Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-05154-271

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Sheridan VA Healthcare System Sheridan, Wyoming

April 21, 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

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	primary care
PTSD	post-traumatic stress disorder
VHA	Veterans Health Administration

Table of Contents

	Page
Executive Summary	i
Objectives, Scope, and Methodology	1
Objectives	1
Scope	1
Methodology	2
Results and Recommendations	3
EOC	3
HT Enrollment	8
Outpatient Lab Results Management	9
PTSD Care	10
Appendixes	
A. Clinic Profiles	11
B. Patient Aligned Care Team Compass Metrics	12
C. Veterans Integrated Service Network Director Comments	16
D. Facility Director Comments	17
E. Office of Inspector General Contact and Staff Acknowledgments	22
F. Report Distribution	23
G. Endnotes	24

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 Sheridan VA Healthcare System and Veterans Integrated Service Network 19 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 Afton CBOC, Afton, WY, as a representative site and evaluated the environment of care on March 9, 2016.

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

Environment of Care: Ensure that:

- Employees receive annual training on the Exposure Control Plan for Bloodborne Pathogens.
- A policy/procedure is in place for the identification of individuals entering the Afton CBOC.
- Employees receive the required hazardous communications training.
- A policy/procedure is in place for the cleaning and disinfection of telehealth equipment at the Afton CBOC.

Home Telehealth Enrollment: Ensure that:

- Clinicians document assessments and treatment plans for Home Telehealth patients.
- 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 the timeframe required by VHA.
- Clinicians consistently document in the electronic health record all attempts to communicate with the patients regarding their laboratory results.

Post-Traumatic Stress Disorder Care: Ensure that:

