



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 15-00110-228

**Review of Community Based
Outpatient Clinics and Other
Outpatient Clinics
of
VA Palo Alto Health Care System
Palo Alto, California**

May 5, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244

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(Hotline Information: www.va.gov/oig/hotline)

Glossary

AUD	alcohol use disorder
CBOC	community based outpatient clinic
EHR	electronic health record
EOC	environment of care
ER	emergency room
FY	fiscal year
HCS	Health Care System
HIV	human immunodeficiency virus
NA	not applicable
NM	not met
OIG	Office of Inspector General
OOC	other outpatient clinic
PACT	Patient Aligned Care Teams
RN	registered nurse
VHA	Veterans Health Administration

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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 other outpatient clinics under the oversight of the VA Palo Alto Health Care System and Veterans Integrated Service Network 21 provide safe, consistent, and high-quality health care. The review evaluated the clinics' compliance with selected requirements for alcohol use disorder care, human immunodeficiency virus screening, and outpatient documentation. We also randomly selected the Fremont, CA, CBOC as a representative site and evaluated the environment of care on February 24, 2015.

Review Results: We conducted four focused reviews and had no findings for the Outpatient Documentation review. However, we made recommendations for improvement in the following three review areas:

Environment of Care: Ensure that Clinic:

- Employees at the Fremont CBOC receive the required training on hazardous materials.
- Staff protect patient-identifiable information on laboratory specimens during transport from the Fremont CBOC to the parent facility.

Alcohol Use Disorder Care: Ensure that Clinic:

- Staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
- Registered Nurse Care Managers receive motivational interviewing and health coaching training within 12 months of appointment to Patient Aligned Care Teams.
- Providers and clinical associates in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Human Immunodeficiency Virus Screening: Ensure that clinicians:

- Develop policies and procedures that facilitate human immunodeficiency virus testing as part of routine medical care for patients.
- Consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Community Based Outpatient Clinic and other outpatient clinic 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 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 OOC 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 OOC reviews are recurring evaluations of selected outpatient care activities that focus on patient care quality and the EOC. In general, our objectives are to determine whether:

- The selected CBOC is compliant with EOC requirements.
- The CBOCs/OOCs are compliant with selected VHA requirements for AUD care.
- The CBOCs/OOCs are compliant with selected VHA requirements for HIV Screening.
- Healthcare practitioners at the CBOCs/OOCs comply with the requirements for outpatient documentation.

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 Care
- HIV Screening
- Outpatient Documentation

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

Methodology

The onsite EOC inspection was conducted at a randomly selected outpatient site of care that had not been previously inspected.¹ Details of the targeted study populations

¹ Each outpatient site selected for physical inspection was randomized from all primary care CBOCs, multi-specialty CBOCs, and health care centers reporting to the parent facility and was operational and classified as such in VA's Site Tracking Database by October 1, 2014.

for the AUD Care, HIV Screening, and Outpatient Documentation focused reviews are noted in Table 1.

Table 1. CBOC/OOC Focused Reviews and Study Populations

Review Topic	Study Population
AUD Care	All CBOC and OOC patients screened within the study period of July 1, 2013, through June 30, 2014, and who had a positive AUDIT-C score; ² and all licensed independent providers, RN Care Managers, and clinical associates assigned to PACT prior to October 1, 2013.
HIV Screening	All outpatients who had a visit in FY 2012 and had at least one visit at the parent facility's CBOCs and/or OOCs within a 12-month period during April 1, 2013, through March 31, 2014.
Outpatient Documentation	All patients new to VHA who had at least three outpatient encounters (face-to-face visits, telephonic/telehealth care, and telephonic communications) during April 1, 2013, through March 31, 2014.

