Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00011-259

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Eastern Oklahoma VA Health Care System Muskogee, Oklahoma

April 14, 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

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Executive Summary

Review Purpose: The purpose of the review was to evaluate selected patient care activities to determine whether the Community Based Outpatient Clinics and other outpatient clinics under the oversight of the Eastern Oklahoma VA Health Care 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 Hartshorne VA Clinic, Hartshorne, OK, as a representative site and evaluated the environment of care on January 25, 2016.

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

Environment of Care: Ensure at the Hartshorne VA Clinic that:

- Employees receive annual training on the Exposure Control Plan for Bloodborne Pathogens.
- Staff participate in regular emergency management training and exercises.
- A policy/procedure is in place for the identification of individuals entering the clinic.
- A Workplace Behavioral Risk Assessment is in place.
- Examination room doors are equipped with electronic or manual locks.
- A privacy sign is available for use when a telehealth visit is in progress.
- Feminine hygiene disposal bins are provided in the women's public restrooms.
- Access to the information technology server closet is maintained according to information technology safety and security standards.

Outpatient Lab Results Management: Ensure that:

- The facility's written policy for the communication of laboratory results includes all required elements.
- Clinicians consistently notify patients of their laboratory results within 14 days as 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 perform and document suicide risk assessments for all 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 Interim Facility Directors agreed with the Community Based Outpatient Clinic and other outpatient clinic review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 17–22, for the full text of the Directors' comments.) We will follow up on the planned actions for the open recommendations until they are completed.

Additionally, we are continuing work to evaluate the facility's outpatient care processes and analyze data from VA's Patient Aligned Care Team Compass Metrics. Our results from these reviews will be addressed in a future Office of Inspector General report.

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.

We are continuing work to evaluate the facility's outpatient care processes and analyze data from VA's Patient Aligned Care Team Compass Metrics. Our results from these reviews will be addressed in a future OIG report.

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 Hartshorne 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.

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 Hartshorne VA Clinic, 2 of 12 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 Hartshorne VA Clinic 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 clinic staff to receive regular information on their responsibilities in emergency response operations.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinic staff participated in regular emergency management training and exercises.	Two of 12 clinic employees did not participate in regular emergency management training and exercises.	**2.** We recommended that managers ensure that Hartshorne VA Clinic staff participate in 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 Hartshorne VA Clinic.	**3.** We recommended that the Facility Director ensures that a policy/procedure is in place for the identification of individuals entering the Hartshorne VA Clinic.
X	The clinic had a Workplace Behavioral Risk Assessment in place.	The Hartshorne VA Clinic did not have a Workplace Behavioral Risk Assessment in place.	**4.** We recommended that the Facility Director ensures that a Workplace Behavioral Risk Assessment is in place for the Hartshorne VA Clinic.
	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.		
	Clinic employees received training on the new chemical label elements and safety data sheet format.		
	The clinic had a policy/procedure for the cleaning and disinfection of telehealth equipment.		
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.		
	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.		
X	Examination room doors were equipped with either an electronic or manual lock.	Examination room doors at the Hartshorne VA Clinic were not equipped with either an electronic or manual lock.	**5.** We recommended that the Facility Director ensures examination room doors are equipped with electronic or manual locks at the Hartshorne VA Clinic.
X	A privacy sign was available for use to indicate that a telehealth visit was in progress.	The Hartshorne VA Clinic did not have a privacy sign available for use to indicate that a telehealth visit was in progress.	**6.** We recommended that the Hartshorne VA Clinic manager ensures that a privacy sign is available for use when a telehealth visit is 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.		
X	Women's public restrooms had feminine hygiene products and disposal bins available for use.	Managers did not provide feminine hygiene disposal bins for use in women's public restrooms at the Hartshorne VA Clinic.	**7.** We recommended that the Hartshorne VA Clinic manager provides feminine hygiene disposal bins in women's public restrooms.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Multi-dose medication vials were not expired.		
	All medications were secured from unauthorized access.		
	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.		
X	Access to the information technology network room/server closet was documented, as evidenced by the presence of a sign-in/sign-out log.	The Hartshorne VA Clinic did not document access to the information technology network room/server closet.	**8.** We recommended that the Hartshorne VA Clinic manager ensures that the information technology server closet is maintained according to information technology safety and security standards.

