Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-05158-74

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Edward Hines, Jr. VA Hospital Hines, Illinois

January 12, 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
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 Edward Hines, Jr. VA Hospital and Veterans Integrated Service Network 12 provide safe, consistent, and high-quality health care. The review evaluated the clinics' compliance with selected requirements for home telehealth enrollment, outpatient lab results management, and post-traumatic stress disorder. We also randomly selected the Joliet VA Clinic, Joliet, IL, as a representative site and evaluated the environment of care on November 2, 2015.

Review Results: We conducted four focused reviews and had no findings for the Home Telehealth Enrollment review. However, we made recommendations for improvement in the following three review areas:

Environment of Care: Ensure that Joliet VA Clinic staff position monitors or use privacy screens to prevent viewing of personally identifiable information on computers in public areas.

Outpatient Lab Results Management: Ensure that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.

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.

Comments

The Veterans Integrated Service Network and Acting 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 17–20, for the full text of the Directors' comments.) We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives, Scope, and Methodology

Objectives

The CBOC and OOC reviews are an element of the OIG's efforts to ensure that our Nation's veterans receive high-quality VA health care services. As such, the CBOC and OOC reviews are recurring evaluations of selected outpatient care activities that focus on patient care quality and the EOC. In general, our objectives are to determine whether:

- The selected CBOC is compliant with EOC requirements.
- The CBOCs/OOCs are compliant with selected VHA 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 Joliet 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.		
	Managers have a policy that requires CBOC 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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Managers ensured that sterile commercial supplies are not expired.		
	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 manual lock.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	All computer screens are locked when not in use.		