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 performed in accordance with OIG standard operating procedures for CBOC and OOC 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 a physical inspection of the Fremont 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	Recommendations
	The furnishings are clean and in good repair.		
	The CBOC is clean (walls, floors, and equipment are clean).		
	The CBOC's inventory of hazardous materials was reviewed for accuracy twice within the prior 12 months.		
	The CBOC's safety data sheets for chemicals are readily available to staff.		
	If safety data sheets are in electronic form, the staff can demonstrate ability to access the electronic version without coaching.		
X	Employees received training on the new chemical label elements and safety data sheet format.	Twenty-two of the 34 employees (65 percent) at the Fremont CBOC had not received training on the new chemical label elements and safety data sheet format.	1. We recommended that employees at the Fremont CBOC receive the required training on hazardous materials.
	Clinic managers ensure that safety inspections of CBOC medical equipment are performed in accordance with Joint Commission standards.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Hand hygiene is monitored for compliance.		
	Personal protective equipment is readily available.		
	Sterile commercial supplies are not expired.		
	The CBOC staff members minimize the risk of infection when storing and disposing of medical (infectious) waste.		
	The CBOC has procedures to disinfect non-critical reusable medical equipment between patients.		
	There is evidence of fire drills occurring at least every 12 months.		
	Means of egress from the building are unobstructed.		
	Access to fire extinguishers is unobstructed.		
	Fire extinguishers are located in large rooms or are obscured from view, and the CBOC has signs identifying the locations of the fire extinguishers.		
	Exit signs are visible from any direction.		
	Multi-dose medication vials are not expired.		
	All medications are secured from unauthorized access.		
X	The staff protects patient-identifiable information on laboratory specimens during transport.	At the Fremont CBOC, staff did not protect patient-identifiable information on laboratory specimens during transport.	2. We recommended that staff protect patient-identifiable information on laboratory specimens during transport from the Fremont CBOC to the parent facility.
	Documents containing patient-identifiable information are not visible or unsecured.		
	Adequate privacy is provided at all times.		
	The women veterans' exam room is equipped with either an electronic or manual door lock.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The information technology network room/server closet is locked.		
	Access to the information technology network room/server closet is restricted to personnel authorized by Office of Information and Technology.		
	Access to the information technology network room/server closet is documented.		
	All computer screens are locked when not in use.		
	Information is not viewable on monitors in public areas.		
	The CBOC has an automated external defibrillator.		
	There is an alarm system and/or panic buttons installed and tested in high-risk areas (for example, mental health clinic), and the testing is documented.		
	CBOC staff receive regular information/updates on their responsibilities in emergency response operations.		
	The staff participates in scheduled emergency management training and exercises.		

AUD Care

The purpose of this review was to determine whether the facility’s CBOCs and OOCs complied with selected alcohol use screening and treatment requirements.^b

We reviewed relevant documents and 40 EHRs. We also 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 Care

NM	Areas Reviewed	Findings	Recommendations
X	Diagnostic assessments are completed for patients with a positive alcohol screen.	Staff did not complete diagnostic assessments for 25 of 40 patients (63 percent) who had positive alcohol use screens.	3. We recommended that clinic staff consistently complete diagnostic assessments 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.		
	Documentation reflects the offer of further treatment for patients diagnosed with alcohol dependence.		
	For patients with AUD care who decline referral to specialty care, clinic staff monitored them and their alcohol use.		
	Counseling, education, and brief treatments for AUD are provided within 2 weeks of positive screening.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinic RN Care Managers have received motivational interviewing training within 12 months of appointment to PACT.	We found that 13 of 36 RN Care Managers (36 percent) did not receive MI training within 12 months of appointment to PACT.	4. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training within 12 months of appointment to Patient Aligned Care Teams.
X	Clinic 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.	We found that 26 of 36 RN Care Managers (72 percent) did not receive health coaching training within 12 months of appointment to PACT.	
X	Providers in the outpatient clinics 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.	We found that 29 of 54 providers (54 percent) did not receive health coaching training within 12 months of appointment to PACT.	5. We recommended that providers and clinical associates in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.
X	Clinical associates in the outpatient clinics 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.	We found that 24 of 28 clinical associates 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.		