- Acceptable providers document plans of care and disposition for patients with positive PTSD screens.
- Further diagnostic evaluations are offered to patients with positive PTSD screens.
- Providers complete diagnostic evaluations for patients with positive PTSD screens.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Community Based Outpatient Clinic and other outpatient clinic review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 16–21, 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 health 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 Afton CBOC. 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			
	Managers monitored clinic staff's hand hygiene compliance.		
X	Clinic managers provided training for employees on the Exposure Control Plan for Bloodborne Pathogens within the past 12 months for those newly hired and annually for others.	At the Afton CBOC, one of five employees did not receive training on the Exposure Control Plan for Bloodborne Pathogens within the past 12 months.	**1.** We recommended that employees at the Afton CBOC receive annual training on the Exposure Control Plan for Bloodborne Pathogens.
	The clinic had a policy/procedure for life safety elements.		
	The clinic had a policy for the management of clinical emergencies.		
	The clinic had a policy for the management of mental health emergencies.		
	The clinic had a documented Hazard Vulnerability Assessment to identify potential emergencies.		
	The Hazard Vulnerability Assessment was reviewed annually.		
	The clinic had a policy that requires staff to receive regular information on their responsibilities in emergency response operations.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinic staff participated in regular emergency management training and exercises.		
	The clinic conducted fire drills at least once every 12 months for the past 24 months with documented critiques of the drills.		
X	The clinic had a policy/procedure for the identification of individuals entering the clinic.	The clinic had no policy/procedure for the identification of individuals entering the Afton CBOC.	**2.** We recommended that the Facility Director ensures that a policy/procedure is in place for the identification of individuals entering the Afton CBOC.
	The clinic had a Workplace Behavioral Risk Assessment in place.		
	The alarm system or panic buttons in high-risk areas were tested during the past 12 months.		
	The clinic had written procedures to follow in the event of a security incident.		
X	Clinic employees received training on the new chemical label elements and safety data sheet format.	One of five clinic employees had not received any hazardous communications training on the new chemical label elements and safety data sheet format.	**3.** We recommended that the clinic manager ensures that Afton CBOC employees receive the required hazardous communications training.
X	The clinic had a policy/procedure for the cleaning and disinfection of telehealth equipment.	There was no policy/procedure for the cleaning and disinfection of telehealth equipment at the Afton CBOC.	**4.** We recommended that the Facility Director ensures there is a policy/procedure for the cleaning and disinfection of telehealth equipment at the Afton CBOC.
Physical Inspection			
	The clinic was clean.		
	The furnishings and equipment were safe and in good repair.		
	Hand hygiene facilities and product dispensers were working and readily accessible to employees.		
	Personal protective equipment was available.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Sharps containers were closable, easily accessible, and not overfilled.		
	Clinic staff did not store food and drinks in refrigerators or freezers or on countertops or other areas where there is blood or other potentially infectious materials.		
	Sterile commercial supplies were not expired.		
	The clinic minimized the risk of infection when storing and disposing of medical waste.		
	The clinic had unobstructed access to fire alarms/pull stations.		
	The clinic had unobstructed access to fire extinguishers.		
NA	For fire extinguishers located in large rooms or are obscured from view, the clinic identified the locations of the fire extinguishers with signs.		
	The exit signs were visible from every direction.		
	Exit routes from the building were unobstructed.		
	Staff wore VA-issued identification badges.		
	The clinic controlled access to and from areas identified as security sensitive.		
	The clinic had an alarm system or panic buttons installed in high-risk areas.		
	The clinic's inventory of hazardous materials was reviewed for accuracy twice within the prior 12 months.		
	The clinic's safety data sheets for chemicals were readily available for the staff.		
	The clinic provided visual and auditory privacy for veterans at check-in.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The clinic provided visual and auditory privacy for patients in the interview areas.		
	Examination room doors were equipped with either an electronic or manual lock.		
	A privacy sign was available for use to indicate that a telehealth visit was in progress.		
	Documents containing patient-identifiable information were not visible or unsecured.		
	Clinic staff locked computer screens when they were not in use.		
	Information was not viewable on monitors in public areas.		
	Window coverings, if present, provided privacy.		
	Clinic staff protected patient-identifiable information to maintain patient privacy on laboratory specimens during transport.		
	The clinic had examination room(s) for women veterans which were located in a space where they did not open into a public waiting room or a high-traffic public corridor.		
	The clinic provided adequate privacy for women veterans in the examination rooms.		
	The clinic provided feminine hygiene products in examination rooms where pelvic examinations were performed or in bathrooms within close proximity.		
	Women's public restrooms had feminine hygiene products and disposal bins available for use.		
	Multi-dose medication vials were not expired.		
	All medications were secured from unauthorized access.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The information technology network room/server closet was secured/locked.		
	Access to the information technology network room/server closet was 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 was 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 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 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.		
X	Clinicians documented assessments and treatment plans for HT patients.	Clinicians did not document assessments and treatment plans for 11 of 50 patients (22 percent).	**5.** We recommended that clinicians document assessments and treatment plans for Home Telehealth patients.
X	Providers signed HT assessments and treatment plans.	Providers did not sign any of the 39 patients' HT assessments and treatment plans (100 percent).	**6.** 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 32 of 39 EHRs (82 percent).	**7.** 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 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 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 13 of 47 patients (28 percent) of their lab results within 14 days as required by VHA.	**8.** We recommended that clinicians consistently notify patients of their laboratory results within the timeframe required by VHA.
X	Clinicians documented in the EHR all attempts to communicate with the patients regarding their lab results.	Clinicians did not document all communication attempts for any of the 10 patients who could not be contacted regarding their results.	**9.** We recommended that clinicians consistently document in the electronic health record all attempts to communicate with the patients regarding their laboratory 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
	Each patient with a positive PTSD screen received a suicide risk assessment.		
	Suicide risk assessments for patients with positive PTSD screens are completed by acceptable providers.		
X	Acceptable providers established plans of care and disposition for patients with positive PTSD screens.	Acceptable providers did not establish plans of care and disposition when indicated in 4 of 38 EHRs (11 percent) reviewed.	**10.** We recommended that acceptable providers document 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 5 of 38 EHRs (13 percent).	**11.** 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 evaluations in 5 of 38 EHRs (13 percent).	**12.** We recommended that providers complete diagnostic evaluations for patients with positive PTSD screens.
	Patients, when applicable, received mental health treatment.		

Clinic Profiles

This 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 services provided at each location.

