Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-05151-81

# Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Chalmers P. Wylie Ambulatory Care Center Columbus, Ohio

January 13, 2016

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

| | |
|---|---|
| BBP | bloodborne pathogen |
| CBOC | community based outpatient clinic |
| EHR | electronic health record |
| EOC | environment of care |
| FY | fiscal year |
| HT | home telehealth |
| lab | laboratory |
| NA | not applicable |
| NM | not met |
| OIG | Office of Inspector General |
| OOC | other outpatient clinic |
| PC | primacy care |
| PTSD | post-traumatic stress disorder |
| 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 Chalmers P. Wylie Ambulatory Care Center and Veterans Integrated Service Network 10 provide safe, consistent, and high-quality health care. The review evaluated the clinics' compliance with selected requirements for home telehealth enrollment, outpatient laboratory results management, and post-traumatic stress disorder care. We also randomly selected the Grove City VA Clinic, Grove City, OH, as a representative site and evaluated the environment of care on November 3, 2015.

**Review Results:** We conducted four focused reviews and made recommendations for improvement in the following four review areas:

*Environment of Care:* Ensure that:

- Managers at the Grove City VA Clinic develop and implement a policy requiring staff to receive regular information on their responsibilities in emergency response operations.

*Home Telehealth Enrollment*: Ensure that:

- Clinicians document verbal informed consent for Home Telehealth services.
- Providers sign Home Telehealth assessments and treatment plans.

*Outpatient Laboratory Results Management*: Ensure that:

- The facility director ensures that the facility's written policy for the communication of laboratory results includes all required elements.
- Clinicians notify patients of their laboratory results within 14 days as required by Veterans Health Administration.

*Post-Traumatic Stress Disorder Care*: Ensure that:

- Acceptable providers perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screens.
- Further diagnostic evaluations are offered to patients with positive post-traumatic stress disorder screens.

## 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 16–20, 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 documentation requirements for the enrollment, assessment, and monitoring of HT patients.
- The CBOCs/OOCs are compliant with VHA requirements for the patient notification and follow up of selected outpatient lab results.
- The CBOCs/OOCs are compliant with selected VHA requirements related to PTSD screening, diagnostic evaluation, and treatment.

## 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 four activities:

- EOC
- HT Enrollment
- Outpatient Lab Results Management
- PTSD Care

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 HT Enrollment, Outpatient Lab Results Management, and PTSD Care focused reviews are noted in Table 1.

**Table 1. CBOC/OOC Focused Reviews and Study Populations**

| Review Topic | Study Population |
|---|---|
| HT Enrollment | All CBOC and OOC patients screened within the study period of July 1, 2014, through June 30, 2015, who have had at least one "683" Monthly Monitoring Note and did not have Monthly Monitoring Notes documented before July 1, 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 through December 31, 2014. |
| PTSD Care | All patients who had a positive PTSD screen at the parent facility's outpatient clinics during July 1, 2014, through June 30, 2015. |

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 August 15, 2015.

# Results and Recommendations

## EOC

The purpose of this review was to assess 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 Grove City VA Clinic. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