X	Information is not viewable on monitors in public areas.	Personally identifiable information was viewable on monitors in public areas at the Joliet VA Clinic.	**1**. We recommended that clinic staff at the Joliet VA Clinic position monitors or use privacy screens to prevent viewing of personally identifiable information on computers 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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 49 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 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.		
	Clinicians documented the patient or caregiver's verbal informed consent for HT services.		
	Clinicians documented assessments and treatment plans for HT patients.		
	Providers signed HT 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 45 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 needs 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.		
	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 26 of 45 patients (58 percent) of their lab results within 14 days as required by VHA.	**2.** 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 47 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 improvements.

Table 5. PTSD Care

NM	Areas Reviewed	Findings	Recommendations
X	Each patient with a positive PTSD screen received a suicide risk assessment.	Twelve of 47 patients (26 percent) with positive PTSD screens did not receive a suicide risk assessment.	**3.** 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.		
	Acceptable providers offered further diagnostic evaluations 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

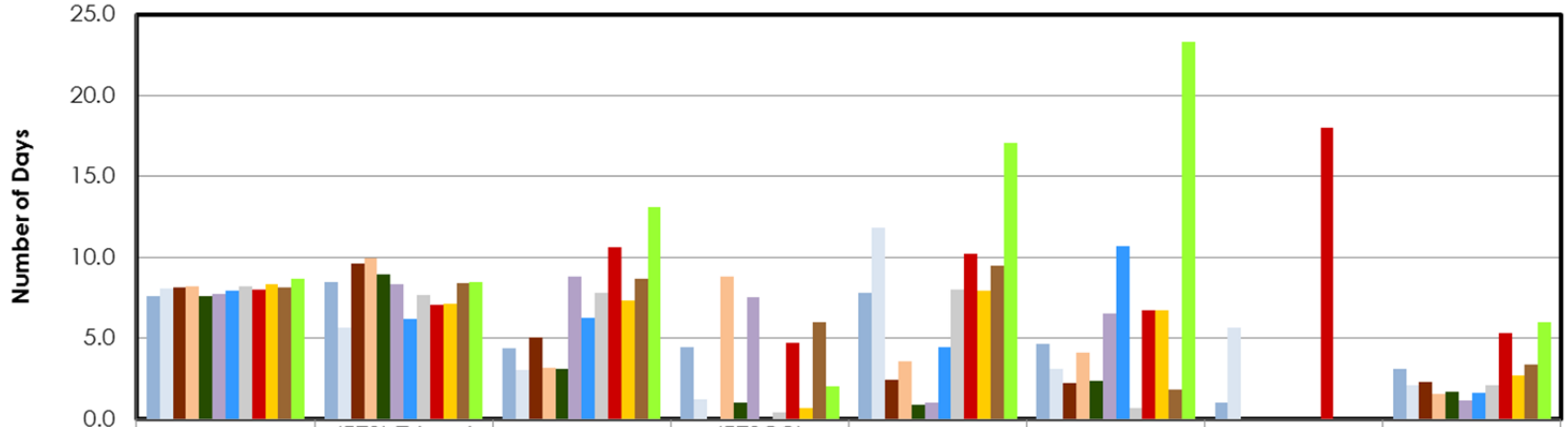
The CBOC/OOC review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[2] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. 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]**	
Joliet, IL	578GA	Urban	Multi-Specialty	13,118	6,592	97	NA	Audiology Diabetic Retinal Screening Home Based Primary Care	MOVE! Program[10] Nutrition Pharmacy Rehabilitation Services
Bourbonnais, IL	578GC	Urban	Multi-Specialty	6,564	3,288	64	NA	Audiology Home Based Primary Care	Nutrition Rehabilitation Services
North Aurora, IL	578GD	Urban	Primary Care	8,535	3,630	99	NA	Audiology Nutrition	Pharmacy
Elgin, IL	578GE	Urban	Primary Care	9,016	2,882	99	NA	Diabetic Retinal Screening	Nutrition Pharmacy
Peru, IL	578GF	Rural	Primary Care	6,163	5,132	91	NA	Audiology Nutrition	Pharmacy Rehabilitation Services
Oak Lawn, IL	578GG	Urban	Primary Care	13,626	3,730	135	NA	Nutrition	Pharmacy

