Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-05160-161

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Northern Arizona VA Health Care System Prescott, Arizona

March 9, 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

Table of Contents

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 Northern Arizona VA Health Care System and Veterans Integrated Service Network 18 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 care. We also randomly selected the Chinle VA Clinic, Chinle, AZ, as a representative site and evaluated the environment of care on November 18, 2015.

Review Results: We conducted four focused reviews and made recommendations for improvement in those areas:

Environment of Care: Ensure that:

- Managers monitor hand hygiene compliance at the Chinle VA Clinic.
- Managers develop and implement a policy/procedure for the life safety elements at the Chinle VA Clinic.
- Managers develop and implement a policy that requires the Chinle VA Clinic staff to receive regular information on their responsibilities in emergency response operations.
- Managers ensure that Chinle VA Clinic staff participate in emergency management exercises.
- Managers ensure walls in patient care areas at the Chinle VA Clinic are repaired.
- Managers ensure that the Chinle VA Clinic has functional and accessible hand hygiene facilities.
- Managers at the Chinle VA Clinic ensure food and drink are not kept in refrigerators or freezers in patient care areas.
- Managers control access to and from areas identified as security sensitive at the Chinle VA Clinic.
- Managers review the Chinle VA Clinic's hazardous materials inventory twice within a 12-month period.
- Managers equip examination room doors with electronic or manual locks at the Chinle VA Clinic.
- Managers provide feminine hygiene products and disposal bins in women's public restrooms at the Chinle VA Clinic.

- Managers at the Chinle VA Clinic ensure the information technology server closet is maintained according to information technology safety and security standards.

Home Telehealth Enrollment: Ensure that:

- Providers sign Home Telehealth assessments and treatment plans.
- Clinicians document the Home Telehealth enrollment process prior to the entry of monthly monitoring notes.

Outpatient Lab Results Management:

- Ensure that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA policy.

Post-Traumatic Stress Disorder Care: Ensure that:

- Acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens.
- Diagnostic evaluations are offered to patients with positive PTSD screens.
- Providers complete diagnostic evaluations for patients with positive PTSD screens.

Comments

The Acting Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 17–24, for 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 Chinle VA Clinic. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

Table 2. EOC

NM	Areas Reviewed	Findings	Recommendations
Document and Training Review			
X	Managers monitored hand hygiene compliance.	Managers did not monitor hand hygiene compliance at the Chinle VA Clinic.	**1.** We recommended that managers monitor hand hygiene compliance at the Chinle VA Clinic.
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	In the Exposure Control Plan for BBPs, managers document employees' declination statements for the Hepatitis B vaccine.		
	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.		
X	Managers have a policy/procedure for CBOC life safety elements.	Managers did not have a policy/procedure for life safety elements at the Chinle VA Clinic.	**2.** We recommended that managers develop and implement a policy/procedure for the life safety elements at the Chinle VA Clinic.
	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 Chinle VA Clinic staff to receive regular information on their responsibilities in emergency response operations.	**3.** We recommended that managers develop and implement a policy that requires the Chinle VA Clinic staff to receive regular information on their responsibilities in emergency response operations.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	CBOC staff participate in regular emergency management training and exercises.	None of six Chinle VA Clinic employees participated in regular emergency management exercises.	**4.** We recommended that managers ensure that Chinle VA Clinic staff participate in emergency management exercises.
	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.		
NA	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.		
X	The furnishings, walls, and equipment are safe and in good repair.	Walls in the examination room at the Chinle VA Clinic were in need of repair.	**5**. We recommended that managers ensure walls in patient care areas at the Chinle VA Clinic are repaired.
X	Hand hygiene facilities and product dispensers are working and readily accessible to employees.	Managers did not have functional and accessible hand hygiene facilities at the Chinle VA Clinic.	**6.** We recommended that managers ensure that the Chinle VA Clinic has functional and accessible hand hygiene facilities.
	Personal protective equipment is available.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Sharps containers are closable, easily accessible, and not overfilled.		
X	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.	The Chinle VA Clinic staff stored food and drinks in refrigerators or freezers in the patient care area.	**7.** We recommended that managers at the Chinle VA Clinic ensure food and drink are not kept in refrigerators or freezers in patient care areas.
	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.		
X	Managers control access to and from areas identified as security sensitive.	Clinic managers did not control access to and from areas identified as security sensitive at the Chinle VA Clinic.	**8.** We recommended that managers control access to and from areas identified as security sensitive at the Chinle VA Clinic.
NA	Managers installed an alarm system or panic buttons in high-risk areas.		
X	Managers reviewed the CBOC's inventory of hazardous materials for accuracy twice within the prior 12 months.	Managers did not review the inventory of hazardous materials and waste at the Chinle VA Clinic for accuracy twice within the prior 12 months.	**9**. We recommended that managers review the Chinle VA Clinic's hazardous materials inventory twice within a 12-month period.
	Managers had the CBOC's safety data sheets for chemicals readily available for the staff.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Managers provided visual and auditory privacy for veterans at check-in.		
	Managers provided visual and auditory privacy for patients in the interview areas.		
X	Managers equipped examination room doors with either an electronic or manual lock.	Managers did not equip examination rooms at the Chinle VA Clinic with either an electronic or manual lock.	**10**. We recommended that managers equip examination room doors with electronic or manual locks at the Chinle VA Clinic.
	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.		
	Information is not viewable on monitors in public areas.		
NA	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.		
X	Women's public restrooms have feminine hygiene products and disposal bins available for use.	Managers did not provide feminine hygiene products and disposal bins for use in women's public restrooms at the Chinle VA Clinic.	**11.** We recommended that managers provide feminine hygiene products and disposal bins in women's public restrooms at the Chinle VA Clinic.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Multi-dose medication vials are not expired.		
	All medications are secured from unauthorized access.		
	The information technology network room/server closet is secured/locked.		
X	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 at the Chinle VA Clinic was not restricted to personnel authorized by Office of Information and Technology.	12. We recommended that managers at the Chinle VA Clinic ensure the information technology server closet is maintained according to information technology safety and security standards.
X	Access to the information technology network room/server closet is documented, as evidenced by the presence of a sign-in/sign-out log.	The Chinle VA Clinic did not document access to the information technology network room/server closet.	

