Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00128-359

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Phoenix VA Health Care System Phoenix, Arizona

June 4, 2015

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
EOC	environment of care
ER	emergency room
FY	fiscal year
HCS	Health Care System
HIV	human immunodeficiency virus
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 and other outpatient clinics under the oversight of the Phoenix VA Health Care System and Veterans Integrated Service Network 18 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 Southeast VA Community Based Outpatient Clinic, Gilbert, AZ, as a representative site and evaluated the environment of care on March 11, 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 at the Southeast VA Community Based Outpatient Clinic that:

- The hazardous materials inventory occurs twice within a 12-month period.
- Hand hygiene compliance is monitored and reported to the Infection Control Committee.
- Examination tables and curtains provide adequate privacy for women veterans.
- The information technology server closets are maintained according to information technology safety and security standards.
- The staff participate in scheduled emergency management training.

Alcohol Use Disorder Care: Ensure that Clinic:

- Staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
- Staff provide education and counseling for patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits.
- Managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening.
- 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 receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Human Immunodeficiency Virus Screening: Ensure that clinicians:

- Provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored.

Comments

The Acting Veterans Integrated Service Network and Interim 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 15–21, 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 heath 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 Southeast VA 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).		
X	The CBOC's inventory of hazardous materials was reviewed for accuracy twice within the prior 12 months.	The CBOC's inventory of hazardous materials and waste at the Southeast VA CBOC was not reviewed for accuracy twice within the prior 12 months.	**1.** We recommended that managers ensure review of the hazardous materials inventory occurs twice within a 12-month period at the Southeast VA CBOC.
	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.		
	Employees received training on the new chemical label elements and safety data sheet format.		
	Clinic managers ensure that safety inspections of CBOC medical equipment are performed in accordance with Joint Commission standards.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Hand hygiene is monitored for compliance.	Hand hygiene was not monitored for compliance at the Southeast VA CBOC.	**2.** We recommended that hand hygiene compliance is monitored at the Southeast VA CBOC and reported to the Infection Control Committee.
	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.		
	The staff protects patient-identifiable information on laboratory specimens during transport.		
	Documents containing patient-identifiable information are not visible or unsecured.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Adequate privacy is provided at all times.	Examination tables at the Southeast VA CBOC were not fully shielded by privacy curtains.	**3.** We recommended that examination tables and curtains provide adequate privacy for women veterans at the Southeast VA CBOC.
	The women veterans' exam room is equipped with either an electronic or manual door lock.		
	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.		
X	Access to the information technology network room/server closet is documented.	Access to the information technology network room/server closets at the Southeast VA CBOC was not documented.	**4.** We recommended that the information technology server closets at the Southeast VA CBOC are maintained according to information technology safety and security standards.
	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 receives regular information/updates on their responsibilities in emergency response operations.		
X	The staff participates in scheduled emergency management training and exercises.	The staff at the Southeast VA CBOC did not participate in scheduled emergency management training.	**5.** We recommended that the staff at the Southeast VA CBOC participate in scheduled emergency management training.

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 38 electronic health records. 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 30 of 38 patients (79 percent) who had positive alcohol use screens.	**6.** We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
X	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.	Staff did not provide education and counseling for two of eight patients who had positive alcohol use screens.	**7.** We recommended that clinic staff provide education and counseling for patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits.
	Documentation reflects the offer of further treatment for patients diagnosed with alcohol dependence.		
	For patients with AUD who decline referral to specialty care, clinic staff monitored them and their alcohol use.		
X	Counseling, education, and brief treatments for AUD Care are provided within 2 weeks of positive screening.	Treatment was not provided within 2 weeks of positive screening for 2 of 14 patients.	**8.** We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the 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 5 of 44 RN Care Managers (11 percent) did not receive MI training within 12 months of appointment to PACT.	**9.** 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 5 of 44 RN Care Managers (11 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 8 of 50 providers (16 percent) did not receive health coaching training within 12 months of appointment to PACT.	**10.** 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 8 of 45 clinical associates (18 percent) 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 38 electronic health records 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.		
	The facility has policies and procedures to facilitate HIV testing.		
	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.		
X	Clinicians provided HIV testing as part of routine medical care for patients.	Clinicians did not provide HIV testing to 32 of 38 (84 percent) patients.	**11.** We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored.
	When HIV testing occurred, clinicians consistently documented informed consent.		
	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 43 electronic health records. 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 electronic health record.		