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 46 EHRs. We also validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Table 3. HT Enrollment

NM	Areas Reviewed	Findings	Recommendations
	Clinicians entered a consult for HT services.		
	Clinicians completed the HT enrollment requests or "consults."		
	Clinicians documented contact with the patient to evaluate suitability for HT services.		
	Clinicians documented the patient or caregiver's verbal informed consent for HT services.		
	Clinicians documented assessments and treatment plans for HT patients.		
	Providers signed HT assessments and treatment plans.		
	Monthly monitoring notes were documented for each month of HT program participation.		
	Documentation of HT enrollment (consult, screening, and/or initial assessment notes) was completed prior to the entry of monthly monitoring notes.		

Outpatient Lab Results Management

The purpose of this review was to determine whether CBOCs/OOCs are compliant with VHA requirements for the patient notification and follow up of selected outpatient lab results.[c]

We reviewed relevant documents and 48 EHRs. We also validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 4. Outpatient Lab Results Management

NM	Areas Reviewed	Findings	Recommendations
	The facility has a written policy regarding communication of lab results from diagnostic practitioner to ordering practitioner.		
X	The facility has a written policy for the communication of lab results that included all required elements.	The facility's written policy for the communication of lab results did not define the acceptable length of time between the availability of critical tests, values, or results and receipt by the responsible provider and did not require the communication of lab results to patients no later than 14 days from the date on which the results are available to the ordering practitioner.	**9.** We recommended that the Facility Director ensures that the facility's written policy for the communication of laboratory results includes all required elements.
X	Clinicians notified patients of their lab results.	Clinicians did not consistently notify 12 of 48 patients (25 percent) of their lab results within 14 days as required by VHA.	**10.** We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.
X	Clinicians documented in the EHR all attempts to communicate with the patients regarding their lab results.	For the patients who could not be contacted regarding their results, clinicians did not document all communication attempts with all of the eight patients.	**11.** 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 48 EHRs. We also validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 5. PTSD Care

NM	Areas Reviewed	Findings	Recommendations
X	Each patient with a positive PTSD screen received a suicide risk assessment.	Thirteen of 48 patients (27 percent) with positive PTSD screens did not receive a suicide risk assessment.	**12.** 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 48 EHRs (19 percent).	**13.** 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 2 of 10 EHRs.	**14.** 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.[3]

				Outpatient Workload / Encounters[4]			Services Provided[5]		
Location	**Station #**	**Rurality**	**Outpatient Classification[6]**	**PC**	**Mental Health**	**Specialty Clinics[7]**	**Specialty Care[8]**	**Ancillary Services[9]**	
Tulsa, OK	623BY	Urban	Multi-Specialty CBOC	40,931	43,138	21,719	Dental ENT General Surgery Nephrology Oncology Optometry Orthopedics Pain Clinic Pulmonary Podiatry Urology	Audiology Anti-Coagulation Clinic Blind Rehabilitation Diabetes Care Diabetic Retinal Screening Enterostomal Wound/Skin Care	EKG HBPC Imaging Services Laboratory Nutrition MOVE! Program[10] Speech Pathology Rehabilitation Services Social Work VIST
Hartshorne, OK	623GA	Rural	Primary Care CBOC	4,894	2,115	11	NA	Anti-Coagulation Clinic	Diabetic Retinal Screening

