



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 16-00103-160

**Combined Assessment Program
Review of the
VA Manila Outpatient Clinic
Manila, Philippines**

March 9, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

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Glossary

CAP	Combined Assessment Program
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	VA Manila Outpatient Clinic
FY	fiscal year
HIV	human immunodeficiency virus
lab	laboratory
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care. We conducted the review the week of January 25, 2016.

Review Results: The review covered 10 activities. We made no recommendations in the following five activities:

- Continuity of Care
- Outpatient Laboratory Results Management
- Human Immunodeficiency Virus Screening
- Post-Traumatic Stress Disorder Screening
- Management of Workplace Violence

The facility's reported accomplishments were continuity of care, the Veterans Advocacy Committee, the Going Green initiative, improved facility access, and electronic access to information and services.

Recommendations: We made recommendations in the following five activities:

Quality, Safety, and Value: Consistently review Ongoing Professional Practice Evaluation data every 6 months.

Environment of Care: Ensure Infection Control Committee meeting minutes consistently reflect discussion of identified high-risk areas and include actions to address those areas.

Medication Management – Controlled Substances Inspection Program: Complete drug destructions at least quarterly.

Suicide Prevention Program: Consistently document that patients are at high risk prior to placing flags in the electronic health records. Include in Suicide Prevention Safety Plans the contact numbers of family or friends for support.

Alcohol Use Disorder Care: Provide education and counseling about adverse consequences of heavy drinking to patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism guidelines.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes B and C, pages 23–27, 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

Objective and Scope

Objective

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following 10 activities:

- QSV
- EOC
- Medication Management – CS Inspection Program
- Continuity of Care
- Outpatient Lab Results Management
- HIV Screening
- Suicide Prevention Program
- PTSD Screening
- Alcohol Use Disorder Care
- Management of Workplace Violence

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2015 and FY 2016 through January 29, 2016, and inspectors conducted the review in accordance with OIG

standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Manila Outpatient Clinic, Manila, Philippines*, Report No. 13-00894-216, June 18, 2013).

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 57 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

Continuity of Care

Collaboration and partnership between community providers and facility employees has improved continuity of care for veterans and timely payment of services provided. The facility is a standalone clinic in the Philippines with no inpatient care beds. To ensure continuity of care for veterans, the facility coordinates inpatient care services with non-VA community providers throughout the country. It outsources any services not available at the facility. For oversight, a facility nurse conducts telephone rounds to monitor the treatment and management of all inpatient admissions throughout the country. Facility employees scan all medical reports from community providers into veterans' EHRs. Once information is scanned, employees complete a note in the EHR describing the scanned reports and alerting the appropriate physician for medical review and determination of future care. The facility also automated the billing process resulting in timely payments to community providers.

Veterans Advocacy Committee

The facility created the Veterans Advocacy Committee as a forum for veterans throughout the country to discuss plans and make recommendations to facility leadership for the purpose of creating a VA facility that represents veterans' viewpoints. The Veterans Advocacy Committee recommends changes and improvements to the physical environment, interpretation of authorities affecting operations and benefits, outreach efforts, and other operational functions within the VA Manila Regional Office and Outpatient Clinic. The committee is chaired by a Veterans Service Office representative, and members include post commanders from several Veterans Service Organizations—Veterans of Foreign Wars, the American Legion, Vietnam Veterans, and Retired Activities Offices.

Going Green Initiative

In FY 2014, the facility began converting all internal and external correspondence to paperless processing, using digital signatures as a secure method to document verification while reducing overall printer maintenance and paper costs. Additionally, documents are now stored electronically, which further reduces the amount of paper stored in filing cabinets, freeing up much needed usable workspace.

- More than 30,000 pounds of paper have been pulped and recycled.
- A total of 60 high density cabinets have been removed, creating 2,269 square feet of additional workspace.

Veteran Access and Experience

Prior to FY 2015, an appointment was necessary for veterans to access the facility. In order to improve veterans' experiences, facility leaders implemented an open access where veterans without an appointment can come to the facility on a walk-in basis. In FY 2015, the facility reported 1,000 walk-ins for benefits and 380 walk-ins for medical care per month. While at the facility, veterans have free access to wireless internet in waiting areas.

