Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00023-252

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Fargo VA Health Care System Fargo, North Dakota

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

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected patient care activities to determine whether the Community Based Outpatient Clinics and other outpatient clinics under the oversight of the Fargo VA Health Care System and Veterans Integrated Service Network 23 provide safe, consistent, and high-quality health care. The review evaluated the clinics' compliance with selected requirements for home telehealth enrollment, outpatient lab results management, and post-traumatic stress disorder. We also randomly selected the Williston VA Community Based Outpatient Clinic, Williston, ND, as a representative site and evaluated the environment of care on March 8, 2016.

Review Results: We conducted four focused reviews and had no findings for the Environment of Care and Post-Traumatic Stress Disorder Care reviews. However, we made recommendations for improvement in the following two review areas:

Home Telehealth Enrollment: Ensure that clinicians:

- Document assessments and treatment plans for Home Telehealth patients.
- Document the Home Telehealth enrollment process prior to the entry of monthly monitoring notes.

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 the timeframe required by VHA.
- Clinicians consistently document in the electronic health record all attempts to communicate with the patients regarding their laboratory results.

Comments

The Acting 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 16–19, 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.[i]

We reviewed relevant documents and conducted a physical inspection of the Williston VA CBOC. 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.

Table 2. EOC

NM	Areas Reviewed	Findings	Recommendations
Document and Training Review			
	Managers monitored clinic staff's hand hygiene compliance.		
	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.		
	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.		
	The clinic had a policy/procedure for the identification of individuals entering the clinic.		
	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.		
	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 dispenser were working and readily accessible to employees.		
	Personal protective equipment was available.		
	Sharps containers were closable, easily accessible, and not overfilled.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	The clinic provided visual and auditory privacy for patients in the interview areas.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	The information technology network room/server closet was secured/locked.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 49 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 9 of 49 patients (18 percent).	**1.** We recommended that clinicians document assessments and treatment plans for Home Telehealth patients.
	Providers signed HT 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 34 of 40 EHRs (85 percent).	**2.** 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 46 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 include the required documentation of treatment actions in response to abnormal test results in the patient's electronic health record.	**3**. We recommended that the Facility Director ensure 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 6 of 46 patients (13 percent) of their lab results within 14 days as required by VHA.	**4**. 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 six patients who could not be contacted regarding their results.	**5.** 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 43 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 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.		
	Acceptable providers established plans of care and disposition for patients with positive PTSD screens.		
	Acceptable providers offered further diagnostic evaluations to patients with positive PTSD screens.		
	Providers completed diagnostic evaluations for patients with positive PTSD screens.		
	Patients, when applicable, received mental health treatment.		

Clinic Profiles

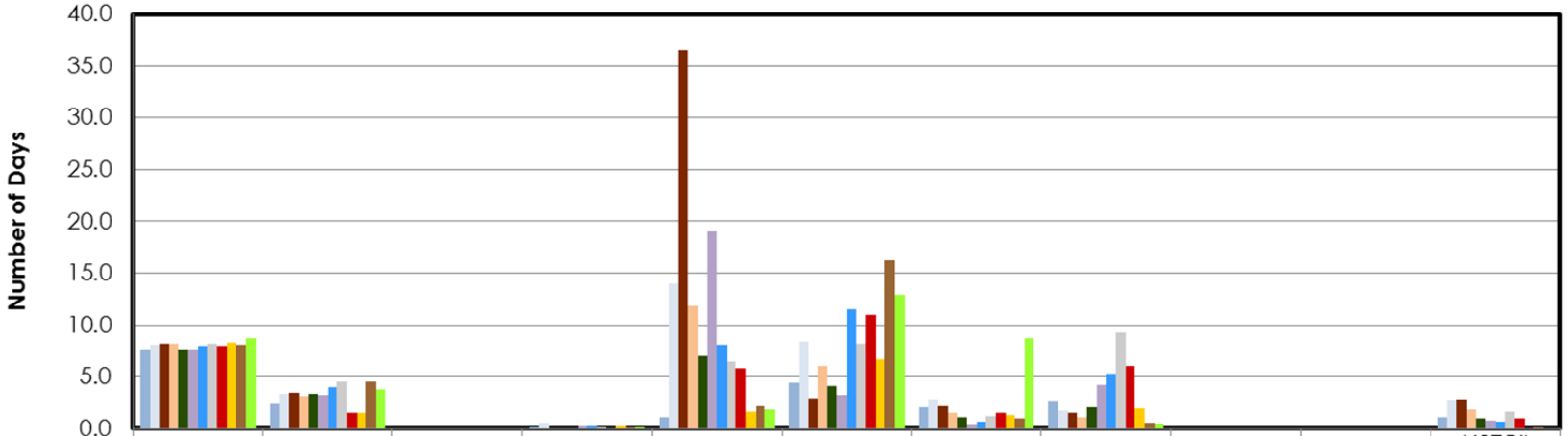
The CBOC/OOC review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[2] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. The following table provides information relative to each of the outpatient clinics and lists the additional specialty care and ancillary services provided at each location.[3]

