Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00158-499

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Durham VA Medical Center Durham, North Carolina

September 1, 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
EHR	electronic health record
EOC	environment of care
FY	fiscal year
HIV	human immunodeficiency virus
lab	laboratory
NA	not applicable
NM	not met
OIG	Office of Inspector General
OOC	other outpatient clinic
PACT	Patient Aligned Care Teams
PC	primary care
RN	registered nurse
VAMC	VA Medical Center
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 Durham VA Medical Center and Veterans Integrated Service Network 6 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, outpatient documentation, and outpatient lab results management. We also randomly selected the Raleigh II CBOC (also known as the Wake County VA Clinic), Raleigh, NC, as a representative site and evaluated the environment of care on July 13, 2015.

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

Environment of Care: Ensure that:

- Managers review the hazardous materials inventory twice within a 12-month period at the Raleigh II Community Based Outpatient Clinic.
- Staff at the Raleigh II Community Based Outpatient Clinic participate in scheduled emergency management training and exercises.

Alcohol Use Disorder Care: Ensure 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.
- Clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
- 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.
- Clinic 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.

Outpatient Lab Results Management: Ensure that:

- Clinicians consistently notify patients of their laboratory results within 14 days as required by local policy.

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 15–20, 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.
- The CBOCs/OOCs are compliant with VHA requirements for the patient notification and follow up of selected outpatient lab results.

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 five activities:

- EOC
- AUD Care
- HIV Screening
- Outpatient Documentation
- Outpatient Lab Results Management

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 for the AUD Care, HIV Screening, Outpatient Documentation, and Outpatient Lab Results Management 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.
Outpatient Lab Results Management	All patients who had outpatient (excluding emergency department, urgent care, or same day surgery orders) potassium and sodium serum lab test results during January 1, 2014, through December 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.

[1] Each outpatient site selected for physical inspection was randomized from all PC 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.
[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 Raleigh II CBOC. 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	Recommendations
	The furnishings are clean and in good repair.		
	The CBOC is 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 Raleigh II CBOC was not reviewed for accuracy twice within the prior 12 months.	**1**. We recommended that managers ensure that review of the hazardous materials inventory occurs twice within a 12-month period at the Raleigh II CBOC.
	The CBOC's safety data sheets for chemicals are readily available to staff.		
NA	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.		
	Hand hygiene is monitored for compliance.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 protect patient-identifiable information on lab specimens during transport.		
	Documents containing patient-identifiable information are not visible or unsecured.		
	Adequate privacy is provided at all times.		
NA	The women veterans' exam room is equipped with either an electronic or manual door lock.		
	The information technology network room/server closet is locked.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
X	The staff participates in scheduled emergency management training and exercises.	The staff at the Raleigh II CBOC did not participate in scheduled emergency management training and exercises.	**2.** We recommended that the staff at the Raleigh II CBOC participate 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 34 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
	Diagnostic assessments are completed 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 2 of 15 patients who had positive alcohol use screens.	**3**. 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.
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 two of nine patients diagnosed with alcohol dependence.	**4**. We recommended that clinic staff consistently document the offer of further treatment to 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 17 patients.	**5**. 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 14 of 30 RN Care Managers (47 percent) did not receive motivational interviewing training within 12 months of appointment to PACT.	**6**. 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 8 of 30 RN Care Managers (27 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 30 of 55 providers (55 percent) did not receive health coaching training within 12 months of appointment to PACT.	**7**. 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 7 of 22 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 29 EHRs and 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 4. HIV Screening

NM	Areas Reviewed	Findings	Recommendations
	The facility has a Lead HIV 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.		
	Clinicians provided HIV testing as part of routine medical care for patients.		
	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 45 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.		

Outpatient Lab Results Management

The purpose of this review was to determine whether CBOCs/OOCs are compliant with VHA requirements for the patient notification and follow up of selected outpatient lab results.[e]

We reviewed relevant documents and 46 EHRs. We also 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 6. Outpatient Lab Results Management

NM	Areas Reviewed	Findings	Recommendations
	The facility has a written policy regarding communication of lab results from diagnostic practitioner to ordering practitioner.		
	The facility has a written policy for the communication of lab results that included all required elements.		
X	Clinicians notified patients of their lab results.	Clinicians did not consistently notify 10 of 46 patients (22 percent) of their lab results within 14 days as required by VHA.	**8**. We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by local policy.
	Clinicians documented in the EHR all attempts to communicate with the patients regarding their lab results.		
	Clinicians provided interventions for clinically significant abnormal lab results.		