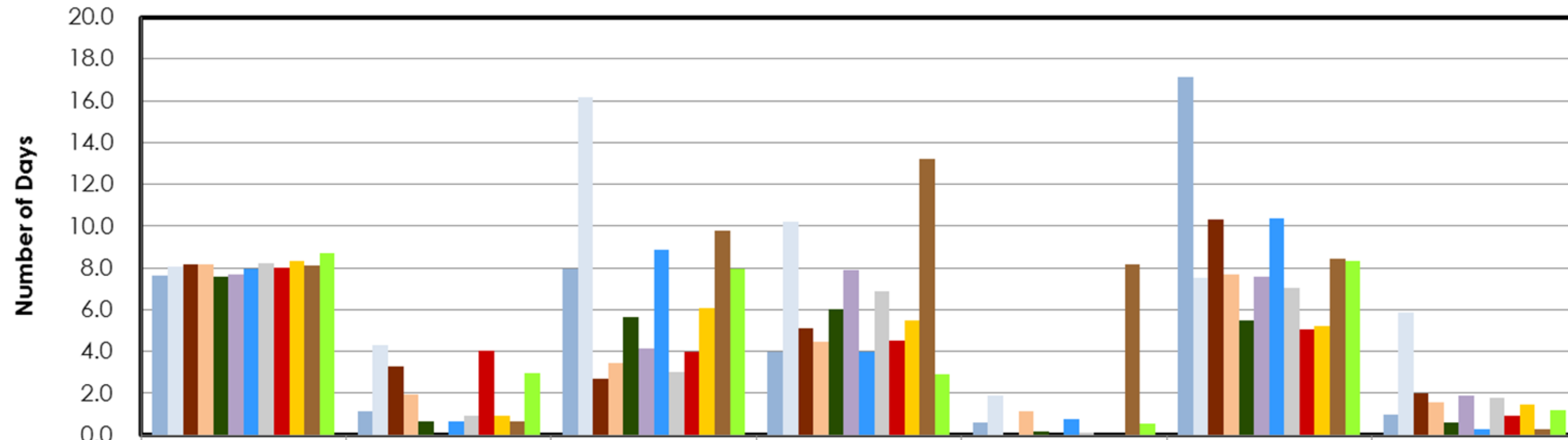
				Outpatient Workload / Encounters[3]			Services Provided[4]	
Location	**Station #**	**Rurality[5]**	**Outpatient Classification[6]**	**PC**	**Mental Health**	**Specialty Clinics[7]**	**Specialty Care[8]**	**Ancillary Services[9]**
Casper, WY	666GB	Urban	Primary Care CBOC	5,644	2,656	648	Cardiology Podiatry	Electrocardiography Pharmacy Respiratory Therapy Social work
Riverton, WY	666GC	Rural	Primary Care CBOC	5,362	2,037	242	Surgery	Electrocardiography Respiratory Therapy Social work
Powell, WY	666GD	Rural	Primary Care CBOC	2,992	891	111	NA	Respiratory Therapy
Gillette, WY	666GE	Rural	Primary Care CBOC	3,536	1,162	492	Podiatry	Electrocardiography Respiratory Therapy Social work
Rock Springs, WY	666GF	Rural	Primary Care CBOC	3,510	1,735	75	NA	Respiratory Therapy Social work

---

[2] Includes all CBOCs in operation before August 15, 2015. We have omitted 666QA (Afton), 666QB (Evanston), and 666QC (Worland), 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.

