Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00179-34

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Southern Nevada Healthcare System North Las Vegas, Nevada

November 24, 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
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

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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 VA Southern Nevada Healthcare System and Veterans Integrated Service Network 21 provide safe, consistent, and high-quality health care. The review evaluated the clinics' compliance with selected requirements for alcohol use disorder care, human immunodeficiency virus screening, outpatient documentation and outpatient lab results management. We also randomly selected the Southeast VA Clinic, Henderson, NV, as a representative site and evaluated the environment of care on September 15, 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:

- Staff protect patient identifiable information on laboratory specimens during transport from the Southeast VA Clinic to the parent facility or contracted processing facility.
- Panic alarm testing documentation includes specific testing locations at the Southeast VA Clinic.
- Managers at the Southeast VA Clinic maintain attendance records to verify staff participation during 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 guidelines.
- Clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
- Clinic staff provide brief treatment to patients with excessive alcohol use.
- Clinic Registered Nurse Care Managers receive motivational interviewing training and health coaching training and that providers and clinical associates in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Human Immunodeficiency Virus Screening: Ensure that clinicians:

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

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

Outpatient Lab Results Management: Ensure that clinicians:

- Consistently notify patients of their laboratory results within the timeframe specified by VHA policy.

- Document in the electronic health record all attempts to communicate laboratory results with the patients.

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 15–21, for 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 Fiscal Year 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 Southeast VA Clinic. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 2. EOC

NM	Areas Reviewed	Findings	Recommendations
	The furnishings are clean and in good repair.		
	The CBOC is clean.		
	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.		
	Sterile commercial supplies are not expired.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The CBOC staff members minimize the risk of infection when storing and disposing of medical (infectious) waste.		
	The CBOC has procedures to disinfect non-critical reusable medical equipment between patients.		
	There is evidence of fire drills occurring at least every 12 months.		
	Means of egress from the building are unobstructed.		
	Access to fire extinguishers is unobstructed.		
	Fire extinguishers are located in large rooms or are obscured from view, and the CBOC has signs identifying the locations of the fire extinguishers.		
	Exit signs are visible from any direction.		
	Multi-dose medication vials are not expired.		
	All medications are secured from unauthorized access.		
X	The staff protect patient-identifiable information on lab specimens during transport.	At the Southeast VA Clinic, staff did not protect patient-identifiable information on laboratory specimens during transport.	**1**. We recommended that staff protect patient identifiable information on laboratory specimens during transport from the Southeast VA Clinic to the parent facility or contracted processing facility.
	Documents containing patient-identifiable information are not visible or unsecured.		
	Adequate privacy is provided at all times.		
	The women veterans' exam room is equipped with either an electronic or manual door lock.		
	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.		
X	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.	Testing of the alarm/panic buttons at the Southeast VA Clinic did not have documentation of the specific testing locations.	**2**. We recommended that panic alarm testing documentation includes specific testing locations at the Southeast VA Clinic.
	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 Southeast VA Clinic did not maintain attendance records to verify staff participation in scheduled emergency management training and exercises.	**3**. We recommended that managers at the Southeast VA Clinic maintain attendance records to verify staff participation during 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 36 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 14 of 27 patients who had positive alcohol use screens.	**4**. 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 four of five patients diagnosed with alcohol dependence.	**5**. 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 3 of 14 patients.	**6**. We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment within 2 weeks of the screening.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinic RN Care Managers have received motivational interviewing training within 12 months of appointment to PACT.	We found that 5 of 37 RN Care Managers (14 percent) did not receive MI training within 12 months of appointment to PACT.	**7**. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training and that providers and clinical associates in the outpatient clinics receive 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 11 of 37 RN Care Managers (30 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 13 of 40 providers (33 percent) 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 13 of 44 clinical associates (30 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 HIV Lead Clinician to carry out responsibilities as required.		
	The facility has policies and procedures to facilitate HIV testing.		
	The facility had developed policies and procedures that include requirements for the communication of HIV test results.		
	Written patient educational materials utilized prior to or at the time of consent for HIV testing include all required elements.		
X	Clinicians provided HIV testing as part of routine medical care for patients.	Clinicians did not provide HIV testing to 19 of 35 patients (54 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 4 of 10 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 41 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 48 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.		
	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 17 of 48 patients (35 percent) of their lab results within 14 days as required by VHA.	**10**. 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 five of six EHRs reviewed where the patient could not be notified of their lab results, clinicians did not document all attempts to communicate with the patients.	**11**. We recommended that clinicians document in the electronic health record all attempts to communicate laboratory results with the patients.
	Clinicians provided interventions for clinically significant abnormal lab results.		