Veterans' Automated Access to Information and Services—*MyHealthVet*

The facility discontinued mailing appointment letters 2 years ago. As part of the check-out procedure for medical care, veterans were enrolled in and provided training on how to access *MyHealthVet* through the internet before they left the facility. The facility reported having the highest rate in VISN 21 for authenticated primary care patients. Eighty-one percent of enrolled primary care patients in the Philippines can view their VA records and future appointments online and communicate directly with their providers. Enrollment in *MyHealthVet* has also reduced the number of Release of Information requests. Additionally, the facility subscribed to "*Text Connect*," which allows staff to send text messages to veterans' cell phones regarding upcoming appointments, instructions to call the facility, or facility closures due to bad weather events.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.^a

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 27 licensed independent practitioners' profiles, 5 protected peer reviews, and other relevant documents. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. <ul style="list-style-type: none"> • The committee routinely reviewed aggregated data. 		
X	Credentialing and privileging processes met selected requirements: <ul style="list-style-type: none"> • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired. 	<ul style="list-style-type: none"> • Twenty-six profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months. 	<ol style="list-style-type: none"> 1. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	<p>Protected peer reviews met selected requirements:</p> <ul style="list-style-type: none"> • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions. 		
NA	<p>Utilization management met selected requirements:</p> <ul style="list-style-type: none"> • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data. 		
	<p>Patient safety met selected requirements:</p> <ul style="list-style-type: none"> • The Patient Safety Manager entered all reported patient incidents into the WEBSPOt database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders. 		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.^b

We inspected all clinical areas. Additionally, we reviewed relevant documents and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
X	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.	Four sets of Infection Control Committee meeting minutes reviewed: <ul style="list-style-type: none"> • Minutes did not consistently include discussion of the facility’s high-risk areas and implementation of actions to address those areas. 	2. We recommended that Infection Control Committee meeting minutes consistently reflect discussion of identified high-risk areas and include actions to address those areas.
	The facility had established a process for cleaning equipment between patients.		
NA	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
NA	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
NA	Dental clinic employees received hazard communication training on chemical classification, labeling, and Safety Data Sheets.		
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
NA	The facility tested dental water lines in accordance with local policy.		
NA	The facility met environmental safety and infection prevention requirements in the dental clinic.		
NA	The facility met laser safety requirements in the dental clinic.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

NM	Areas Reviewed for the OR	Findings	Recommendations
NA	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
NA	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
NA	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
NA	The facility monitored OR temperature, humidity, and positive pressure.		
NA	The facility met fire safety requirements in the OR.		
NA	The facility met environmental safety requirements in the OR.		
NA	The facility met infection prevention requirements in the OR.		
NA	The facility met medication safety and security requirements in the OR.		
NA	The facility met laser safety requirements in the OR.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management – CS Inspection Program

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.^c

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of two CS Coordinators and four CS inspectors and inspection documentation from the outpatient pharmacy. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy was consistent with VHA requirements.		
NA	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and the facility corrected any identified deficiencies.		
NA	The facility had documented instructions for inspecting automated dispensing machines that included all required elements, and CS inspectors followed the instructions.		
	The CS Coordinator provided monthly CS inspection findings summaries and quarterly trend reports to the Facility Director.		
	The CS Coordinator position description or functional statement included CS oversight duties, and the CS Coordinator completed required certification and was free from conflicts of interest.		
	The Facility Director appointed CS inspectors in writing, and inspectors were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	CS inspectors inspected non-pharmacy areas with CS in accordance with VHA requirements, and inspections included all required elements.		
X	CS inspectors conducted pharmacy CS inspections in accordance with VHA requirements, and inspections included all required elements.	Documentation of pharmacy CS inspections conducted during the past 12 months reviewed: <ul style="list-style-type: none"> • The facility did not consistently complete drug destructions at least quarterly. 	3. We recommended that facility managers ensure completion of drug destructions at least quarterly.
	The facility complied with any additional elements required by VHA or local policy.		

Continuity of Care

The purpose of this review was to evaluate whether clinical information from patients’ community hospitalizations at VA expense was scanned and available to facility providers and whether providers documented acknowledgement of it.^d

We reviewed relevant documents and the EHRs of 25 patients who had been hospitalized at VA expense in the local community October 1, 2014–September 30, 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Clinical information was consistently available to the primary care team for the clinic visit subsequent to the non-VA hospitalization.		
	Members of the patients’ primary care teams documented that they were aware of the patients’ non-VA hospitalization.		
	The facility complied with any additional elements required by VHA or local policy.		