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.

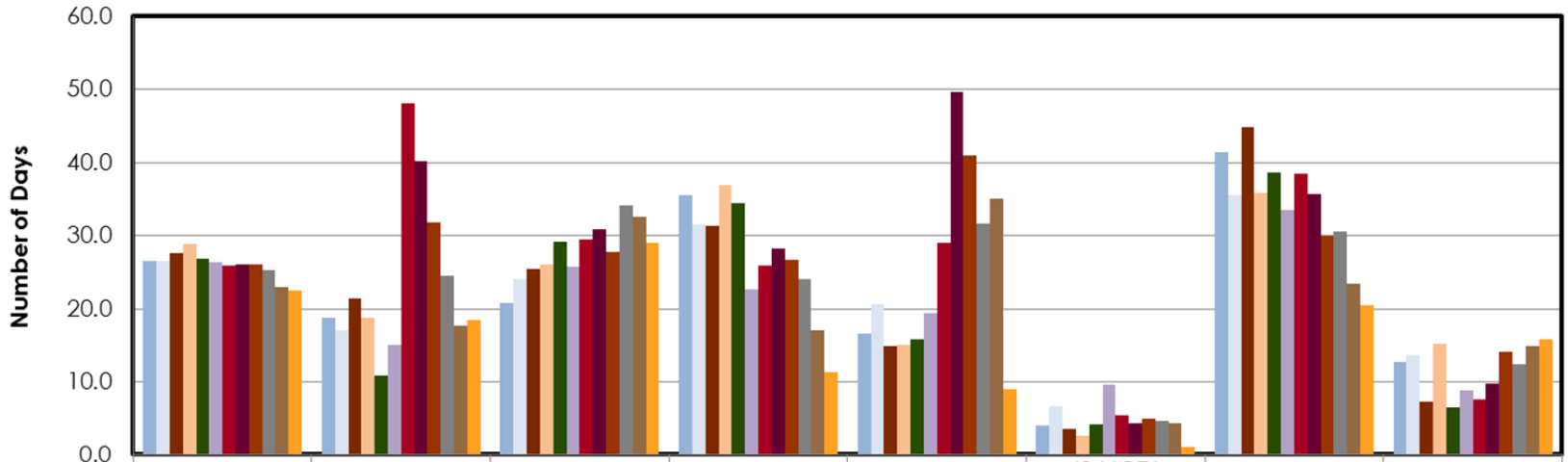
			Outpatient Workload / Encounters[4]			Services Provided[5]		
Location	**Station #**	**Rurality[6]**	**PC**	**MH**	**Specialty Clinics[7]**	**Specialty Care[8]**	**Ancillary Services[9]**	
Gilbert, AZ	644BY	Urban	29,492	14,055	892	Dental Dermatology	Audiology Diabetic Retinal Screening Imaging Services Kinesiotherapy	MOVE! Program[10] Nutrition Pharmacy Social Work Speech Pathology
Surprise, AZ	644GA	Urban	17,822	12,346	3,396	Dental Dermatology	Audiology Diabetes Care Diabetic Retinal Screening Imaging Services MOVE! Program	Nutrition Pharmacy Rehabilitation Services Social Work
Show Low, AZ	644GB	Rural	5,181	2,595	80	NA	Social Work	
Payson, AZ	644GD	Rural	3,301	108	NA	NA	NA	

[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.