[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.

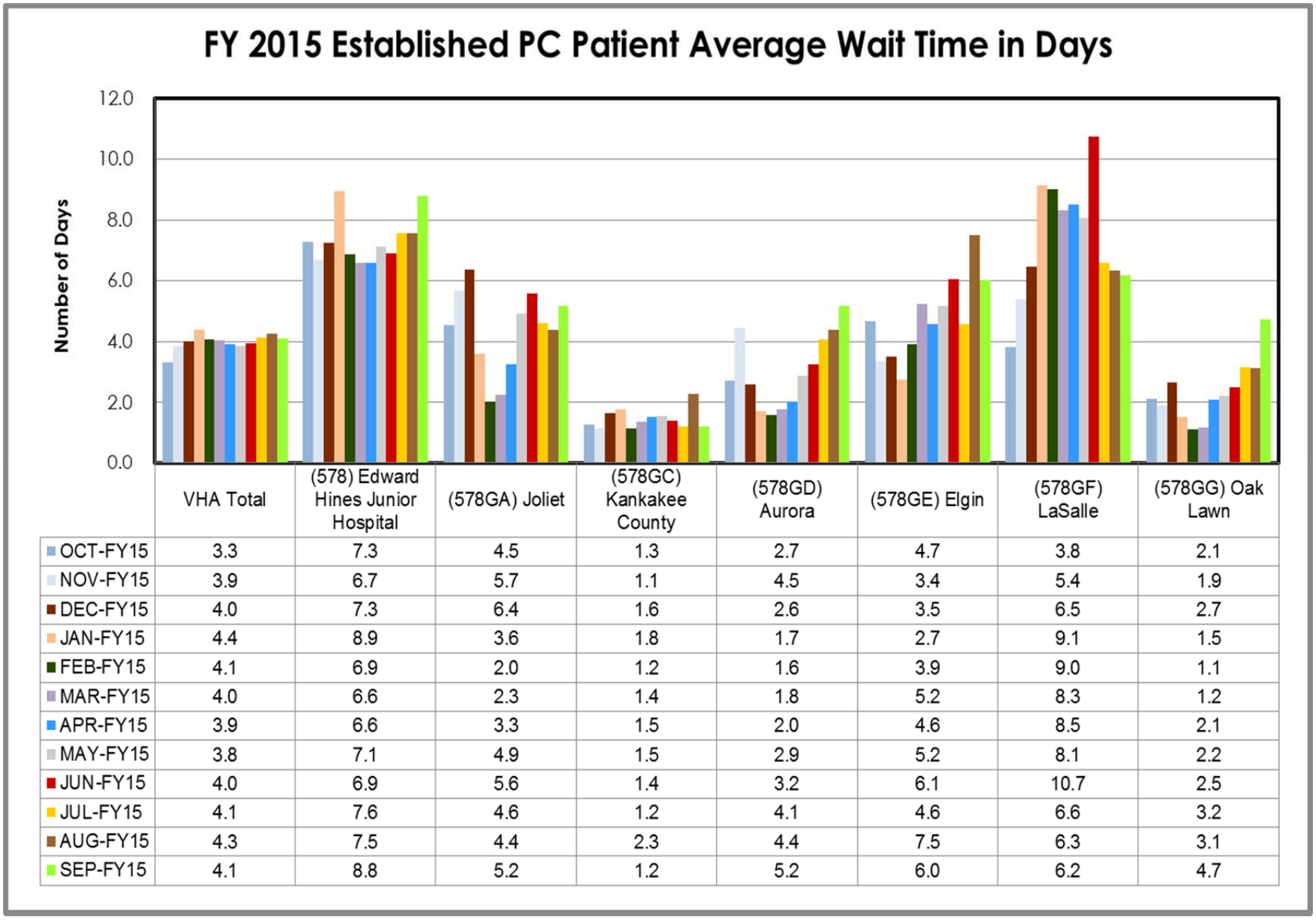
Patient Aligned Care Team Compass Metrics