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 47 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.		
	Clinicians documented the patient or caregiver's verbal informed consent for HT services.		
	Clinicians documented assessments and treatment plans for HT patients.		
X	Providers signed HT assessments and treatment plans.	Providers did not sign 11 of 47 patients' HT assessments and treatment plans (23 percent).	**13**. We recommended that providers sign Home Telehealth assessments and treatment plans.
	Monthly monitoring notes were documented for each month of HT program participation.		
X	Documentation of HT enrollment (consult, screening, and/or initial assessment notes) was completed prior to the entry of monthly monitoring notes.	Clinicians did not document the enrollment process prior to the entry of monthly monitoring notes in 11 of 47 EHRs (23 percent).	**14.** We recommended that clinicians document the Home Telehealth enrollment process 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 areas 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.		
	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 22 of 50 patients (44 percent) of their lab results within 14 days as required by VHA.	**15.** We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA policy.
	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 38 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.	Fifteen of 38 patients (39 percent) with positive PTSD screens did not receive a suicide risk assessment.	**16.** 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 9 of 38 EHRs (24 percent).	**17**. We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.
X	Providers completed diagnostic evaluations for patients with positive PTSD screens.	Providers did not complete clinical diagnostic evaluation in 3 of 25 EHRs.	**18**. We recommended that providers complete diagnostic evaluations for patients with positive PTSD screens.
	Patients, when applicable, received mental health treatment.		

Clinic Profiles

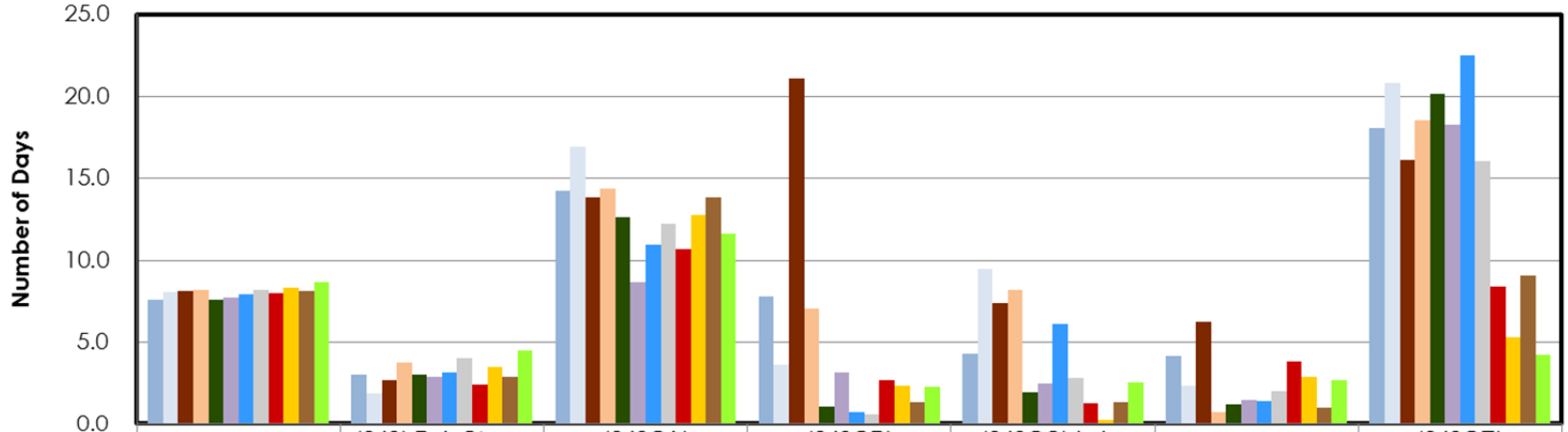
The CBOC/OOC review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[2] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. 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]**
Kingman, AZ	649GA	Rural	Primary Care CBOC	7,222	3,849	118	NA	Diabetic Retinal Screening Home Based Primary Care
Flagstaff, AZ	649GB	Urban	Primary Care CBOC	2,836	2,133	64	NA	Audiology Home Based Primary Care
Lake Havasu City, AZ	649GC	Urban	Primary Care CBOC	7,116	1,473	230	Cardiology	Diabetic Retinal Screening Electrocardiography
Anthem, AZ	649GD	Urban	Primary Care CBOC	2,799	1,383	75	NA	NA
Cottonwood, AZ	649GE	Rural	Primary Care CBOC	5,952	1,597	36	NA	Diabetic Retinal Screening