HIV Screening

The purpose of this review was to determine whether CBOCs/OOCs are compliant with selected VHA requirements for HIV Screening.^c

We reviewed the facility's self-assessment, VHA and local policies, and guidelines to assess administrative controls over the HIV screening process. We also reviewed 37 EHRs and validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Table 4. HIV Screening

NM	Areas Reviewed	Findings	Recommendations
	The facility has a HIV Lead Clinician to carry out responsibilities as required.		
X	The facility has policies and procedures to facilitate HIV testing.	Facility policies did not require HIV testing as part of routine medical care for patients.	6. We recommended that the Facility Director develops policies and procedures that facilitate human immunodeficiency virus testing as part of routine medical care for patients.
	The facility had developed policies and procedures that include requirements for the communication of HIV test results.		
	Written patient educational materials utilized prior to or at the time of consent for HIV testing include all required elements.		
	Clinicians provided HIV testing as part of routine medical care for patients.		
X	When HIV testing occurred, clinicians consistently documented informed consent.	Clinicians did not document informed consent for HIV testing for 5 of 16 patients.	7. We recommended that clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.
	The facility complied with additional elements as required by local policy.		

Outpatient Documentation

The purpose of this review was to determine whether healthcare practitioners at the CBOCs/OOCs comply with selected requirements for outpatient documentation.^d

We reviewed relevant documents and 42 EHRs. We also validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Table 5. Outpatient Documentation

NM	Areas Reviewed	Findings	Recommendations
	A relevant history of the illness or injury and physical findings are documented when the patient is first admitted for VA medical care on an outpatient level.		
	Randomly selected progress notes contain the required documentation components in the EHR.		

Clinic Profiles

The CBOC/OOC review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.³ In addition to primary care integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. The following table provides information relative to each of the outpatient clinics and lists the additional specialty care and ancillary services provided at each location.

Location	Station #	Rurality ⁶	Outpatient Workload / Encounters ⁴			Services Provided ⁵		
			PC	MH	Specialty Clinics ⁷	Specialty Care ⁸	Ancillary Services ⁹	
San Jose, CA	640BY	Urban	17,388	26,086	9,831	Cardiology Dermatology Gastroenterology Neurology Optometry Orthopedics Podiatry	Adult Day Health Care Audiology HBPC MOVE! Program ¹⁰ Nutrition Pharmacy	Prosthetics/Orthotics Rehabilitation Services Sleep Medicine Social Work Speech Pathology
Capitola, CA	640GA	Urban	1,675	1,629	N/A	N/A	N/A	
Sonora, CA	640GB	Rural	6,993	4,370	16	N/A	Audiology Imaging Services	Social Work
Fremont, CA	640GC	Urban	4,789	5,938	12	N/A	MOVE! Program Pharmacy	Sleep Medicine Social Work

³ Includes all CBOCs in operation before April 1, 2014.

⁴ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting.

⁵ The denoted Specialty Care and Ancillary Services are limited to Primary Clinic Stops with a count ≥ 100 encounters during the October 1, 2013, through September 30, 2014, timeframe at the specified CBOC.

⁶ <http://vssc.med.va.gov/>

⁷ The total number of encounters for the services provided in the "Specialty Care" column.