**Table 2. EOC**

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| **Document and Training Review** | | | |
| | Managers monitored hand hygiene compliance. | | |
| | Managers had an Exposure Control Plan for BBP. | | |
| | Managers reviewed the Exposure Control Plan annually. | | |
| | Managers included an exposure determination for all job classifications in the Exposure Control Plan for BBPs. | | |
| | Managers included the Hepatitis B vaccine in the Exposure Control Plan for BBP. | | |
| | In the Exposure Control Plan for BBPs, managers provide the Hepatitis B vaccine to employees upon exposure to a BBP. | | |
| | In the Exposure Control Plan for BBPs, managers provide the Hepatitis B vaccine to employees within 10 days of job assignment. | | |
| | In the Exposure Control Plan for BBPs, managers document employees' declination statements for the Hepatitis B vaccine. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | In the Exposure Control Plan for BBPs, managers provide post exposure prophylaxis within 72 hours. | | |
| | Managers documented their consideration and implementation of safety needle devices. | | |
| | Managers documented their consideration and implementation of safety needle devices annually. | | |
| | Training for CBOC employees on the Exposure Control Plan for BBP has been provided within the past 12 months for those newly hired and annually for others. | | |
| | Managers have a policy/procedure for CBOC life safety elements. | | |
| | Managers have a policy for the management of clinical emergencies. | | |
| | CBOC managers have a policy for the management of mental health emergencies. | | |
| | Managers have a documented Hazard Vulnerability Assessment to identify potential CBOC emergencies. | | |
| | Managers reviewed the Hazard Vulnerability Assessment annually. | | |
| X | Managers have a policy that requires CBOC staff to receive regular information on their responsibilities in emergency response operations. | Managers did not have a policy that requires Grove City VA Clinic staff to receive regular information on their responsibilities in emergency response operations. | **1.** We recommended that managers develop and implement a policy that requires the Grove City VA Clinic staff to receive regular information on their responsibilities in emergency response operations. |
| | CBOC staff participate in regular emergency management training and exercises. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Managers conducted fire drills at the CBOC at least once every 12 months for the past 24 months and documented critiques of the fire drills. | | |
| | Managers have a policy/procedure for the identification of individuals entering the CBOC. | | |
| | Managers had a Workplace Behavioral Risk Assessment in place. | | |
| | Managers tested the alarm system or panic buttons in high-risk areas during the past 12 months. | | |
| | Managers had written procedures to follow in the event of a security incident. | | |
| | CBOC employees received training on the new chemical label elements and safety data sheet format. | | |
| | Managers have a policy/procedure for the cleaning and disinfection of telehealth equipment. | | |
| **Physical Inspection** | | | |
| | The CBOC is clean. | | |
| | The furnishings and equipment are safe and in good repair. | | |
| | Hand hygiene facilities and product dispensers are working and readily accessible to employees. | | |
| | Personal protective equipment is available. | | |
| | Sharps containers are closable, easily accessible, and not overfilled. | | |
| | Clinic staff do not store food and drinks in refrigerators or freezers or on countertops or other areas where there is blood or other potentially infectious materials. | | |
| | Managers ensured that sterile commercial supplies are not expired. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Managers minimize the risk of infection when storing and disposing of medical (infectious) waste. | | |
| | Managers ensured unobstructed access to fire alarms/pull stations. | | |
| | Access to fire extinguishers is unobstructed. | | |
| | For fire extinguishers located in large rooms or are obscured from view, managers identified the locations of the fire extinguishers with signs. | | |
| | Exit signs are visible from any direction. | | |
| | Exit routes from the building are unobstructed. | | |
| | Staff wear VA-issued identification badges. | | |
| | Managers control access to and from areas identified as security sensitive. | | |
| | Managers installed an alarm system or panic buttons in high-risk areas. | | |
| | Managers reviewed the CBOC's inventory of hazardous materials for accuracy twice within the prior 12 months. | | |
| | Managers had the CBOC's safety data sheets for chemicals readily available for the staff. | | |
| | Managers provided visual and auditory privacy for veterans at check-in. | | |
| | Managers provided visual and auditory privacy for patients in the interview areas. | | |
| | Managers equipped examination room doors with either an electronic or a manual lock. | | |
| | Managers ensured the availability and use of a privacy sign to indicate that a telehealth visit is in progress. | | |
| | Documents containing patient-identifiable information are not visible or unsecured. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | All computer screens are locked when not in use. | | |
| | Information is not viewable on monitors in public areas. | | |
| | Window coverings, if present, provide privacy. | | |
| | Patient-identifiable information is protected on laboratory specimens during transport so that patient privacy is maintained. | | |
| | The examination room(s) for women veterans are located in a space where they do not open into a public waiting room or a high-traffic public corridor. | | |
| | Adequate privacy for women veterans is provided in the examination rooms. | | |
| | Feminine hygiene products are available in examination rooms where pelvic examinations are performed or in bathrooms within close proximity. | | |
| | Women's public restrooms have feminine hygiene products and disposal bins available for use. | | |
| | Multi-dose medication vials are not expired. | | |
| | All medications are secured from unauthorized access. | | |
| | The information technology network room/server closet is secured/locked. | | |
| | Access to the information technology network room/server closet is restricted to personnel authorized by Office of Information and Technology, as evidenced by a list of authorized individuals. | | |
| | Access to the information technology network room/server closet is documented, as evidenced by the presence of a sign-in/sign-out log. | | |

## HT Enrollment

The purpose of this review was to determine whether the facility's CBOCs and OOCs are compliant with selected VHA documentation requirements for the enrollment, assessment, and monitoring of HT patients.[b]

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 3. HT Enrollment**

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| | Clinicians entered a consult for HT services. | | |
| | Clinicians completed the HT enrollment requests or "consults." | | |
| | Clinicians documented contact with the patient to evaluate suitability for HT services. | | |
| X | Clinicians documented the patient or caregiver's verbal informed consent for HT services. | Clinicians did not document verbal informed consent for HT services in 8 of 48 EHRs (17 percent). | **2.** We recommended that clinicians document verbal informed consent for Home Telehealth services. |
| | Clinicians documented assessments and treatment plans for HT patients. | | |
| X | Providers signed HT assessments and treatment plans. | Providers did not sign 5 of 48 patients' HT assessments and treatment plans (10 percent). | **3.** We recommended that providers sign Home Telehealth assessments and treatment plans. |
| | Monthly monitoring notes were documented for each month of HT program participation. | | |
| | Documentation of HT enrollment (consult, screening, and/or initial assessment notes) was completed prior to the entry of monthly monitoring notes. | | |