				Outpatient Workload / Encounters[4]			Services Provided[5]	
Location	**Station #**	**Rurality**	**Outpatient Classification[6]**	**PC**	**MH**	**Specialty Clinics[7]**	**Specialty Care[8]**	**Ancillary Services[9]**
Grafton, ND	437GA	Rural	Other Outpatient Services	1,572	319	42	NA	NA
Bismarck, ND	437GB	Urban	Primary Care CBOC	7,553	2,607	503	NA	Audiology Enterostomal Wound/Skin Care Home Based Primary Care Nutrition Pharmacy
Fergus Falls, MN	437GC	Rural	Primary Care CBOC	3,687	1,474	90	NA	NA
Minot, ND	437GD	Rural	Primary Care CBOC	3,656	1,481	501	Optometry	Audiology
Bemidji, MN	437GE	Rural	Primary Care CBOC	7,179	2,619	365	NA	Audiology
Williston, ND	437GF	Rural	Primary Care CBOC	2,717	711	79	NA	NA
Grand Forks, ND	437GI	Rural	Primary Care CBOC	5,708	2,165	229	NA	Audiology

[2] Includes all CBOCs in operation before August 15, 2015. We have omitted 437GJ (Dickinson), 437GK (Jamestown), and 437GL (Devils Lake), 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.

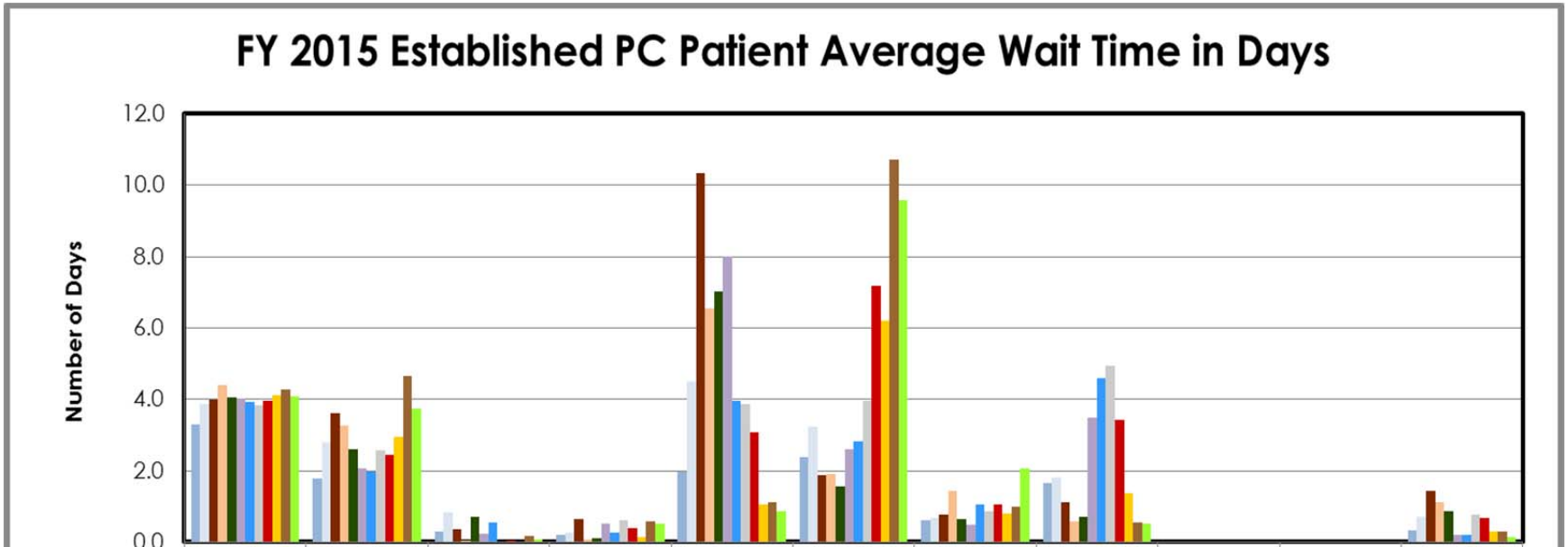
Patient Aligned Care Team Compass Metrics