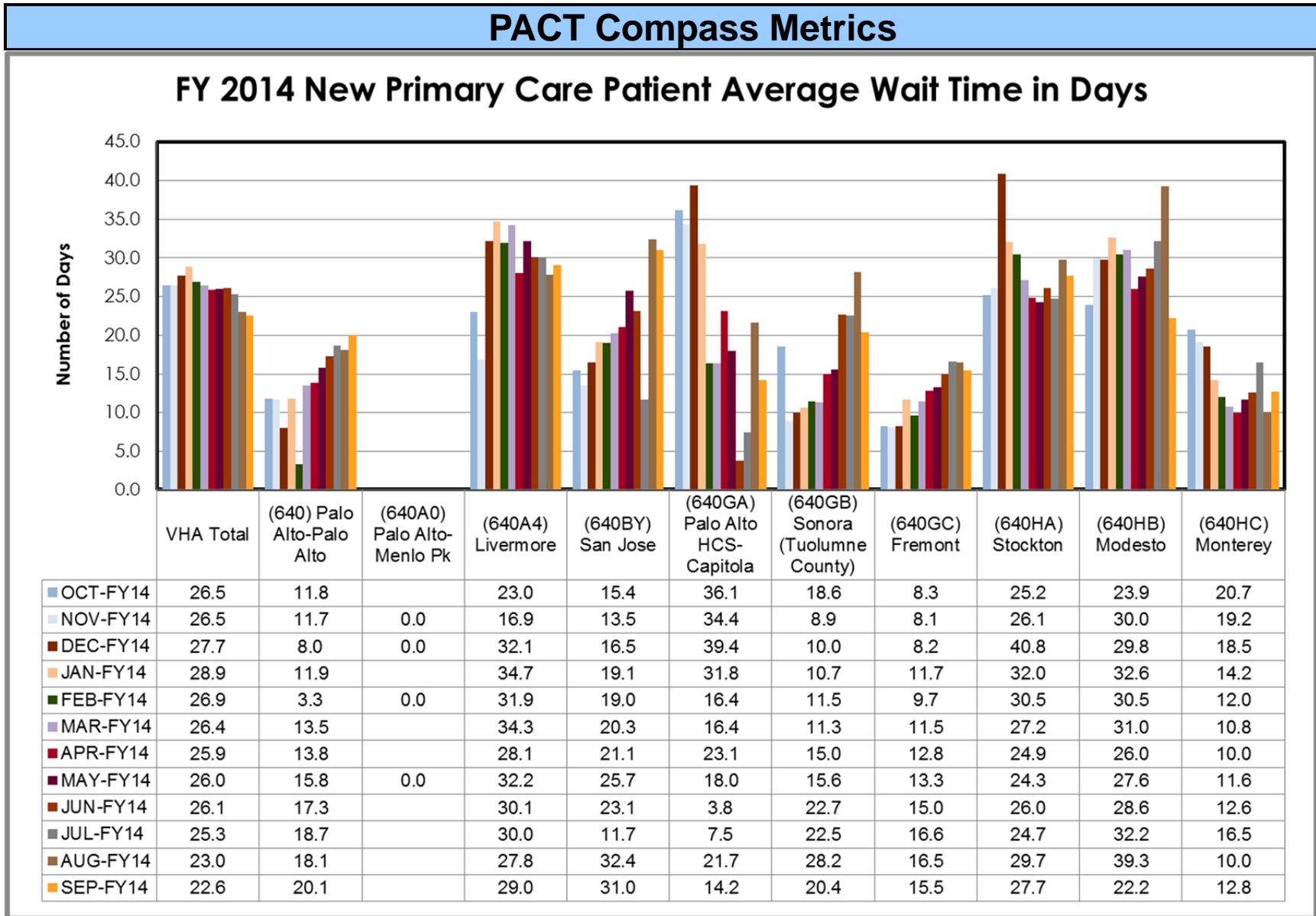
⁸ Specialty Care Services refer to non-Primary Care and non-Mental Health services provided by a physician.

⁹ Ancillary Services refer to non-Primary Care and non-Mental Health services that are not provided by a physician.

¹⁰ VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.