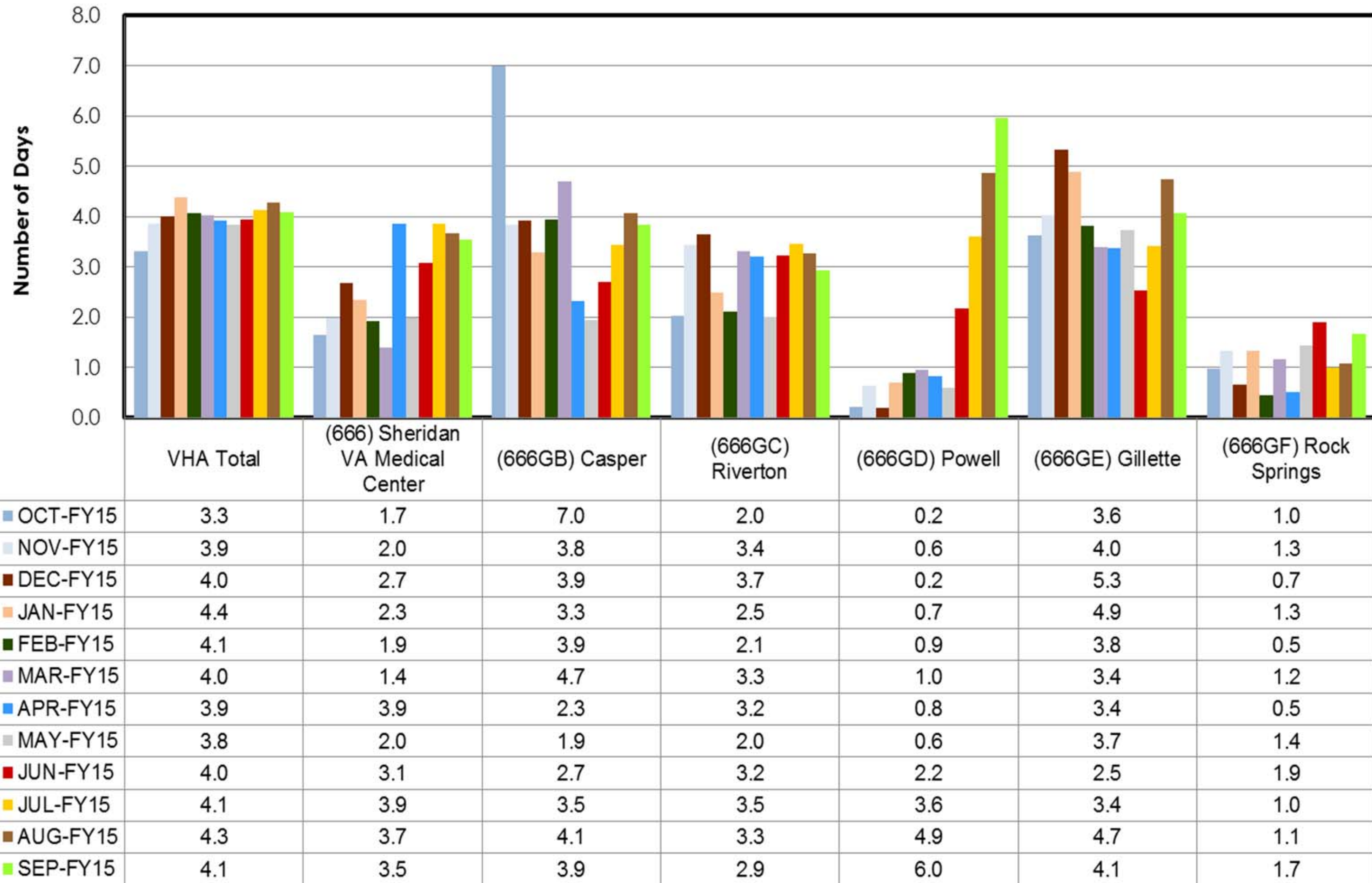
Patient Aligned Care Team Compass Metrics

FY 2015 New PC Patient Average Wait Time in Days



	VHA Total	(666) Sheridan VA Medical Center	(666GB) Casper	(666GC) Riverton	(666GD) Powell	(666GE) Gillette	(666GF) Rock Springs
OCT-FY15	7.6	1.1	8.0	4.0	0.6	17.2	1.0
NOV-FY15	8.1	4.3	16.1	10.2	1.9	7.5	5.9
DEC-FY15	8.1	3.3	2.7	5.1	0.0	10.3	2.0
JAN-FY15	8.2	1.9	3.4	4.5	1.1	7.7	1.6
FEB-FY15	7.6	0.6	5.6	6.0	0.2	5.5	0.6
MAR-FY15	7.7	0.0	4.2	7.9	0.0	7.6	1.9
APR-FY15	7.9	0.6	8.9	4.0	0.8	10.4	0.3
MAY-FY15	8.2	0.9	3.0	6.9	0.1	7.1	1.8
JUN-FY15	8.0	4.1	4.0	4.5	0.0	5.1	0.9
JUL-FY15	8.3	0.9	6.1	5.5	0.0	5.2	1.4
AUG-FY15	8.1	0.6	9.8	13.2	8.2	8.4	0.3
SEP-FY15	8.7	3.0	8.0	2.9	0.6	8.3	1.2