## 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.[c]

We reviewed relevant documents and 50 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 4. 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 communication of lab results to patients no later than 14 days from the date on which the results are available to the ordering practitioner | **4.** We recommended that the facility director ensure 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 28 of 50 patients (56 percent) of their lab results within 14 days as required by VHA. | **5.** 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. | | |

## PTSD Care

The purpose of this review was to assess whether CBOCs/OOCs are compliant with selected VHA requirements for PTSD follow up in the outpatient setting.[d]

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 5. PTSD Care**

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| X | Each patient with a positive PTSD screen received a suicide risk assessment. | Eleven of 49 patients (22 percent) with positive PTSD screens did not receive a suicide risk assessment. | **6.** We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens. |
| | Suicide risk assessments for patients with positive PTSD screens are completed by acceptable providers. | | |
| | Acceptable providers established plans of care and disposition for patients with positive PTSD screens. | | |
| X | Acceptable providers offered further diagnostic evaluations to patients with positive PTSD screens. | Acceptable providers did not offer patients with positive PTSD screens referrals for diagnostic evaluations in 6 of 49 EHRs (12 percent). | **7.** We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens. |
| | Providers completed diagnostic evaluations for patients with positive PTSD screens. | | |
| | Patients, when applicable, received mental health treatment. | | |

# 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.[2] 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.

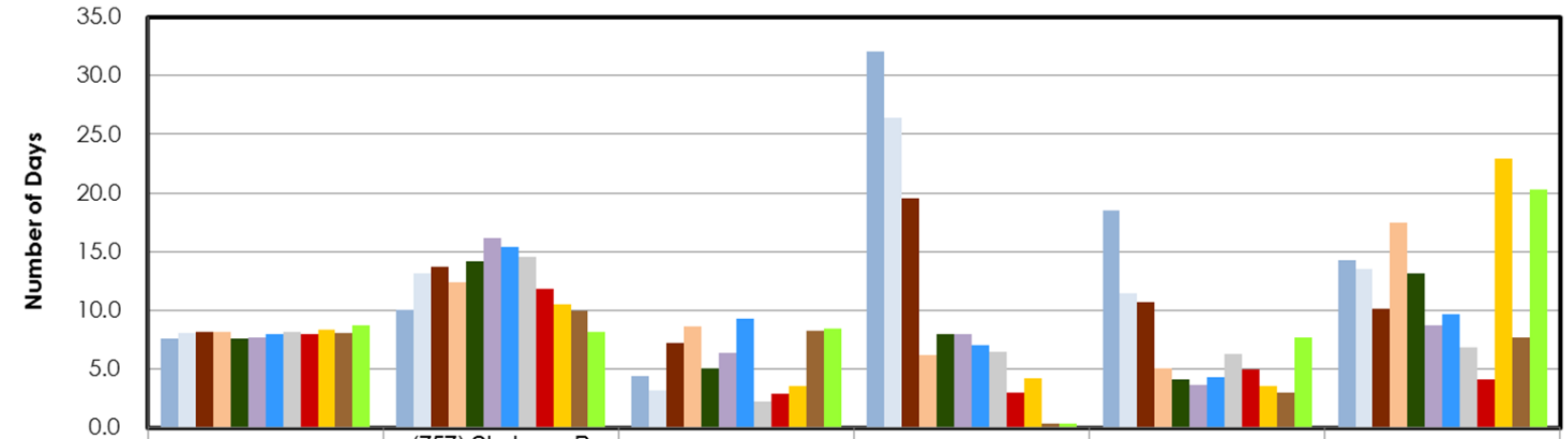
| | | | | Outpatient Workload / Encounters[3] | | | Services Provided[4] | | |
|---|---|---|---|---|---|---|---|---|---|
| **Location** | **Station #** | **Rurality[5]** | **Outpatient Classification[6]** | **PC** | **MH** | **Specialty Clinics[7]** | **Specialty Care[8]** | **Ancillary Services[9]** | |
| Zanesville, OH | 757GA | Rural | Primary Care | 7,901 | 2,765 | 1,629 | Dermatology<br>Optometry | Diabetic Retinal Screening<br>HBPC | MOVE! Program[10]<br>Pharmacy |
| Grove City, OH | 757GB | Urban | Primary Care | 5,565 | 2,311 | 246 | Dermatology | Audiology<br>Diabetic Retinal Screening | MOVE! Program<br>Pharmacy |
| Marion, OH | 757GC | Rural | Primary Care | 5,899 | 2,910 | 1,516 | Dermatology<br>Optometry | EKG<br>HBPC | MOVE! Program<br>Pharmacy |
| Newark, OH | 757GD | Urban | Multi-Specialty | 7,186 | 2,981 | 2,386 | Dermatology<br>Optometry | Audiology<br>Diabetic Retinal Screening<br>EKG<br>HBPC | MOVE! Program<br>Pharmacy |

EKG = Electrocardiography; HBPC = Home Based Primary Care

[2] Includes all CBOCs in operation before August 15, 2015.
[3] 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.
[4] The denoted Specialty Care and Ancillary Services are limited to Primary Clinic Stops with a count ≥ 100 encounters during the October 1, 2014, through September 30, 2015, timeframe at the specified CBOC.
[5] http://vssc.med.va.gov/
[6] VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.
[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.