FY 2015 New PC Patient Average Wait Time in Days



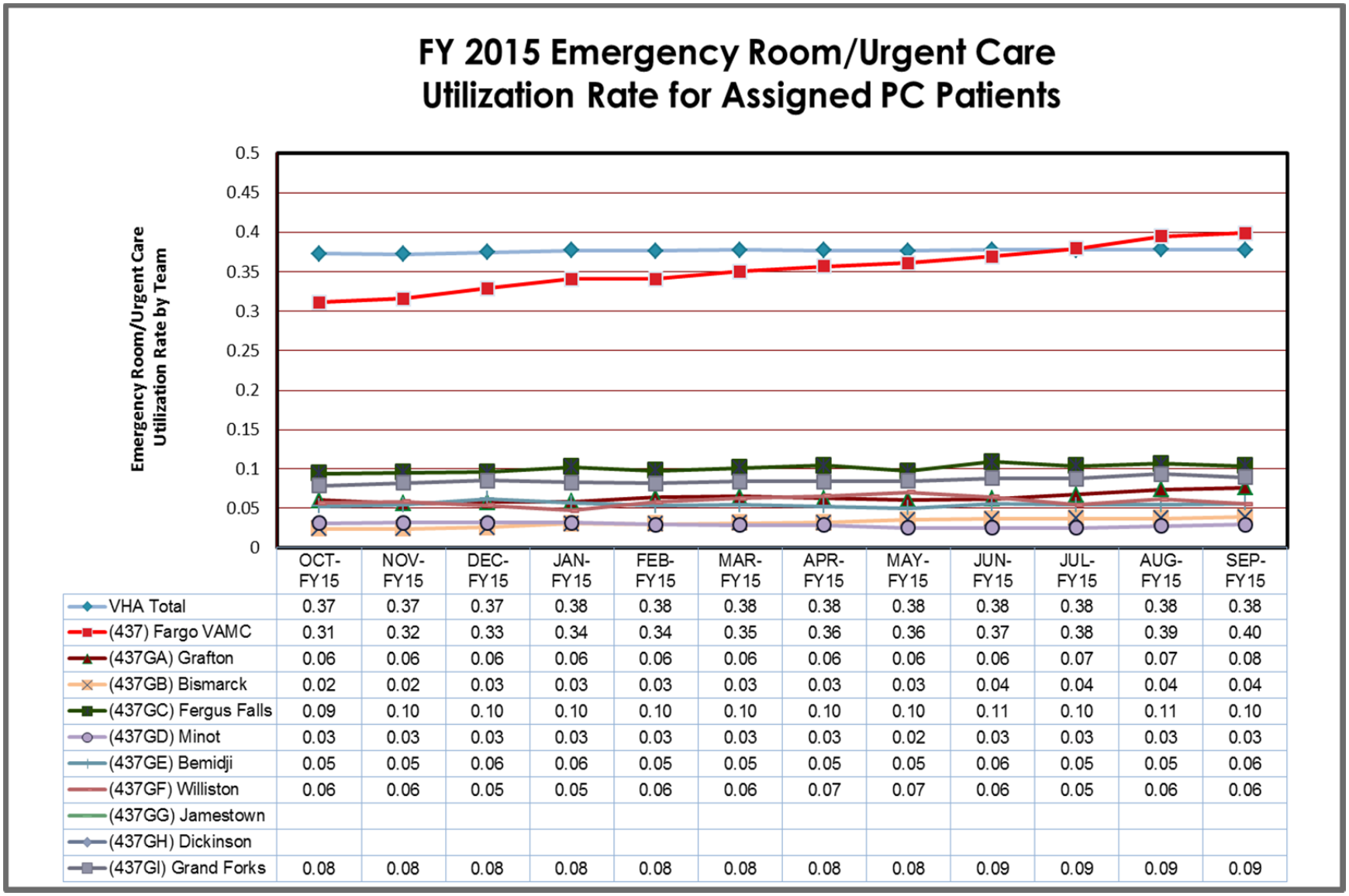
	VHA Total	(437) Fargo VAMC	(437GA) Grafton	(437GB) Bismarck	(437GC) Fergus Falls	(437GD) Minot	(437GE) Bemidji	(437GF) Williston	(437GG) Jamestown	(437GH) Dickinson	(437GI) Grand Forks
OCT-FY15	7.6	2.3	0.0	0.1	1.1	4.4	2.0	2.5			1.1
NOV-FY15	8.1	3.3	0.0	0.6	14.0	8.4	2.8	1.8			2.7
DEC-FY15	8.1	3.5	0.0	0.0	36.5	2.9	2.2	1.5			2.8
JAN-FY15	8.2	3.2	0.0	0.0	11.8	6.1	1.5	1.1			1.8
FEB-FY15	7.6	3.4	0.0	0.0	7.0	4.1	1.1	2.0			1.0
MAR-FY15	7.7	3.3	0.0	0.2	19.1	3.2	0.3	4.2			0.8
APR-FY15	7.9	4.0	0.0	0.3	8.1	11.5	0.7	5.3			0.7
MAY-FY15	8.2	4.5	0.0	0.1	6.5	8.2	1.2	9.2			1.6
JUN-FY15	8.0	1.5	0.0	0.0	5.8	11.0	1.5	6.1			1.0
JUL-FY15	8.3	1.5	0.0	0.2	1.6	6.7	1.3	1.9			0.0
AUG-FY15	8.1	4.6	0.0	0.2	2.2	16.3	1.0	0.5			0.1
SEP-FY15	8.7	3.8	0.0	0.0	1.8	12.9	8.8	0.5			0.0