[2] Includes all CBOCs in operation before August 15, 2015. We have omitted 649QA (Chinle), 649QB (Holbrook), 649QD (Page), 649QE (Prescott), 649QF (Tuba City), 649QG (Polacca), and 649QH (Kayenta), as no workload/encounters or services were reported.
[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.

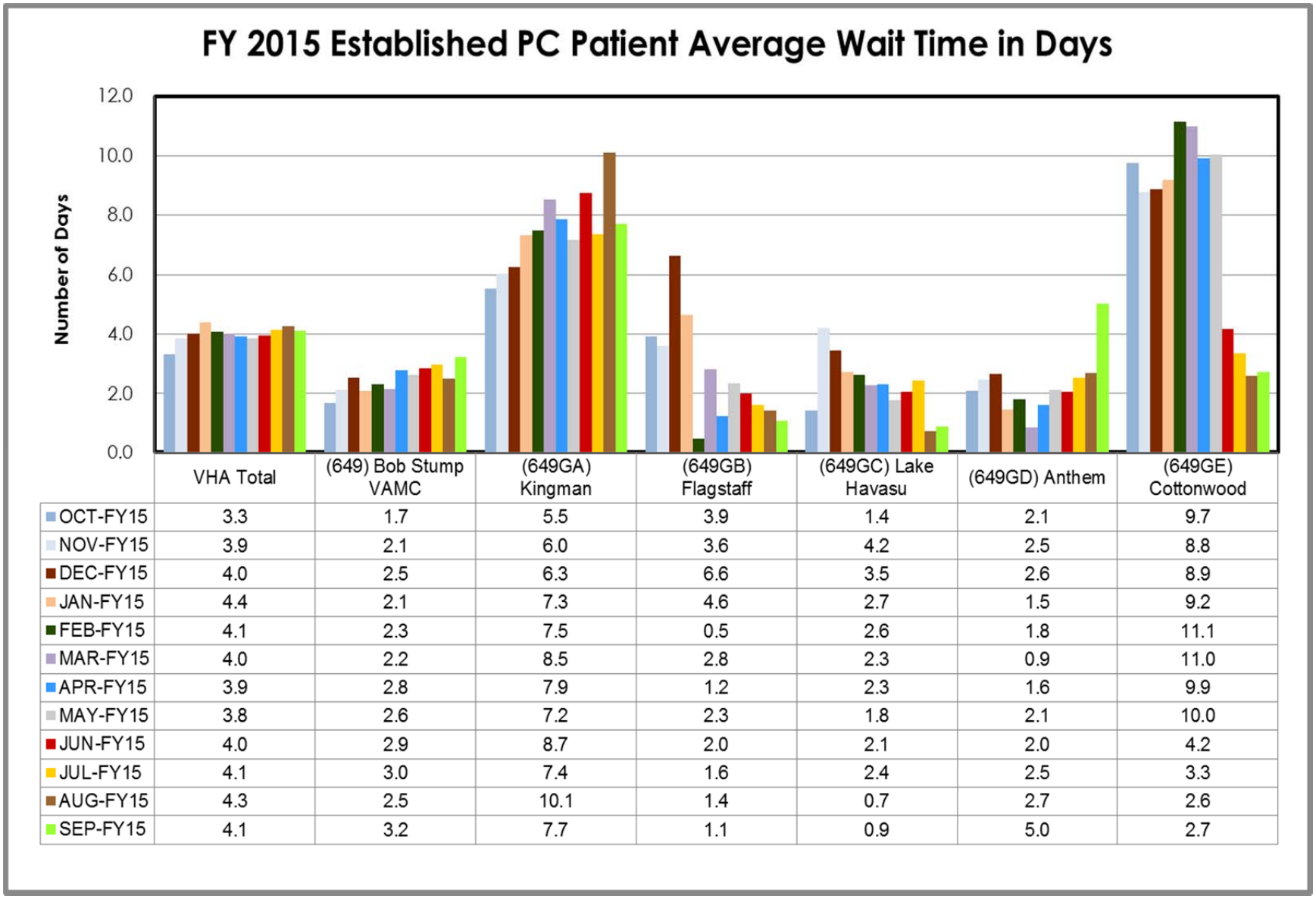
Patient Aligned Care Team Compass Metrics