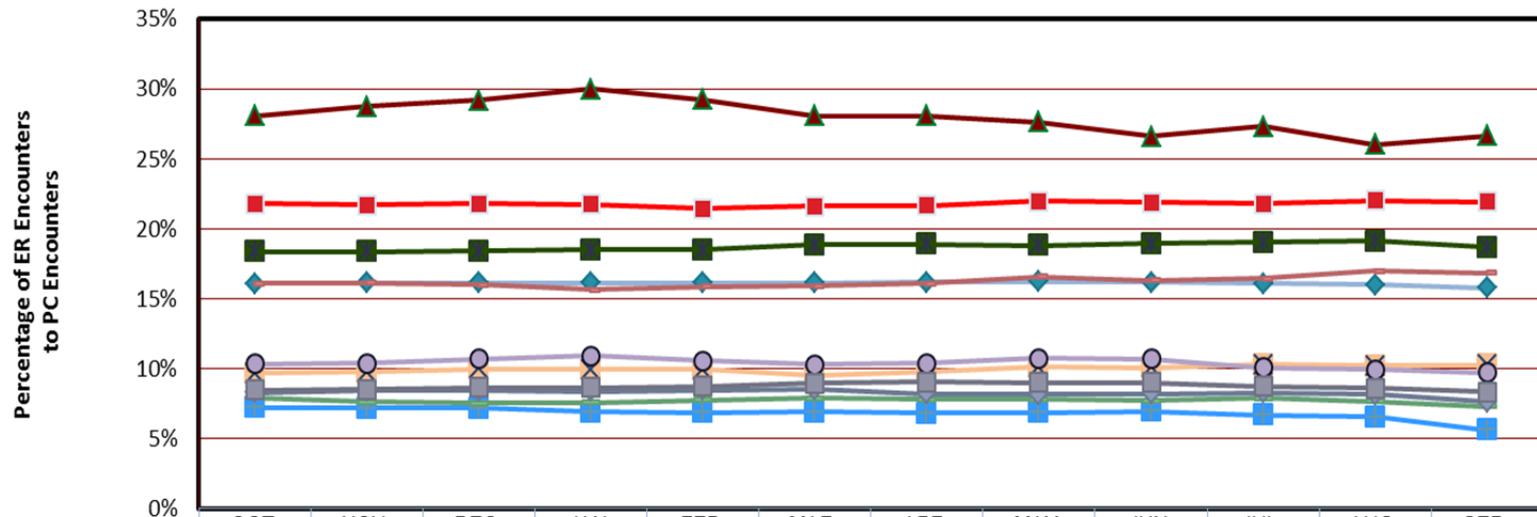
Location (continued)	Station #	Rurality	Outpatient Workload / Encounters			Services Provided		
			PC	MH	Specialty Clinics	Specialty Care	Ancillary Services	
French Camp, CA	640HA	Urban	15,372	13,268	171	N/A	Imaging Services MOVE! Program Nutrition	Pharmacy Social Work
Modesto, CA	640HB	Urban	16,504	8,096	946	Gastroenterology Hematology Rheumatology Urology	Audiology HBPC Imaging Services MOVE! Program Nutrition	Pharmacy Rehabilitation Services Sleep Medicine Social Work
Seaside, CA	640HC	Urban	16,622	17,204	14,358	Cardiology Dermatology Gastroenterology Hematology Neurology Ophthalmology Optometry Orthopedics Podiatry Urology	Audiology MOVE! Program Nutrition Pharmacy Rehabilitation Services	Sleep Medicine Social Work Speech Pathology VICTORS & Advanced Low Vision

HBPC=Home Based Primary Care



Data Definition.⁶ The average number of calendar days between a new patient’s Primary Care appointment (clinic stops 322, 323, and 350), excluding compensation and pension appointments, and the earliest creation date. Blank cells indicate the absence of reported data.