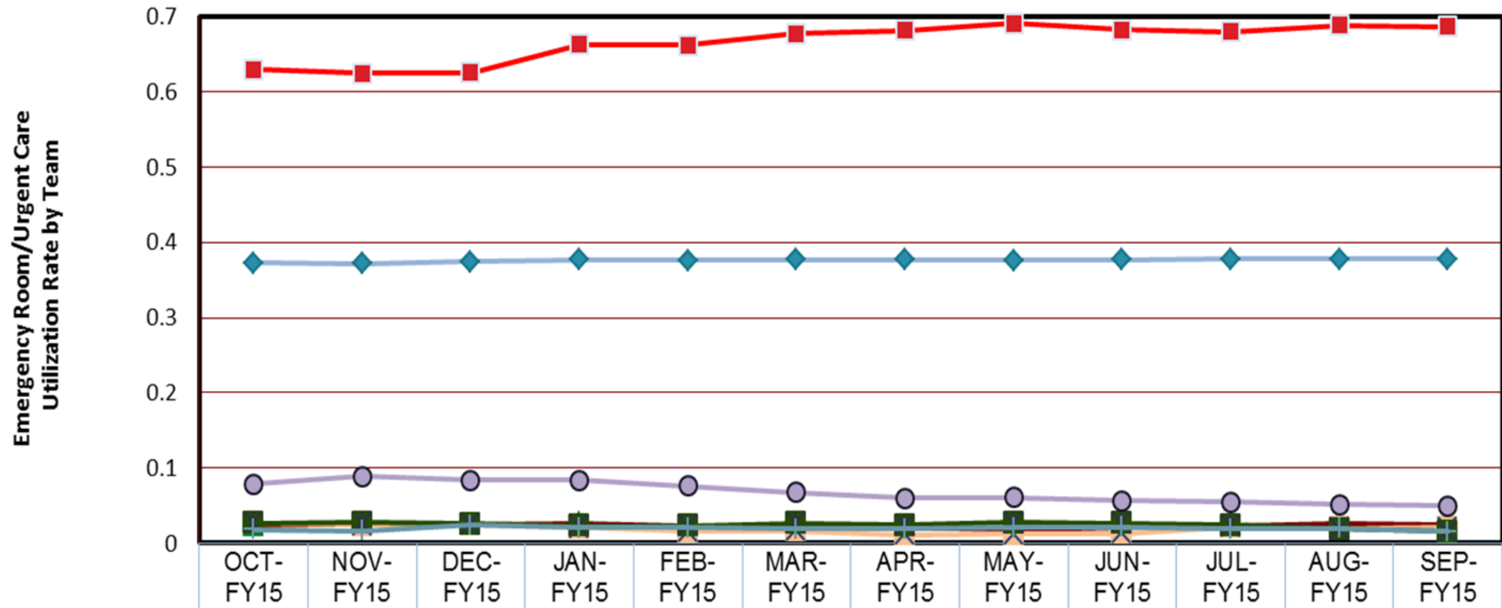
Data Definition.[e] The average number of calendar days between a New Patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment,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



	VHA Total	(666) Sheridan VA Medical Center	(666GB) Casper	(666GC) Riverton	(666GD) Powell	(666GE) Gillette	(666GF) Rock Springs
OCT-FY15	3.3	1.7	7.0	2.0	0.2	3.6	1.0
NOV-FY15	3.9	2.0	3.8	3.4	0.6	4.0	1.3
DEC-FY15	4.0	2.7	3.9	3.7	0.2	5.3	0.7
JAN-FY15	4.4	2.3	3.3	2.5	0.7	4.9	1.3
FEB-FY15	4.1	1.9	3.9	2.1	0.9	3.8	0.5
MAR-FY15	4.0	1.4	4.7	3.3	1.0	3.4	1.2
APR-FY15	3.9	3.9	2.3	3.2	0.8	3.4	0.5
MAY-FY15	3.8	2.0	1.9	2.0	0.6	3.7	1.4
JUN-FY15	4.0	3.1	2.7	3.2	2.2	2.5	1.9
JUL-FY15	4.1	3.9	3.5	3.5	3.6	3.4	1.0
AUG-FY15	4.3	3.7	4.1	3.3	4.9	4.7	1.1
SEP-FY15	4.1	3.5	3.9	2.9	6.0	4.1	1.7