FY 2015 New PC Patient Average Wait Time in Days



	VHA Total	(649) Bob Stump VAMC	(649GA) Kingman	(649GB) Flagstaff	(649GC) Lake Havasu	(649GD) Anthem	(649GE) Cottonwood
OCT-FY15	7.6	3.1	14.3	7.8	4.3	4.2	18.1
NOV-FY15	8.1	1.9	17.0	3.7	9.5	2.3	20.8
DEC-FY15	8.1	2.7	13.9	21.1	7.4	6.2	16.1
JAN-FY15	8.2	3.7	14.4	7.1	8.2	0.8	18.6
FEB-FY15	7.6	3.0	12.7	1.1	2.0	1.3	20.1
MAR-FY15	7.7	2.9	8.7	3.2	2.5	1.5	18.3
APR-FY15	7.9	3.2	11.0	0.7	6.1	1.4	22.5
MAY-FY15	8.2	4.0	12.3	0.6	2.8	2.0	16.0
JUN-FY15	8.0	2.4	10.7	2.7	1.3	3.9	8.4
JUL-FY15	8.3	3.5	12.8	2.4	0.2	2.9	5.3
AUG-FY15	8.1	2.9	13.8	1.4	1.4	1.0	9.1
SEP-FY15	8.7	4.5	11.6	2.3	2.6	2.7	4.3

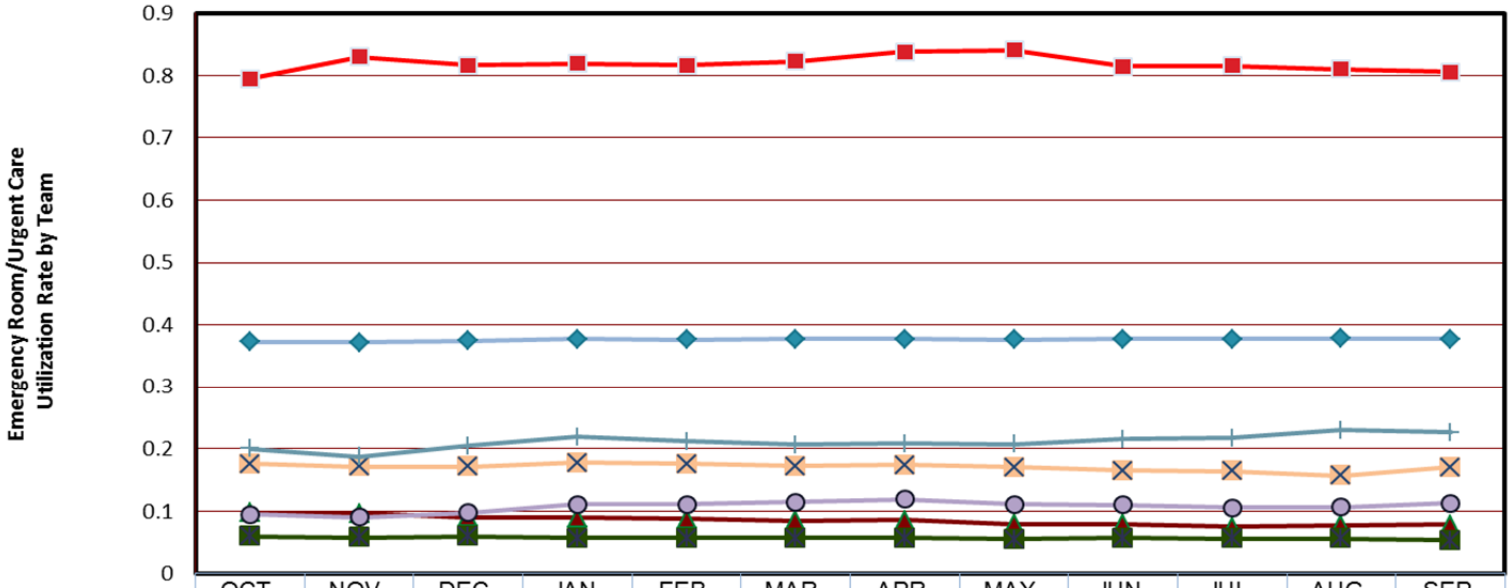
Data Definition.[e] The average number of calendar days between a New Patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment,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



	VHA Total	(649) Bob Stump VAMC	(649GA) Kingman	(649GB) Flagstaff	(649GC) Lake Havasu	(649GD) Anthem	(649GE) Cottonwood
OCT-FY15	3.3	1.7	5.5	3.9	1.4	2.1	9.7
NOV-FY15	3.9	2.1	6.0	3.6	4.2	2.5	8.8
DEC-FY15	4.0	2.5	6.3	6.6	3.5	2.6	8.9
JAN-FY15	4.4	2.1	7.3	4.6	2.7	1.5	9.2
FEB-FY15	4.1	2.3	7.5	0.5	2.6	1.8	11.1
MAR-FY15	4.0	2.2	8.5	2.8	2.3	0.9	11.0
APR-FY15	3.9	2.8	7.9	1.2	2.3	1.6	9.9
MAY-FY15	3.8	2.6	7.2	2.3	1.8	2.1	10.0
JUN-FY15	4.0	2.9	8.7	2.0	2.1	2.0	4.2
JUL-FY15	4.1	3.0	7.4	1.6	2.4	2.5	3.3
AUG-FY15	4.3	2.5	10.1	1.4	0.7	2.7	2.6
SEP-FY15	4.1	3.2	7.7	1.1	0.9	5.0	2.7