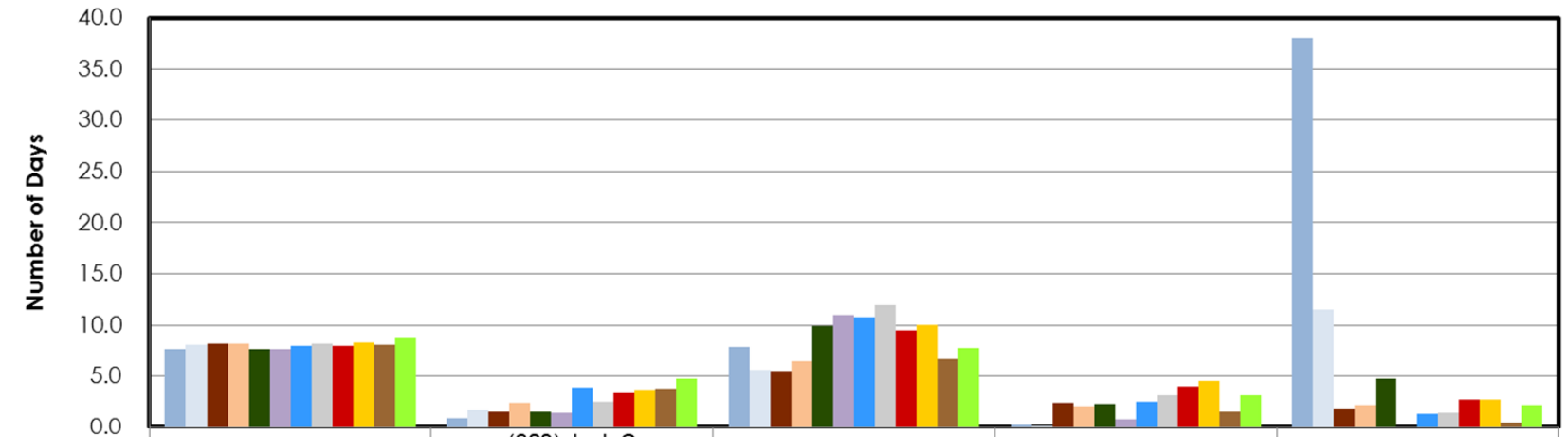
[2] Includes all CBOCs in operation before August 15, 2015. We have omitted Tulsa (623QB), as no workload/encounters or services were reported.
[3] http://vssc.med.va.gov/
[4] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting.
[5] 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.
[6] VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.
[7] The total number of encounters for the services provided in the "Specialty Care" column.
[8] Specialty Care Services refer to non-Primary Care and non-Mental Health services provided by a physician.
[9] Ancillary Services refer to non-Primary Care and non-Mental Health services that are not provided by a physician.
[10] VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.

				Outpatient Workload / Encounters			Services Provided		
Location (continued)	**Station #**	**Rurality**	**Outpatient Classification**	**PC**	**Mental Health**	**Specialty Clinics**	**Specialty Care**	**Ancillary Services**	
Vinita, OK	623GB	Rural	Primary Care CBOC	5,045	3,613	3	NA	Anti-Coagulation Clinic Diabetic Retinal Screening	HBPC MOVE! Program Nutrition Social Work
Muskogee, OK	623QA	Rural	Other Outpatient Services	0	372	0	NA	NA	

EKG=Electrocardiography; ENT=Ear, Nose and Throat; HBPC=Home Based Primary Care; VIST=Visual Impairment Services Team