Outpatient Lab Results Management

The purpose of this review was to determine whether the facility complied with VHA requirements for patient notification and follow-up of selected outpatient lab results.^e

We reviewed relevant documents and the EHRs of 50 patients who had at least 3 outpatient encounters during the period October 1, 2014–September 30, 2015. We also validated findings with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a written policy regarding communication of lab results from diagnostic practitioners to ordering practitioners.		
	The facility had a written policy for the communication of lab results that included all required elements.		
	Clinicians notified patients of their lab results.		
	Clinicians documented in the EHR all attempts to communicate with the patients regarding their lab results.		
	Clinicians provided interventions for clinically significant abnormal lab results.		
	The facility complied with any additional elements required by VHA or local policy.		

HIV Screening

The purpose of this review was to determine whether the facility complied with selected VHA requirements for HIV screening.^f

We reviewed the facility’s self-assessment, VHA and local policies, and guidelines to assess administrative controls over the HIV screening process. We also reviewed the EHRs of 46 patients who had at least 1 clinic visit during the period October 1, 2014–September 30, 2015, and validated findings with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a Lead HIV Clinician to carry out responsibilities.		
	The facility had policies and procedures to facilitate HIV testing.		
	The facility had developed policies and procedures that include requirements for the communication of HIV test results.		
	Written patient educational materials used prior to or at the time of consent for HIV testing include all required elements.		
	Clinicians provided HIV testing as part of patients’ routine medical care.		
	When HIV testing occurred, clinicians consistently documented informed consent.		
	The facility complied with any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility’s MH providers consistently complied with selected suicide prevention program requirements.⁹

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 16 patients assessed to be at risk for suicide during the period October 1, 2013–November 30, 2015. We also reviewed the training records of 10 new employees. 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.

NM	Areas Reviewed	Findings	Recommendations
NA	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
	The facility provided training within required timeframes: <ul style="list-style-type: none"> • Suicide prevention training to new employees • Suicide risk management training to new clinical employees 		
NA	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
NA	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	<p>Clinicians appropriately placed Patient Record Flags:</p> <ul style="list-style-type: none"> • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags. 	<ul style="list-style-type: none"> • In 13 EHRs, clinicians had not documented that patients were high risk prior to placing flags in the EHRs. 	<p>4. We recommended that clinicians consistently document that patients are at high risk prior to placing flags in the electronic health records and that facility managers monitor compliance.</p>
X	<p>Clinicians documented Suicide Prevention Safety Plans that contained the following required elements:</p> <ul style="list-style-type: none"> • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe 	<ul style="list-style-type: none"> • Twelve safety plans lacked documentation of the identification of contact numbers of family or friends for support. 	<p>5. We recommended that clinicians include the identification of contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.</p>
	<p>Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.</p>		
	<p>The treatment team evaluated patients as follows:</p> <ul style="list-style-type: none"> • At least four times during the first 30 days after discharge • Every 90 days to review Patient Record Flags 		
	<p>The facility complied with any additional elements required by VHA or local policy.</p>		

PTSD Screening

The purpose of this review was to assess whether the facility complied with selected VHA requirements for PTSD follow-up in the outpatient setting.^h

We reviewed relevant documents and the EHRs of 50 patients who had a positive PTSD screen during the period October 1, 2014–September 30, 2015. We also validated findings with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Each patient with a positive PTSD screen received a suicide risk assessment.		
	Acceptable providers completed suicide risk assessments for patients with positive PTSD screens.		
	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.		
	When applicable, patients received MH treatment.		
	The facility complied with any additional elements required by VHA or local policy.		