Clinic Profiles

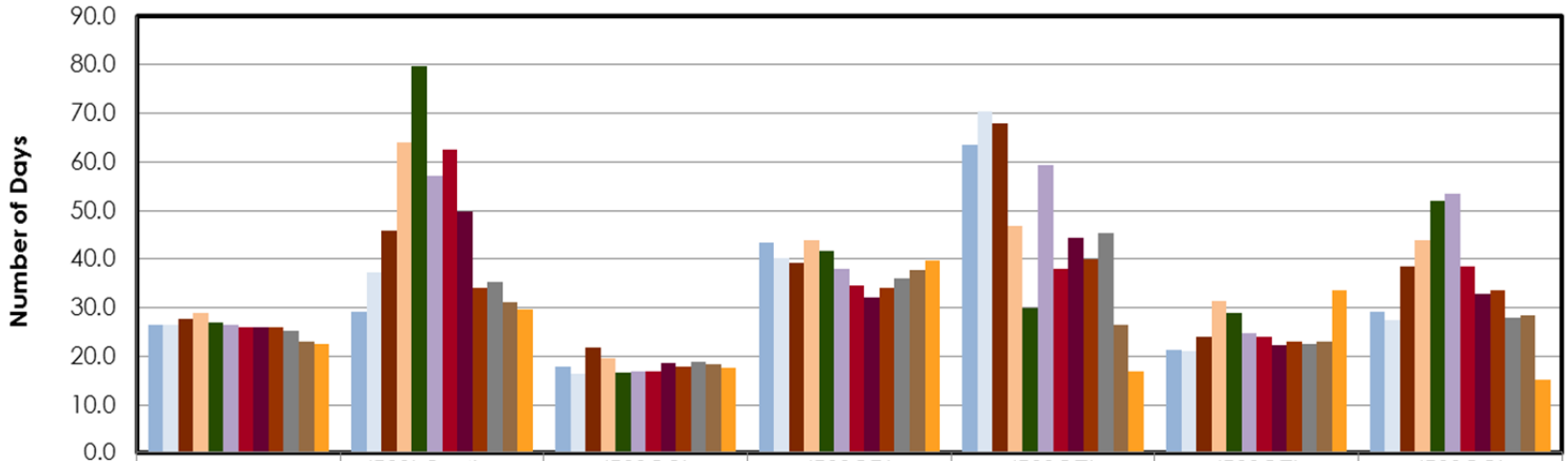
The CBOC/OOC review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[3] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. 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]**	
Pahrump, NV	593GC	Highly Rural	8,271	4,230	214	Dermatology	Diabetic Retinal Screening	Nutrition
Las Vegas, NV	593GD	Urban	29,839	9,894	194	Dermatology	Diabetic Retinal Screening Imaging Services MOVE! Program[10]	Nutrition Pharmacy Social Work
Henderson, NV	593GE	Urban	23,176	8,703	171	Dermatology	Diabetic Retinal Screening Imaging Services Nutrition	Pharmacy Social Work
Las Vegas, NV	593GF	Urban	21,963	14,722	432	Dermatology Geriatrics	Diabetic Retinal Screening Imaging Services MOVE! Program	Nutrition Pharmacy Social Work
Las Vegas, NV	593GG	Urban	23,064	5,927	276	Dermatology	Diabetic Retinal Screening Imaging Services	Nutrition Pharmacy

[3] Includes all CBOCs in operation before April 1, 2014.
[4] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting.
[5] The denoted Specialty Care and Ancillary Services are limited to Primary Clinic Stops with a count ≥ 100 encounters during the October 1, 2013, through September 30, 2014, timeframe at the specified CBOC.
[6] http://vssc.med.va.gov/
[7] The total number of encounters for the services provided in the "Specialty Care" column.
[8] Specialty Care Services refer to non-Primary Care and non-Mental Health services provided by a physician.
[9] Ancillary Services refer to non-Primary Care and non-Mental Health services that are not provided by a physician.
[10] VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.