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



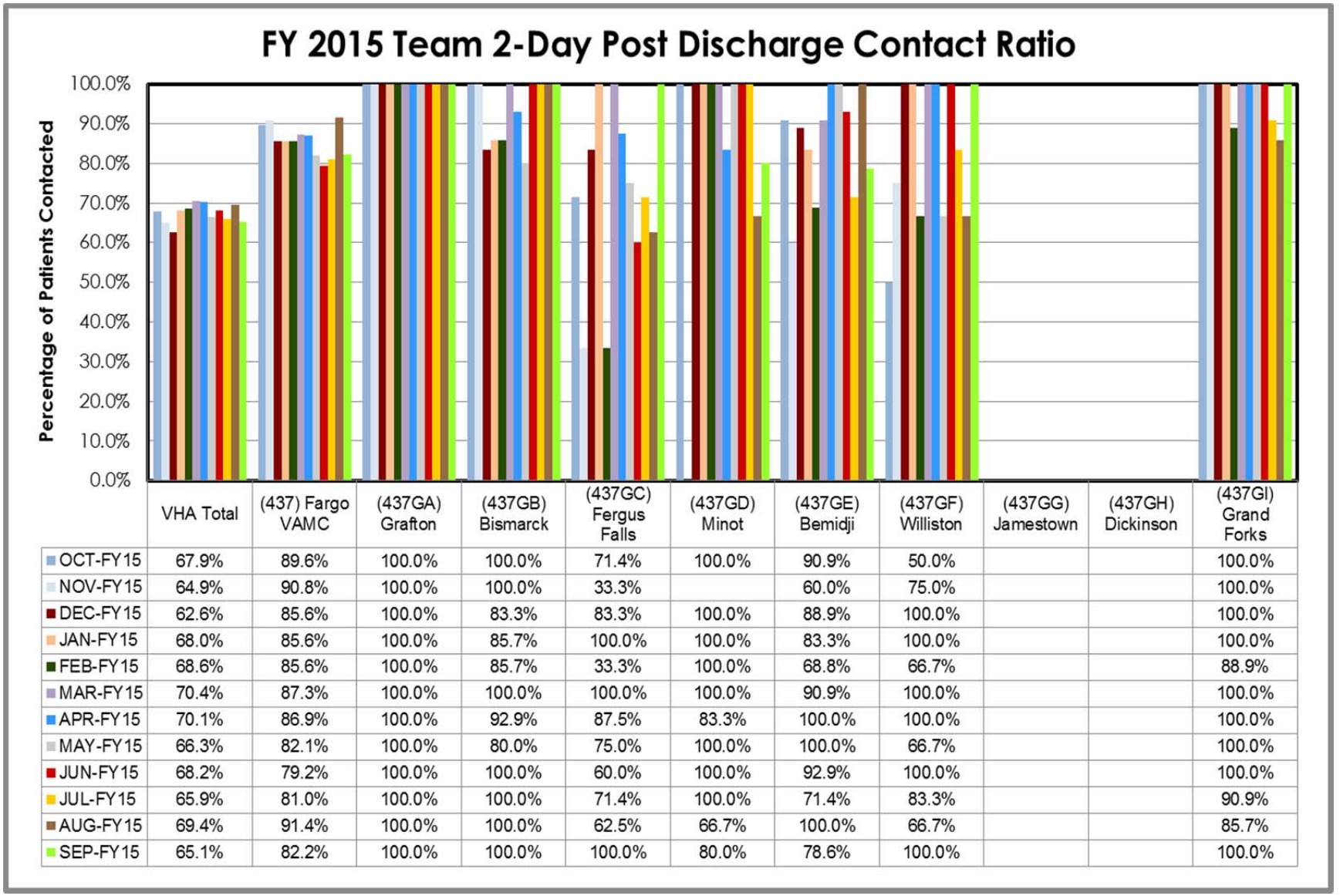
	VHA Total	(437) Fargo VAMC	(437GA) Grafton	(437GB) Bismarck	(437GC) Fergus Falls	(437GD) Minot	(437GE) Bemidji	(437GF) Williston	(437GG) Jamestown	(437GH) Dickinson	(437GI) Grand Forks
OCT-FY15	3.3	1.8	0.3	0.2	2.0	2.4	0.6	1.6			0.3
NOV-FY15	3.9	2.8	0.8	0.3	4.5	3.2	0.7	1.8			0.7
DEC-FY15	4.0	3.6	0.4	0.6	10.3	1.9	0.8	1.1			1.4
JAN-FY15	4.4	3.3	0.1	0.1	6.5	1.9	1.4	0.6			1.1
FEB-FY15	4.1	2.6	0.7	0.1	7.0	1.6	0.7	0.7			0.9
MAR-FY15	4.0	2.1	0.2	0.5	8.0	2.6	0.5	3.5			0.2
APR-FY15	3.9	2.0	0.6	0.3	4.0	2.8	1.1	4.6			0.2
MAY-FY15	3.8	2.6	0.0	0.6	3.9	4.0	0.9	4.9			0.8
JUN-FY15	4.0	2.4	0.1	0.4	3.1	7.2	1.1	3.4			0.7
JUL-FY15	4.1	2.9	0.0	0.2	1.1	6.2	0.8	1.4			0.3
AUG-FY15	4.3	4.6	0.2	0.6	1.1	10.7	1.0	0.6			0.3
SEP-FY15	4.1	3.7	0.1	0.5	0.9	9.6	2.1	0.5			0.2

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. Blank cells indicate the absence of reported data.



	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
(437) Fargo VAMC	0.31	0.32	0.33	0.34	0.34	0.35	0.36	0.36	0.37	0.38	0.39	0.40