Alcohol Use Disorder Care

The purpose of this review was to determine whether the facility complied with selected alcohol use screening and treatment requirements.ⁱ

We reviewed relevant documents and the EHRs of 50 patients who had a positive Alcohol Use Disorders Identification Test (AUDIT-C) score during the period October 1, 2014–September 30, 2015. We also validated findings with key managers and employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Patients with a positive alcohol screen had diagnostic assessments completed.		
X	Facility employees provided education and counseling about drinking levels and adverse consequences of heavy drinking to patients with positive alcohol screens and drinking levels above National Institute on Alcohol Abuse and Alcoholism guidelines.	<ul style="list-style-type: none"> For 4 of the 23 applicable patients, employees did not provide education and counseling about adverse consequences of heavy drinking. 	<p>6. We recommended that facility employees provide education and counseling about adverse consequences of heavy drinking to patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism guidelines.</p>
	Documentation reflected the offer of further treatment for patients diagnosed with alcohol dependence.		
	For patients with alcohol use disorder who declined referral to specialty care, facility employees monitored them and their alcohol use.		
	Counseling, education, and brief treatments for alcohol use disorder were provided within 2 weeks of positive screening.		
NA	Outpatient clinic registered nurse care managers received motivational interviewing training within 12 months of appointment to a Patient Aligned Care Team.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	Outpatient clinic registered nurse care managers, providers, and clinical associates received VHA National Center for Health Promotion and Disease Prevention-approved health coaching training (most likely TEACH for Success) within 12 months of appointment to a Patient Aligned Care Team.		
	The facility complied with any additional elements required by VHA or local policy.		

Management of Workplace Violence

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of workplace violence.^j

We reviewed relevant documents, 3 Reports of Contact from disruptive patient/employee/other (visitor) incidents that occurred during the 12-month period October 1, 2014–September 30, 2015, and 15 training records of employees who worked in areas at low, moderate, or high risk for violence. Additionally, we conversed with key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing workplace violence.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
	The facility had implemented: <ul style="list-style-type: none"> • An Employee Threat Assessment Team • A Disruptive Behavior Committee/Board • A disruptive behavior reporting and tracking system. 		
	The facility used and tested appropriate physical security precautions and equipment in accordance with the local risk assessment.		
	The facility had an employee security training plan that either used the mandated prevention and management of disruptive behavior training or an alternative that addressed the issues of awareness, preparedness, precautions, and police assistance. <ul style="list-style-type: none"> • Employees received the required training. 		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility managed selected incidents appropriately according to its policy.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Manila/358) FY 2016 through December 2015	
Type of Organization	Outpatient clinic
Complexity Level	NA
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	\$4.6
Number of:	
• Unique Patients	2,956
• Outpatient Visits	3,980
• Unique Employees¹	71
Type and Number of Operating Beds:	
• Hospital	0
• Community Living Center	0
• MH	0
Average Daily Census:	
• Hospital	NA
• Community Living Center	NA
• MH	NA
Number of Community Based Outpatient Clinics	0
Location(s)/Station Number(s)	NA
VISN Number	21

¹ Unique employees involved in direct medical care (cost center 8200).

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 26, 2016

From: Director, Sierra Pacific Network (10N21)

Subject: **CAP Review of the VA Manila Outpatient Clinic, Manila, PI**

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

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

1. Thank you for the opportunity to review the draft report from the Manila OPC OIG site visit. The clinic has already established their corrective actions and will ensure ongoing monitoring.
2. If you have any questions regarding this plan, please contact Terry Sanders, Associate Quality Manager for VISN 21 at (707) 562-8350.



Sheila M. Cullen

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: February 26, 2016

From: Director, VA Regional Office and Outpatient Clinic, Manila Philippines

Subject: Inspection of the VA Manila Outpatient Clinic

To: Director, VAOIG Office of Healthcare Inspections

1. The VA Manila Outpatient Clinic concurs with the recommendations made on the OIG Draft Report: Combined Assessment Program Review of the VA Manila Outpatient Clinic in the Philippines.
2. The Outpatient clinic has completed action plans and implemented the plan for each recommendation.
3. Please refer questions to Vicki Randall, Clinic Manager, VA Manila Outpatient Clinic at (632) 318-8335.



RimaAnn O. Nelson

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 facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: Completed and Ongoing

Facility response: Medical chart reviews and collection of data for the provider profile will be conducted every quarter and rolled up every six months for review by the CMO and provider. The QA Manager will monitor the schedule of the bi-annual Ongoing Professional Practice Evaluations and updates will be reported to the Medical Executive Board (MEB).

Recommendation 2. We recommended that Infection Control Committee meeting minutes consistently reflect discussion of identified high-risk areas and include actions to address those areas.