Clinic Profiles

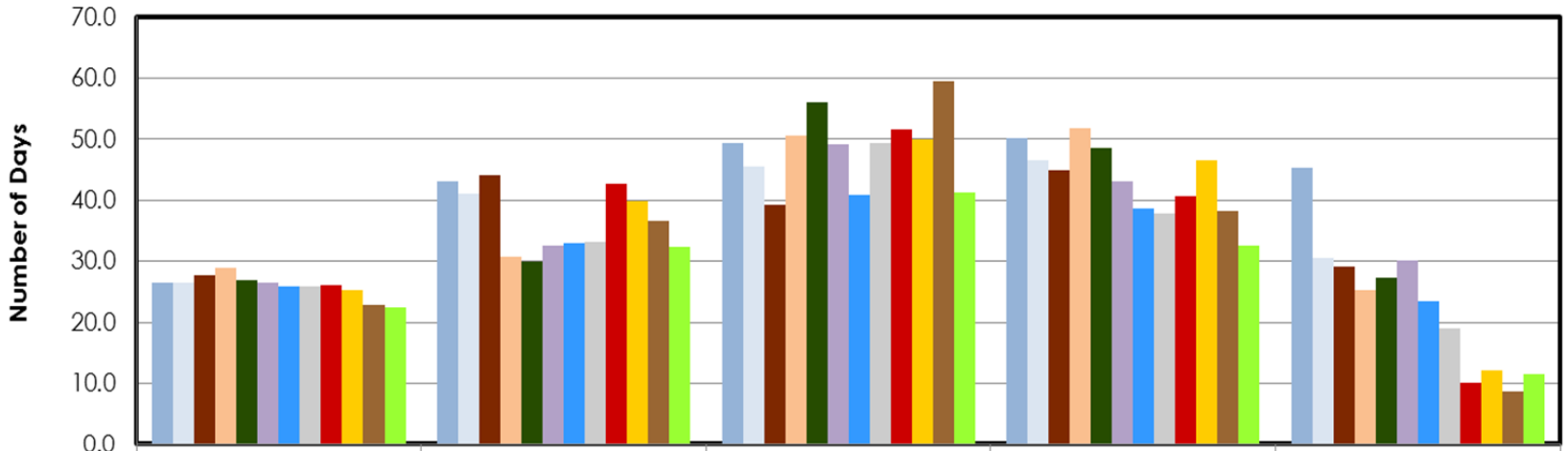
The CBOC/OOC review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[3] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. 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]**	
Greenville, NC	558GA	Urban	24,746	15,880	3,029	Cardiology Dental Endocrinology Medicine Specialties Neurology Optometry	Audiology Diabetes Care Diabetic Retinal Screening Imaging Services	MOVE! Program[10] Nutrition Pharmacy Rehabilitation Services
Raleigh, NC	558GB	Urban	24,910	22,586	456	Dermatology	Diabetic Retinal Screening MOVE! Program	Nutrition Pharmacy Rehabilitation Services
Morehead City, NC	558GC	Rural	12,010	5,031	4,063	Dental Medicine Specialties Optometry	Diabetes Care MOVE! Program Nutrition Pharmacy	Rehabilitation Services Speech Pathology

[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-PC and non-Mental Health services provided by a physician.
[9] Ancillary Services refer to non-PC 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.