FY 2015 New PC Patient Average Wait Time in Days



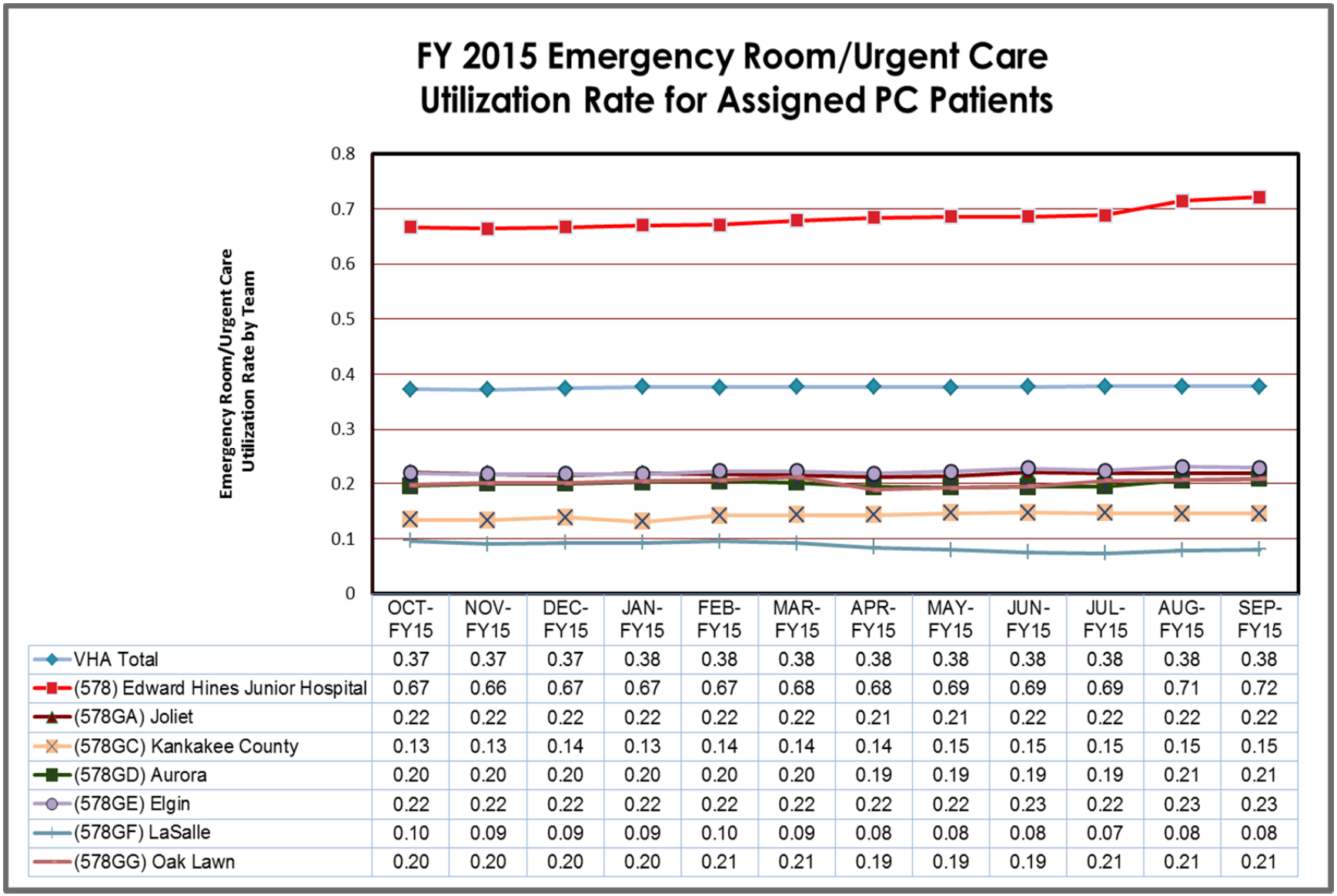
	VHA Total	(578) Edward Hines Junior Hospital	(578GA) Joliet	(578GC) Kankakee County	(578GD) Aurora	(578GE) Elgin	(578GF) LaSalle	(578GG) Oak Lawn
OCT-FY15	7.6	8.5	4.4	4.4	7.8	4.6	1.0	3.1
NOV-FY15	8.1	5.6	3.0	1.2	11.8	3.1	5.7	2.1
DEC-FY15	8.1	9.6	5.1	0.0	2.4	2.3		2.3
JAN-FY15	8.2	9.9	3.2	8.8	3.5	4.1		1.6
FEB-FY15	7.6	8.9	3.1	1.0	0.9	2.3		1.7
MAR-FY15	7.7	8.4	8.8	7.5	1.0	6.5	0.0	1.2
APR-FY15	7.9	6.2	6.2	0.0	4.4	10.7	0.0	1.6
MAY-FY15	8.2	7.7	7.8	0.4	8.0	0.7		2.1
JUN-FY15	8.0	7.0	10.6	4.7	10.2	6.8	18.0	5.3
JUL-FY15	8.3	7.1	7.3	0.7	7.9	6.8		2.7
AUG-FY15	8.1	8.4	8.6	6.0	9.5	1.8		3.4
SEP-FY15	8.7	8.4	13.1	2.0	17.1	23.3		6.0