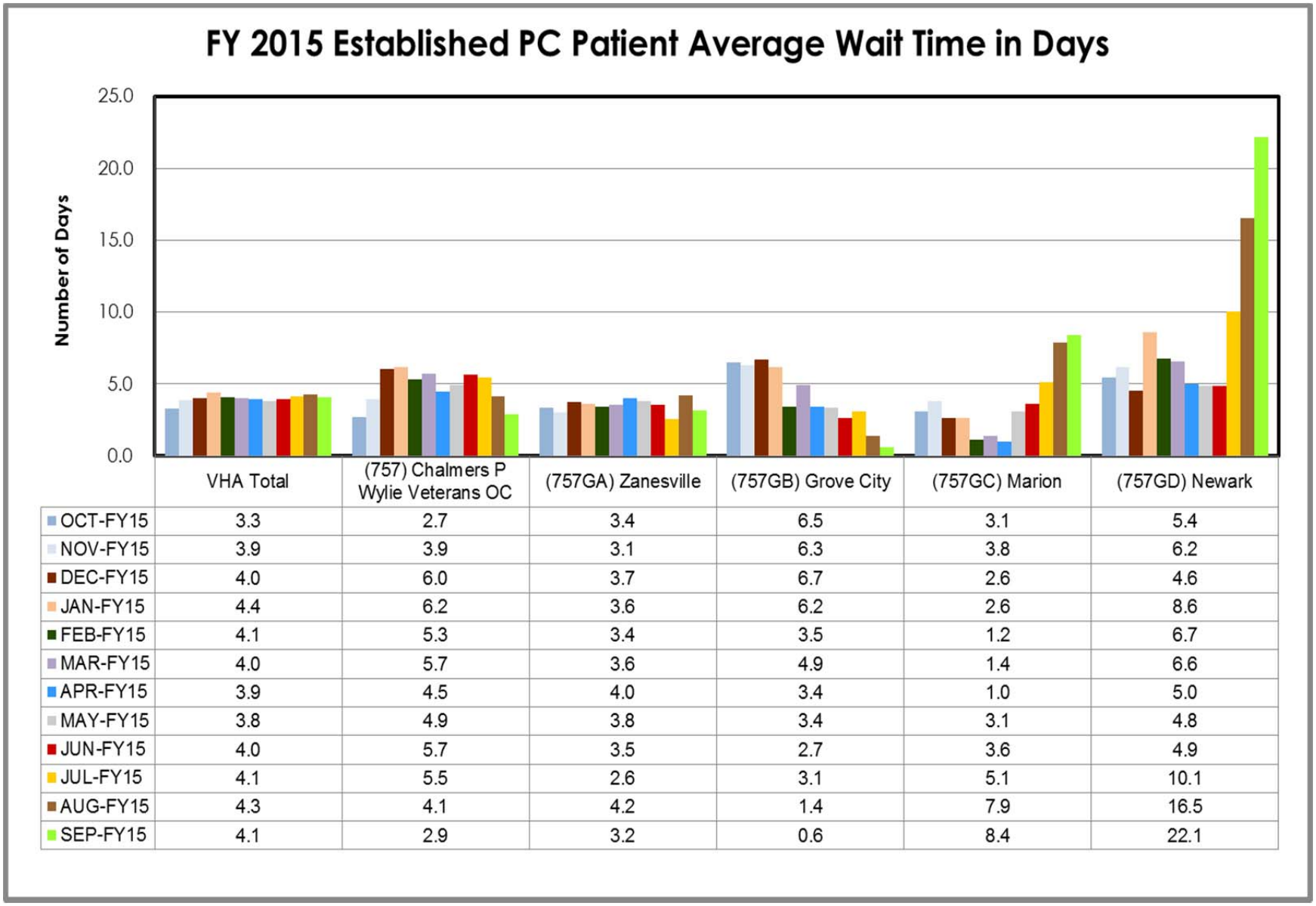
# Patient Aligned Care Team Compass Metrics

