Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00175-50

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Charles George VA Medical Center Asheville, North Carolina

December 7, 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

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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 Charles George VA Medical Center and Veterans Integrated Service Network 6 provide safe, consistent, and high-quality health care. The review evaluated the clinics' compliance with selected requirements for alcohol use disorder care, human immunodeficiency virus screening, outpatient documentation, and outpatient lab results management. We also randomly selected the Franklin VA Clinic, Franklin, NC, 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 Environment of Care and Outpatient Documentation reviews. However, we made recommendations for improvement in the following three review areas:

Alcohol Use Disorder Care: Ensure that:

- Clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
- Clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care.
- Managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening.
- Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.
- Providers 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.

Outpatient Lab Results Management: Ensure that:

- The Facility Director ensures that the facility's written policy for the communication of laboratory results includes all required elements.

Comments

The VISN 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 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 Franklin VA Clinic. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

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.		
	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.		
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 receives 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 35 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.		
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 three of nine patients diagnosed with alcohol dependence.	**1**. We recommended that clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
X	For patients with AUD who decline referral to specialty care, clinic staff monitored them and their alcohol use.	Staff did not monitor the alcohol use of one of three patients who declined referral to specialty care.	**2**. We recommended that clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care.
X	Counseling, education, and brief treatments for AUD care are provided within 2 weeks of positive screening.	Treatment was not provided within 2 weeks of positive screening for 2 of 12 patients.	**3**. We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinic RN Care Managers have received motivational interviewing training within 12 months of appointment to PACT.	We found that 3 of 10 RN Care Managers did not receive MI training within 12 months of appointment to PACT.	**4**. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.
	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 7 of 15 providers did not receive health coaching training within 12 months of appointment to PACT.	**5**. We recommended that providers in the outpatient clinics 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 37 EHRs and validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Table 4. HIV Screening

NM	Areas Reviewed	Findings	Recommendations
	The facility has a Lead HIV Clinician to carry out responsibilities as required.		
	The facility has policies and procedures to facilitate HIV testing.		
	The facility had developed policies and procedures that include requirements for the communication of HIV test results.		
	Written patient educational materials utilized prior to or at the time of consent for HIV testing include all required elements.		
X	Clinicians provided HIV testing as part of routine medical care for patients.	Clinicians did not provide HIV testing to 10 of 37 patients (27 percent).	**6**. We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored.
	When HIV testing occurred, clinicians consistently documented informed consent.		
	The facility complied with additional elements as required by local policy.		

Outpatient Documentation

The purpose of this review was to determine whether healthcare practitioners at the CBOCs/OOCs comply with selected requirements for outpatient documentation.[d]

We reviewed relevant documents and 45 EHRs. We also validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Table 5. Outpatient Documentation

NM	Areas Reviewed	Findings	Recommendations
	A relevant history of the illness or injury and physical findings are documented when the patient is first admitted for VA medical care on an outpatient level.		
	Randomly selected progress notes contain the required documentation components in the EHR.		

Outpatient Lab Results Management

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

We reviewed relevant documents and 46 EHRs. We also validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Table 6. Outpatient Lab Results Management

NM	Areas Reviewed	Findings	Recommendations
	The facility has a written policy regarding communication of lab results from diagnostic practitioner to ordering practitioner.		
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 require the documentation of treatment actions in response to abnormal test results in the patient's EHR.	**7**. We recommended that the Facility Director ensures that the facility's written policy for the communication of laboratory results includes all required elements.
	Clinicians notified patients of their lab results.		
	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

