Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00165-529

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of William S. Middleton Memorial Veterans Hospital, Madison, WI

September 28, 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
ER	emergency room
FY	fiscal year
HIV	human immunodeficiency virus
lab	laboratory
NM	not met
OIG	Office of Inspector General
OOC	other outpatient clinic
PACT	Patient Aligned Care Teams
PC	primary care
RN	registered nurse
VHA	Veterans Health Administration

Table of Contents

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 William S. Middleton Memorial Veterans Hospital and Veterans Integrated Service Network 12 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 Baraboo VA Clinic, Baraboo, WI, as a representative site and evaluated the environment of care on August 5, 2015.

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

Environment of Care: Ensure that:

- The doors to the examination rooms designated for women veterans are equipped with electronic or manual locks at the Baraboo VA Clinic.

Alcohol Use Disorder Care: Ensure that:

- Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.

- Clinic Registered Nurse Care Managers, 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:

- The Acting Facility Director defines the requirements for communication of human immunodeficiency virus test results.

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

- Clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.

Outpatient Lab Results Management: Ensure that:

- The facility's written policy for the communication of lab results includes all required elements.

- Clinicians consistently notify patients of their lab results within 14 days as required by VHA.

- Clinicians document in the electronic health record all attempts to communicate with the patients regarding their lab results.

Comments

The Acting 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 Baraboo VA Clinic. The table below shows the areas reviewed for this topic. The area 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.		
	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.		
	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.		
	Personal protective equipment is readily available.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
X	The women veterans' exam room is equipped with either an electronic or manual door lock.	The women veterans' exam rooms at the Baraboo VA Clinic were not equipped with either an electronic or manual door lock.	**1.** We recommended that the doors to the examination rooms designated for women veterans are equipped with electronic or manual locks at the Baraboo VA Clinic.

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 39 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.		
	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 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.		
X	Clinic RN Care Managers have received motivational interviewing training within 12 months of appointment to PACT.	We found that 10 of 16 Clinic RN Care Managers did not receive motivational interviewing training within 12 months of appointment to PACT.	**2.** We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.

NM	Areas Reviewed (continued)	Findings	Recommendations
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 10 of 16 Clinic RN Care Managers did not receive health coaching training within 12 months of appointment to PACT.	**3.** We recommended that Clinic Registered Nurse Care Managers, providers, and clinical associates in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.
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 19 of 29 providers did not receive health coaching training within 12 months of appointment to PACT.	
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 27 of 44 clinical associates (61 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 35 EHRs and validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 4. 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.		
X	The facility had developed policies and procedures that include requirements for the communication of HIV test results.	The facility did not have a policy in place for communication of HIV test results.	**4.** We recommended that the Acting Facility Director defines the requirements for communication of human immunodeficiency virus 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 5 of 35 patients (14 percent).	**5.** We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored.
X	When HIV testing occurred, clinicians consistently documented informed consent.	Clinicians did not document informed consent for HIV testing for two of nine patients.	**6.** 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 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 areas 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.		
X	The facility has a written policy for the communication of lab results that included all required elements.	The facility's written policy for the communication of lab results did not define critical test results and values, did not require the communication of lab results to patients no later than 14 days from the date on which the results are available to the ordering practitioner, and did not require the documentation of treatment actions in response to abnormal test results in the patient's EHR.	**7**. We recommended that the Acting Facility Director ensures that the facility's written policy for the communication of laboratory results included all required elements.
X	Clinicians notified patients of their lab results.	Clinicians did not consistently notify 32 of 46 patients (70 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 VHA.
X	Clinicians documented in the EHR all attempts to communicate with the patients regarding their lab results.	For all 32 EHRs (100 percent) reviewed, clinicians did not document all attempts to communicate with the patients regarding their results.	**9.** We recommended that clinicians consistently document in the electronic health record all attempts to communicate with the patients regarding their laboratory results.
	Clinicians provided interventions for clinically significant abnormal lab results.		

