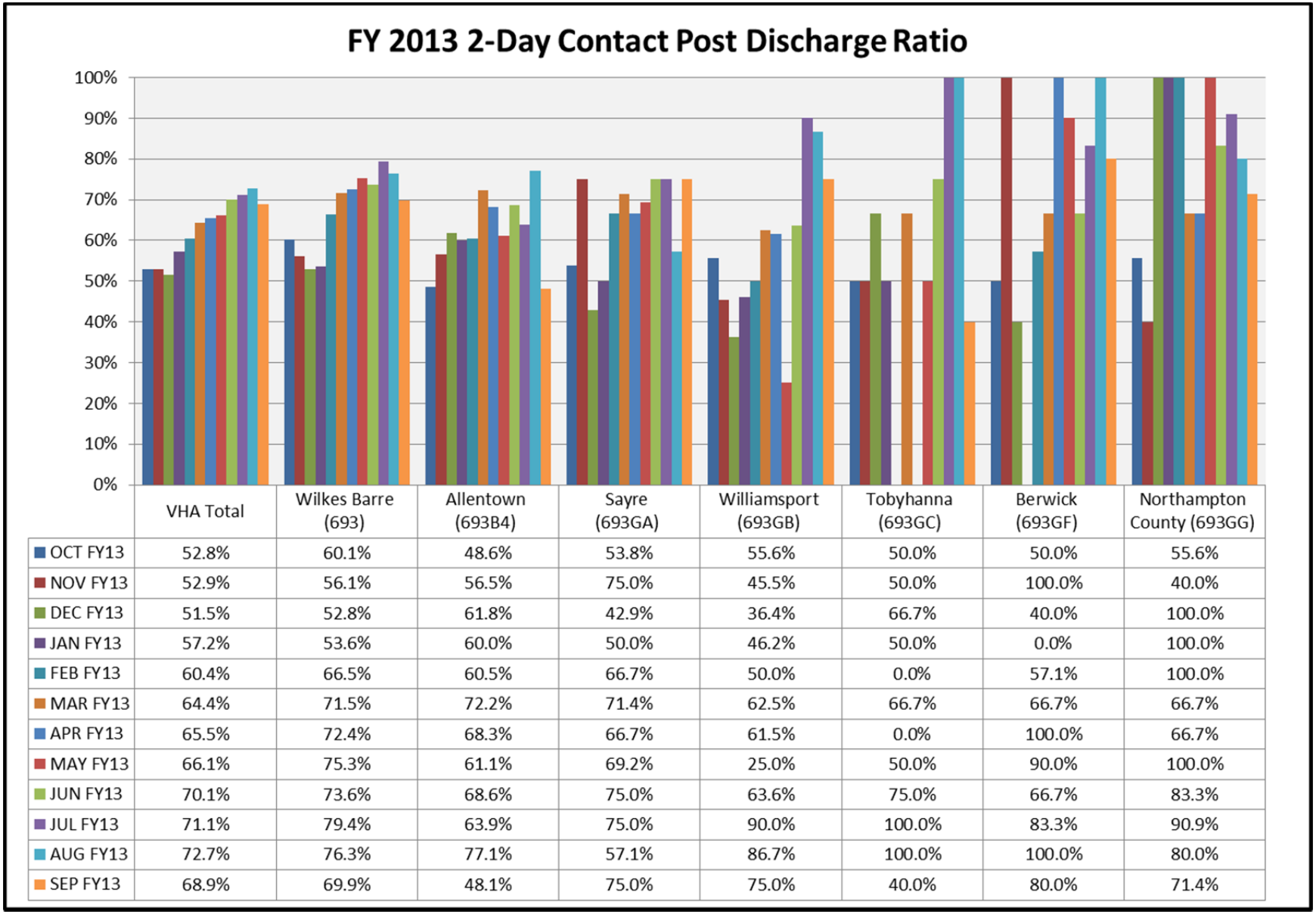
Data Definition.[e] The percent of patients scheduled within 7 days of the desired date. Data source is the Wait Times Prospective Wait Times measures. The total number of scheduled appointments for primary care-assigned patients in primary care clinics 322, 323 and 350. Data is collected twice a month 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.