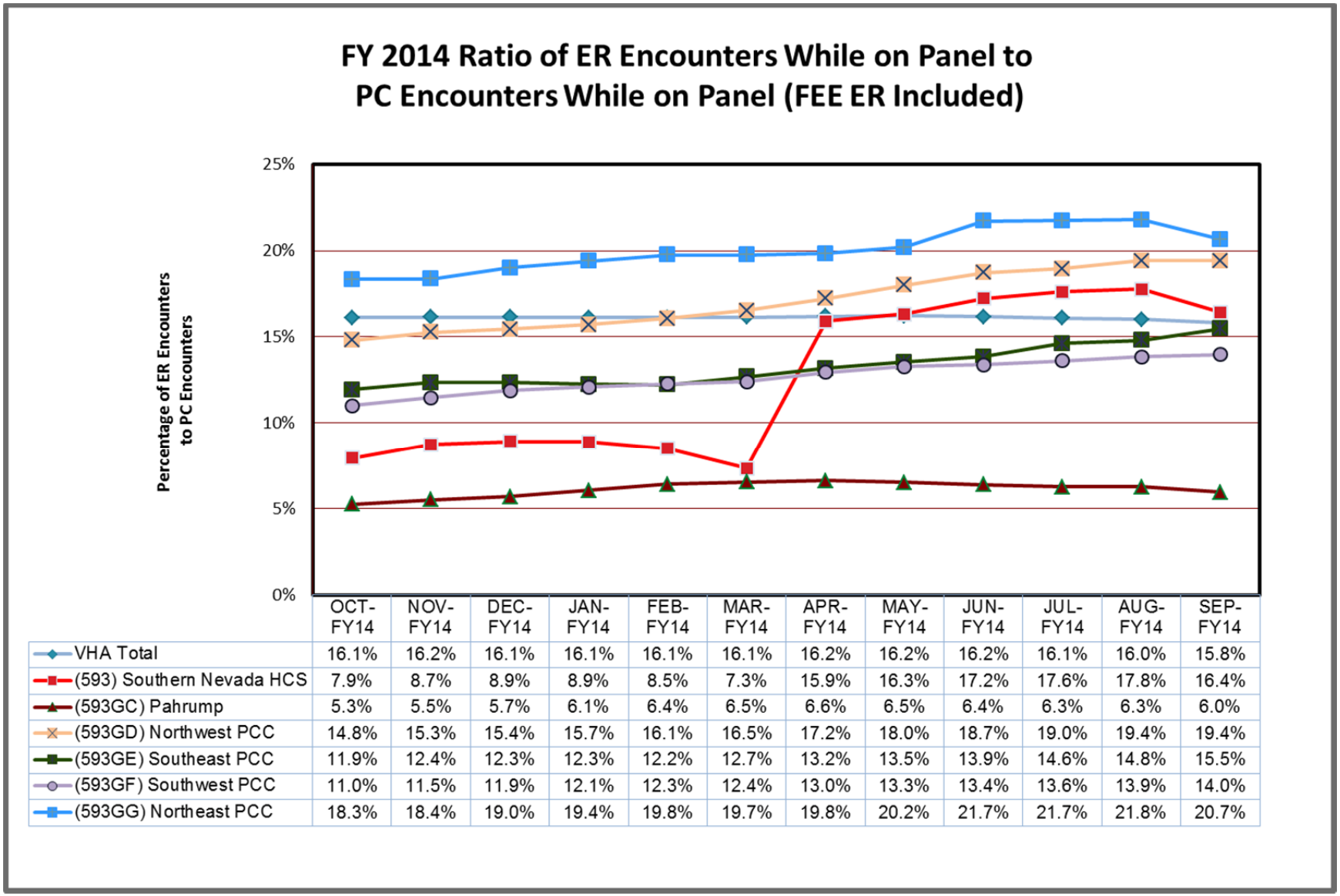
PACT Compass Metrics

FY 2014 New Primary Care Patient Average Wait Time in Days



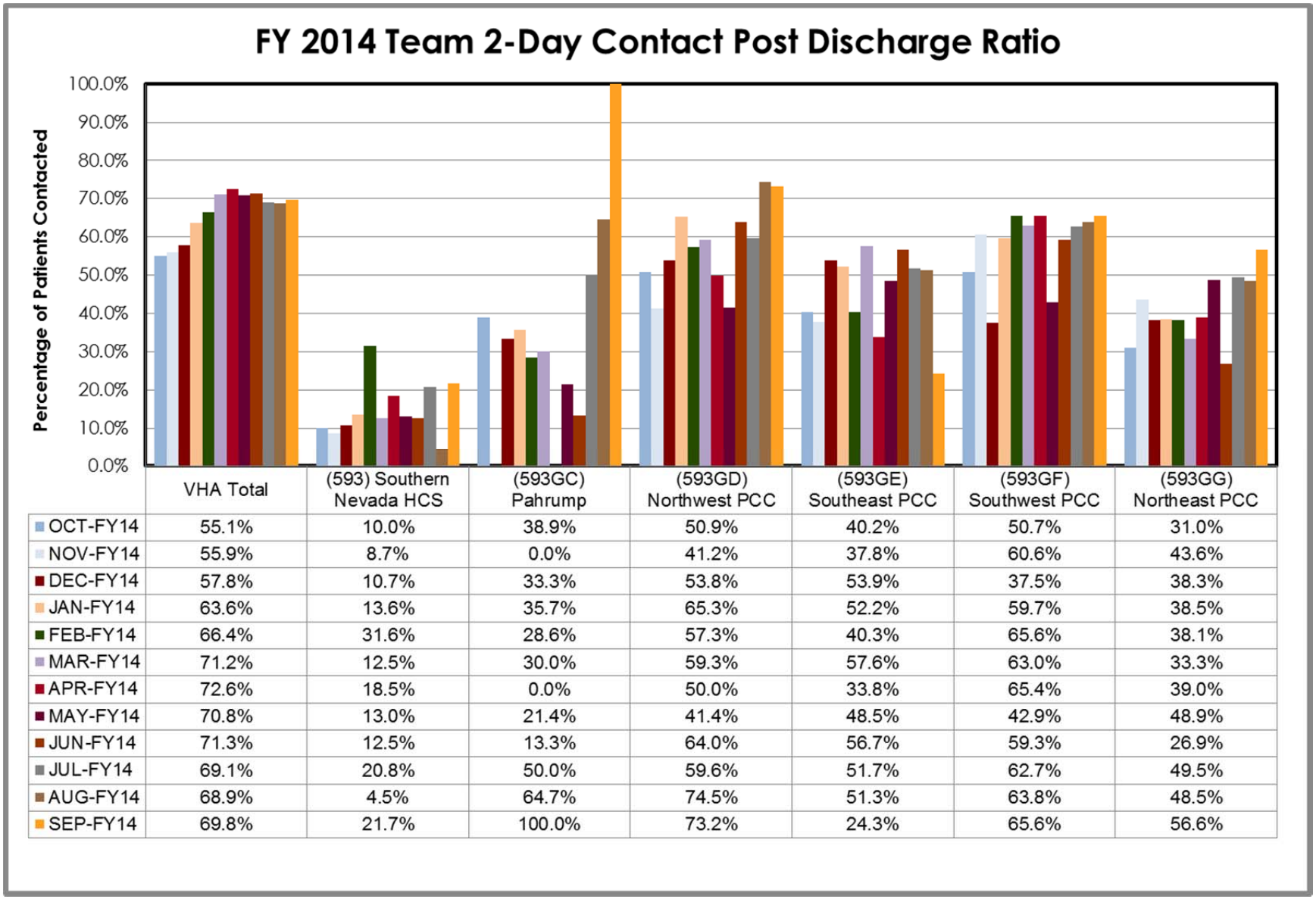
	VHA Total	(593) Southern Nevada HCS	(593GC) Pahrump	(593GD) Northwest PCC	(593GE) Southeast PCC	(593GF) Southwest PCC	(593GG) Northeast PCC
OCT-FY14	26.5	29.2	17.9	43.4	63.5	21.2	29.2
NOV-FY14	26.5	37.2	16.4	40.2	70.5	21.0	27.5
DEC-FY14	27.7	45.9	21.7	39.2	67.8	24.1	38.5
JAN-FY14	28.9	64.1	19.6	44.0	46.9	31.3	43.8
FEB-FY14	26.9	79.8	16.6	41.7	29.9	28.9	51.9
MAR-FY14	26.4	57.2	17.0	38.1	59.3	24.6	53.5
APR-FY14	25.9	62.5	16.9	34.6	38.1	24.0	38.5
MAY-FY14	26.0	49.7	18.7	32.0	44.4	22.4	32.7
JUN-FY14	26.1	34.1	17.9	34.2	40.0	23.0	33.6
JUL-FY14	25.3	35.4	18.9	36.1	45.3	22.6	27.8
AUG-FY14	23.0	31.0	18.4	37.7	26.5	22.9	28.4
SEP-FY14	22.6	29.6	17.6	39.8	16.9	33.6	15.2