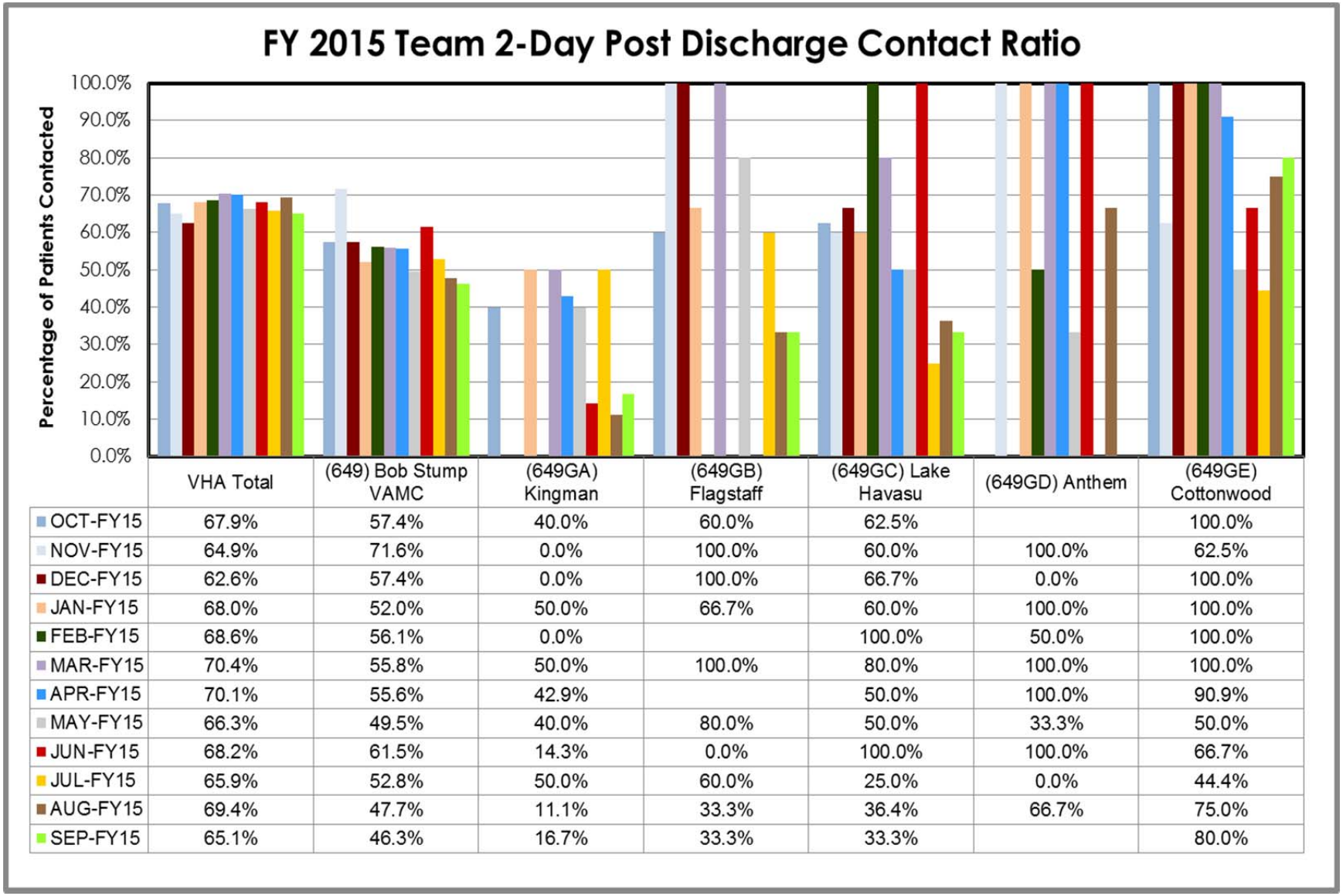
Data Definition.[e] The average number of calendar days between an Established Patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic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

FY 2015 Emergency Room/Urgent Care Utilization Rate for Assigned PC Patients



	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
(649) Bob Stump VAMC	0.79	0.83	0.82	0.82	0.82	0.82	0.84	0.84	0.81	0.82	0.81	0.81
(649GA) Kingman	0.10	0.10	0.09	0.09	0.09	0.09	0.09	0.08	0.08	0.07	0.08	0.08
(649GB) Flagstaff	0.18	0.17	0.17	0.18	0.18	0.17	0.17	0.17	0.17	0.16	0.16	0.17
(649GC) Lake Havasu	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.05
(649GD) Anthem	0.09	0.09	0.10	0.11	0.11	0.11	0.12	0.11	0.11	0.11	0.11	0.11
(649GE) Cottonwood	0.20	0.19	0.20	0.22	0.21	0.21	0.21	0.21	0.22	0.22	0.23	0.23