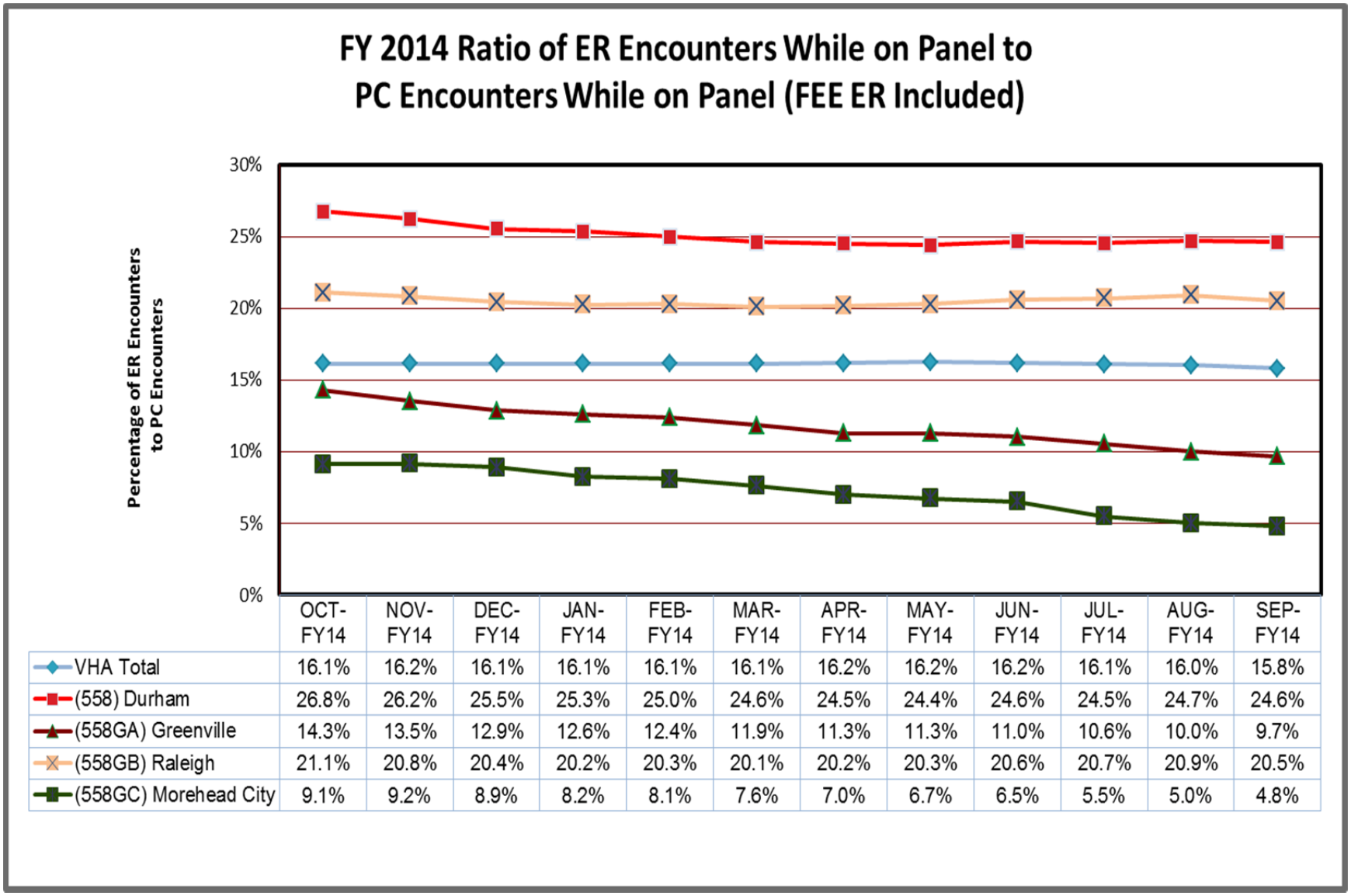
PACT Compass Metrics

FY 2014 New Primary Care Patient Average Wait Time in Days



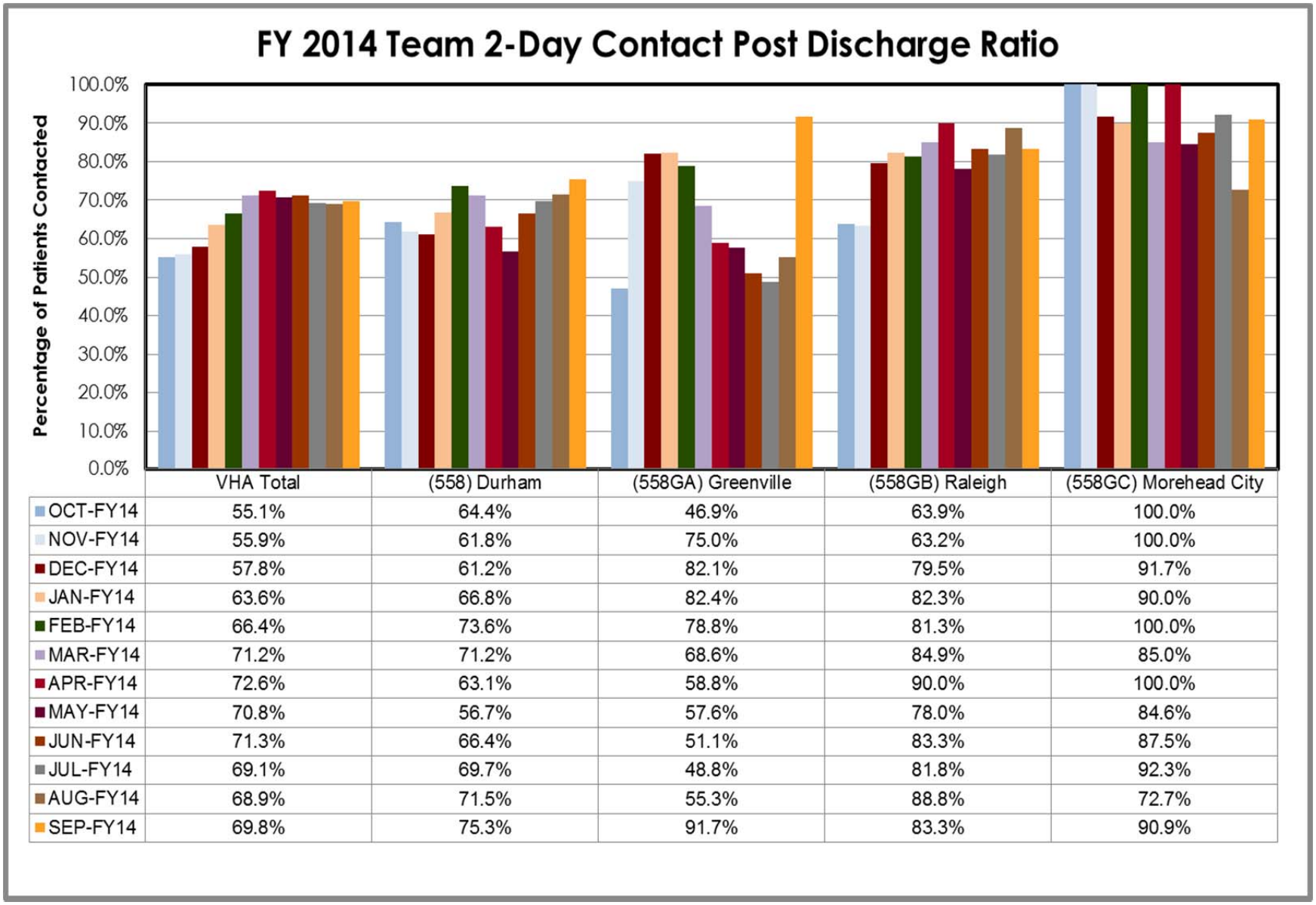
	VHA Total	(558) Durham	(558GA) Greenville	(558GB) Raleigh	(558GC) Morehead City
OCT-FY14	26.5	43.1	49.3	50.2	45.4
NOV-FY14	26.5	41.0	45.5	46.5	30.5
DEC-FY14	27.7	44.1	39.4	45.0	29.1
JAN-FY14	28.9	30.7	50.5	51.7	25.3
FEB-FY14	26.9	30.0	56.0	48.5	27.3
MAR-FY14	26.4	32.6	49.2	43.0	30.1
APR-FY14	25.9	33.0	40.9	38.6	23.6
MAY-FY14	26.0	33.2	49.4	37.9	19.0
JUN-FY14	26.1	42.6	51.5	40.6	10.1
JUL-FY14	25.3	40.0	50.0	46.5	12.2
AUG-FY14	23.0	36.7	59.6	38.2	8.7
SEP-FY14	22.6	32.4	41.4	32.6	11.5