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.



	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%
(593) Southern Nevada HCS	7.9%	8.7%	8.9%	8.9%	8.5%	7.3%	15.9%	16.3%	17.2%	17.6%	17.8%	16.4%
(593GC) Pahrump	5.3%	5.5%	5.7%	6.1%	6.4%	6.5%	6.6%	6.5%	6.4%	6.3%	6.3%	6.0%
(593GD) Northwest PCC	14.8%	15.3%	15.4%	15.7%	16.1%	16.5%	17.2%	18.0%	18.7%	19.0%	19.4%	19.4%
(593GE) Southeast PCC	11.9%	12.4%	12.3%	12.3%	12.2%	12.7%	13.2%	13.5%	13.9%	14.6%	14.8%	15.5%
(593GF) Southwest PCC	11.0%	11.5%	11.9%	12.1%	12.3%	12.4%	13.0%	13.3%	13.4%	13.6%	13.9%	14.0%
(593GG) Northeast PCC	18.3%	18.4%	19.0%	19.4%	19.8%	19.7%	19.8%	20.2%	21.7%	21.7%	21.8%	20.7%

Data Definition.[e] 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	(593) Southern Nevada HCS	(593GC) Pahrump	(593GD) Northwest PCC	(593GE) Southeast PCC	(593GF) Southwest PCC	(593GG) Northeast PCC
OCT-FY14	55.1%	10.0%	38.9%	50.9%	40.2%	50.7%	31.0%
NOV-FY14	55.9%	8.7%	0.0%	41.2%	37.8%	60.6%	43.6%
DEC-FY14	57.8%	10.7%	33.3%	53.8%	53.9%	37.5%	38.3%
JAN-FY14	63.6%	13.6%	35.7%	65.3%	52.2%	59.7%	38.5%
FEB-FY14	66.4%	31.6%	28.6%	57.3%	40.3%	65.6%	38.1%
MAR-FY14	71.2%	12.5%	30.0%	59.3%	57.6%	63.0%	33.3%
APR-FY14	72.6%	18.5%	0.0%	50.0%	33.8%	65.4%	39.0%
MAY-FY14	70.8%	13.0%	21.4%	41.4%	48.5%	42.9%	48.9%
JUN-FY14	71.3%	12.5%	13.3%	64.0%	56.7%	59.3%	26.9%
JUL-FY14	69.1%	20.8%	50.0%	59.6%	51.7%	62.7%	49.5%
AUG-FY14	68.9%	4.5%	64.7%	74.5%	51.3%	63.8%	48.5%
SEP-FY14	69.8%	21.7%	100.0%	73.2%	24.3%	65.6%	56.6%

Data Definition.[e] 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: October 30, 2015

From: Director, VA Sierra Pacific Network (10N21)

Subject: **Review of CBOCs and OOCs of VA Southern Nevada Healthcare System, North Las Vegas, NV**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. Thank you for the opportunity to review the draft report from the recent OIG site visit at the Las Vegas facility. Attached is the action plan developed by the facility.