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	(649) Bob Stump VAMC	(649GA) Kingman	(649GB) Flagstaff	(649GC) Lake Havasu	(649GD) Anthem	(649GE) Cottonwood
OCT-FY15	67.9%	57.4%	40.0%	60.0%	62.5%		100.0%
NOV-FY15	64.9%	71.6%	0.0%	100.0%	60.0%	100.0%	62.5%
DEC-FY15	62.6%	57.4%	0.0%	100.0%	66.7%	0.0%	100.0%
JAN-FY15	68.0%	52.0%	50.0%	66.7%	60.0%	100.0%	100.0%
FEB-FY15	68.6%	56.1%	0.0%		100.0%	50.0%	100.0%
MAR-FY15	70.4%	55.8%	50.0%	100.0%	80.0%	100.0%	100.0%
APR-FY15	70.1%	55.6%	42.9%		50.0%	100.0%	90.9%
MAY-FY15	66.3%	49.5%	40.0%	80.0%	50.0%	33.3%	50.0%
JUN-FY15	68.2%	61.5%	14.3%	0.0%	100.0%	100.0%	66.7%
JUL-FY15	65.9%	52.8%	50.0%	60.0%	25.0%	0.0%	44.4%
AUG-FY15	69.4%	47.7%	11.1%	33.3%	36.4%	66.7%	75.0%
SEP-FY15	65.1%	46.3%	16.7%	33.3%	33.3%		80.0%

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. Blank cells indicate the absence of reported data.

Appendix C

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: January 15, 2016

From: Acting Director, VA Southwest Health Care Network (10N18)

Subject: **Review of CBOCs and OOCs of Northern Arizona VA Health Care System**

To: Director**,** Chicago Office of Healthcare Inspections (54CH)
Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have reviewed and concur with the findings and recommendations in the draft OIG report entitled, "Review of CBOCs and OOCs of Northern Arizona VA Health Care System."

2. If you have any questions or concerns, please contact Terri Elsholz, Acting VISN 18 Quality Management Officer, at 480-397-2782.

(original signed by:)
Marie L. Weldon, FACHE

Appendix D

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 15, 2016

From: Acting Director, Northern Arizona VA Health Care System (649/00)

Subject: **Review of CBOCs and OOCs of Northern Arizona VA Health Care System, Prescott, AZ**

To: Acting Director, VA Southwest Health Care Network (10N18)

1. Please find the Northern Arizona VA Health Care System response to the Office of Inspector General Health Inspection conducted from November 18, 2015, report entitled, Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Northern Arizona VA Health Care System, Prescott, Arizona.

2. If you have any questions or concerns, please contact James T. Johnson, MD, MSEd, Acting Chief of Staff and Quality Programs Service Line Manager at 928-445-4860, ext. 6961.

(original signed by:)
M. Keith Piatt, MD, FACP, MHA

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 monitor hand hygiene compliance at the Chinle VA Clinic.

Concur

Target date for completion: June 15, 2016

Facility response: In order to ensure that hand hygiene compliance is monitored at the Chinle VA Clinic, the Primary Care Northeast Regional Nurse Manager will ensure completion of the hand hygiene observation tools each month. The results of the hand hygiene observations will be sent to the NAVAHCS Quality Programs MDRO Coordinator who will track and trend the observations quarterly. Quarterly results will be shared at the Infection Control Committee meeting. A target compliance rate of 90% has been established.

Recommendation 2. We recommended that the managers develop and implement a policy/procedure for the life safety elements at the Chinle VA Clinic.

Concur

Target date for completion: June 15, 2016

Facility response: In order to ensure that the Chinle VA Clinic is included in the NAVAHCS Environment of Care Program HCSM that includes life safety elements, this HCSM will be updated to include the Chinle VA Clinic. To ensure that Life Safety elements are monitored at the Chinle VA Clinic, the Rural Health Program Manager will work with the Life Safety Manager at NAVAHCS to ensure that semi-annual reviews of the Life Safety elements are completed.

Recommendation 3. We recommended that managers develop and implement a policy that requires the Chinle VA Clinic staff to receive regular information on their responsibilities in emergency response operations.

Concur

Target date for completion: June 15, 2016

Facility response: In order to ensure that emergency response operations at the Chinle VA Clinic are communicated to the employees, the Rural Health Program Manager will work with the NAVAHCS Emergency Preparedness Coordinator to ensure that the

Chinle VA Clinic is included in training of emergency response operations as outlined in Recommendation 4. The NAVAHCS HCSM Comprehensive Emergency Operations Plan will be updated to include the Chinle VA Clinic.