Clinic Profiles

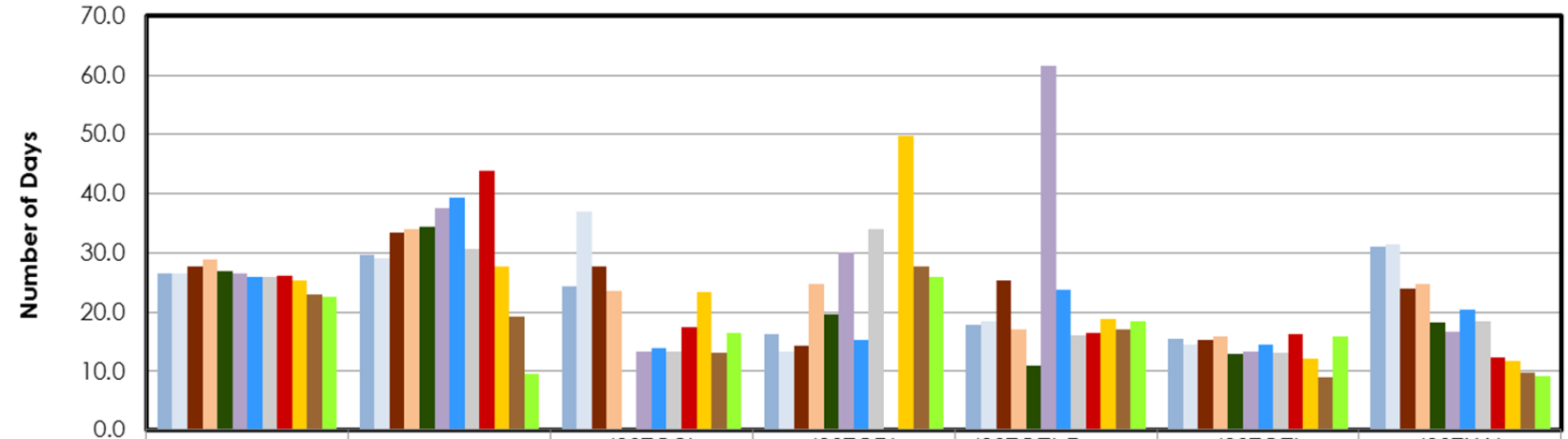
The CBOC/OOC review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[3] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. 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]**
Janesville, WI	607GC	Urban	4,757	1,937	35	N/A	Audiology Diabetic Retinal Screening MOVE! Program[10] Pharmacy
Baraboo, WI	607GD	Rural	2,393	818	17	N/A	Audiology MOVE! Program Pharmacy
Beaver Dam, WI	607GE	Rural	3,172	869	37	N/A	Audiology MOVE! Program
Freeport, IL	607GF	Rural	3,620	580	33	N/A	Audiology MOVE! Program Pharmacy
Rockford, IL	607HA	Urban	14,612	16,433	2,763	Gastroenterology Podiatry	Audiology Diabetic Retinal Screening MOVE! Program Nutrition Pharmacy Rehabilitation Services 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-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.