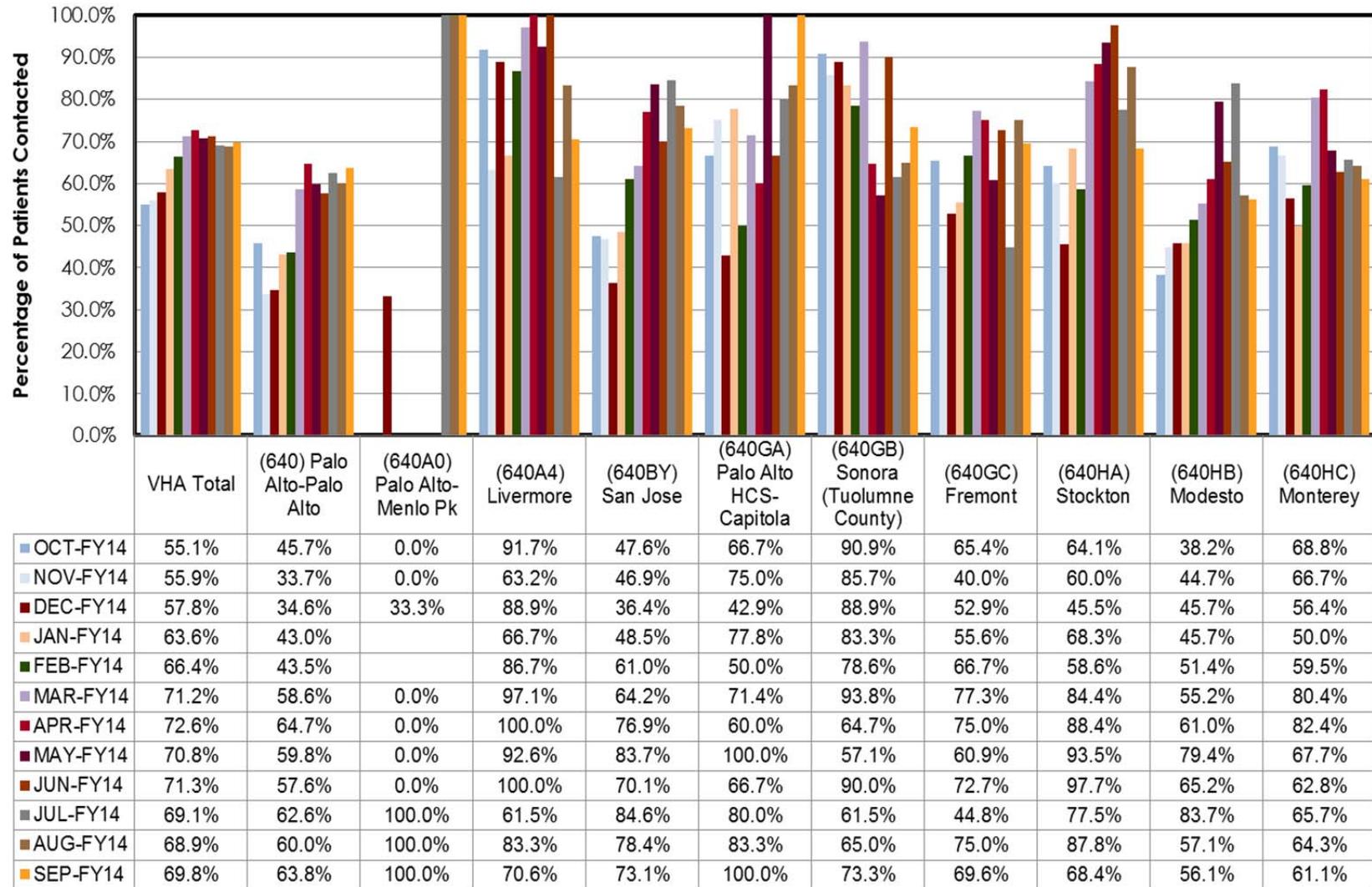
FY 2014 Ratio of ER Encounters While on Panel to PC Encounters While on Panel (FEE ER Included)



	OCT-FY14	NOV-FY14	DEC-FY14	JAN-FY14	FEB-FY14	MAR-FY14	APR-FY14	MAY-FY14	JUN-FY14	JUL-FY14	AUG-FY14	SEP-FY14
◆ VHA Total	16.1%	16.2%	16.1%	16.1%	16.1%	16.1%	16.2%	16.2%	16.2%	16.1%	16.0%	15.8%
■ (640) Palo Alto-Palo Alto	21.8%	21.7%	21.8%	21.8%	21.5%	21.6%	21.7%	22.0%	21.9%	21.8%	22.0%	21.9%
▲ (640A0) Palo Alto-Menlo Pk	28.1%	28.7%	29.2%	30.0%	29.2%	28.1%	28.1%	27.6%	26.6%	27.3%	26.1%	26.6%
× (640A4) Livermore	9.7%	9.8%	10.0%	9.9%	9.9%	9.5%	9.8%	10.1%	10.1%	10.3%	10.2%	10.3%
■ (640BY) San Jose	18.4%	18.4%	18.4%	18.5%	18.5%	18.9%	18.9%	18.8%	18.9%	19.0%	19.1%	18.7%
○ (640GA) Palo Alto HCS-Capitola	10.4%	10.4%	10.7%	10.9%	10.6%	10.3%	10.4%	10.7%	10.7%	10.1%	10.0%	9.7%
■ (640GB) Sonora (Tuolumne County)	7.2%	7.2%	7.2%	6.9%	6.9%	6.9%	6.8%	6.9%	7.0%	6.7%	6.6%	5.6%
■ (640GC) Fremont	16.1%	16.2%	16.0%	15.6%	15.9%	15.9%	16.1%	16.6%	16.3%	16.4%	17.0%	16.9%
■ (640HA) Stockton	8.0%	7.6%	7.6%	7.6%	7.8%	7.9%	7.8%	7.8%	7.7%	7.9%	7.7%	7.3%
■ (640HB) Modesto	8.3%	8.4%	8.4%	8.4%	8.5%	8.5%	8.2%	8.2%	8.2%	8.3%	8.2%	7.6%
■ (640HC) Monterey	8.5%	8.5%	8.6%	8.6%	8.7%	9.0%	9.1%	9.0%	9.0%	8.7%	8.6%	8.4%