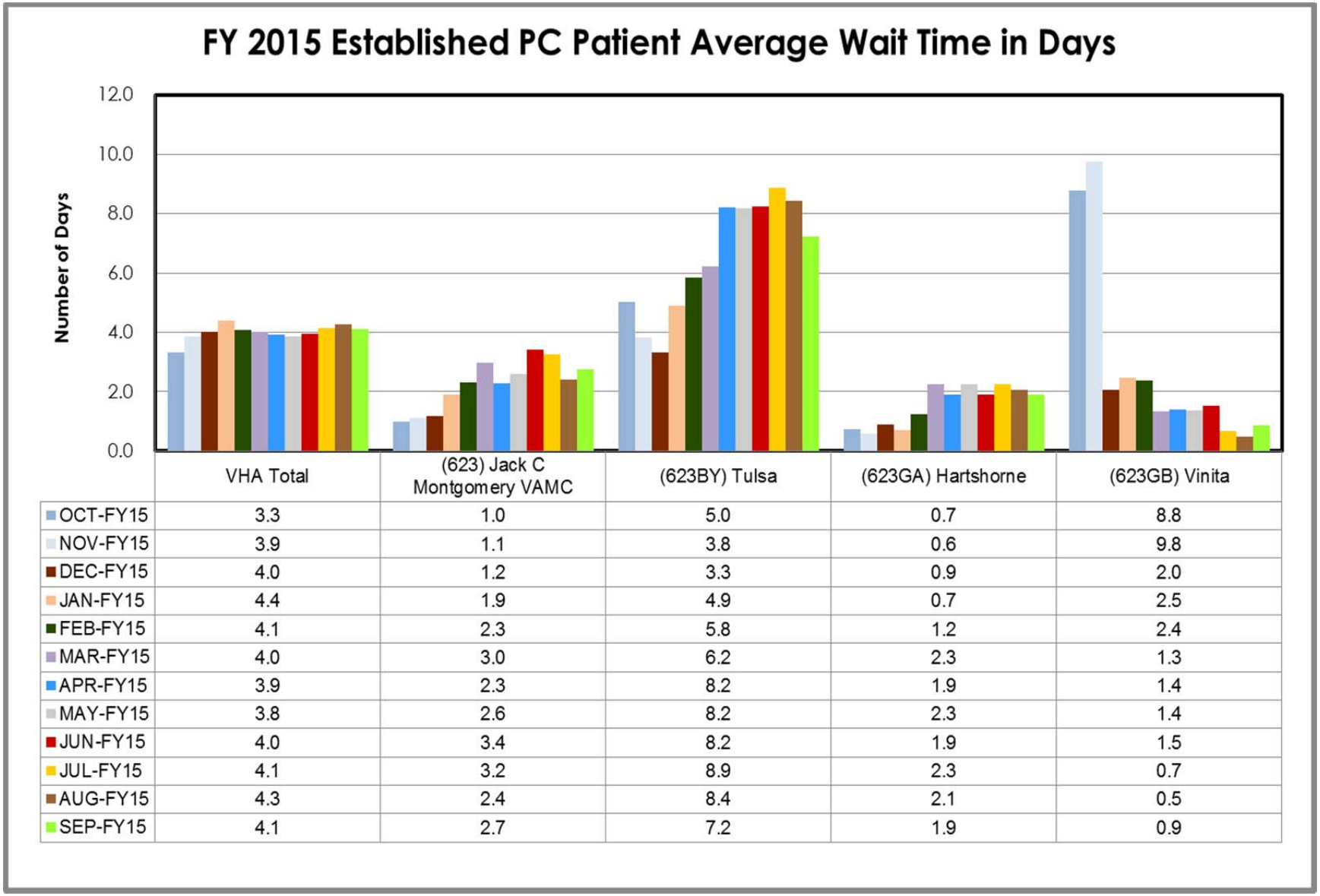
Patient Aligned Care Team Compass Metrics