## FY 2015 New PC Patient Average Wait Time in Days



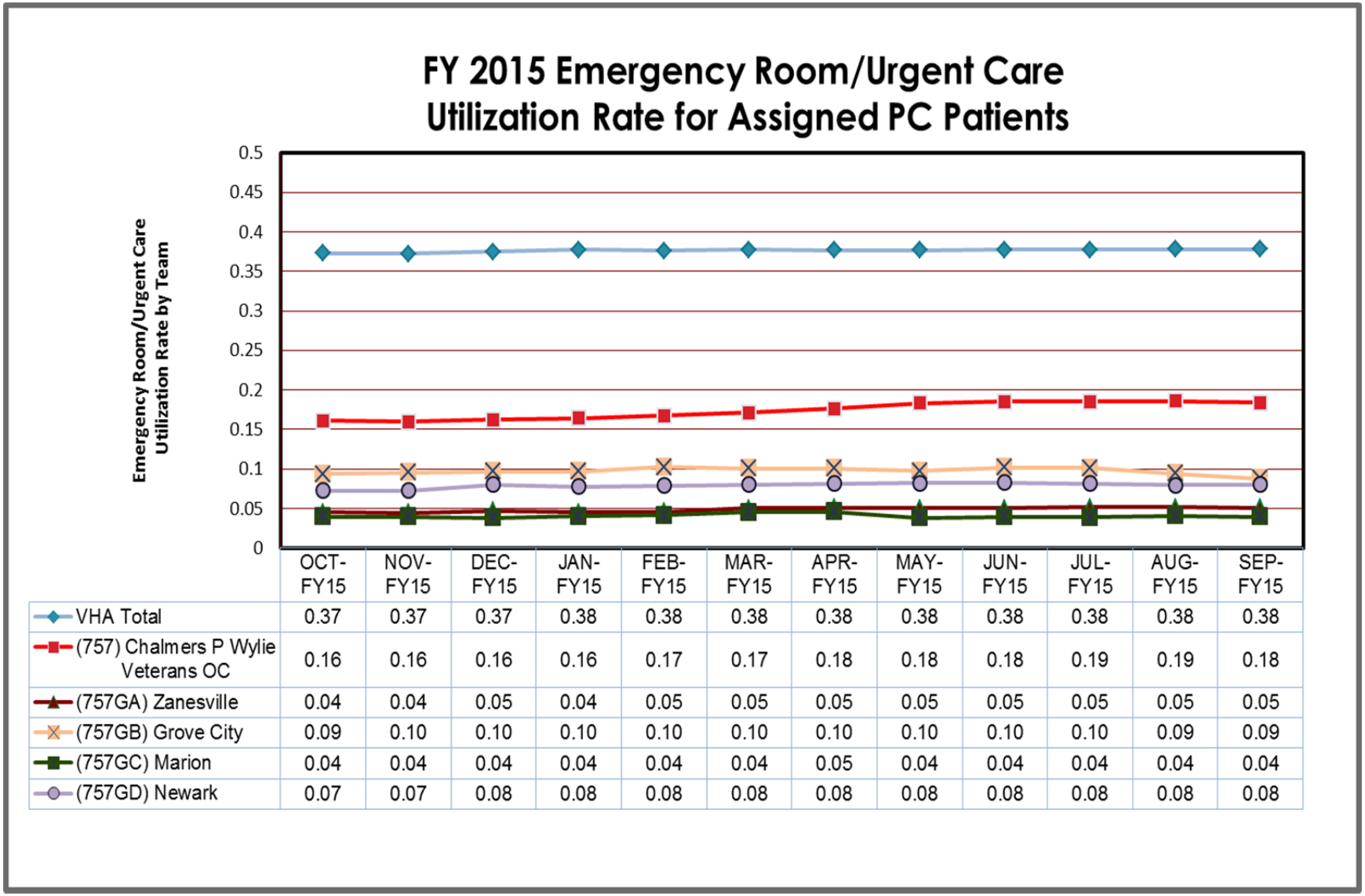

| | VHA Total | (757) Chalmers P Wylie Veterans OC | (757GA) Zanesville | (757GB) Grove City | (757GC) Marion | (757GD) Newark |
|---|---|---|---|---|---|---|
| OCT-FY15 | 7.6 | 10.0 | 4.4 | 32.1 | 18.5 | 14.2 |
| NOV-FY15 | 8.1 | 13.1 | 3.2 | 26.4 | 11.4 | 13.5 |
| DEC-FY15 | 8.1 | 13.7 | 7.2 | 19.6 | 10.7 | 10.2 |
| JAN-FY15 | 8.2 | 12.4 | 8.7 | 6.2 | 5.1 | 17.5 |
| FEB-FY15 | 7.6 | 14.2 | 5.1 | 8.0 | 4.1 | 13.2 |
| MAR-FY15 | 7.7 | 16.1 | 6.3 | 8.0 | 3.7 | 8.7 |
| APR-FY15 | 7.9 | 15.4 | 9.3 | 7.0 | 4.3 | 9.7 |
| MAY-FY15 | 8.2 | 14.5 | 2.3 | 6.5 | 6.3 | 6.8 |
| JUN-FY15 | 8.0 | 11.8 | 2.9 | 3.0 | 5.0 | 4.1 |
| JUL-FY15 | 8.3 | 10.5 | 3.5 | 4.2 | 3.5 | 22.9 |
| AUG-FY15 | 8.1 | 10.0 | 8.2 | 0.4 | 3.0 | 7.7 |
| SEP-FY15 | 8.7 | 8.2 | 8.5 | 0.4 | 7.7 | 20.3 |