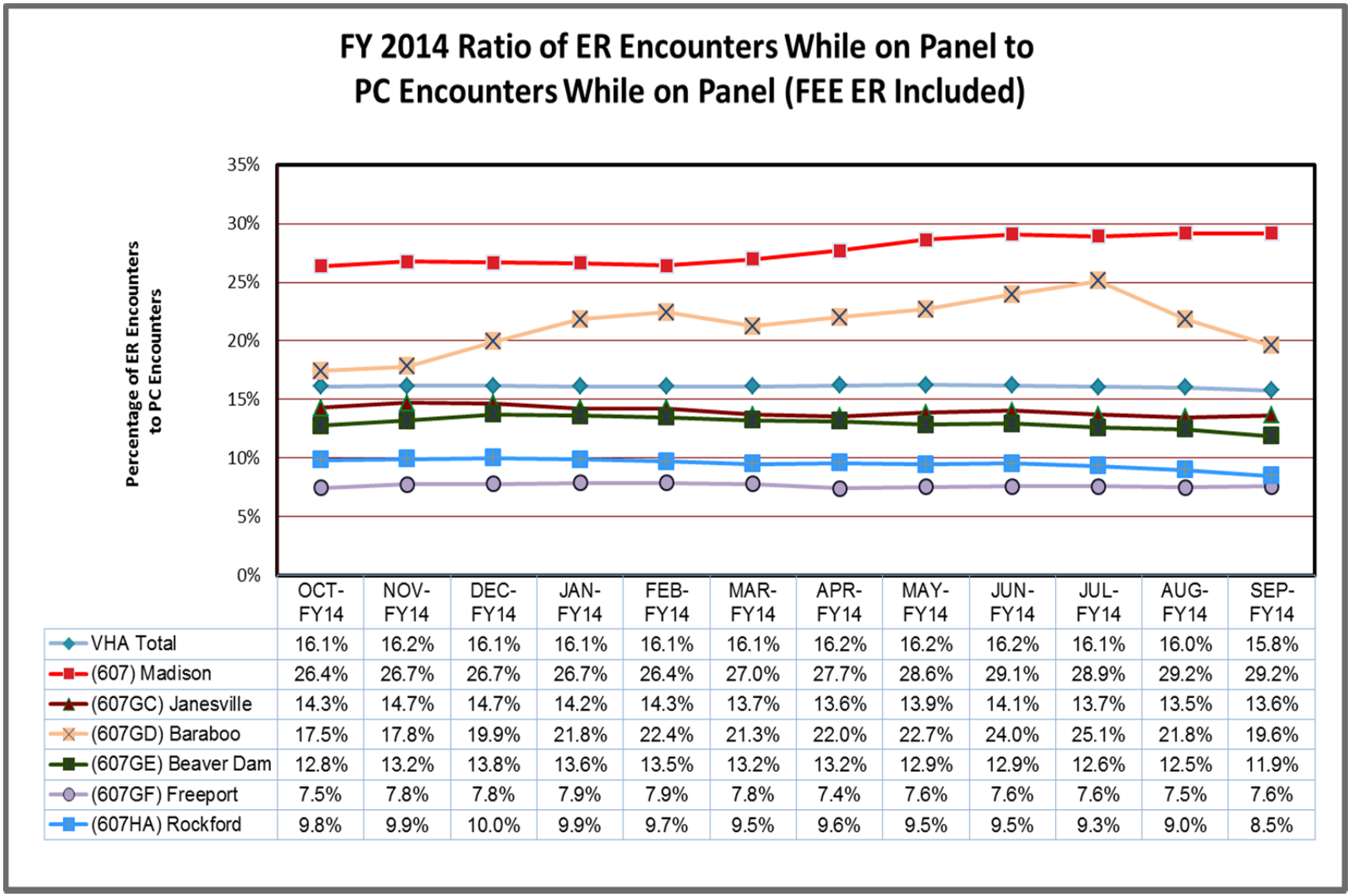
PACT Compass Metrics

FY 2014 New Primary Care Patient Average Wait Time in Days



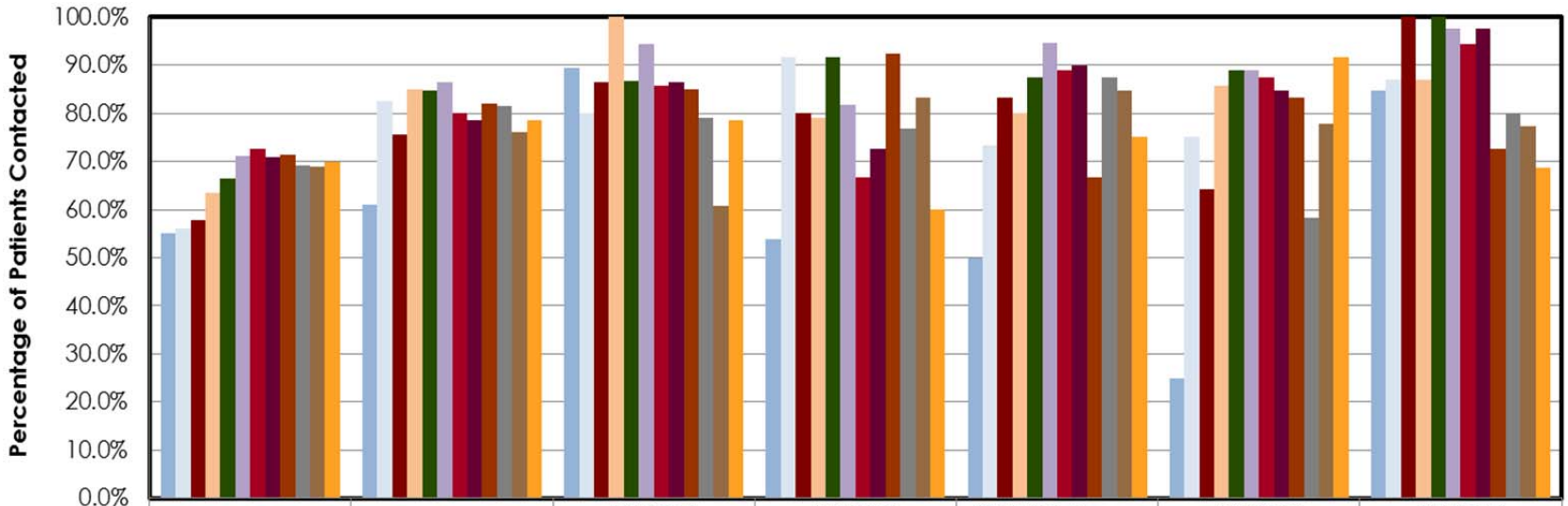
	VHA Total	(607) Madison	(607GC) Janesville	(607GD) Baraboo	(607GE) Beaver Dam	(607GF) Freeport	(607HA) Rockford
OCT-FY14	26.5	29.8	24.4	16.2	17.9	15.5	31.0
NOV-FY14	26.5	29.0	36.9	13.4	18.4	14.5	31.4
DEC-FY14	27.7	33.4	27.7	14.3	25.3	15.3	24.0
JAN-FY14	28.9	34.0	23.5	24.8	17.0	15.8	24.7
FEB-FY14	26.9	34.3		19.6	11.0	13.0	18.2
MAR-FY14	26.4	37.6	13.4	30.0	61.7	13.3	16.8
APR-FY14	25.9	39.3	13.9	15.3	23.8	14.5	20.4
MAY-FY14	26.0	30.6	13.4	34.0	16.1	13.2	18.5
JUN-FY14	26.1	43.9	17.5		16.4	16.3	12.4
JUL-FY14	25.3	27.8	23.4	49.7	18.9	12.2	11.7
AUG-FY14	23.0	19.2	13.1	27.8	17.1	9.0	9.7
SEP-FY14	22.6	9.7	16.5	26.0	18.5	15.9	9.1

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. Blank cells indicate the absence of reported data.



	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%
(607) Madison	26.4%	26.7%	26.7%	26.7%	26.4%	27.0%	27.7%	28.6%	29.1%	28.9%	29.2%	29.2%
(607GC) Janesville	14.3%	14.7%	14.7%	14.2%	14.3%	13.7%	13.6%	13.9%	14.1%	13.7%	13.5%	13.6%
(607GD) Baraboo	17.5%	17.8%	19.9%	21.8%	22.4%	21.3%	22.0%	22.7%	24.0%	25.1%	21.8%	19.6%
(607GE) Beaver Dam	12.8%	13.2%	13.8%	13.6%	13.5%	13.2%	13.2%	12.9%	12.9%	12.6%	12.5%	11.9%
(607GF) Freeport	7.5%	7.8%	7.8%	7.9%	7.9%	7.8%	7.4%	7.6%	7.6%	7.6%	7.5%	7.6%
(607HA) Rockford	9.8%	9.9%	10.0%	9.9%	9.7%	9.5%	9.6%	9.5%	9.5%	9.3%	9.0%	8.5%