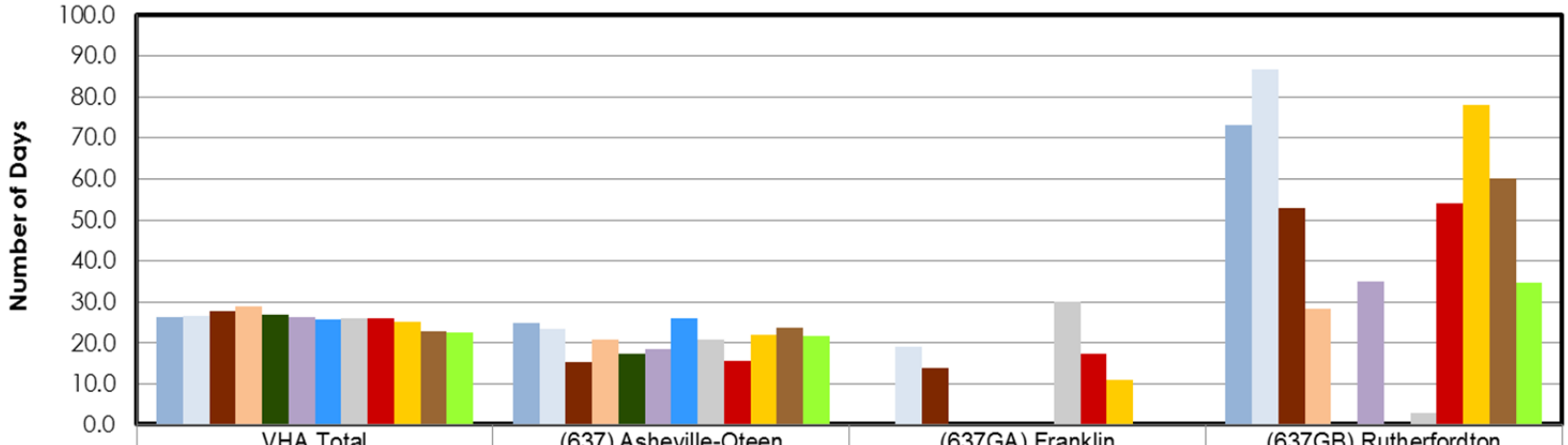
The CBOC/OOC review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[3] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. 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]**
Franklin, NC	637GA	Rural	6,924	2,503	1,751	Ophthalmology Optometry	Anti-Coagulation Clinic Diabetic Retinal Screening Home Based PC MOVE! Program[10] Pharmacy Social Work
Rutherfordton, NC	637GB	Rural	7,262	3,385	164	Medicine Specialties	Anti-Coagulation Clinic Diabetic Retinal Screening Enterostomal Wound/Skin Care Home Based PC MOVE! Program Pharmacy 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.