**Data Definition.**[e] The average number of calendar days between a New Patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY15, this metric was calculated using the earliest possible create date.*

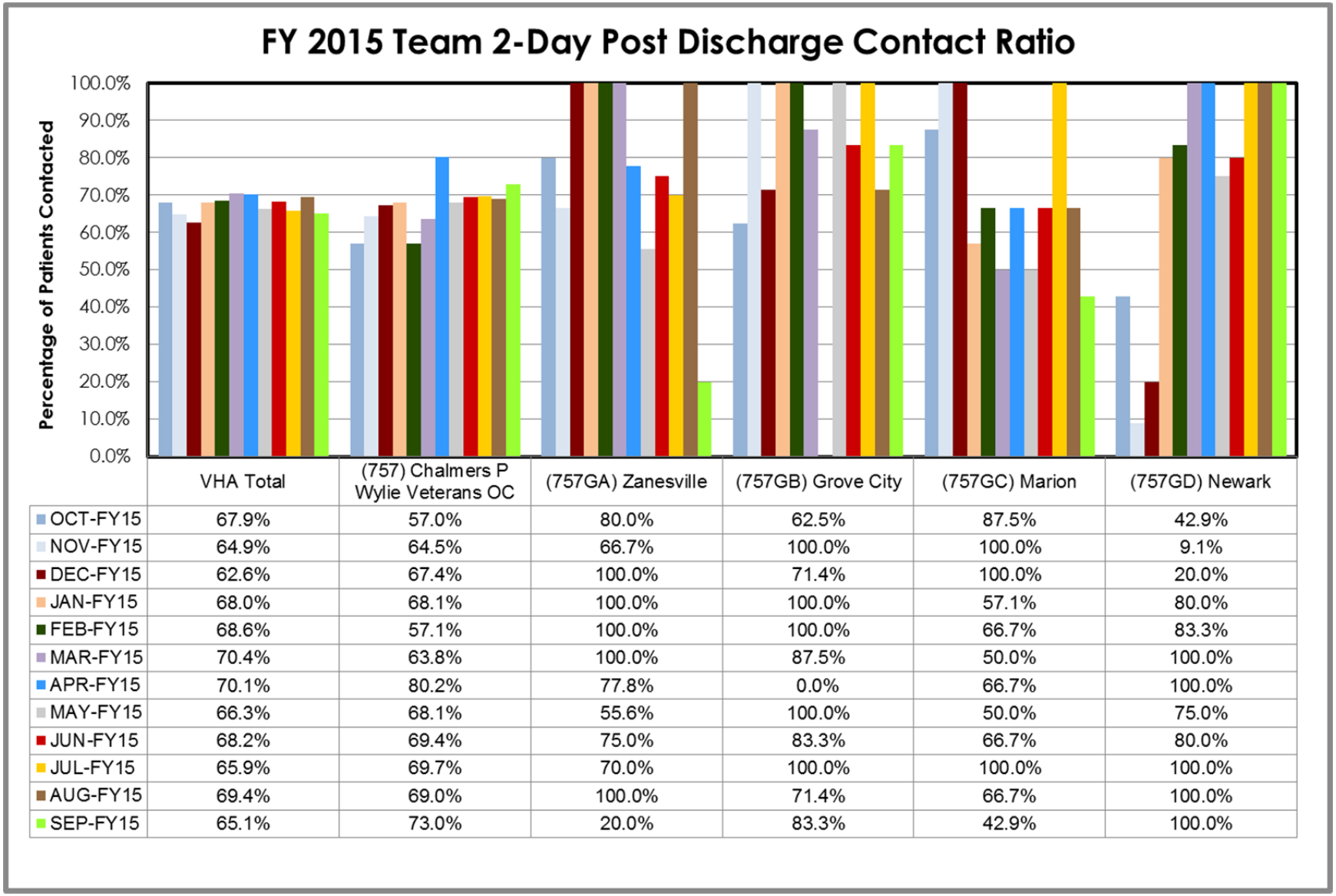



| | VHA Total | (757) Chalmers P Wylie Veterans OC | (757GA) Zanesville | (757GB) Grove City | (757GC) Marion | (757GD) Newark |
|---|---|---|---|---|---|---|
| OCT-FY15 | 3.3 | 2.7 | 3.4 | 6.5 | 3.1 | 5.4 |
| NOV-FY15 | 3.9 | 3.9 | 3.1 | 6.3 | 3.8 | 6.2 |
| DEC-FY15 | 4.0 | 6.0 | 3.7 | 6.7 | 2.6 | 4.6 |
| JAN-FY15 | 4.4 | 6.2 | 3.6 | 6.2 | 2.6 | 8.6 |
| FEB-FY15 | 4.1 | 5.3 | 3.4 | 3.5 | 1.2 | 6.7 |
| MAR-FY15 | 4.0 | 5.7 | 3.6 | 4.9 | 1.4 | 6.6 |
| APR-FY15 | 3.9 | 4.5 | 4.0 | 3.4 | 1.0 | 5.0 |
| MAY-FY15 | 3.8 | 4.9 | 3.8 | 3.4 | 3.1 | 4.8 |
| JUN-FY15 | 4.0 | 5.7 | 3.5 | 2.7 | 3.6 | 4.9 |
| JUL-FY15 | 4.1 | 5.5 | 2.6 | 3.1 | 5.1 | 10.1 |
| AUG-FY15 | 4.3 | 4.1 | 4.2 | 1.4 | 7.9 | 16.5 |
| SEP-FY15 | 4.1 | 2.9 | 3.2 | 0.6 | 8.4 | 22.1 |

**Data Definition**.[e] The average number of calendar days between an Established Patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.




**Data Definition.**[e] The total Emergency Room/Urgent Care encounters for assigned PC patients in the last 12 months divided by the Team Assignments. VHA Emergency Room/Urgent Care encounters are defined as encounters with a Primary Stop Code of 130 or 131 in either the primary or secondary position, excluding encounters with a Secondary Stop Code of 107, 115, 152, 311, 333, 334, 999, 474, 103, 430, 328, 321, 329, or 435 and the encounter was with a licensed independent practitioner (MD, DO, RNP, PA).




| | VHA Total | (757) Chalmers P Wylie Veterans OC | (757GA) Zanesville | (757GB) Grove City | (757GC) Marion | (757GD) Newark |
|---|---|---|---|---|---|---|
| OCT-FY15 | 67.9% | 57.0% | 80.0% | 62.5% | 87.5% | 42.9% |
| NOV-FY15 | 64.9% | 64.5% | 66.7% | 100.0% | 100.0% | 9.1% |
| DEC-FY15 | 62.6% | 67.4% | 100.0% | 71.4% | 100.0% | 20.0% |
| JAN-FY15 | 68.0% | 68.1% | 100.0% | 100.0% | 57.1% | 80.0% |
| FEB-FY15 | 68.6% | 57.1% | 100.0% | 100.0% | 66.7% | 83.3% |
| MAR-FY15 | 70.4% | 63.8% | 100.0% | 87.5% | 50.0% | 100.0% |
| APR-FY15 | 70.1% | 80.2% | 77.8% | 0.0% | 66.7% | 100.0% |
| MAY-FY15 | 66.3% | 68.1% | 55.6% | 100.0% | 50.0% | 75.0% |
| JUN-FY15 | 68.2% | 69.4% | 75.0% | 83.3% | 66.7% | 80.0% |
| JUL-FY15 | 65.9% | 69.7% | 70.0% | 100.0% | 100.0% | 100.0% |
