Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00166-531

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Alaska VA Healthcare System Anchorage, Alaska

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
FY	fiscal year
HCS	Healthcare System
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 Team
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 Alaska VA Healthcare System and Veterans Integrated Service Network 20 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 (HIV) screening, outpatient documentation, and outpatient lab results management. We also randomly selected the Fairbanks Community Based Outpatient Clinic, Fort Wainwright, AK, as a representative site and evaluated the environment of care on August 4, 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 at the Fairbanks Community Based Outpatient Clinic that:

- Hazardous materials inventory review occurs twice within a 12-month period.
- Staff store clean supplies separate from infectious materials.

Alcohol Use Disorder Care: Ensure that:

- Clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
- Clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
- Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.
- Providers receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

HIV Screening: Ensure that:

- Facility Director defines the requirements for communication of HIV test results.
- Clinicians provide HIV testing as part of routine medical care for patients and that compliance is monitored.
- Clinicians consistently document informed consent for HIV testing and that compliance is monitored.

Outpatient Lab Results Management: Ensure that:

- The facility's written policy for the communication of laboratory results includes all required elements.
- Clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Community Based Outpatient Clinic and other outpatient clinic review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 15–19, for the full text of the Directors' comments.) We will follow up on the planned actions 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 Fairbanks 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 inventory of hazardous materials at the Fairbanks 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 Fairbanks 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.	.	
	Hand hygiene is monitored for compliance.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Personal protective equipment is readily available.		
	Sterile commercial supplies are not expired.		
X	The CBOC staff members minimize the risk of infection when storing and disposing of medical (infectious) waste.	The Fairbanks CBOC staff are storing clean supplies in the same area as infectious materials.	**2**. We recommended that staff store clean supplies separate from infectious materials at the Fairbanks CBOC.
	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.		
NA	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.		
NA	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.		
	The women veterans' exam room is equipped with either an electronic or manual door lock.		
NA	The information technology network room/server closet is locked.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	Access to the information technology network room/server closet is restricted to personnel authorized by Office of Information and Technology.		
NA	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.		
NA	There is an alarm system and/or panic buttons installed and tested in high-risk areas (for example, mental health clinic), and the testing is documented.		
	CBOC staff receive regular information/updates on their responsibilities in emergency response operations.		
	The staff participates in scheduled emergency management training and exercises.		

AUD Care

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

We reviewed relevant documents and 40 EHRs. We also validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 3. AUD Care

NM	Areas Reviewed	Findings	Recommendations
X	Diagnostic assessments are completed for patients with a positive alcohol screen.	Staff did not complete diagnostic assessments for 16 of 40 patients (40 percent) who had positive alcohol use screens.	**3**. We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
	Education and counseling about drinking levels and adverse consequences of heavy drinking are provided for patients with positive alcohol screens and drinking levels above National Institute on Alcohol Abuse and Alcoholism guidelines.		
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.		
	Counseling, education, and brief treatments for AUD care 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 two of three RN Care Managers did not receive motivational interviewing training within 12 months of appointment to PACT.	**5**. 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
	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.		
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 none of the three providers reviewed received health coaching training within 12 months of appointment to PACT.	**6**. We recommended that providers receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.
	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.		
	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.	**7.** We recommended that the 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 4 of 35 patients (11 percent).	**8.** 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 6 of 15 patients.	**9.** 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 34 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 49 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 establish the process for the communication of emergent test results to another practitioner who can take action.	**10**. We recommended that the Facility Director ensures that the facility's written policy for the communication of laboratory results includes all required elements.
X	Clinicians notified patients of their lab results.	Clinicians did not consistently notify 15 of 49 patients (31 percent) of their lab results within 14 days as required by VHA.	**11**. We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.
	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