FY 2015 New PC Patient Average Wait Time in Days



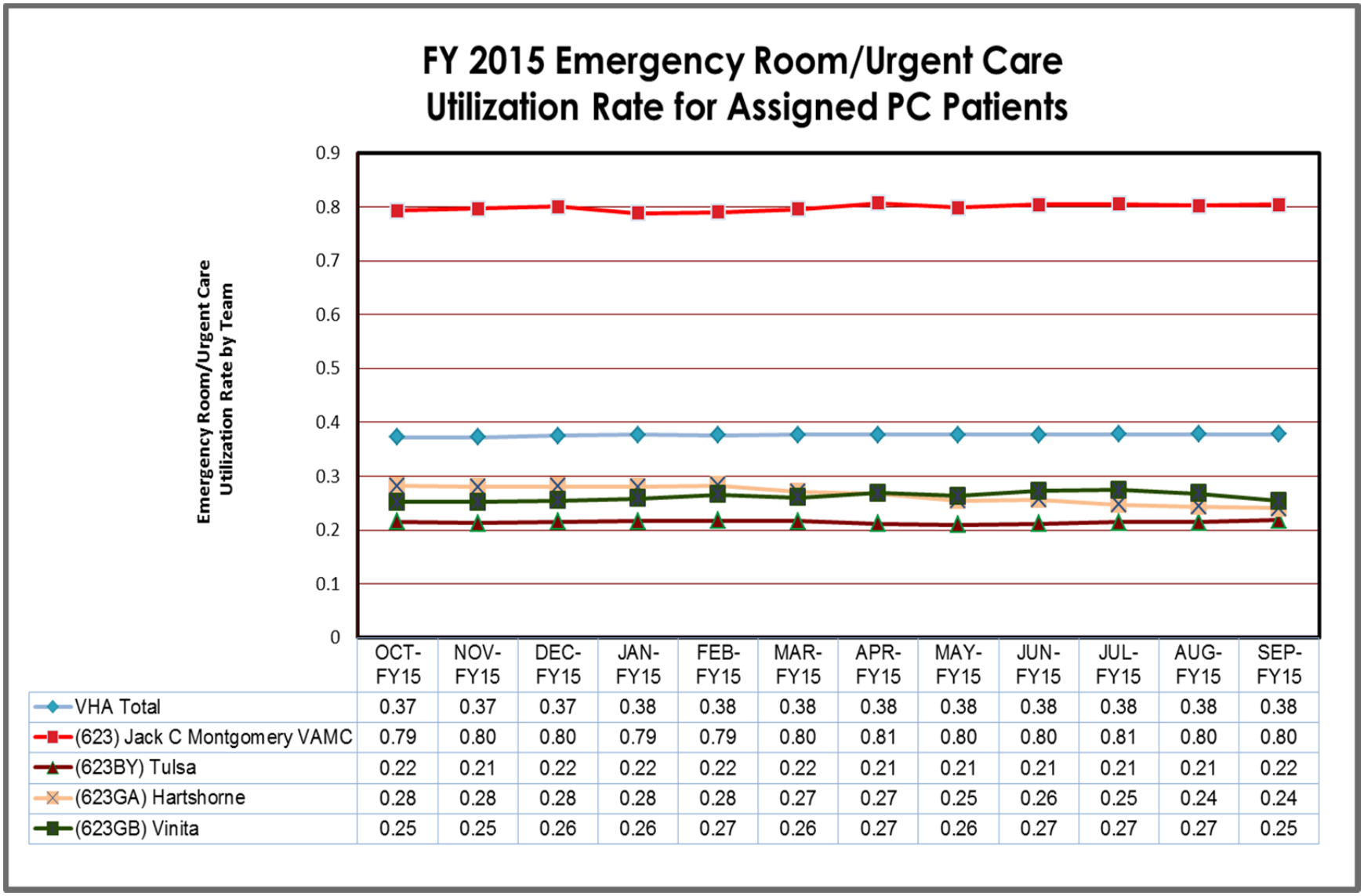
	VHA Total	(623) Jack C Montgomery VAMC	(623BY) Tulsa	(623GA) Hartshorne	(623GB) Vinita
OCT-FY15	7.6	0.9	7.9	0.3	38.0
NOV-FY15	8.1	1.7	5.6	0.1	11.5
DEC-FY15	8.1	1.6	5.5	2.4	1.8
JAN-FY15	8.2	2.4	6.5	2.1	2.1
FEB-FY15	7.6	1.5	9.9	2.3	4.8
MAR-FY15	7.7	1.4	11.0	0.8	0.0
APR-FY15	7.9	3.9	10.8	2.5	1.4
MAY-FY15	8.2	2.5	11.9	3.2	1.4
JUN-FY15	8.0	3.4	9.4	4.0	2.7
JUL-FY15	8.3	3.7	10.0	4.5	2.7
AUG-FY15	8.1	3.8	6.6	1.5	0.5
SEP-FY15	8.7	4.8	7.8	3.1	2.2