Data Definition.[f] The average number of calendar days between a new patient's PC 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%
(558) Durham	26.8%	26.2%	25.5%	25.3%	25.0%	24.6%	24.5%	24.4%	24.6%	24.5%	24.7%	24.6%
(558GA) Greenville	14.3%	13.5%	12.9%	12.6%	12.4%	11.9%	11.3%	11.3%	11.0%	10.6%	10.0%	9.7%
(558GB) Raleigh	21.1%	20.8%	20.4%	20.2%	20.3%	20.1%	20.2%	20.3%	20.6%	20.7%	20.9%	20.5%
(558GC) Morehead City	9.1%	9.2%	8.9%	8.2%	8.1%	7.6%	7.0%	6.7%	6.5%	5.5%	5.0%	4.8%

Data Definition.[f] This is a measure of where the patient receives his PC 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 PC encounters while on panel with the patient's assigned PC (or associate) provider plus the total VHA ER/Urgent Care/FEE ER encounters (including FEE ER visits) while on panel plus the number of PC encounters while on panel with a provider other than the patient's PC Provider/Associate Provider.



	VHA Total	(558) Durham	(558GA) Greenville	(558GB) Raleigh	(558GC) Morehead City
OCT-FY14	55.1%	64.4%	46.9%	63.9%	100.0%
NOV-FY14	55.9%	61.8%	75.0%	63.2%	100.0%
DEC-FY14	57.8%	61.2%	82.1%	79.5%	91.7%
JAN-FY14	63.6%	66.8%	82.4%	82.3%	90.0%
FEB-FY14	66.4%	73.6%	78.8%	81.3%	100.0%
MAR-FY14	71.2%	71.2%	68.6%	84.9%	85.0%
APR-FY14	72.6%	63.1%	58.8%	90.0%	100.0%
MAY-FY14	70.8%	56.7%	57.6%	78.0%	84.6%
JUN-FY14	71.3%	66.4%	51.1%	83.3%	87.5%
JUL-FY14	69.1%	69.7%	48.8%	81.8%	92.3%
AUG-FY14	68.9%	71.5%	55.3%	88.8%	72.7%
SEP-FY14	69.8%	75.3%	91.7%	83.3%	90.9%

Data Definition.[f] The percent of discharges (VHA inpatient discharges) for the reporting timeframe for assigned PC 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.

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: August 12, 2015

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **Review of CBOCs and OOCs of Durham VA Medical Center, Durham, NC**

To: Director**,** Atlanta Office of Healthcare Inspections (54AT)

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

1. Attached please find the CBOCs and OOC response to the report from the Durham VA Medical Center review.

2. I have reviewed the completed response.

3. I appreciate the Office of Inspector General's efforts to ensure high quality care to veterans at DVAMC.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Network Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: August 12, 2015

From: Director, Durham VA Medical Center (558/00)

Subject: **Review of CBOCs and OOCs of Durham VA Medical Center, Durham, NC**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. Thank you for the opportunity to review the report of the Review of CBOCs and OOCs of Durham VA Medical Center, Durham NC.

2. I have reviewed the document and concur with the recommendations. Relevant action plans have been established as detailed in the attached report. Attached please find the facility concurrence and response to the findings from the review.

3. If you have any questions or need further information, please contact Sheila Hardy-Middelton, Chief Quality Management at (919) 286-0411.

(original signed by:)
(Ms DeAnne Seekins)

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 that review of the hazardous materials inventory occurs twice within a 12-month period at the Raleigh II CBOC.

Concur

Target date for completion: January 31, 2016

Facility response: A hazardous materials inventory was completed by the Industrial Hygienist in November 2014**,** and a second inventory was completed in April 2015. The Industrial Hygienist set up an electronic tracking system allowing greater internal transparency and oversight of inventory status. A third hazardous materials inventory is scheduled for the first quarter, fiscal year 2016. The hazardous materials inventory completion information will be reported to the Environment of Care Committee through Durham Governance Board for Executive Leadership oversight.

Recommendation 2. We recommended that the staff at the Raleigh II CBOC participate in scheduled emergency management training and exercises.