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.* Blank cells indicate the absence of reported data.



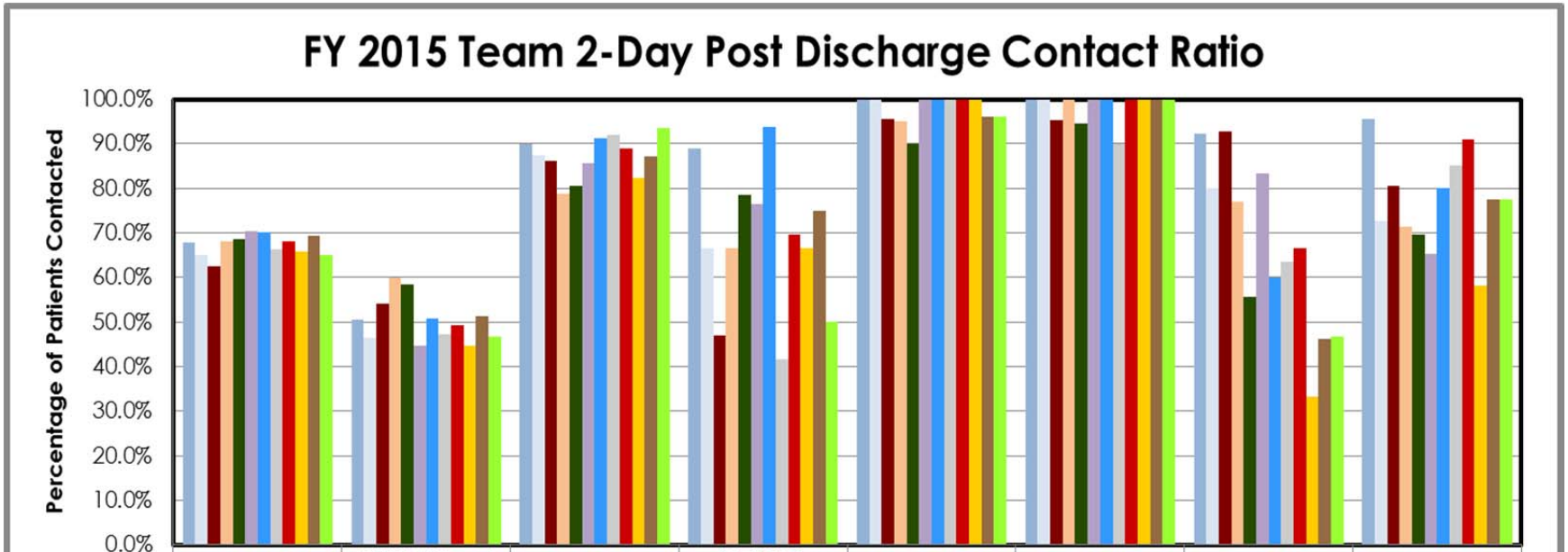
	VHA Total	(578) Edward Hines Junior Hospital	(578GA) Joliet	(578GC) Kankakee County	(578GD) Aurora	(578GE) Elgin	(578GF) LaSalle	(578GG) Oak Lawn
OCT-FY15	3.3	7.3	4.5	1.3	2.7	4.7	3.8	2.1
NOV-FY15	3.9	6.7	5.7	1.1	4.5	3.4	5.4	1.9
DEC-FY15	4.0	7.3	6.4	1.6	2.6	3.5	6.5	2.7
JAN-FY15	4.4	8.9	3.6	1.8	1.7	2.7	9.1	1.5
FEB-FY15	4.1	6.9	2.0	1.2	1.6	3.9	9.0	1.1
MAR-FY15	4.0	6.6	2.3	1.4	1.8	5.2	8.3	1.2
APR-FY15	3.9	6.6	3.3	1.5	2.0	4.6	8.5	2.1
MAY-FY15	3.8	7.1	4.9	1.5	2.9	5.2	8.1	2.2
JUN-FY15	4.0	6.9	5.6	1.4	3.2	6.1	10.7	2.5
JUL-FY15	4.1	7.6	4.6	1.2	4.1	4.6	6.6	3.2
AUG-FY15	4.3	7.5	4.4	2.3	4.4	7.5	6.3	3.1
SEP-FY15	4.1	8.8	5.2	1.2	5.2	6.0	6.2	4.7

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.



	OCT-FY15	NOV-FY15	DEC-FY15	JAN-FY15	FEB-FY15	MAR-FY15	APR-FY15	MAY-FY15	JUN-FY15	JUL-FY15	AUG-FY15	SEP-FY15
VHA Total	0.37	0.37	0.37	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38
(578) Edward Hines Junior Hospital	0.67	0.66	0.67	0.67	0.67	0.68	0.68	0.69	0.69	0.69	0.71	0.72
(578GA) Joliet	0.22	0.22	0.22	0.22	0.22	0.22	0.21	0.21	0.22	0.22	0.22	0.22
(578GC) Kankakee County	0.13	0.13	0.14	0.13	0.14	0.14	0.14	0.15	0.15	0.15	0.15	0.15
(578GD) Aurora	0.20	0.20	0.20	0.20	0.20	0.20	0.19	0.19	0.19	0.19	0.21	0.21
(578GE) Elgin	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.23	0.22	0.23	0.23
(578GF) LaSalle	0.10	0.09	0.09	0.09	0.10	0.09	0.08	0.08	0.08	0.07	0.08	0.08
(578GG) Oak Lawn	0.20	0.20	0.20	0.20	0.21	0.21	0.19	0.19	0.19	0.21	0.21	0.21