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.*



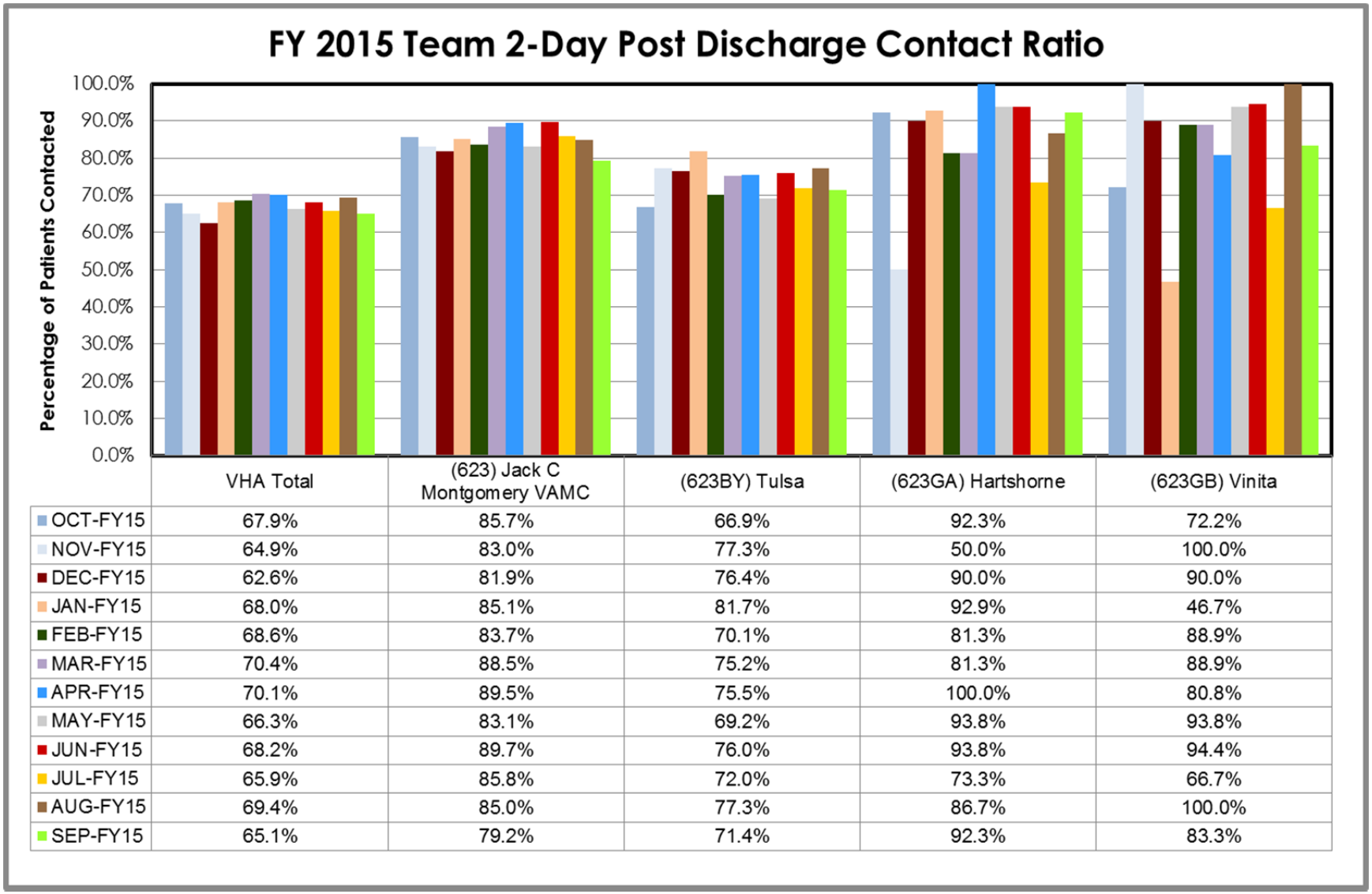
	VHA Total	(623) Jack C Montgomery VAMC	(623BY) Tulsa	(623GA) Hartshorne	(623GB) Vinita
OCT-FY15	3.3	1.0	5.0	0.7	8.8
NOV-FY15	3.9	1.1	3.8	0.6	9.8
DEC-FY15	4.0	1.2	3.3	0.9	2.0
JAN-FY15	4.4	1.9	4.9	0.7	2.5
FEB-FY15	4.1	2.3	5.8	1.2	2.4
MAR-FY15	4.0	3.0	6.2	2.3	1.3
APR-FY15	3.9	2.3	8.2	1.9	1.4
MAY-FY15	3.8	2.6	8.2	2.3	1.4
JUN-FY15	4.0	3.4	8.2	1.9	1.5
JUL-FY15	4.1	3.2	8.9	2.3	0.7
AUG-FY15	4.3	2.4	8.4	2.1	0.5
SEP-FY15	4.1	2.7	7.2	1.9	0.9