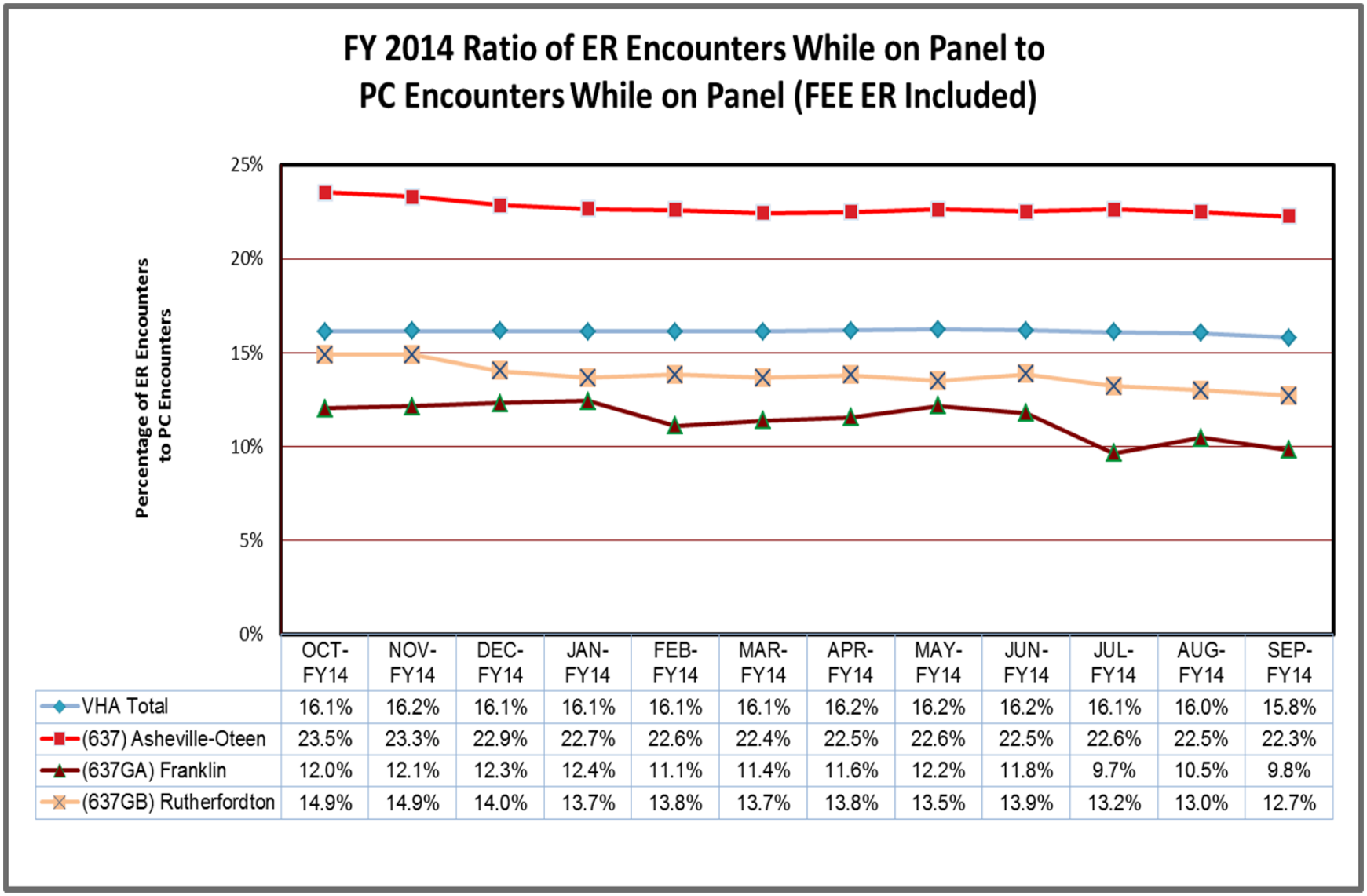
PACT Compass Metrics

FY 2014 New Primary Care Patient Average Wait Time in Days



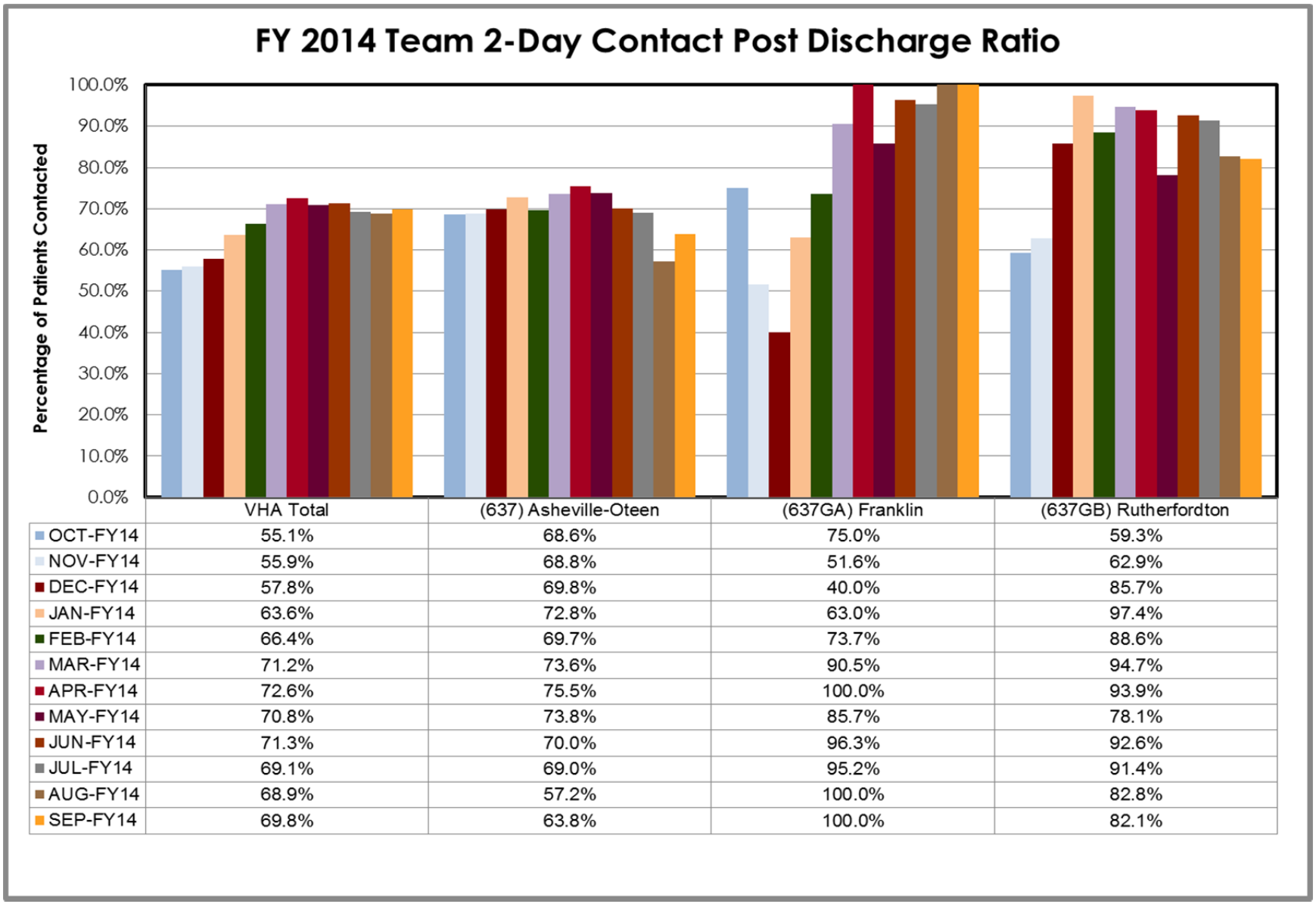
	VHA Total	(637) Asheville-Oteen	(637GA) Franklin	(637GB) Rutherfordton
OCT-FY14	26.5	24.8		73.0
NOV-FY14	26.5	23.4	19.0	86.7
DEC-FY14	27.7	15.3	14.0	53.0
JAN-FY14	28.9	20.8		28.5
FEB-FY14	26.9	17.4		
MAR-FY14	26.4	18.4		35.0
APR-FY14	25.9	26.0		
MAY-FY14	26.0	20.7	30.0	3.0
JUN-FY14	26.1	15.8	17.4	54.0
JUL-FY14	25.3	21.9	11.2	78.0
AUG-FY14	23.0	23.9		60.0
SEP-FY14	22.6	21.8		34.8