2. Should you have any questions regarding the plan, please contact Terry Sanders, Associate Quality Manager for VISN 21 at (707) 562-8350.

Sheila M. Cullen

Attachments

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 27, 2015

From: Director, VA Southern Nevada Healthcare System (593/00)

Subject: **Review of CBOCs and OOCs of VA Southern Nevada Healthcare System, North Las Vegas, NV**

To: Director, VA Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations resulting from the OIG CBOC/OOC site visit conducted at VA Southern Nevada Healthcare System the week of September 14th.

2. Please find attached the response to each recommendation. We are in the process of completing, or have completed, actions to address the recommendations. Monitoring will continue until compliance has been ensured.

William Caron, Acting 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 staff protect patient identifiable information on laboratory specimens during transport from the Southeast VA Clinic to the parent facility or contracted processing facility.

Concur

Target date for completion: January 31, 2016

Facility Response: Chief, Engineering will ensure that all laboratory specimens are transported in containers with a lockable cable to secure patient specimens during transport from CBOC/PCCs to the main hospital laboratory. Monitoring will occur until the target of 90% compliance is sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Recommendation 2. We recommended that panic alarm testing documentation includes specific testing locations at the Southeast VA Clinic.

Concur

Target date for completion: March 31, 2016

Facility Response: VA Police Service will manually update the panic alarm database for all locations throughout VASNHS, to include the Southeast VA Clinic, to ensure each location is displayed accurately on the panic alarm testing reports by December 15, 2015. Monitoring to ensure all locations are being displayed correctly will occur until the target of 90% compliance is sustained for three months. Results will be reported to the Safety Committee and the Organizational Excellence Leadership Board.

Recommendation 3. We recommended that managers at the Southeast VA Clinic maintain attendance records to verify staff participation during emergency management training and exercises.

Concur

Target date for completion: January 31, 2016

Facility Response: Emergency Management (EM) will distribute an attendance list to all departments and service chiefs. Each service will maintain a list of all employees/volunteers assigned to their area. On the day of the event or mock event, the person responsible for completing the attendance list will account for everyone

present. All services will submit the completed attendance list to EM for debriefing and event review. Monitoring during Environment of Care (EOC) rounds will occur until the target of 90% compliance is sustained for three consecutive months. Results will be reported to the EOC Committee and the Organizational Excellence Leadership Board.

Recommendation 4. 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: January 31, 2016

Facility Response: Chief, Primary Care and Associate Nurse Executive – Outpatient Services will ensure Primary Care staff complete the clinical reminder on alcohol screening at required intervals (annually). For patients who screen positive for alcohol use that exceeds recommended limits, a secondary clinical reminder will be completed that addresses counseling and follow-up options such as Mental Health and/or referral for ADTP treatment. Compliance will be monitored by reviewing delinquent clinical reminder reports which provide real-time information about each patient who was due for alcohol screening and/or follow up, but did not receive such screening or follow up. Monitoring will occur until the target of 90% has been sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Recommendation 5. 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: Chief, Primary Care will ensure that Primary Care Clinic staff complete the clinical reminder on alcohol screening at required intervals (annually) and ensure staff document offer of further treatments to patients diagnosed with alcohol dependence. For patients who screen positive for alcohol use that exceeds recommended limits or diagnosed with alcohol dependence, a secondary clinical reminder will be completed that addresses counseling and follow up treatment such as options for Mental Health and/or referral for ADTP treatment. Compliance will be monitored by reviewing delinquent clinical reminder reports which provide real-time information about each patient who screened positive for alcohol use that exceeds recommended limits or diagnosed with alcohol dependence, but did not receive the offer for further treatment. Monitoring will occur until the target of 90% has been sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Recommendation 6. We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment within 2 weeks of the screening.