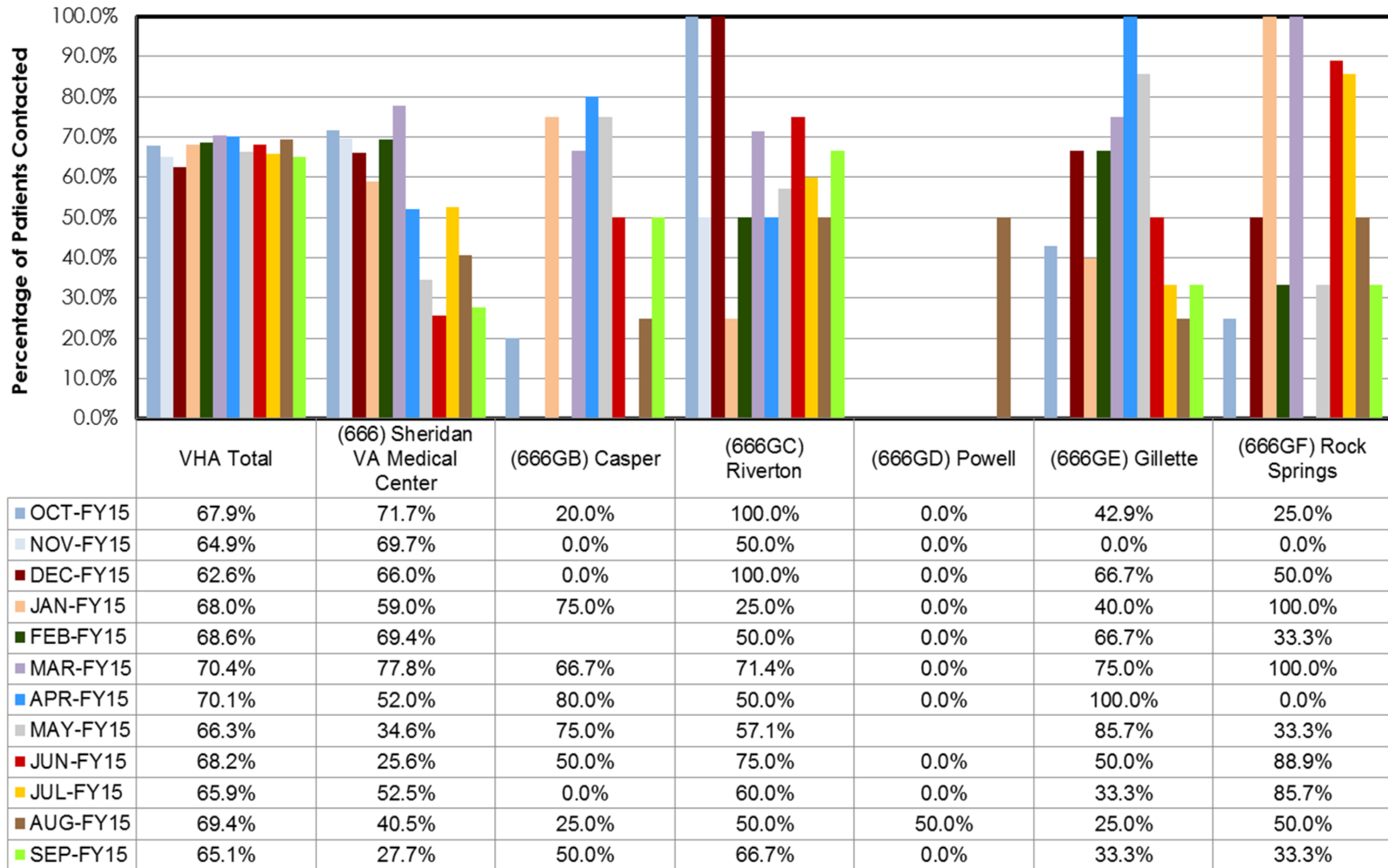
Data Definition.[e] The average number of calendar days between an Established Patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic 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
(666) Sheridan VA Medical Center	0.63	0.62	0.63	0.66	0.66	0.68	0.68	0.69	0.68	0.68	0.69	0.69
(666GB) Casper	0.02	0.03	0.02	0.03	0.02	0.02	0.02	0.02	0.02	0.02	0.03	0.02
(666GC) Riverton	0.03	0.02	0.03	0.02	0.02	0.02	0.01	0.01	0.01	0.02	0.02	0.02
(666GD) Powell	0.03	0.03	0.03	0.02	0.02	0.03	0.02	0.03	0.03	0.02	0.02	0.02
(666GE) Gillette	0.08	0.09	0.08	0.08	0.08	0.07	0.06	0.06	0.06	0.05	0.05	0.05
(666GF) Rock Springs	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02