Recommendation 4. We recommended that managers ensure that Chinle VA Clinic staff participate in emergency management exercises.

Concur

Target date for completion: June 15, 2016

Facility response: In order to ensure that Chinle VA Clinic employees participate in emergency management exercises, the Rural Health Program Manager will work with the NAVAHCS Emergency Preparedness Coordinator to conduct semi-annual exercises that include training on responses to emergency situations. Currently, Chinle VA Clinic staff is included in the Indian Health Services (IHS) emergency management exercises semi-annually. In order to document involvement in IHS exercises, the Chinle VA staff will provide the NAVAHCS Safety Manager confirmation of participation in the IHS emergency management drills.

Recommendation 5. We recommended that managers ensure walls in patient care areas at the Chinle VA Clinic are repaired.

Concur

Target date for completion: December 12, 2015

Facility response: In order to ensure a safe environment, the Chinle VA Clinic relocated to a renovated room where all walls are intact. Exam room 7 identified in this report is no longer used by the VA Clinic.

Recommendation 6. We recommended that managers ensure that the Chinle VA Clinic has functional and accessible hand hygiene facilities.

Concur

Target date for completion: December 12, 2015

Facility response: In order to ensure that functional and accessible hand hygiene facilities are available, the Chinle VA Clinic was relocated to a renovated room that has hand hygiene facilities.

Recommendation 7. We recommended that managers at the Chinle VA Clinic ensure food and drink are not kept in refrigerators or freezers in patient care areas.

Concur

Target date for completion: December 12, 2015

Facility response: In order to ensure that food and drink are not kept in refrigerators or freezers in patient care areas, the staff-only food refrigerator was moved into a non-patient care location.

Recommendation 8. We recommended that managers control access to and from areas identified as security sensitive at the Chinle VA Clinic.

Concur

Target date for completion: December 12, 2015

Facility response: In order to manage access to and from areas identified as security sensitive at the Chinle VA, the clinic area was moved to a renovated space which is controlled by VA staff. The new area requires that Veterans are escorted by VA staff as they enter the locked VA clinic reception area. All offices within the clinic have locks with access available only via key and Veterans must be escorted by VA staff as they enter and exit a clinic examination room. Access to patient care areas from the facility main entrance is controlled by IHS installed security badge card readers.

Recommendation 9. We recommended that managers review the Chinle VA Clinic's hazardous materials inventory twice within a 12-month period.

Concur

Target date for completion: July 31, 2016

Facility response: In order to ensure review of the Chinle VA Clinic's hazardous materials inventory, the Rural Health Program Manager will send a list of all hazardous materials located at the Chinle VA Clinic to the Green Management Environmental Services Program Manager every year in January and July. The Green Management Environmental Services Program Manager will report to the Environment of Care/Safety Board the results of the inventory review at the following scheduled board meeting after receipt of the report for that period.

Recommendation 10. We recommended that managers equip examination room doors with electronic or manual locks at the Chinle VA Clinic.

Concur

Target date for completion: December 12, 2015

Facility response: In order to ensure equipment examination room doors have individual manual locks, the clinic was relocated to a renovated space. Part of the renovation was the installation of individual manual locks in every examination room. Exam room 7, identified in this report, is no longer used by the VA Clinic.

Recommendation 11. We recommended that managers provide feminine hygiene products and disposal bins in women's public restrooms at the Chinle VA Clinic.

Concur

Target date for completion: January 31, 2016

Facility response: In order to ensure availability of feminine hygiene products in women's public restrooms at the Chinle VA Clinic, a sign will be posted in the restroom and in the exam rooms that states "Sanitary products are available at no cost for women Veterans from the VA clinic staff". The Chinle VA Clinic is integrated within the IHS and uses shared waiting and restroom areas. The IHS facility has over 37,000 active users with approximately 587 being VA users. A trial of placing 40 feminine hygiene products in the public restroom at no cost was discontinued after all products were taken within an hour. Disposal bins are available in all public restrooms.

Recommendation 12. We recommended that managers at the Chinle VA Clinic ensure the information technology server closet is maintained according to information technology safety and security standards.

Concur

Target date for completion: January 31, 2016

Facility response: In order to ensure the information technology server closet is maintained according to information technology safety and security standards, the Facility Chief Information Officer will complete an access request form that will include a list of individuals who are authorized to access the Chinle VA Clinic communication closet, area and equipment. A log will be implemented to document access to the information technology network room/server closet at the Chinle VA Clinic. Both forms will be attached to the rack/cabinet for the VA server at the Chinle VA Clinic. Education on these forms will be provided to the Rural Health Manager, the RN Supervisor, NAVAHCS IT personnel and IHS IT personnel.

Recommendation 13. We recommended that providers sign Home Telehealth assessments and treatment plans.