Concur

Target date for completion: April 1, 2016

Facility response: On March 3, 2016, training will be held via live meeting regarding Infection Control Risk Assessment which will be conducted by the Infection Control Nurse from Palo Alto to all Nurses, Senior Medical Technologist, Chief of Pharmacy, Clinical Pathologist, Chief Medical Officer, and Physician Leads for Primary Care, Compensation and Pension and Specialty Care. Immediately following the March 3rd training, a high risk assessment will be completed. Leads will train their staff and minutes will be maintained for each training session. Infection Control and other designated staff will collaborate and complete the Infection Control Risk Assessment tool and report the results to the Clinical Operations Committee (COC). Discussion of identified high-risk areas and actions to address those areas will be tracked until completion in the Clinical Operations Committee (COC) meeting minutes.

Recommendation 3. We recommended that facility managers ensure completion of drug destructions at least quarterly.

Concur

Target date for completion: Completed

Facility response: On February 18, 2016, Pharmacy chief witnessed destruction of returned/expired controlled and non-controlled medications. A temporary certificate of treatment was issued by the Vendor pending the final Certificate with the stamp from the Department of Environmental and National Resources. Pharmacy standard operating procedure has been revised regarding disposal of expired/returned medications for both controlled and non-controlled medication to include:

1. Disposal of expired and turned-in drugs is performed the second month of each quarter no matter the amount.
2. A certificate of treatment from the Vendor along with a Destroyed Controlled Substance Report will be reported to the Clinical Operations Committee quarterly.

Recommendation 4. We recommended that clinicians consistently document that patients are at high risk prior to placing flags in the electronic health records and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: Flags for high risk Veterans will only be placed when they have been assessed in person or over the telephone. The suicide prevention (SP) team developed a local "Suicide Risk Assessment 2016" template to standardize assessment needs for patients high risk for suicide.

This template will be utilized for all cases categorized as high risk. Monitoring of the template and flags will be accomplished by the suicide prevention coordinator (SPC) who will run the VistA Patient Record Flag (PRF) report monthly. Local policy has been revised to reflect this change of process. A consolidated report will be submitted and discussed quarterly during the Clinical Operations Committee (COC) meeting.

Recommendation 5. We recommended that clinicians include the identification of contact numbers of family or friends for support in Suicide Prevention Safety Plans and that facility managers monitor compliance.

Concur

Target date for completion: July 1, 2016

Facility response: The clinicians were educated on the need to ensure contact numbers are contained in the Safety plan. The suicide prevention coordinator (SPC) will be a co-signer of the Suicide Safety Plan and will report compliance to the clinic manager and will discuss compliance quarterly during the Clinical Operations Committee (COC) meeting.

Recommendation 6. We recommended that facility staff provide education and counseling about adverse consequences of heavy drinking to patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism guidelines.

Concur

Target date for completion: July 1, 2016

Facility response: Audit C reminder has a field that contains a review of the medical problems associated with alcohol which is completed when the patient drinks more than the acceptable limits. Providers were re-educated on the need to complete this portion when accomplishing their assessment. The Clinical Administrative Coordinator (CAC) is working with VISN 21 Informatics to revise the VA-prefixed dialogs in the template to make it a required field before it can be closed.

To monitor compliance Quality Assurance Office will conduct a monthly chart review and results will be reported and discussed monthly in the Medical Executive Board (MEB) and quarterly in the Clinical Operations Committee (COC) meeting.

Office of Inspector General Contact and Staff Acknowledgments

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Endnotes

^a The references used for this topic were:

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- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
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^b The references used for this topic included:

- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

^c The references used for this topic included:

- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
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- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013.

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- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Various requirements of the Joint Commission.

^e The references used for this topic included:

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^f The references used for this topic included:

- VHA Directive 2008-082, *National HIV Program*, December 5, 2008.
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- VHA Directive 2009-036, *Testing for Human Immunodeficiency Virus in Veterans Health Administration Facilities*, August 14, 2009.
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- Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, “VAIQ # 741734 – Documentation of Oral Consent for Human Immunodeficiency Virus (HIV) Testing,” January 10, 2014.

^g The references used for this topic included:

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^h The references used for this topic included:

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- 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.

ⁱ The references used for this topic included:

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- VHA Directive 2009-008 (also listed as 2010-008), *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.
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