Concur

Target date for completion: November 30, 2015

Facility response: The Durham Emergency Manager plans training and exercises based on the Hazard Vulnerability Assessment (HVA) each year. This plan includes the CBOCs. The next scheduled emergency management training for the Raleigh II CBOC is October 6, 2015. The results of this training will be reported to the Emergency Management Committee through Environment of Care Committee through Durham Governance Board for Executive Leadership oversight.

Recommendation 3. 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: December 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 education and counseling is monitored through random monthly audit of fifty charts to demonstrate practice adherence. Audits will continue until 90% compliance is achieved for three consecutive months. The results of these chart audits are submitted to the Survey Readiness Committee monthly, through Quality Safety Council and Durham Governance Board for Executive Leadership oversight.

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

Concur

Target date for completion: December 31, 2015

Facility response: Primary care providers were missing positive screens as a result of providers starting documentation in CPRS prior to the nursing staff completing their intake note. If the providers did not refresh CPRS, the reminders were missed. Education regarding these screens has been completed. Staff education and targeted feedback is ongoing. Compliance is monitored through a random monthly audit of fifty charts to demonstrate practice adherence. Audits will continue until 90% compliance is achieved for three consecutive months. The results of these chart audits are submitted to the Survey Readiness Committee monthly, through Quality Safety Council and Durham Governance Board for Executive Leadership oversight.

Recommendation 5. 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: December 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 is monitored through random monthly audit of fifty charts to demonstrate practice adherence. Audits will continue until 90% compliance is achieved for three consecutive months. The results of these chart audits are submitted to the Survey Readiness Committee monthly, through Quality Safety Council and Durham Governance Board for Executive Leadership oversight.

Recommendation 6. 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: October 31, 2015

Facility response: As of August 2015, we have provided motivational interviewing and health coaching training (TEACH) for the Clinic Registered Nurse Care Managers, as follows:

RN Care Managers:
Health Coaching Training (TEACH)

All 39 RNs appointed to PACT between 10-1-2013 and 7-1-2015 have completed TEACH training.

Motivational Interviewing MI Training

- 39 RNs appointed to PACT between 10-1-2013 and 7-1-2015
- Of these 39 RNs, one (1) RN is on military deployment (38), and one (1) RN has until late 2015 before her retraining requirement expires (37).
- Of the remaining 37 RNs, 34 RNs have completed MI within 12 months of PACT appointment, resulting in 92% compliance

The next MI training will be September 2015. Those RNs who are eligible for training will complete their training during this September 2015 class.

Recommendation 7. 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: October 31, 2015

Facility response: As of August 2015, we have provided health coaching training (TEACH) for the providers and clinical associates, as follows:

- PACT Clinicians: Providers (88 out of 106) and LPNs (97 out of 136), appointed to PACT after 10-1-13 and before 7-1-15 trained in TEACH within 12 months, resulting in 92% compliance.
- The next health coaching training (TEACH) will be September 2015. The remaining PACT Clinicians: Providers (18) and LPNs (39) will complete their training during this September 2015 class.

Recommendation 8. We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by local policy.

Concur

Target date for completion: October 31, 2015

Facility response: As of April 2015, test result notification within 14 days performance indicator was added to provider OPPEs/FPPEs. Providers were reeducated on test result notification within 14 days, with special emphasis on those providers who did not meet a 90% threshold per the results of the OPPEs/FPPEs. Ongoing compliance is monitored through random monthly audit of fifty charts to demonstrate practice adherence. Audits will continue until 90% compliance is achieved for three consecutive months. The results of these chart audits are submitted to the Survey Readiness Committee monthly, through Quality Safety Council and Durham Governance Board for Executive Leadership oversight.

Office of Inspector General
Contact and Staff Acknowledgments

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U.S. House of Representatives: G.K. Butterfield, Renee Ellmers, George Holding, Walter B. Jones, David Price, David Rouzer, Mark Walker

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

Endnotes

[a] References used for the EOC review included:
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[b] References used for the AUD Care review included:
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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] References used for the Outpatient Lab Results Management review included:
- VHA Handbook 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.
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[f] Reference used for PACT Compass data graphs:
- Department of Veterans' Affairs, *Patient Aligned Care Teams Compass Data Definitions*, June 24, 2014.