FY 2013 Ratio of ER Encounters While on Panel to PC Encounters While on Panel (FEE ER Included)



	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%
Wilkes Barre (693)	17.8%	17.6%	17.8%	17.7%	17.8%	18.0%	18.0%	18.3%	18.7%	18.8%	18.8%	18.7%
Allentown (693B4)	4.0%	3.9%	3.9%	3.8%	3.6%	3.5%	3.4%	3.4%	3.6%	3.6%	3.6%	3.5%
Sayre (693GA)	1.3%	1.4%	1.3%	1.3%	1.3%	1.3%	1.5%	1.6%	1.5%	1.6%	1.5%	1.5%
Williamsport (693GB)	2.8%	2.7%	2.7%	2.8%	2.8%	2.7%	2.8%	3.0%	3.1%	3.0%	2.8%	2.7%
Tobyhanna (693GC)	12.0%	11.3%	11.3%	10.7%	10.3%	10.5%	10.5%	10.3%	10.1%	10.0%	10.5%	10.2%
Berwick (693GF)	4.8%	4.5%	4.6%	4.7%	4.8%	4.9%	5.1%	5.3%	5.2%	5.2%	5.2%	5.1%
Northampton County (693GG)	5.4%	5.4%	5.3%	5.2%	5.3%	4.9%	5.0%	5.1%	4.8%	5.1%	5.3%	5.5%

Data Definition.[e] 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	Wilkes Barre (693)	Allentown (693B4)	Sayre (693GA)	Williamsport (693GB)	Tobyhanna (693GC)	Berwick (693GF)	Northampton County (693GG)
OCT FY13	52.8%	60.1%	48.6%	53.8%	55.6%	50.0%	50.0%	55.6%
NOV FY13	52.9%	56.1%	56.5%	75.0%	45.5%	50.0%	100.0%	40.0%
DEC FY13	51.5%	52.8%	61.8%	42.9%	36.4%	66.7%	40.0%	100.0%
JAN FY13	57.2%	53.6%	60.0%	50.0%	46.2%	50.0%	0.0%	100.0%
FEB FY13	60.4%	66.5%	60.5%	66.7%	50.0%	0.0%	57.1%	100.0%
MAR FY13	64.4%	71.5%	72.2%	71.4%	62.5%	66.7%	66.7%	66.7%
APR FY13	65.5%	72.4%	68.3%	66.7%	61.5%	0.0%	100.0%	66.7%
MAY FY13	66.1%	75.3%	61.1%	69.2%	25.0%	50.0%	90.0%	100.0%
JUN FY13	70.1%	73.6%	68.6%	75.0%	63.6%	75.0%	66.7%	83.3%
JUL FY13	71.1%	79.4%	63.9%	75.0%	90.0%	100.0%	83.3%	90.9%
AUG FY13	72.7%	76.3%	77.1%	57.1%	86.7%	100.0%	100.0%	80.0%
SEP FY13	68.9%	69.9%	48.1%	75.0%	75.0%	40.0%	80.0%	71.4%

Data Definition.[e] 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: September 16, 2014

From: Interim Director, VA Healthcare – VISN 4 (10N4)

Subject: **CBOC and PCC Reviews of the Wilkes-Barre VA Medical Center, Wilkes-Barre, PA**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. I have reviewed the response provided by the Wilkes-Barre VA Medical Center and I am submitting to your office as requested. I concur with all responses.

2. If you have any questions or require additional information, please contact Moira Hughes, Acting VISN Quality Management Officer at 412-822-3294.

Gary W. Devansky

Attachment

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 16, 2014

From: Director, Wilkes-Barre VA Medical Center (693/00)

Subject: **CBOC and PCC Reviews of Wilkes-Barre VA Medical Center, Wilkes-Barre, PA**

To: Interim Director, VA Healthcare – VISN 4 (10N4)

1. VA Medical Center Wilkes-Barre, PA, (WBVAMC) concurs with the OIG recommendations as outlined in the report.

2. Attached please find WBVAMC response to recommendations outlined in the OIG report.

Michael D. Adelman, M.D.

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 the parent facility includes staff at the Northampton County and Williamsport CBOCs in required education, training, planning, and participation in annual disaster exercises.