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	(666) Sheridan VA Medical Center	(666GB) Casper	(666GC) Riverton	(666GD) Powell	(666GE) Gillette	(666GF) Rock Springs
OCT-FY15	67.9%	71.7%	20.0%	100.0%	0.0%	42.9%	25.0%
NOV-FY15	64.9%	69.7%	0.0%	50.0%	0.0%	0.0%	0.0%
DEC-FY15	62.6%	66.0%	0.0%	100.0%	0.0%	66.7%	50.0%
JAN-FY15	68.0%	59.0%	75.0%	25.0%	0.0%	40.0%	100.0%
FEB-FY15	68.6%	69.4%		50.0%	0.0%	66.7%	33.3%
MAR-FY15	70.4%	77.8%	66.7%	71.4%	0.0%	75.0%	100.0%
APR-FY15	70.1%	52.0%	80.0%	50.0%	0.0%	100.0%	0.0%
MAY-FY15	66.3%	34.6%	75.0%	57.1%		85.7%	33.3%
JUN-FY15	68.2%	25.6%	50.0%	75.0%	0.0%	50.0%	88.9%
JUL-FY15	65.9%	52.5%	0.0%	60.0%	0.0%	33.3%	85.7%
AUG-FY15	69.4%	40.5%	25.0%	50.0%	50.0%	25.0%	50.0%
SEP-FY15	65.1%	27.7%	50.0%	66.7%	0.0%	33.3%	33.3%

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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 30, 2016

From: Director, Rocky Mountain Network (10N19)

Subject: **Review of CBOCs and OOCs of Sheridan VA Healthcare System, Sheridan, WY**

To: Director, Seattle Office of Healthcare Inspections (54SE)

Director, Management Review Service (VHA 10E1D MRS OIG CAP CBOC)

1. I have reviewed the response from the Sheridan VA Healthcare System and concur with the response.

2. If you have any questions or concerns please contact Ruth Hammond, VISN 19, Quality Management Specialist, 303-639-7016.

Ralph T. Gigliotti, FACHE

Director, VA Rocky Mountain Network (10N19)

Appendix D

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 25, 2016

From: Director, Sheridan VA Healthcare System (666/00)

Subject: **Review of CBOCs and OOCs of Sheridan VA Healthcare System, Sheridan, WY**

To: Director, Rocky Mountain Network (10N19)

1. After reviewing this report, I concur with the identified findings.
2. The Sheridan VA Healthcare System developed and implemented the following action plans with designated anticipated completion dates.
3. If you have any questions or would like to discuss this response, please contact me at 307-675-3530.

Kathy W. Berger

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 employees at the Afton CBOC receive annual training on the Exposure Control Plan for Bloodborne Pathogens.

Concur

Target date for completion: 9/30/2016

Facility response: Training will be developed no later than 6/30/2016, provided for contract staff and performed on an annual basis to maintain >95% compliance. Compliance will be defined as number of employees with completed training over number of employees in order to obtain the percentage.

Recommendation 2. We recommended that the Facility Director ensures that a policy/procedure is in place for the identification of individuals entering the Afton CBOC.

Concur

Target date for completion: 9/30/2016

Facility response: Policy is being developed/updated for individuals entering CBOCs and will be completed no later than 6/30/2016. Training/Re-training will be provided no later than 9/30/2016. A >95% compliance will be defined as number of employees with completed training over number of employees in order to obtain the percentage.

Recommendation 3. We recommended that the clinic manager ensures that Afton CBOC employees receive the required hazardous communications training.

Concur

Target date for completion: 9/30/2016

Facility response: Training will be developed no later than 6/30/2016, provided for contract staff and performed on an annual basis to maintain >95% compliance. Compliance will be defined as number of employees with completed training over number of employees in order to obtain the percentage.

Recommendation 4. We recommended that the Facility Director ensures there is a policy/procedure for the cleaning and disinfection of telehealth equipment at the Afton CBOC.

Concur

Target date for completion: 9/30/2016

Facility response: Policy will be updated no later than 6/30/2016 to incorporate telehealth equipment in use in Clinics/CBOCs. All staff responsible for cleaning of Telehealth equipment will be educated and competency validated. A >90% compliance will be maintained and defined as number of staff with completed training over total number of staff to obtain the percentage.