Concur

Target date for completion: January 31, 2016

Facility Response: Chief, Primary Care will ensure that Primary Care Clinic staff complete the clinical reminder on alcohol screening at required intervals (annually). For patients who screen positive for alcohol use that exceeds recommended limits, a secondary clinical reminder will be completed that addresses counseling and follow up options for Mental Health and/or referral for ADTP treatment. Compliance will be monitored by reviewing delinquent clinical reminder reports which provide real-time information about each patient with excessive persistent alcohol use who did not receive brief treatment within 2 weeks of the screening. Monitoring will occur until the target of 90% has been sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Recommendation 7. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training and 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: January 31, 2016

Facility Response: Associate Nurse Executive - Outpatient Services will monitor to ensure RN Care Managers complete motivational interviewing and health coaching training and clinical associates complete health coaching training within 12 months of appointment to a Patient Aligned Care Team (PACT) by ensuring compliance is documented in the Talent Management System (TMS). Chief, Primary Care will monitor to ensure Primary Care Providers complete health coaching training within 12 months of appointment to a PACT by ensuring compliance is documented in TMS. Employees identified as non-compliant will be required to complete the training within 90 days. Compliance will be monitored by reviewing TMS reports for all nurses, providers and clinical associates until the target of 90% is sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

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: February 28, 2016

Facility Response: Chief, Primary Care will ensure Primary Care Providers document HIV testing as part of their routine medical care. A new clinical reminder is being trialed and will be implemented by November 30, 2015. Compliance will be monitored by reviewing delinquent clinical reminder reports which provide real-time information about each patient who was due, but did not receive HIV screening. Monitoring will occur until the target of 90% has been sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

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: February 28, 2016

Facility Response: Chief, Primary Care will ensure Primary Care providers document the informed consent for HIV testing. A new clinical reminder will be trialed and implemented by November 30, 2015. Compliance will be monitored by reviewing delinquent clinical reminder reports which provide real-time information about each patient who was tested for HIV without documented informed consent. Monitoring will occur until the target of 90% has been sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Recommendation 10. We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.

Concur

Target date for completion: February 28, 2016

Facility Response: Chief, Primary Care will ensure Primary Care Clinic staff document communication of test results within 14 days in a CPRS progress note template with the required fields for documentation. Repeated attempts will also be documented using this note. Compliance will be monitored by reviewing a list of at least 30 patients who have had lab work completed within the previous 30 days. Monitoring will occur until the target of 90% has been sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Recommendation 11. We recommended that clinicians document in the electronic health record all attempts to communicate laboratory results with the patients.

Concur

Target date for completion: February 28, 2016

Facility Response: Chief, Primary Care will ensure Primary Care Clinic staff document communication of test results within 14 days in a CPRS progress note template with the

required fields for documentation. Repeated attempts will also be documented using this note. Compliance will be monitored by reviewing a list of at least 30 patients who have had lab work completed within the previous 30 days. Monitoring will occur until the target of 90% has been sustained for three consecutive months. Results will be reported to Quality Management and the Organizational Excellence Leadership Board.

Office of Inspector General
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Endnotes

[a] References used for the EOC review included:

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- VHA Directive 2011-007, *Required Hand Hygiene Practices,* February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults & Other Defined Public Safety Incidents in VHA Facilities,* September 27, 2012.
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- VHA Handbook 1330.01, *Health Care Services for Women Veterans,* May 21, 2010.

[b] References used for the Mark included:

- VHA Handbook 1101.10, *Patient Aligned Care Teams (PACT),* February 5, 2014.
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[c] References used for the HIV Screening review included:

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- VHA Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, *VAIQ #741734 – Documentation of Oral Consent for Human Immunodeficiency Virus (HIV) Testing*, January 10, 2014.
- VHA Directive 2008-082, *National HIV Program,* December 5, 2008.
- 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.