Concur

Target date for completion: September 9, 2014

Facility response: CBOCs were included in the preparation/training related to the upcoming disaster drill "Exercise Roll Call" via Video - Teleconference and Email and Phone on an as needed basis. Exercise was conducted on 9/9/2014 with after action report to be completed by 9/26/2014 which will identify subsequent training requirements.

This will continue to be an annual ongoing process for continued maintenance of the Emergency Management Program.

Recommendation 2. We recommended that the parent facility documents Emergency Management Preparedness-specific training completed for the Northampton County and Williamsport CBOCs' clinical providers.

Concur

Target date for completion: September 9, 2014

Facility response: Emergency Management Coordinator is in the process of conducting initial site surveys to determine site specific requirements and vulnerabilities of each site of service. Actions include identifying key personnel (roles/responsibilities) and fostering relationships with Emergency Response Units (Fires/Police/EMS) and Community Emergency Managers. Exercise was conducted on 9/9/2014.

An Emergency Management Drill, "Exercise Roll Call" is scheduled for September at the CBOCs. The drill will service to identify the strengths and weaknesses of each site, with subsequent training modeled from the findings. Findings will be documented via Knowledge Center LOG (on-line program) and documented on an After Action Review.

Training began in August 2014 with documentation maintained by the Emergency Management Coordinator.

This will continue to be an annual ongoing process for continued maintenance of the Emergency Management Program.

Recommendation 3. We recommended that the parent facility's Emergency Management Committee evaluates the Northampton County and Williamsport CBOCs' emergency preparedness activities, participation in annual disaster exercises, and staff training/education relating to emergency preparedness requirements.

Concur

Target date for completion: September 19, 2014

Facility response: Representatives from all CBOC's are members of the Emergency Management Committee. The Emergency Management Committee will discuss and evaluate CBOC's training event held on 9/9/14 at the next meeting on September 19, 2014. Long range planning for FY 15 will also be discussed at this time.

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: January 31, 2015

Facility response: The AUDIT-C clinical reminder was modified in February 2014 to make referral options mandatory. The charts reviewed were completed prior to the clinical reminder change.

The Fourth Quarter FY 14 EPRP data shows that WBVAMC is at 96.7 percent and 97.51percent since implementation of AUDIT-C clinical reminder. We will continue to monitor on a quarterly basis.

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: April 15, 2015

Facility response: "Medication Reconciliation" is initiated at every episode or transition in level of care where medications will be administered, prescribed, modified, or may influence the care given" based by current VHA Directive 2011-012 "Medication Reconciliation."

Providers will be documenting medication reconciliation in the Medication reconciliation note. Written education/guidance sent via e-mail through chief of Staff's office on how

to appropriately document medication reconciliation. There will be follow up face to face education at staff meetings.

A monthly administrative audit is conducted on three random charts per provider and reported to patient safety each month. Going forward the clinical services will change the audit to make it a clinical audit to assess if the medication reconciliation was completed appropriately with a bench mark of > 90%. Pharmacy will provide in-service for all providers on how to complete medication reconciliation appropriately.

Process change initiation September 15, 2014.

Recommendation 6. We recommended that staff consistently provide written medication information that includes the fluoroquinolone.

Concur

Target date for completion: April 15, 2015

Facility response: Patients receive written information in the form of FDA medication guide and standard auxiliary labels and prescription drug information accompanied with each fluoroquinolone prescription. Written educational resources made available to providers and nursing for distribution to the patients at the time of initiating a prescription. A mandatory fluoroquinolone template was initiated on August 29, 2014 to confirm written information distributed to the patient.

Recommendation 7. We recommended that staff provide medication counseling/education as required.

Concur

Target date for completion: December 31, 2014

Facility response: A fluoroquinolone mandatory template was implemented on July 29th. This template is all inclusive and includes information on details of education that will be provided to the patient and patient's understanding of education provided.

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This report is available at www.va.gov/oig.

Endnotes

[a] 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.

[b] References used for the AUD review included:
- National Center for Health Promotion and Disease Prevention (NCP), Veteran Health Education and Information (NVEI) Program, *Patient Education: TEACH for Success.* Retrieved from http://www.prevention.va.gov/Publications/Newsletters/2013/HealthPOWER_Prevention_News_Winter_2012_2013_FY12_TEACH_MI_Facilitator_Training.asp on January 17, 2014.
- 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.

[c] 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.

[d] 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.

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