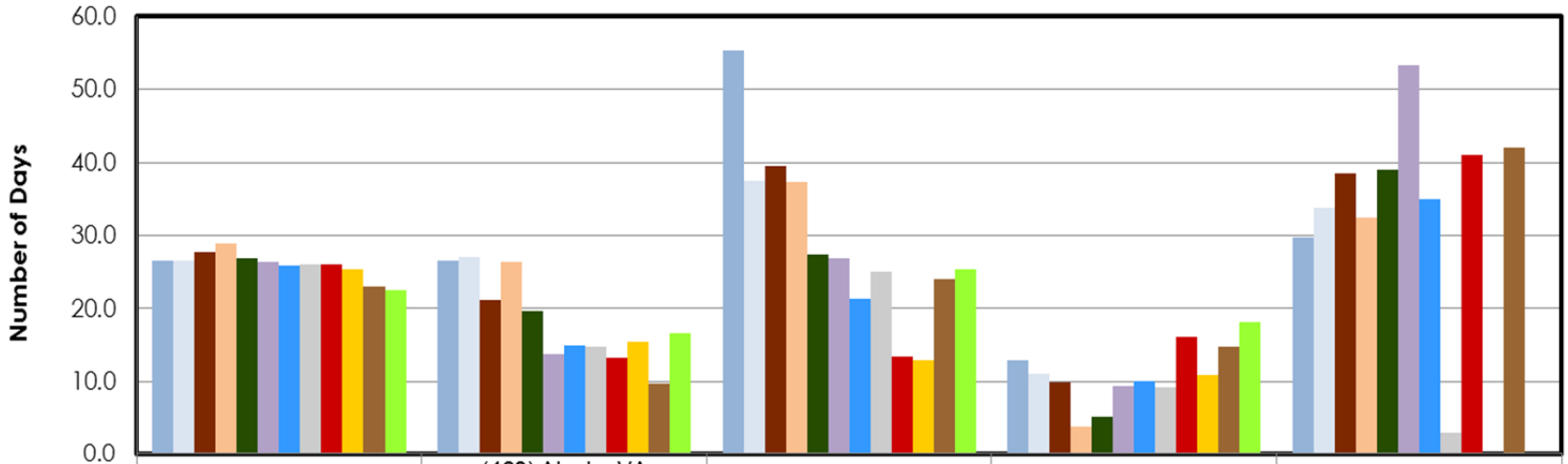
The CBOC/OOC review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[3] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. 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]**
Fort Wainwright, AK	463GA	Urban	6,797	1,851	192	Orthopedics	Audiology Lab
Kenai, AK	463GB	Highly Rural	6,125	1,592	494	Hepatology Podiatry	Audiology
Wasilla, AK	463GC	Highly Rural	4,480	1,578	7	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-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.