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%
(637) Asheville-Oteen	23.5%	23.3%	22.9%	22.7%	22.6%	22.4%	22.5%	22.6%	22.5%	22.6%	22.5%	22.3%
(637GA) Franklin	12.0%	12.1%	12.3%	12.4%	11.1%	11.4%	11.6%	12.2%	11.8%	9.7%	10.5%	9.8%
(637GB) Rutherfordton	14.9%	14.9%	14.0%	13.7%	13.8%	13.7%	13.8%	13.5%	13.9%	13.2%	13.0%	12.7%

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.



	VHA Total	(637) Asheville-Oteen	(637GA) Franklin	(637GB) Rutherfordton
OCT-FY14	55.1%	68.6%	75.0%	59.3%
NOV-FY14	55.9%	68.8%	51.6%	62.9%
DEC-FY14	57.8%	69.8%	40.0%	85.7%
JAN-FY14	63.6%	72.8%	63.0%	97.4%
FEB-FY14	66.4%	69.7%	73.7%	88.6%
MAR-FY14	71.2%	73.6%	90.5%	94.7%
APR-FY14	72.6%	75.5%	100.0%	93.9%
MAY-FY14	70.8%	73.8%	85.7%	78.1%
JUN-FY14	71.3%	70.0%	96.3%	92.6%
JUL-FY14	69.1%	69.0%	95.2%	91.4%
AUG-FY14	68.9%	57.2%	100.0%	82.8%
SEP-FY14	69.8%	63.8%	100.0%	82.1%

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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: October 30, 2015

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

Subject: **Review of CBOCs and OOCs of Charles George VA Medical Center, Asheville, NC**

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

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

1. Attached, please find the Charles George VA Medical Center response to the report from the Office of Inspector review of the CBOCs and OOCs.
2. I have reviewed and concur with the completed response.
3. I appreciate the Office of Inspector General's efforts to ensure high quality care is provided to the Veterans at the CBOCs and OOCs of Charles George VA VAMC.
4. For further inquiries, please contact Lisa Shear, QMO at (919) 956-5541.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 30, 2015

From: Director, Charles George VA Medical Center (637/00)

Subject: **Review of CBOCs and OOCs of Charles George VA Medical Center, Asheville, NC**

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

1. Thank you for the opportunity to review the report from the Office of Inspector General for the CBOCs and OOCs of the Charles George VA Medical Center, Asheville, NC.
2. I have reviewed the document and concur with the recommendations. Relevant action plans have been established as detailed in the attached report. Below please find the facility concurrence and response to the findings from the review.
3. If you have any questions or need further information, please contact Robin James, Chief Quality Management at (828) 298-7911 Ext. 5596.

(original signed by:)

Cynthia Breyfogle, FACHE

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 clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.

Concur

Target date for completion: May 2016

Facility response: The follow up on positive alcohol screening was incorporated into the physician performance pay plan for Primary Care in May 2015 and is being carried over for FY16. At the Primary Care staff meeting on September 2, 2015, the staff was educated on the need to document the care for positive alcohol screening. On September 30, 2015, a custom clinical reminder report was created to better monitor this item. Monthly clinical reminder reports are being used to collect the data that shows overall performance and meeting the standard going forward.