Data Definition.^e This is a measure of where the patient receives his primary care and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care/FEE ER encounters while on panel (including FEE ER visits) divided by the number of Primary Care encounters while on panel with the patient’s assigned primary care (or associate) provider plus the total VHA ER/Urgent Care/FEE ER encounters (including FEE ER visits) while on panel plus the number of Primary Care encounters while on panel with a provider other than the patient’s Primary Care Provider/Associate Provider.

FY 2014 Team 2-Day Contact Post Discharge Ratio



Data Definition.^e The percent of discharges (VHA inpatient discharges) for the reporting timeframe for assigned Primary Care patients where the patient was contacted by a member of the Patient Aligned Care Team the patient is assigned to within 2 business days post discharge. 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.

Veterans Integrated Service Network Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 16, 2015

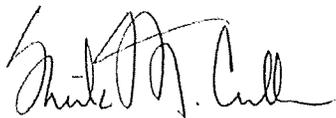
From: Director, Sierra Pacific Network (10N21)

Subject: **Review of CBOCs and OOCs of VA Palo Alto Health Care System, Palo Alto, CA**

To: Director, San Diego Office of Healthcare Inspections (54SD)

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

1. Thank you for allowing Palo Alto Leadership to review the draft recommendations for the recent CBOC and OCC review conducted by your office.
2. The Facility concurs with your findings and developed a corrective action plan which is attached.
3. Should you have any questions please feel free to contact Terry Sanders, Associate Quality Manager for Network 21 at (707) 562-8370.



Sheila M. Cullen

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 14, 2015

From: Director, VA Palo Alto Health Care System (640/00)

Subject: Review of CBOCs and OOCs of VA Palo Alto Health Care System, Palo Alto, CA

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations for the OIG CBOC Review conducted at the VA Palo Alto Health Care System during February 23-27, 2015.
2. Please find the attached response to each recommendation included in the report. We have completed, or are in the process of completing, actions to resolve these issues.


Elizabeth Joyce Freeman
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 employees at the Fremont CBOC receive the required training on hazardous materials.

Concur

Target date for completion: July 1, 2015

Facility response: All Health Care System employees have been assigned the Globally Harmonized System for Hazard Communications TMS module. Additionally, hazardous material inventories and Safety Data Sheets (SDSs) are available through a link on the VAPAHCS intranet home page. Monitoring for compliance with the training requirement will be performed by the Industrial Hygienist and reported monthly to the EOCC.

Recommendation 2. We recommended that staff protect patient-identifiable information on laboratory specimens during transport from the Fremont CBOC to the parent facility.

Concur

Target date for completion: Completed

Facility response: At the time of the inspection, non-transparent, solid coolers with dual latches were being used to transport specimens and associated documentation, which prevented patient identifiable information (PII) from being readily visible during transport. Also, to reduce the risk of tampering and/or indicate if tampering has occurred, tamper proof labels were being used to cover the openings of the coolers. The labels change from a solid blue color to say "VOID" when peeled off, providing immediate evidence of unauthorized attempts to enter the container had occurred. At the time the specimens are received at the Palo Alto laboratory, each container will be inspected for signs of tampering and that no PII was accessible. Inspections will be documented and results of inspections submitted to the Privacy Office monthly.

Recommendation 3. We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.