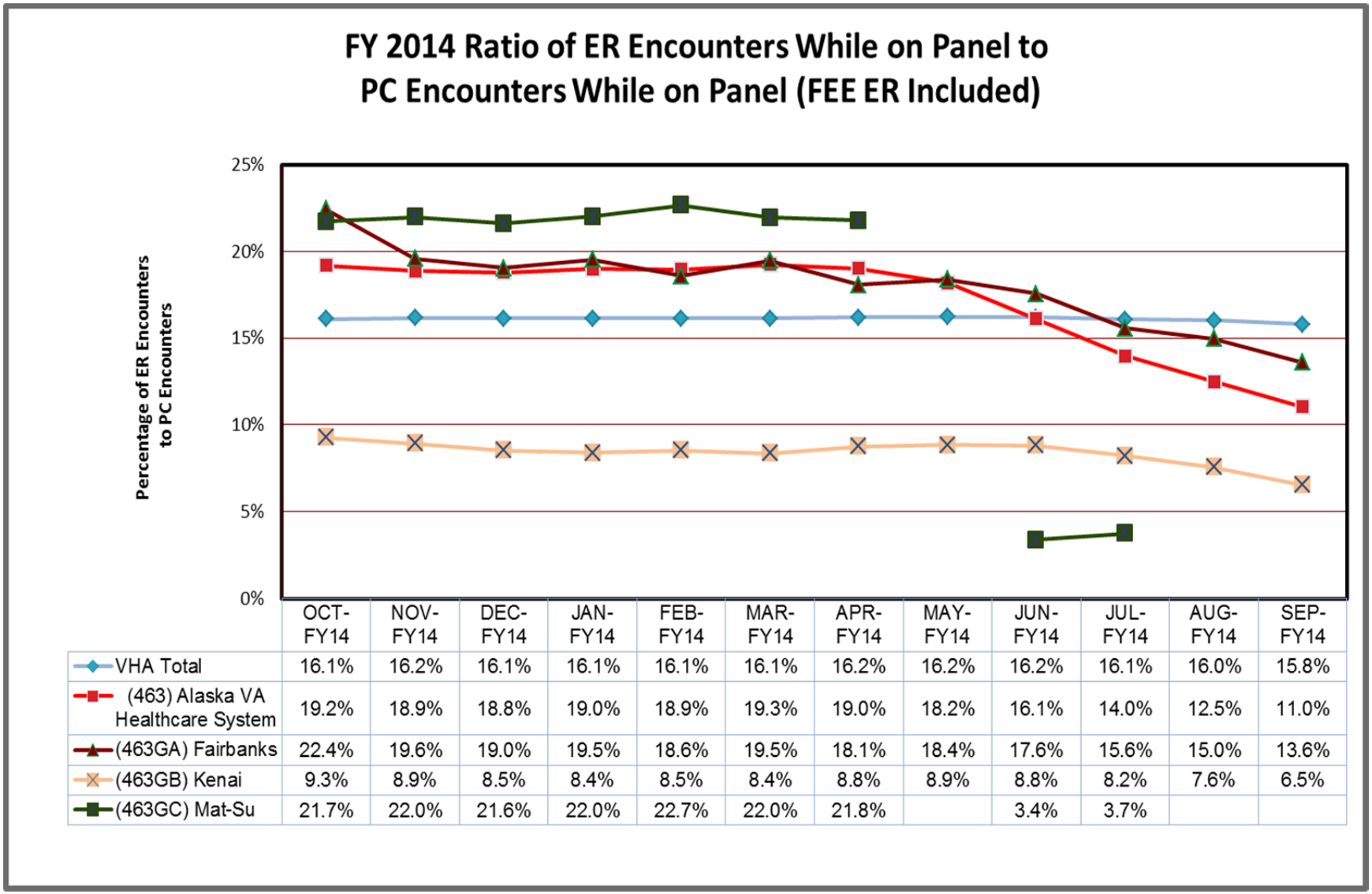
PACT Compass Metrics

FY 2014 New Primary Care Patient Average Wait Time in Days



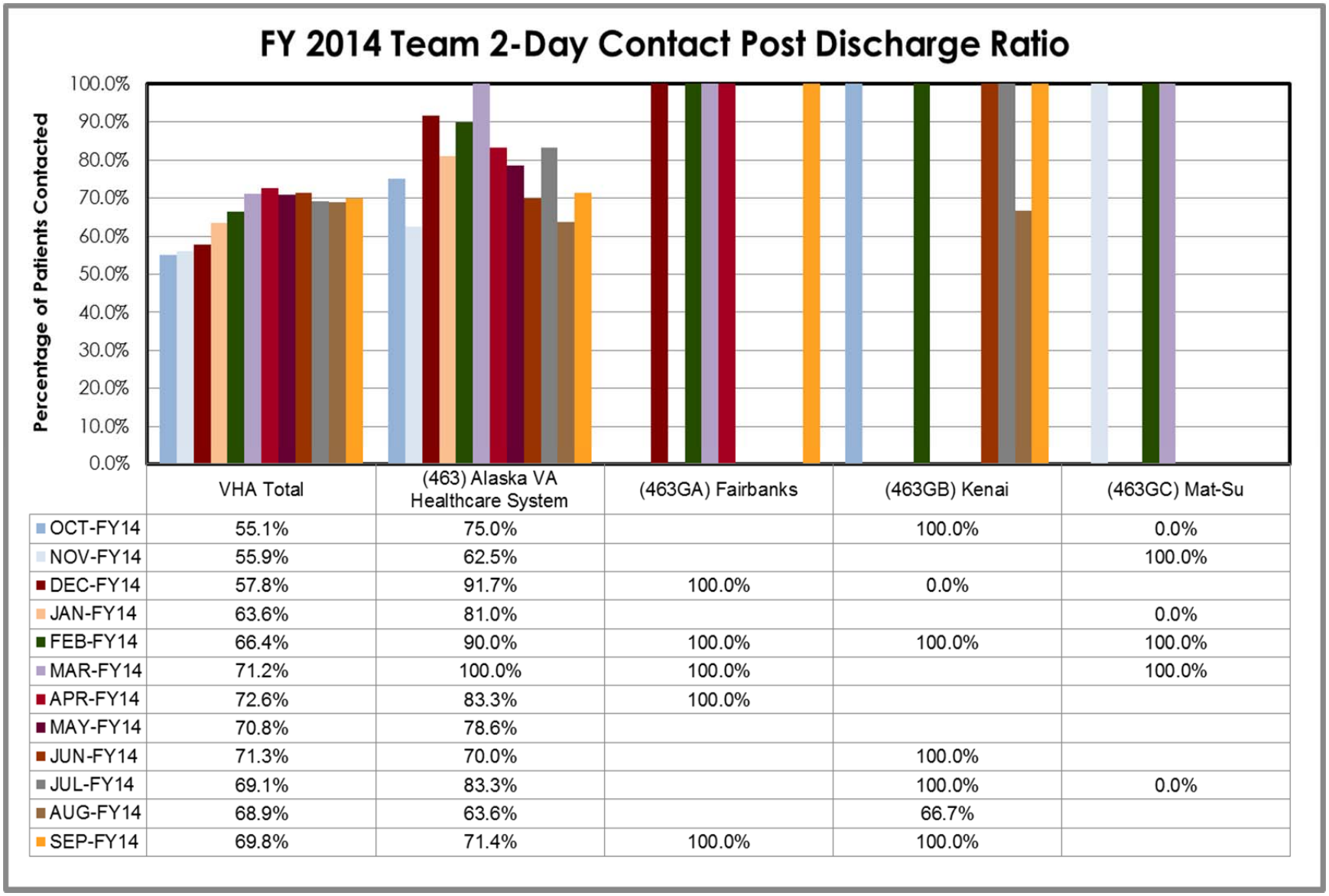
	VHA Total	(463) Alaska VA Healthcare System	(463GA) Fairbanks	(463GB) Kenai	(463GC) Mat-Su
OCT-FY14	26.5	26.6	55.4	12.9	29.7
NOV-FY14	26.5	27.0	37.5	11.1	33.8
DEC-FY14	27.7	21.2	39.5	9.9	38.5
JAN-FY14	28.9	26.5	37.3	3.8	32.4
FEB-FY14	26.9	19.6	27.5	5.2	39.0
MAR-FY14	26.4	13.8	26.9	9.3	53.3
APR-FY14	25.9	14.9	21.3	10.0	35.0
MAY-FY14	26.0	14.7	25.0	9.3	3.0
JUN-FY14	26.1	13.3	13.3	16.2	41.0
JUL-FY14	25.3	15.5	12.9	10.9	
AUG-FY14	23.0	9.7	24.0	14.8	42.0
SEP-FY14	22.6	16.6	25.4	18.2	