Recommendation 2. We recommended that clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care.

Concur

Target date for completion: May 2016

Facility response: The clinical reminder was modified on September 30, 2015 to create a text entry box for documenting the plan. The modification to the clinical reminder was fully implemented with education of the Primary Care staff on October 7, 2015. Monthly clinical reminder reports are being used to collect the data that shows overall performance and meeting the standard going forward.

Recommendation 3. We recommended that managers ensure that patients with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening.

Concur

Target date for completion: May 2016

Facility response: The follow up on positive alcohol screening was incorporated into the physician performance pay plan for Primary Care in May 2015, and is being carried over for FY 16. On September 2, 2015 education was provided regarding the need to document the care for positive alcohol screening which included ensuring that patients

with excessive persistent alcohol use receive brief treatment or are evaluated by a specialty provider within 2 weeks of the screening. On September 30, 2015, a custom clinical reminder report was created to better capture the data and facilitate monitoring. Monthly clinical reminder reports are being used to collect the data that shows overall performance and meeting the standard going forward.

Recommendation 4. 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: Completed September 18, 2015

Facility response: The cited non-compliance preceded June 2013. The current process for ensuring compliance with required trainings for RN Care Managers for Motivational Interviewing has been consistently implemented since June 2013.

Since June 2013, All fourteen (14) 100% of the newly assigned RN Care Managers to PACT teams in PCMM have completed Motivational Interviewing trainings within 12 months of the Medical Center PACT assignment date.

Recommendation 5. We recommended that providers in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target date for completion: Completed September 18, 2015

Facility response: The cited non-compliance proceeded June 2013. The current process for ensuring compliance with required trainings for Primary Care Providers to complete health coaching training has been consistently implemented since June 2013.

Since June 2013, All 15 (15) of the newly assigned Primary Care Providers to PACT teams in PCMM have completed the health coach training within 12 months of the Medical Center PACT assignment date.

Recommendation 6. We recommended that clinicians provide human immunodeficiency virus testing as part of routine medical care for patients and that compliance is monitored.

Concur

Target date for completion: May 2016

Facility response: By email and at the Primary Care Service staff meeting of September 2, 2015, all Primary Care Service staff was educated on the VHA Directive

and CDC guidelines recommending the offer of HIV testing to all patients as part of routine medical care. This item will be added to physician performance pay for FY2016 for Primary Care Service. Compliance data is being monitored through routine clinical reminder reports and being communicated to staff.

Recommendation 7. 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: November 2015

Facility response: The MCM 637-11-124 Ordering and Reporting Diagnostic Tests, is in the process of being reviewed and revised to include the requirement of documentation in Electronic Health Record of treatment actions and response to abnormal test results. The MCM will be subsequently published and implemented.

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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U.S. Senate: Richard Burr, Thom Tillis
U.S. House of Representatives: Alma S. Adams, Patrick T. McHenry, Mark Meadows, Robert M. Pittenger

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

Endnotes

[a] References used for the EOC review included:
- International Association of Healthcare Central Services Materiel Management, *Central Service Technical Manual*, 7th ed.
- Joint Commission, *Joint Commission Comprehensive Accreditation and Certification Manua*l, July 1, 2014.
- US Department of Health and Human Services, Health Insurance Portability and Accountability Act, *The Privacy Rule*, February 16, 2006.
- US Department of Labor, Occupational Safety and Health Administration, *Laws and Regulations*, *1910 General Industry Standards*.
- US Department of Labor, Occupational Safety and Health Administration, *Guidelines for Preventing Workplace Violence*, 2004.
- VA Directive 0059, *VA Chemicals Management and Pollution Prevention,* May 25, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information System,* September 20, 2012.
- VHA Center for Engineering, Occupational Safety, and Health, *Online National Fire Protection Association Codes, Standards, Handbooks, and Annotated Editions of Select Codes and Standards*, July 9, 2013.
- VHA Directive 2011-007, *Required Hand Hygiene Practices,* February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults & Other Defined Public Safety Incidents in VHA Facilities,* September 27, 2012.
- VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics,* May 19, 2004.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans,* May 21, 2010.

[b] References used for the AUD Care review included:
- VHA Handbook 1101.10, *Patient Aligned Care Teams (PACT),* February 5, 2014.
- VHA Handbook 1120.02, *Health Promotion Disease Prevention (HPDP) Program*, July 5, 2012.
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