			Outpatient Workload / Encounters			Services Provided		
Location (continued)	**Station #**	**Rurality**	**PC**	**MH**	**Specialty Clinics**	**Specialty Care**	**Ancillary Services**	
Phoenix, AZ	644GE	Urban	8,095	6,141	164	Dermatology	Diabetes Care Diabetic Retinal Screening	MOVE! Program Pharmacy Social Work
Globe, AZ	644GF	Rural	1,728	389	34	NA	NA	

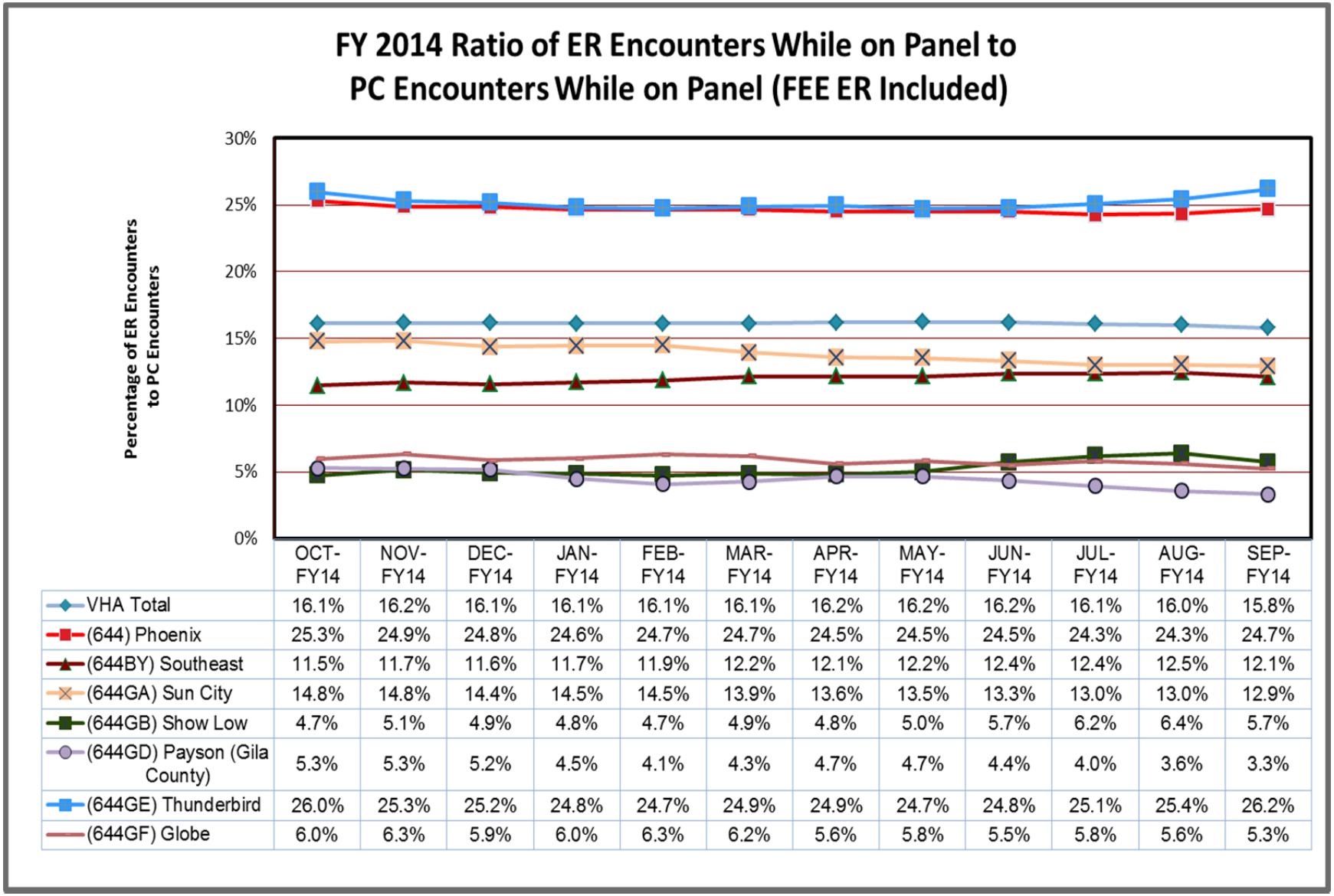
PACT Compass Metrics

FY 2014 New Primary Care Patient Average Wait Time in Days



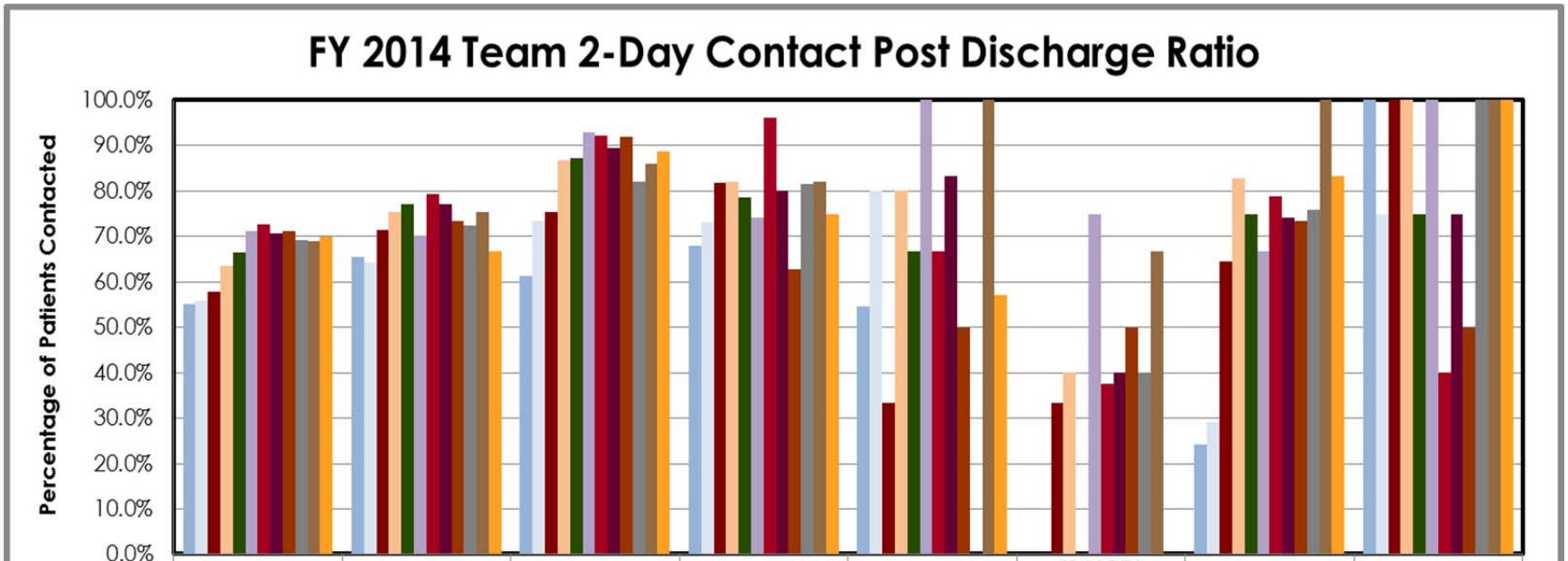
	VHA Total	(644) Phoenix	(644BY) Southeast	(644GA) Sun City	(644GB) Show Low	(644GD) Payson (Gila County)	(644GE) Thunderbird	(644GF) Globe
OCT-FY14	26.5	18.8	20.8	35.5	16.6	4.1	41.4	12.7
NOV-FY14	26.5	17.1	24.0	31.5	20.7	6.7	35.6	13.6
DEC-FY14	27.7	21.4	25.5	31.4	15.0	3.5	44.8	7.3
JAN-FY14	28.9	18.7	26.1	36.9	15.2	2.7	35.8	15.3
FEB-FY14	26.9	10.8	29.2	34.4	15.9	4.2	38.7	6.5
MAR-FY14	26.4	15.2	25.8	22.7	19.4	9.6	33.5	8.8
APR-FY14	25.9	48.2	29.5	26.0	29.1	5.4	38.5	7.7
MAY-FY14	26.0	40.1	30.8	28.3	49.6	4.3	35.8	9.8
JUN-FY14	26.1	31.8	27.8	26.6	41.0	5.0	30.0	14.2
JUL-FY14	25.3	24.6	34.2	24.1	31.7	4.7	30.5	12.4
AUG-FY14	23.0	17.7	32.6	17.0	35.1	4.3	23.4	14.9
SEP-FY14	22.6	18.6	29.0	11.4	9.0	1.1	20.4	15.9

Data Definition.[e] 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.