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



	OCT-FY15	NOV-FY15	DEC-FY15	JAN-FY15	FEB-FY15	MAR-FY15	APR-FY15	MAY-FY15	JUN-FY15	JUL-FY15	AUG-FY15	SEP-FY15
VHA Total	0.37	0.37	0.37	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38
(623) Jack C Montgomery VAMC	0.79	0.80	0.80	0.79	0.79	0.80	0.81	0.80	0.80	0.81	0.80	0.80
(623BY) Tulsa	0.22	0.21	0.22	0.22	0.22	0.22	0.21	0.21	0.21	0.21	0.21	0.22
(623GA) Hartshorne	0.28	0.28	0.28	0.28	0.28	0.27	0.27	0.25	0.26	0.25	0.24	0.24
(623GB) Vinita	0.25	0.25	0.26	0.26	0.27	0.26	0.27	0.26	0.27	0.27	0.27	0.25

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	(623) Jack C Montgomery VAMC	(623BY) Tulsa	(623GA) Hartshorne	(623GB) Vinita
OCT-FY15	67.9%	85.7%	66.9%	92.3%	72.2%
NOV-FY15	64.9%	83.0%	77.3%	50.0%	100.0%
DEC-FY15	62.6%	81.9%	76.4%	90.0%	90.0%
JAN-FY15	68.0%	85.1%	81.7%	92.9%	46.7%
FEB-FY15	68.6%	83.7%	70.1%	81.3%	88.9%
MAR-FY15	70.4%	88.5%	75.2%	81.3%	88.9%
APR-FY15	70.1%	89.5%	75.5%	100.0%	80.8%
MAY-FY15	66.3%	83.1%	69.2%	93.8%	93.8%
JUN-FY15	68.2%	89.7%	76.0%	93.8%	94.4%
JUL-FY15	65.9%	85.8%	72.0%	73.3%	66.7%
AUG-FY15	69.4%	85.0%	77.3%	86.7%	100.0%
SEP-FY15	65.1%	79.2%	71.4%	92.3%	83.3%

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.

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 22, 2016

From: Director, Rocky Mountain Network (10N19)

Subject: **Review of CBOCs and OOCs of Eastern Oklahoma VA Health Care System, Muskogee, OK**

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

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

1. I have reviewed the response from the Eastern Oklahoma VA Health Care System, Muskogee, OK 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.

For Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 21, 2016

From: Interim Director, Eastern Oklahoma VA Health Care System (623/00)

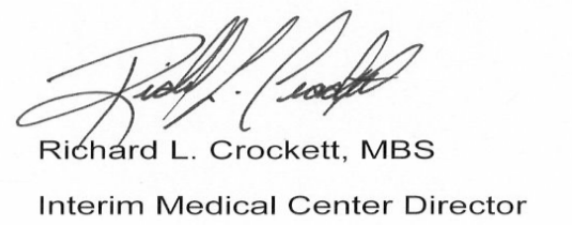
Subject: **Review of CBOCs and OOCs of Eastern Oklahoma VA Health Care System, Muskogee, OK**

To: Director, Rocky Mountain Network (10N19)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

2. I concur with the findings and recommendations of the OIG CBOC Survey Team. The importance of this review is acknowledged as we continually strive to provide the best possible care.

3. If you have any questions, please contact Martha Hardesty, Quality, Safety and Value Specialist, at 918-577-3473.



Richard L. Crockett, MBS

Interim Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that employees at the Hartshorne VA Clinic receive annual training on the Exposure Control Plan for Bloodborne Pathogens.