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	(607) Madison	(607GC) Janesville	(607GD) Baraboo	(607GE) Beaver Dam	(607GF) Freeport	(607HA) Rockford
OCT-FY14	55.1%	60.9%	89.5%	53.8%	50.0%	25.0%	84.6%
NOV-FY14	55.9%	82.5%	80.0%	91.7%	73.3%	75.0%	86.8%
DEC-FY14	57.8%	75.6%	86.4%	80.0%	83.3%	64.3%	100.0%
JAN-FY14	63.6%	85.0%	100.0%	78.9%	80.0%	85.7%	86.8%
FEB-FY14	66.4%	84.6%	86.7%	91.7%	87.5%	88.9%	100.0%
MAR-FY14	71.2%	86.6%	94.4%	81.8%	94.7%	88.9%	97.5%
APR-FY14	72.6%	80.0%	85.7%	66.7%	88.9%	87.5%	94.4%
MAY-FY14	70.8%	78.6%	86.4%	72.7%	90.0%	84.6%	97.6%
JUN-FY14	71.3%	81.9%	85.0%	92.3%	66.7%	83.3%	72.5%
JUL-FY14	69.1%	81.5%	78.9%	76.9%	87.5%	58.3%	80.0%
AUG-FY14	68.9%	76.2%	60.9%	83.3%	84.6%	77.8%	77.4%
SEP-FY14	69.8%	78.5%	78.6%	60.0%	75.0%	91.7%	68.6%

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.

Appendix C

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: September 8, 2015

From: Acting Director, VA Great Lakes Health Care System (10N12)

Subject: **Review of CBOCs and OOCs of William S. Middleton Memorial Veterans Hospital, Madison, WI**

To: Director**,** Denver Office of Healthcare Inspections (54DV)

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

1. Attached please find the CBOC and OOC response to the draft report from the William S. Middleton Memorial Veterans Hospital, Madison, WI review.

2. I have reviewed the completed response.

3. I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans at William S. Middleton Memorial Veterans Hospital and Clinics.

James W. Rice
Acting Network Director

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: September 3, 2015

From: Acting Director, William S. Middleton Memorial Veterans Hospital (607/00)

Subject: **Review of CBOCs and OOCs of William S. Middleton Memorial Veterans Hospital, Madison, WI**

To: Acting Director, VA Great Lakes Health Care System (10N12)

1. Thank you for the opportunity to review the draft report on the Community Based Outpatient Clinics and OOC at William S. Middleton Memorial Veterans Hospital and Clinics, Madison WI (Baraboo Clinic).

2. I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in attached report.

Christine Kleckner

CHRISTINE KLECKNER

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the doors to the examination rooms designated for women veterans are equipped with electronic or manual locks at the Baraboo VA Clinic.

Concur

Target date for completion: 10/31/2015

Facility response: All Baraboo VA Clinic examination room doors will be equipped with locking hardware. Madison VA Hospital has obtained a quote through Baraboo VA Clinic landlord to replace the door hardware (8/26/15) and has entered procurement request with VA VISN 12 Contracting Office (8/27/2015). Plan with target dates going forward:

- September 2015 – VA VISN 12 Contracting Office issues purchase order to Baraboo VA Clinic landlord to complete the work
- October 2015 – Baraboo VA Clinic landlord equips the examination room doors with locking hardware
- October 2015 – Baraboo VA Clinic management confirm installation of locking hardware on examination room doors
- Madison VA Hospital EOC Rounds team will confirm sustained improvement during semi-annual rounds.

Recommendation 2. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target date for completion: 3/1/2016

Facility response: Ambulatory Care leadership will add Motivational Interviewing (MI) Classes to their Phase II orientation plan for any newly hired PACT Nurse Care Managers with the goal that training will be completed within three months of onboarding. Existing PACT Nurse Care Managers who have not completed Motivational Interviewing Classes (N=10) will be registered for classes by 9/14/15 with the goal of having existing staff complete class by 3/1/2016. By March 1, 2016 95% of PACT Nurse Care Managers will have received MI training.

Recommendation 3. We recommended that Clinic Registered Nurse Care Managers, 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: 3/1/2016

Facility response: Ambulatory Care leadership will add health coaching training to the Phase II orientation plan for any newly hired Clinic Registered Nurse Care Managers, Providers, and clinical associates with the goal that training will be completed within three months of onboarding. Existing Clinic Registered Nurse Care Managers, Providers and Clinical Associates who have not completed health coaching training (N=50) will be registered for classes by 9/14/15 with the goal of having existing staff complete class by 3/1/2016. By March 1, 2016 95% of Clinic Registered Nurse Care Managers, Providers, and Clinical Associates will have received health coaching training.