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%
(463) Alaska VA Healthcare System	19.2%	18.9%	18.8%	19.0%	18.9%	19.3%	19.0%	18.2%	16.1%	14.0%	12.5%	11.0%
(463GA) Fairbanks	22.4%	19.6%	19.0%	19.5%	18.6%	19.5%	18.1%	18.4%	17.6%	15.6%	15.0%	13.6%
(463GB) Kenai	9.3%	8.9%	8.5%	8.4%	8.5%	8.4%	8.8%	8.9%	8.8%	8.2%	7.6%	6.5%
(463GC) Mat-Su	21.7%	22.0%	21.6%	22.0%	22.7%	22.0%	21.8%		3.4%	3.7%		

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. Blank cells indicate the absence of reported data.



	VHA Total	(463) Alaska VA Healthcare System	(463GA) Fairbanks	(463GB) Kenai	(463GC) Mat-Su
OCT-FY14	55.1%	75.0%		100.0%	0.0%
NOV-FY14	55.9%	62.5%			100.0%
DEC-FY14	57.8%	91.7%	100.0%	0.0%	
JAN-FY14	63.6%	81.0%			0.0%
FEB-FY14	66.4%	90.0%	100.0%	100.0%	100.0%
MAR-FY14	71.2%	100.0%	100.0%		100.0%
APR-FY14	72.6%	83.3%	100.0%		
MAY-FY14	70.8%	78.6%			
JUN-FY14	71.3%	70.0%		100.0%	
JUL-FY14	69.1%	83.3%		100.0%	0.0%
AUG-FY14	68.9%	63.6%		66.7%	
SEP-FY14	69.8%	71.4%	100.0%	100.0%	

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. Blank cells indicate the absence of reported data.

Veterans Integrated Service Network Director Comments

Memorandum

Department of Veterans Affairs

Date: September 4, 2015

From: Director, Northwest Network (10N20)

Subject: **Review of CBOCs and OOCs of Alaska VA Healthcare System, Anchorage, AK**

To: Director**,** Seattle Office of Healthcare

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

1. Thank you for the opportunity to provide responses to the findings from the Community Based Outpatient Clinic and Other Outpatient Clinics at Alaska VA Healthcare System, Anchorage, Alaska.