	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%
(644) Phoenix	25.3%	24.9%	24.8%	24.6%	24.7%	24.7%	24.5%	24.5%	24.5%	24.3%	24.3%	24.7%
(644BY) Southeast	11.5%	11.7%	11.6%	11.7%	11.9%	12.2%	12.1%	12.2%	12.4%	12.4%	12.5%	12.1%
(644GA) Sun City	14.8%	14.8%	14.4%	14.5%	14.5%	13.9%	13.6%	13.5%	13.3%	13.0%	13.0%	12.9%
(644GB) Show Low	4.7%	5.1%	4.9%	4.8%	4.7%	4.9%	4.8%	5.0%	5.7%	6.2%	6.4%	5.7%
(644GD) Payson (Gila County)	5.3%	5.3%	5.2%	4.5%	4.1%	4.3%	4.7%	4.7%	4.4%	4.0%	3.6%	3.3%
(644GE) Thunderbird	26.0%	25.3%	25.2%	24.8%	24.7%	24.9%	24.9%	24.7%	24.8%	25.1%	25.4%	26.2%
(644GF) Globe	6.0%	6.3%	5.9%	6.0%	6.3%	6.2%	5.6%	5.8%	5.5%	5.8%	5.6%	5.3%

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.



	VHA Total	(644) Phoenix	(644BY) Southeast	(644GA) Sun City	(644GB) Show Low	(644GD) Payson (Gila County)	(644GE) Thunderbird	(644GF) Globe
OCT-FY14	55.1%	65.6%	61.3%	68.0%	54.5%	0.0%	24.4%	100.0%
NOV-FY14	55.9%	64.4%	73.3%	73.1%	80.0%	0.0%	29.3%	75.0%
DEC-FY14	57.8%	71.5%	75.3%	81.8%	33.3%	33.3%	64.5%	100.0%
JAN-FY14	63.6%	75.3%	86.7%	82.1%	80.0%	40.0%	82.9%	100.0%
FEB-FY14	66.4%	77.0%	87.3%	78.6%	66.7%		75.0%	75.0%
MAR-FY14	71.2%	70.2%	92.9%	74.1%	100.0%	75.0%	66.7%	100.0%
APR-FY14	72.6%	79.4%	92.2%	96.2%	66.7%	37.5%	78.8%	40.0%
MAY-FY14	70.8%	77.0%	89.6%	80.0%	83.3%	40.0%	74.1%	75.0%
JUN-FY14	71.3%	73.3%	91.9%	62.9%	50.0%	50.0%	73.3%	50.0%
JUL-FY14	69.1%	72.3%	82.1%	81.6%	0.0%	40.0%	76.0%	100.0%
AUG-FY14	68.9%	75.3%	86.1%	82.1%	100.0%	66.7%	100.0%	100.0%
SEP-FY14	69.8%	66.7%	88.7%	75.0%	57.1%	0.0%	83.3%	100.0%

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.

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 7, 2015

From: Acting Director, VA Southwest Health Care Network (10N18)

Subject: **Review of CBOCs and OOCs of Phoenix VA Health Care System, Phoenix, AZ**

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

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

1. I have reviewed and concur with the findings and recommendations in the Review of CBOCs and OOCs of Phoenix VA Health Care System, Phoenix, AZ.

2. If you have any questions or concerns, please contact Jennifer Kubiak, VISN 18 Quality Management Officer, at 480-397-2781.

for Kathleen R. Fogarty

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 30, 2015

From: Interim Medical Center Director, Phoenix VA Health Care System (644/00)

Subj: **Review of CBOCs and OOCs of Phoenix VA Health Care System, Phoenix, AZ**

To: Acting Director, VA Southwest Health Care Network (10N18)

1. Please find the facility response regarding the Office of Inspector General Community Based Outpatient Clinic (CBOC) review conducted at the Southeast CBOC on March 11, 2015. Implementation and subsequent actions are currently being completed.