Concur

Target date for completion: April 1, 2016

Facility response: In order to ensure that providers sign Home Telehealth assessments and treatment plans, the Home Telehealth Care Coordinators will send all Home Telehealth Assessments and Treatment plans to the patient's provider for signature for concurrence with the assessment and treatment plan. All Home Telehealth Care Coordinators will be reeducated on the need to follow the facility SOP that meets the COP requirements for charting Assessments and Signatures, and compliance will be monitored as a regular part of their competencies. The Home Telehealth Care Coordinators will conduct weekly audits of assessment and treatment plans for signature. Quarterly reports will be reviewed by the Medical Records Committee. A target compliance rate of 90% has been established.

Recommendation 14. We recommended that clinicians document the Home Telehealth enrollment process prior to the entry of monthly monitoring notes.

Concur

Target date for completion: April 1, 2016

Facility response: In order to ensure that clinicians document the Home Telehealth enrollment process prior to the entry of monthly monitoring note, the Home Telehealth process has been revised so that the monthly monitoring note is not entered until after the first patient transmission from the Home Telehealth device has been received by the Home Telehealth Care Coordinator. All Home Telehealth Care Coordinators will be educated on the new process and compliance will be monitored as a regular part of their competencies. The Facility Telehealth Manager and the Home Telehealth Lead will conduct weekly audits of the revised process for 6 weeks or until a 95% compliance rate becomes consistent, then quarterly audits will be conducted. Quarterly reports will be reviewed by the Medical Records Committee. A target compliance rate of 90% has been established.

Recommendation 15. We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA policy.

Concur

Target date for completion: June 24, 2016

Facility response: In order to ensure clinicians consistently notify patients of their laboratory results within 14 days as required by VHA Policy, NAVAHCS will update a written communication of test results policy and establish procedures to ensure compliance with Directive 1088 "Communicating Test Results to Providers and Patients." This includes written procedures and practices for test result communication, coverage in the provider's absence, and plans for the delegation of authority which specify which team members can receive test results and/or notify patients. Education will be provided to clinic providers and clinical staff on the updated policies and procedures. Primary Care PACT Teams will conduct monthly audits on patients being notified of their laboratory results within 14 days. Quarterly reports will be reviewed by the Medical Records Committee. A target compliance rate of 80% has been established.

Recommendation 16. We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens.

Concur

Target date for completion: June 24, 2016

Facility response: In order to ensure that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens, annual education

will be provided to the clinic providers on performing and documenting a suicide risk assessment for patients with a positive PTSD screen as well as including in the orientation training for new staff. Mental Health Service Line will conduct monthly audits on patients with a positive PTSD screen for a corresponding suicide risk assessment and provide feedback to the clinic providers on the results. Quarterly reports will be reviewed by the Medical Records Committee. A target compliance rate of 90% has been established.

Recommendation 17. We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.

Concur

Target date for completion: June 24, 2016

Facility response: In order to ensure that further diagnostic evaluations are offered to patients with a positive PTSD screen, education will be provided to clinic providers on presenting further diagnostic evaluations for patients with a positive PTSD screen as well as including in the orientation training for new staff. Mental Health Service Line will conduct monthly audits on patients with a positive PTSD screen for a corresponding offer for further diagnostic evaluation and provide feedback to the clinic providers on the results. Quarterly reports will be reviewed by the Medical Records Committee. A target compliance rate of 90% has been established.

Recommendation 18. We recommended that providers complete diagnostic evaluations for patients with positive PTSD screens.

Concur

Target date for completion: June 24, 2016

Facility response: In order to ensure that providers complete diagnostic evaluations for patients with positive PTSD screens, annual education will be provided to all Mental Health providers on providing a comprehensive diagnostic and treatment plan evaluation within 30 days for a patient with a positive PTSD screen as well as including in the orientation training for new staff. Mental Health will conduct monthly audits on patients with a positive PTSD screen for a comprehensive diagnostic and treatment plan evaluation within 30 days of the positive PTSD screen and provide feedback to clinic providers on the results. Quarterly reports will be reviewed by the Medical Records Committee. A target compliance rate of 90% has been established.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Jennifer Reed, RN, MSHI, Team Leader Jolynette Spearman, RN
Other Contributors	Judy Brown, Management and Program Analyst Shirley Carlile, BA Sheila Cooley, GNP, MSN Lin Clegg, PhD Marnette Dhooghe, MS Wachita Haywood, RN Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, RN, MSN Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Acting Director, VA Southwest Health Care Network (10N18)
Acting Director, Northern Arizona VA Health Care System (649/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jeff Flake, John McCain
U.S. House of Representatives: Trent Franks, Ruben Gallego, Paul A. Gosar, Raul Grijalva, Ann Kirkpatrick, Martha McSally, Matt Salmon, David Schweikert, Kyrsten Sinema

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, 2015.
- National Fire Protection Association (NFPA), *NFPA 10: Installation of Portable Fire Extinguishers,* 2013.
- National Fire Protection Association (NFPA), *NFPA 101: Life Safety Code,* 2015.
- 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.
- US Department of Labor, Occupational Safety and Health Administration (OSHA), *Regulations (Standards – 29 CFR), 1910 General Industry Standards, 1030 Bloodborne Pathogens,* April 3, 2012.
- 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.