| AUG-FY15 | 69.4% | 69.0% | 100.0% | 71.4% | 66.7% | 100.0% |
| SEP-FY15 | 65.1% | 73.0% | 20.0% | 83.3% | 42.9% | 100.0% |

**Data Definition.**[e] The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge.

**Appendix C**

# Veterans Integrated Service Network Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** December 16, 2015

**From:** Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

**Subject:** **Review of CBOCs and OOCs of Chalmers P. Wylie Ambulatory Care Center**

**To:** Director, Baltimore Office of Healthcare Inspections (54BA)

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

1. I have reviewed and concur with the action plan regarding the Review of CBOCs and OOCs of Chalmers P. Wylie Ambulatory Care Center, Columbus, OH

2. The facility will ensure that the corrective action plan is implemented.

3. If you have any questions please contact Vickie Montague, VISN 10 QMO, at (216) 791-2300, ext. 5305.

Jack G. Hetrick, FACHE

Director, VISN 10

# Facility Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** December 15, 2015

**From:** Director, Chalmers P. Wylie Ambulatory Care Center (757/00)

**Subject:** **Review of CBOCs and OOCs of Chalmers P. Wylie Ambulatory Care Center**

**To:** Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. Attached please find my comments and implementation plans in response to the recommendations identified in the OIG Review of CBOC's and OOC's of the Ambulatory Care Center, Columbus, OH, conducted during the week of November 2-5, 2015. I concur with the findings and recommendations.

2. I appreciate the opportunity for this review as a continuing process to improve care to Veterans.

3. Should you have questions or require further information, please contact me at (614) 257-5450

Keith Sullivan, FACHE

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 develop and implement a policy that requires the Grove City VA Clinic staff to receive regular information on their responsibilities in emergency response operations.

Concur

Target date for completion: November 30, 2015

Facility response: The following has now been added to the Emergency Operations Plan that is located at each CBOC. "EMPLOYEE TRAINING: All VAACC employees including those employees at leased spaces must attend the Emergency Management session of the annual Safety Fair or complete the appropriate TMS course on a yearly basis to receive information on responsibilities in emergency response operations."