Concur

Target date for completion: 3/18/2016

Facility response: The Exposure Control Plan for Bloodborne Pathogens has been completed by all staff at the Hartshorne VA Clinic. Staff has been assigned annual bloodborne (infection control) training in TMS.

Recommendation 2. We recommended that managers ensure that Hartshorne VA Clinic staff participate in emergency management training and exercises.

Concur

Target date for completion: 3/18/2016

Facility response: The Emergency Management training and exercises has been completed by all staff at the Hartshorne VA Clinic.

Recommendation 3. We recommended that the Facility Director ensures that a policy/procedure is in place for the identification of individuals entering the Hartshorne VA Clinic.

Concur

Target date for completion: 4/20/2016

Facility response: A policy is being developed for identification of individuals entering the Hartshorne VA Clinic.

Recommendation 4. We recommended that the Facility Director ensures that a Workplace Behavioral Risk Assessment is in place for the Hartshorne VA Clinic.

Concur

Target date for completion: 3/11/2016

Facility response: This is done annually and was conducted in January 2016. The report was distributed in March. We request that this recommendation be closed.

Recommendation 5. We recommended that the Facility Director ensures examination room doors are equipped with electronic or manual locks at the Hartshorne VA Clinic.

Concur

Target date for completion: 4/ 29/2016

Facility response: Engineering Service has received a cost proposal from a contractor to replace the locks on the examination room doors at the Hartshorne VA Clinic.

Recommendation 6. We recommended that the Hartshorne VA Clinic manager ensures that a privacy sign is available for use when a telehealth visit is in progress.

Concur

Target date for completion: 5/6/2016

Facility response: Privacy sign will be purchased and sent to the facility and will be available for telehealth visits.

Recommendation 7. We recommended that the Hartshorne VA Clinic manager provides feminine hygiene disposal bins in women's public restrooms.

Concur

Target date for completion: 5/6/2016

Facility response: Disposal bins have been purchased and will be installed.

Recommendation 8. We recommended that the Hartshorne VA Clinic manager ensures that the information technology server closet is maintained according to information technology safety and security standards.

Concur

Target date for completion: 4/29/2016

Facility response: Hartshorne VA clinic staff will be trained on the IT telecommunication closet safety and security. Log book in place for login.

Recommendation 9. We recommended that the Facility Director ensures that the facility's written policy for the communication of laboratory results includes all required elements.

Concur

Target date for completion: 4/15/2016

Facility response: Policy will be revised to include the required elements. Staff will be educated on the required elements.

Recommendation 10. We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.

Concur

Target date for completion: 6/20/2016

Facility response: Primary Care providers will be educated on reporting laboratory results to patients. A random sample of medical records will be monitored for compliance.

Recommendation 11. 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: 6/20/2016

Facility response: Primary Care providers will be educated on documentation of attempts to communicate laboratory results to patients. A random sample of medical records will be monitored for compliance.

Recommendation 12. We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens.

Concur

Target date for completion: 6/20/2016

Facility response: Primary Care providers will be educated on the process for performing and documenting the suicide risk assessments for all patients with positive PTSD screens. A random sample of medical records will be monitored for compliance.

Recommendation 13. We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.

Concur

Target date for completion: 6/20/2016

Facility response: Providers will be educated to offer further diagnostic evaluations to patients with positive PTSD screens. A random sample of medical records will be monitored for compliance.

Recommendation 14. We recommended that providers complete diagnostic evaluations for patients with positive PTSD screens.

Concur

Target date for completion: 3/21/2016

Facility response: Mental Health receives hand off in PCMH and consults from Primary Care on patients with positive PTSD screens. Mental Health schedules patients for intakes and evaluations. Consult lists are reviewed weekly to ensure all patients have been contacted and scheduled appointments.

Office of Inspector General
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Endnotes

[a] References used for the EOC review included:

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- Joint Commission, *Joint Commission Comprehensive Accreditation and Certification Manua*l, July 1, 2015.
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- 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.
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- 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.