2. If you have any questions, please contact Michelle Bagford, Chief, Quality, Safety and Improvement, at (602) 277-5551 extension 6092.

GLEN W. GRIPPEN
Interim Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that managers ensure review of the hazardous materials inventory occurs twice within a 12-month period at the Southeast VA CBOC.

Concur

Target date for completion: May 31, 2015 (Complete)

Facility response: The Interim Medical Center Director will ensure that the Engineering Service completes an inventory of hazardous materials twice within a 12-month period for the Southeast CBOC.

An inventory was completed by the Industrial Hygienist in February 2015 and second inventory was completed in April 2015. Documentation will be provided in the first available quarterly update to the Office of Inspector General. A third inventory is scheduled for November 2015. Industrial Hygienist set up an electronic tracking system allowing greater internal transparency and oversight of inventory status. The Inventory completion information will be reported to the Environment of Care Committee bi-annually.

Recommendation 2. We recommended that hand hygiene compliance is monitored at the Southeast VA CBOC and reported to the Infection Control Committee.

Concur

Target date for completion: July 31, 2015

Facility response: A monthly hand hygiene assessment of peers is completed by front line staff at the Southeast VA CBOC. Compliance data is monitored by Clinic managers and data has consistently been collected. A new requirement for the data to be reported to the Infection Control Committee (ICC) quarterly was added. The report requirement will be a standing item at the ICC in the future.

Recommendation 3. We recommended that examination tables and curtains provide adequate privacy for women veterans at the Southeast VA CBOC.

Concur

Target date for completion: April 24, 2015 (Completed)

Facility response: Curtains of an appropriate length to ensure privacy were ordered for the SE CBOC and were installed on April 24, 2015. In addition, exam tables are oriented away from the door as an additional level of privacy. Evidence of the completed action will be provided to the OIG during the first quarterly update.

Recommendation 4. We recommended that the information technology server closets at the Southeast VA CBOC are maintained according to information technology safety and security standards.

Concur

Target date for completion: July 31, 2015

Facility response: The Sign-In Access logs were re-established for both SE CBOC Information Technology server closets on March 12, 2015 and will be monitored monthly by clinic managers. Additionally, compliance will be evaluated during Environment of Care Rounds and reported to the Environment of Care Committee.

Recommendation 5. We recommended that the staff at the Southeast VA CBOC participate in scheduled emergency management training.

Concur

Target date for completion: August 31, 2015

Facility response: The Phoenix Emergency Management Committee Exercise task group has set up a Multiple Year Training and Exercise Plan (MYTEP) which lays out the training events and exercises for the facility. This plan includes the CBOCs. Emergency Preparedness training was provided to the Southeast VA CBOC to prepare for the Ebola virus outbreak during FY2015, Quarter 1. The next scheduled training event will be dealing with an active shooter/hostage situation during the summer of 2015. Evidence of participation by the SE CBOC will be provided to the OIG during the first quarterly update.

Recommendation 6. We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.

Concur

Target date for completion: August 31, 2015

Facility response: Positive Alcohol Screens are noted in documentation by nursing staff during patient check in. Positive Alcohol screens are communicated via CPRS and are written on the 'check in' sheet to serve as a visual cue for the provider. This sheet is placed conspicuously so that the provider is aware of the need for diagnostic assessments associated with a positive alcohol screen. Compliance with completion of the diagnostic assessments will be monitored by evaluating completion of the follow-up Clinical Reminder for a compliance rate greater than 90% for a minimum period of

120 days. The Clinical Application Coordinator responsible for Clinical Reminder collects this information and provides it to individual providers each month. The information will be submitted to the Quality Executive Board on a quarterly basis.

Recommendation 7. We recommended that clinic staff provide education and counseling for patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits.