**Recommendation 2.** We recommended that clinicians document verbal informed consent for Home Telehealth services.

Concur

Target date for completion: April 30, 2016

Facility response: A template was created for the CCHT Screening Consult Note that has a check box to designate if a patient or caregiver's verbal informed consent was obtained. Implementation is pending all required approvals. We will continue to document consent as well in the Technical Education portion of the Initial Assessment Treatment Plan note.

Quarterly audits will be done including, but not limited to, Screening Consult Notes which include the additional documentation of verbal consent. We will demonstrate 3 consecutive months of 90% compliance by April 30, 2016. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

**Recommendation 3.** We recommended that providers sign Home Telehealth assessments and treatment plans.

Concur

Target date for completion: April 30, 2016

Facility response: Verbiage added to the current template, "Note forwarded to Provider for additional signature as per Home Telehealth guidelines." Quarterly audits will continue as to notation of provider's signature on all Home Telehealth Assessment Treatment Plans. We will demonstrate 3 consecutive months of 90% compliance by April 31, 2016. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

**Recommendation 4.** We recommended that the facility director ensure that the facility's written policy for the communication of laboratory results includes all required elements.

Concur

Target date for completion: 3/1/16

Facility response:

1. A facility policy will be written that includes all required elements and complies with VHA Directive 1088.

2. The policy will be approved by the Medical Executive Board.

3. Providers and relevant staff will be educated about the policy via policy review at service level meetings.

Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

**Recommendation 5.** We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.

Concur

Target date for completion: 7/1/16

Facility response:

1. A Six-Sigma green belt team has been chartered for a performance project to improve this process.

2. Provider education will be completed by 4/1/16.

3. Compliance will be monitored through monthly EHR audits for three months to ensure compliance at 90%. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

**Recommendation 6.** We recommended that acceptable providers perform and document suicide risk assessments for all patients with PTSD screens.

Concur

Target date for completion: May 1, 2016

Facility response:

1. Education will be provided to Primary Care (PC) providers related to the performance and documentation of suicide risk assessments for all patients with PTSD screens.

2. Review of EHR will be performed monthly, with a compliance goal of 90%, until compliance is achieved. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

**Recommendation 7.** We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.

Concur

Target date for completion: May 1, 2016

Facility response:

1. Education will be provided to Primary Care (PC) providers related to the offering of further diagnostic evaluations for patients with positive PTSD screens.

2. Review of EHR will be performed monthly, with a goal of 90%, until compliance is sustained. This data is to be reported to the Continuous Readiness Committee. Completion of actions will be documented and reported at the Continuous Readiness Committee, with a communication flow through the governance structure to the Executive Leadership Board.

# Office of Inspector General
# Contact and Staff Acknowledgments

| | |
|---|---|
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# 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, 2015.
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- US Department of Health and Human Services, *Health Information Privacy: The Health Insurance Portability and Accountability Act (HIPAA) Enforcement Rule*, February 16, 2006.
- US Department of Labor, Occupational Safety and Health Administration (OSHA), *Fact Sheet: Hazard Communication Standard Final Rule,* n.d.
- US Department of Labor, Occupational Safety and Health Administration (OSHA), *Regulations (Standards – 29 CFR), 1910 General Industry Standards, 120 Hazardous Waste Operations and Emergency Response,* February 8, 2013.
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- VA Directive 0059, *VA Chemicals Management and Pollution Prevention,* May 25, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program,* March 10, 2015.
- VHA Center for Engineering, Occupational Safety, and Health (CEOSH), *Emergency Management Program Guidebook*, March 2011.
- 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 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans,* May 21, 2010.
- VHA Handbook 1605.1, *Privacy and Release of Information*, May 17, 2006.
- VHA Handbook 1907.01, *Health Information Management*, July 22, 2014.
- VHA Telehealth Services, *Clinic Based Telehealth Operations Manual,* July 2014.

[b] References used for the HT Enrollment review included:

- *VHA Office of VHA Telehealth Services Home Telehealth Operations Manual*, April 13, 2015. Accessed from: http://vaww.telehealth.va.gov/pgm/ht/index.asp.

[c] References used for the Outpatient Lab Results Management review included:

- VHA, *Communication of Test Results Toolkit*, April 2012.
- VHA Handbook 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.

[d] References used for the PTSD Care review included:

- Department of Veterans Affairs Memorandum, *Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 2015.
- *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, Version 2.0, October 2010.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.
- *VHA Technical Manual – PTSD*, VA Measurement Manual PTSD-51.

[e] Reference used for Patient Aligned Care Team Compass data graphs:

- Department of Veterans' Affairs, *Patient Aligned Care Teams Compass Data Definitions*, accessed: June 25, 2015.