Recommendation 4. We recommended that the Acting Facility Director defines the requirements for communication of human immunodeficiency virus test results.

Concur

Target date for completion: 8/1/2015

Facility response: Hospital memorandum approved and available to staff regarding HIV testing and communication of test results August 1, 2015. Staff has been educated related to the HIV Test Memorandum as well as Ambulatory Care Provider meetings. We request that this recommendation be closed.

Recommendation 5. 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: March 1, 2016

Facility response: The William. S. Middleton Memorial Hospital and Clinics has had the HIV test clinical reminder in effect since 2012. A review of Nexus clinic compliance with offering HIV tests for the past three months (June, July, and August) indicates that 67% of patients were offered the test. Documentation for the HIV testing is being monitored on a monthly basis. By March 1, 2016 monitoring will reflect that 90% of Nexus clinic patients are offered HIV tests.

Recommendation 6. We recommended that clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.

Concur

Target date for completion: March 31, 2016

Facility response: Preventive Ethics Committee has been working on the development of an educational training program for all providers related to the requirement for documentation of verbal consent for HIV testing. The Organizational Improvement department has been monitoring compliance of documentation on a monthly basis to insure compliance and foster accountability. Internal audits find the current rate of compliance is 70%. The goal for documentation of verbal consent for HIV testing will be set at 90%.

Recommendation 7. We recommended that the Acting Facility Director ensures that the facility's written policy for the communication of laboratory results included all required elements.

Concur

Target date for completion: 9/5/2015

Facility response: A local hospital memorandum has been written and approved related to the communication of laboratory results as of 9/1/2015. This memorandum incorporates all required elements. The memorandum was uploaded to the facility Share Point site on 9/5/15, providing all staff access. The Chief of Ambulatory Care notified all licensed independent providers, nurse care and case managers in the ambulatory clinics on 9/1/15 of the local hospital memorandum requirements. We request that this recommendation be closed.

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

Concur

Target date for completion: March 1, 2016

Facility response: A local hospital memorandum has been written and approved related to the communication of laboratory results as of 9/1/2015 incorporating the new guidance of communicating normal results in 14 days and abnormal within 7 days of receiving test result information. The memorandum was uploaded to the facility Share Point site on 9/5/15, providing all staff access. The Chief of Ambulatory Care notified all licensed independent providers, nurse care and case managers in the ambulatory clinics on 9/1/15 of the local hospital memorandum requirements. Monitoring of timely patient notification of laboratory results will be conducted monthly until 90% compliance is achieved and sustained.

Recommendation 9. We recommended that clinicians consistently document in the electronic health record all attempts to communicate with the patients regarding their laboratory results.

Concur

Target date for completion: March 1, 2016

Facility response: A local hospital memorandum has been written and approved related to the communication of laboratory results as of 9/1/2015. This memorandum incorporates the guidance of communicating normal results in 14 days and abnormal within 7 days of receiving test result information as well as the need to document all attempts to communicate results to the patient. The memorandum was uploaded to the facility Share Point site on 9/5/15, providing all staff access. The Chief of Ambulatory Care notified all licensed independent providers, nurse care and case managers in the ambulatory clinics on 9/1/15 of the local hospital memorandum requirements. The documentation of communication of test results including attempts to communicate results is monitored on a quarterly basis through our EPRP extracts. The results of these monitors are shared with the Chief of Staff, Chief of Ambulatory Care Services, Clinical Ambulatory Care Nurse Manager. Monitoring of documenting attempts to communicate results to patients will continue until 90% compliance is achieved and sustained.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Ann Ver Linden, RN, MBA, Team Leader Laura Dulcie, BSEE Glen P. Trupp, MHSM, RN
Other Contributors	Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Jennifer Reed, RN, MSHI Patrick Smith, M. Stat Marilyn Stones, BS Mary Toy, RN, MSN Jarvis Yu, MS

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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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[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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- VHA Under Secretary for Health Information, *Letter IL 10-2010-006, Use of Rapid Tests for Routine Human Immunodeficiency Virus Screening*, February 16, 2010.

[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.
- VHA, *Communication of Test Results Toolkit*, April 2012.

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