Recommendation 5. We recommended that clinicians document assessments and treatment plans for Home Telehealth patients.

Concur

Target date for completion: 1/30/2017

Facility response: Clinicians will be educated on documenting assessments and treatment plans for HT patients no later than 6/30/2016. A random sample of 10 records monthly will be monitored for compliance. Monitoring will begin 8/1/2016 and continue until 6 concurrent months of 90% or greater of charts reviewed have achieved proper documentation.

Recommendation 6. We recommended that providers sign Home Telehealth assessments and treatment plans.

Concur

Target date for completion: 1/30/2017

Facility response: Providers will be educated for required signatures on HT assessments and treatment plans no later than 6/30/2016. A random sample of 10 records monthly will be monitored for compliance. Monitoring will begin 8/1/2016 and continue until 6 concurrent months of 90% or greater of charts reviewed have achieved proper signatures.

Recommendation 7. We recommended that clinicians document the Home Telehealth enrollment process prior to the entry of monthly monitoring notes.

Concur

Target date for completion: 1/30/2017

Facility response: Enrollment checklist was revised to ensure enrollment process is completed prior to entry of monthly monitoring notes. Providers will be educated on the enrollment process no later than 6/30/2016. A random sample of 10 records monthly will be monitored for compliance. Monitoring will begin 8/1/2016 and continue until 6 concurrent months of 90% or greater of charts reviewed have achieved proper documentation.

Recommendation 8. We recommended that clinicians consistently notify patients of their laboratory results within the timeframe required by VHA.

Concur

Target date for completion: 1/30/2017

Facility response: Clinicians will be educated on reporting lab results to patients no later than 6/30/2016. A random sample of 10 records monthly will be monitored for compliance. Monitoring will begin 8/1/2016 and continue until 6 concurrent months of 90% or greater of charts reviewed have achieved proper notification in the timeframe required by VHA.

Recommendation 9. We recommended that clinicians consistently document in the electronic health record all attempts to communicate with the patients regarding their laboratory results.

Concur

Target date for completion: 1/30/2017

Facility response: Clinicians will be educated on reporting lab results to patients no later than 6/30/2016. A random sample of 10 records monthly will be monitored for compliance. Monitoring will begin 8/1/2016 and continue until 6 concurrent months of 90% or greater of charts reviewed have documentation of attempts to communicate with the patients regarding their laboratory results.

Recommendation 10. We recommended that acceptable providers document plans of care and disposition for patients with positive PTSD screens.

Concur

Target date for completion: 1/30/2017

Facility response: Providers will be educated on the process for documenting plans of care and disposition for patients with positive PTSD screens no later than 6/30/2016. A random sample of 10 records monthly will be monitored for compliance. Monitoring will begin 8/1/2016 and continue until 6 concurrent months of 90% or greater of charts reviewed have acceptable providers document plans of care and disposition for patients.

Recommendation 11. We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.

Concur

Target date for completion: 1/30/2017

Facility response: Providers will be educated to offer further diagnostic evaluation to patients with positive PTSD screens no later than 6/30/2016. A random sample of 10 records monthly will be monitored for compliance. Monitoring will begin 8/1/2016 and continue until 6 concurrent months of 90% or greater of charts reviewed show further diagnostic evaluations are offered to patients with positive PTSD screens.

Recommendation 12. We recommended that providers complete diagnostic evaluations for patients with positive PTSD screens.

Concur

Target date for completion: 1/30/2017

Facility response: Providers will receive training to complete diagnostic evaluations of patients with positive PTSD screens no later than 6/30/2016. A random sample of 10 records monthly will be monitored for compliance. Monitoring will begin 8/1/2016 and continue until 6 concurrent months of 90% or greater of charts show providers complete diagnostic evaluations for patients with positive PTSD screens.

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	Carol Lukasewicz, RN, BSN, Team Leader Craig Byer, MS, RRA Mary Noel Rees, MPA Monika Spinks, RN, BSN Susan Tostenrude, MS
Other Contributors	Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Marc Lainhart, BS Jennifer Reed, RN, MSHI 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
Director, Rocky Mountain Network (10N19)
Director, Sheridan VA Healthcare System (666/00)

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: John Barrasso, Michael B. Enzi
U.S. House of Representatives: Cynthia M Lummis

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.