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	(578) Edward Hines Junior Hospital	(578GA) Joliet	(578GC) Kankakee County	(578GD) Aurora	(578GE) Elgin	(578GF) LaSalle	(578GG) Oak Lawn
OCT-FY15	67.9%	50.6%	90.0%	88.9%	100.0%	100.0%	92.3%	95.6%
NOV-FY15	64.9%	46.4%	87.5%	66.7%	100.0%	100.0%	80.0%	72.7%
DEC-FY15	62.6%	54.0%	86.2%	47.1%	95.5%	95.2%	92.9%	80.4%
JAN-FY15	68.0%	59.9%	78.8%	66.7%	95.0%	100.0%	76.9%	71.4%
FEB-FY15	68.6%	58.6%	80.6%	78.6%	90.0%	94.4%	55.6%	69.7%
MAR-FY15	70.4%	44.8%	85.7%	76.5%	100.0%	100.0%	83.3%	65.2%
APR-FY15	70.1%	50.7%	91.2%	93.8%	100.0%	100.0%	60.0%	80.0%
MAY-FY15	66.3%	47.3%	92.1%	41.7%	100.0%	90.0%	63.6%	85.2%
JUN-FY15	68.2%	49.4%	88.9%	69.6%	100.0%	100.0%	66.7%	90.9%
JUL-FY15	65.9%	44.7%	82.4%	66.7%	100.0%	100.0%	33.3%	58.1%
AUG-FY15	69.4%	51.3%	87.1%	75.0%	96.0%	100.0%	46.2%	77.4%
SEP-FY15	65.1%	46.8%	93.5%	50.0%	96.2%	100.0%	46.7%	77.4%

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.

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: December 8, 2015

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

Subject: **Review of CBOCs and OOCs of Edward Hines, Jr. VA Hospital, Hines, IL**

To: Director**,** San Diego Office of Healthcare Inspections (54SD)

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

1. Thank you for conducting a comprehensive review at the Edward Hines, Jr. VA Hospital, Hines IL.

2. I have reviewed the document and concur with the response as submitted.

Denise M. Deitzen
Network Director, VISN 12

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 8, 2015

From: Acting Director, Edward Hines Jr. VA Hospital (578/00)

Subject: **Review of CBOCs and OOCs of Edward Hines, Jr. VA Hospital, Hines, IL**

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

1. Hines concurs with all recommendations. Please see the attached action plans for the recommendations identified from the recent review.

2. If you have any questions, please contact Ms. Sabrina R. Hughes, Chief, Quality and System Improvement at (708) 202-4621.

for Lynette J. Taylor, RN, MHSA, VHA-CM
Acting Director, Edward Hines Jr. VA Hospital

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 at the Joliet VA Clinic position monitors or use privacy screens to prevent viewing of personally identifiable information on computers in public areas.

Concur

Target date for completion: March 30, 2016

Facility response: Privacy screens were ordered for all computers located at the check in/out areas in the Joliet Community Based Outpatient Clinic (CBOC) on 11/2/15. Monitoring of the privacy screens at the Joliet CBOC check in/out will be conducted monthly by the Medical Support Assistant (MSA) Supervisor and the Clinical Nurse Manager (CNM) until 90% compliance is achieved and sustained. Results of compliance (usage) will be reported to the Outpatient Steering Committee.

Recommendation 2. We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.

Concur

Target date for completion: May 30, 2016

Facility response: Primary Care has developed a multidisciplinary action plan which delegates responsible team members to notify patients of normal and abnormal test results and document in the electronic health record. Clinical Informatics will develop an Abnormal Lab Result mandatory notification for all providers. A modification of existing primary care progress note templates will be made for providers to document that test results have been discussed with the patient at today's visit. Development of automated processes to batch, print, and mail normal laboratory results to patients with a corresponding automated notification embedded into the Computerized Patient Record System (CPRS) will occur by 2/1/16. A monthly audit will be conducted until 90% compliance with established requirements is reached and sustained.

Recommendation 3. We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens.

Concur

Target date for completion: May 30, 2016

Facility response: The Post-Traumatic Stress Disorder (PTSD) clinical reminder was updated on 10/28/15 to include a forced field entry for a suicide assessment. This is a required field when the PTSD reminder is positive and the provider cannot progress to an additional field until it is completed. A new Standard Operating Procedure was created on 10/22/15 which outlines guidance on completing the depression screening reminder, actions that are required for a positive screen and the notification process for Mental Health and Primary Care Providers. Staff training for the new SOP will be completed by 12/10/15. Beginning 12/30/15, Mental Health will monitor compliance with positive PTSD screens requiring a suicide risk assessment to ensure 90% compliance is achieved and sustained.

Office of Inspector General
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Endnotes

[a] References used for the EOC review included:

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

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[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.