Concur

Target date for completion: October 1, 2015

Facility response: The process for completion of diagnostic assessments will be reviewed with outpatient clinical staff in primary care and mental health. In addition, modification of the current clinical reminder is being explored to improve documentation. Monthly monitoring of a random selection of 30 records per month of patients scoring 5 or greater on Audit C will begin in May 2015 to determine completion of diagnostic assessment until 90 percent compliance has been achieved. Findings will be reported to the Medical Executive Board quarterly.

Recommendation 4. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target date for completion: June 1, 2015

Facility response: Five PACT team members have not completed required training with 12 months of assignment. These 5 individuals will complete training no later than June 1, 2015. Beginning immediately, the Health Promotion/Disease Prevention (HPDP) Program Manager (PM) will publish a training schedule of classes that are to occur within 12 months at each PACT Call. Service Chiefs, Managers and Supervisors will facilitate new staff, within 12 months, being able to attend and notify the HPDP PM of their desired date of attendance. HPDP Program Manager will coordinate and document all trainings in the internal training database and TMS through EES link. Associate Chief of Staff for Ambulatory Care and Chief of Outpatient Nursing will be updated monthly of current progress of staff training and due training. Data related to compliance with training requirement will be presented to the PACT Steering Committee by the ASOC for Ambulatory Care monthly.

Recommendation 5. We recommended that providers and clinical associates in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target date for completion: June 1, 2015

Facility response: Five PACT team members have not completed required training with 12 months of assignment. These 5 individuals will complete training no later than June 1, 2015. Beginning immediately, the Health Promotion/Disease Prevention (HPDP) Program Manager (PM) will publish a training schedule of classes that are to occur within 12 months at each PACT Call. Service Chiefs, Managers and Supervisors will facilitate new staff, within 12 months, being able to attend and notify the HPDP PM of their desired date of attendance. HPDP will then coordinate and document all trainings in the internal training database and TMS through EES link. Associate Chief of Staff for Ambulatory Care and Chief of Outpatient Nursing will be updated monthly of current progress of staff training and due training.

Recommendation 6. We recommended that the Facility Director develops policies and procedures that facilitate human immunodeficiency virus testing as part of routine medical care for patients.

Concur

Target date for completion: September 1, 2015

Facility response: The facility will finalize policy to facilitate human immunodeficiency virus testing as part of routine medical care for patients. A minimum of 30 patient records will be monitored monthly to assure appropriate documentation that HIV testing has been offered as part of routine care. Target completion of HIV consent documentation is 90% compliance for three months.

Recommendation 7. We recommended that clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.

Concur

Target date for completion: October 1, 2015

Facility response: The clinical reminder for HIV screening and the HIV order will be revised to require informed consent (verbal). Reminder reports will be used to monitor compliance. CBOC providers will be reeducated on the revised clinical reminder and also the need to obtain and document verbal informed consent for HIV testing. A minimum of 30 patient records will be monitored monthly to assure appropriate documentation of verbal informed consent for HIV testing as part of routine care. Target completion of HIV consent documentation is 90% compliance for three months.

Office of Inspector General Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Director, VA Palo Alto Health Care System (640/00)

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Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Barbara Boxer, Dianne Feinstein
U.S. House of Representatives: Ami Bera, Jim Costa, Jeff Denham, Mark DeSaulnier, Anna G. Eshoo, Sam Farr, John Garamendi, Mike Honda, Jared Huffman, Doug LaMalfa, Barbara Lee, Zoe Lofgren, Doris O. Matsui, Tom McClintock, Jerry McNerney, Nancy Pelosi, Jackie Speier, Eric Swalwell, Mike Thompson, David Valadao

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

Endnotes

^a References used for the EOC review included:

- International Association of Healthcare Central Services Materiel Management, *Central Service Technical Manual*, 7th ed.
- Joint Commission, *Joint Commission Comprehensive Accreditation and Certification Manual*, July 1, 2014.
- US Department of Health and Human Services, Health Insurance Portability and Accountability Act, *The Privacy Rule*, February 16, 2006.
- US Department of Labor, Occupational Safety and Health Administration, *Laws and Regulations, 1910 General Industry Standards*.
- US Department of Labor, Occupational Safety and Health Administration, *Guidelines for Preventing Workplace Violence*, 2004.
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