Concur

Target date for completion: August 31, 2015

Facility response: Positive alcohol screens trigger a follow-up clinical reminder for providers. This follow-up reminder includes educational material about the problems associated with excessive alcohol consumption and staying within prescribed limits. This educational information is reviewed with patients. Compliance with provision of this information will be monitored by evaluating completion of the follow-up Clinical Reminder for a compliance rate greater than 90% for a minimum period of 120 days. The Clinical Application Coordinator responsible for Clinical Reminder collects this information and provides it to individual providers each month. The information will be submitted to the Quality Executive Board on a quarterly basis.

Recommendation 8. We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening.

Concur

Target date for completion: August 31, 2015

Facility response: Positive alcohol screens trigger a follow-up clinical reminder for providers. This follow-up reminder includes an option to refer the patient to Mental Health/Substance Use Disorder Clinics or programs. Compliance with provision of this referral will be monitored by evaluating completion of the follow-up Clinical Reminder for a compliance rate greater than 90% for a minimum period of 120 days in patients indicated for a substance abuse referral. The Clinical Application Coordinator responsible for Clinical Reminder collects this information and provides it to individual providers each month. The information will be submitted to the Quality Executive Board on a quarterly basis.

Recommendation 9. 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 30, 2015

Facility response: TEACH and MI (health coaching training) are conducted through the Health Promotion and Disease Prevention (HPDP) office. HPDP personnel developed a comprehensive list with the names of staff assigned to Patient Aligned Care Teams (PACT), the date of starting in PACT, and date of completion of training. Each training course is now offered every other month (previously, both courses were offered on the same day, three times per year). The training is being established as a Talent Management System (TMS) module which will notify PACT staff of the training requirement and allow enrollment for the courses. The increased frequency of the course offerings has improved attendance. Course completion is tracked by the Health Promotion and Disease Prevention Committee and is reported to the Quality Executive Board quarterly. Progress will be monitored with a goal of 90% compliance for a period of no less than 120 days.

Recommendation 10. 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 30, 2015

Facility response: TEACH and MI (health coaching training) are conducted through the Health Promotion and Disease Prevention (HPDP) office. HPDP personnel developed a comprehensive list with the names of staff assigned to Patient Aligned Care Teams (PACT), the date of starting in PACT, and date of completion of training. Each training course is now offered every other month (previously, both courses were offered on the same day, three times per year). The training is being established as a Talent Management System (TMS) module which will notify PACT staff of the training requirement and allow enrollment for the courses. The increased frequency of the course offerings has improved attendance. Course completion is tracked by the Health Promotion and Disease Prevention Committee and is reported to the Quality Executive Board quarterly. Progress will be monitored with a goal of 90% compliance for a period of no less than 120 days.

Recommendation 11. We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored.

Concur

Target date for completion: May 31, 2016

Facility response: In an effort to provide human immunodeficiency virus testing as part of routine medical care, PVAHCS formed an HIV Screening Work Group (HIVWG) to benchmark current local practices against VHA national practices. HIVWG members consist of MD and/or RN representatives from pertinent patient care areas including Outpatient, Inpatient, Emergency, Mental Health, Laboratory, Infectious Disease,

Administrative Services, and Informatics. HIVWG developed a method to evaluate the consistent use of the clinical reminder and tracking tools currently available within our facility. First introduced in 2014, these tools have resulted in 4.1% increase in HIV testing at PVAHCS from CY 2013 to CY 2014. A practice standard will be developed and implemented by August 31, 2015. HIV testing rates compliance evaluations will occur through VistA and the Corporate Data Warehouse. This information will be reported to the Quality Executive Board each quarter until 90% testing compliance is achieved for greater than 120 days.

Office of Inspector General
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Endnotes

[a] References used for the EOC review included:
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- 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.

[b] References used for the AUD Care review included:
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[c] References used for the HIV Screening review included:
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- VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.
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- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
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[d] References used for the Outpatient Documentation review included:
- VHA Handbook 1907.01, *Health Information Management and Health Records,* September 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records,* July 22, 2014.

[e] Reference used for PACT Compass data graphs:
- Department of Veterans' Affairs, *Patient Aligned Care Teams Compass Data Definitions*, June 24, 2014.