2. Attached please find the facility concurrence and response to the findings from the review.

3. If you have additional questions or need further information, please contact Susan Green, Survey Coordinator, VISN 20 at (360) 567-4678.

(original signed by:)
Lawrence H. Carroll

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: September 1, 2015

From: Interim Director, Alaska VA Healthcare System (463/00)

Subject: **Draft Report: Review of CBOCs and OOCs of Alaska VA Healthcare System, Anchorage, AK**

To: Director, Northwest Network (10N20)

1. The findings from the reviews of CBOCs and OOCs of Alaska VA Healthcare System, Anchorage, AK review by the Office of the Inspector General (OIG) conducted Aug 3, 2015 through August 7, 2015 have been reviewed.

2. Attached are the facility responses addressing each recommendation including actions that are in progress and those that have been completed.

Linda L. Boyle, DM, MSN, RN
Interim 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 Fairbanks CBOC.

Concur

Target date for completion: December 31, 2015

Facility response: Fairbanks CBOC nurse manager or designee will review the hazardous materials inventory for accuracy twice within a twelve month period, ongoing.

Recommendation 2. We recommended that staff store clean supplies separate from infectious materials at the Fairbanks CBOC.

Concur

Target date for completion: December 31, 2015

Facility response: Clean supplies are now separated from infectious materials. The clean and dirty utility rooms are now clearly marked with signage. We will monitor compliance for three consecutive months.

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

Concur

Target date for completion: January 31, 2016

Facility response: The full diagnostic assessment portion of the provider clinical reminder for positive alcohol screens will be updated as a mandatory field. Updates will be reviewed with all clinical staff in all facility areas in which AUD screening is done. We will monitor until compliance is >90% for three consecutive months.

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: January 31, 2016

Facility response: We will update the response to counseling portion of the clinical reminder to a mandatory field. We will monitor until compliance is >90% for three consecutive months.

Recommendation 5. We recommend 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: December 31, 2015

Facility response: The RN care managers assigned to PACTs will be trained within 12 months and the training will be documented. Motivational interviewing training has been added to the new employee orientation checklist for Clinic Registered Nurse Care Managers and clinical associates.

Recommendation 6. We recommended that providers receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target date for completion: December 31, 2015

Facility response: The Primary Care Providers assigned to PACTs will complete coaching training within 12 months of appointment and the training will be documented. Coaching training will be added to the new employee orientation checklist for Primary Care Providers.

Recommendation 7. We recommended that the Facility Director defines the requirements for communication of human immunodeficiency virus test results.

Concur

Target date for completion: December 31, 2015

Facility response: Local numbered memorandum 11-31, Human Immunodeficiency Virus (HIV) Testing, will be updated to define the requirements for communication of HIV test results and providers will be educated.

Recommendation 8. 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: December 31, 2015

Facility response: To ensure HIV testing is offered to all patients as part of routine healthcare, an HIV clinical reminder was created and added to all patients' charts regardless of risk factors. To ensure compliance, random chart audits will be conducted, until compliance is > 90% for three consecutive months. We will educate the staff in all areas of the facility, in which HIV testing is offered.

Recommendation 9. We recommended that clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.

Concur

Target date for completion: December 31, 2015

Facility response: The facility implemented a mandatory verbal consent field on the HIV order, March 10, 2015. Compliance will be monitored through monthly random chart audits until compliance is > 90% for three consecutive months.

Recommendation 10. We recommended that the Facility Director ensures that the facility's written policy for the communication of laboratory results includes all required elements.

Concur

Target date for completion: January 31, 2016

Facility response: The facility-wide memorandum for communication of lab results will be revised to include the process of communicating emergent lab results to a provider who can take action. The policy will include the process for surrogate coverage for providers on leave and the process for reporting surrogacy coverage to the lab to ensure emergent labs are reported and acted on in a timely manner. Compliance will be monitored through monthly random chart audits until compliance is > 90% for three consecutive months.

Recommendation 11. We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.

Concur

Target date for completion: December 31, 2015

Facility response: Ongoing education will be provided at monthly staff meetings for clinicians, on the 14 day lab notification requirements, including use of the notification letter. Compliance will be monitored through monthly chart audits until compliance is > 90% for three consecutive months.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Interim Director, Alaska VA Healthcare System (463/00)

Non-VA Distribution

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House Committee on Oversight and Government Reform
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U.S. Senate: Lisa Murkowski, Daniel Sullivan
U.S. House of Representatives: Don Young

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

Endnotes

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