(437GA) Grafton	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.07	0.07	0.08
(437GB) Bismarck	0.02	0.02	0.03	0.03	0.03	0.03	0.03	0.03	0.04	0.04	0.04	0.04
(437GC) Fergus Falls	0.09	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.11	0.10	0.11	0.10
(437GD) Minot	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.02	0.03	0.03	0.03	0.03
(437GE) Bemidji	0.05	0.05	0.06	0.06	0.05	0.05	0.05	0.05	0.06	0.05	0.05	0.06
(437GF) Williston	0.06	0.06	0.05	0.05	0.06	0.06	0.07	0.07	0.06	0.05	0.06	0.06
(437GG) Jamestown												
(437GH) Dickinson												
(437GI) Grand Forks	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.09	0.09	0.09	0.09

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). Blank cells indicate the absence of reported data.



	VHA Total	(437) Fargo VAMC	(437GA) Grafton	(437GB) Bismarck	(437GC) Fergus Falls	(437GD) Minot	(437GE) Bemidji	(437GF) Williston	(437GG) Jamestown	(437GH) Dickinson	(437GI) Grand Forks
OCT-FY15	67.9%	89.6%	100.0%	100.0%	71.4%	100.0%	90.9%	50.0%			100.0%
NOV-FY15	64.9%	90.8%	100.0%	100.0%	33.3%		60.0%	75.0%			100.0%
DEC-FY15	62.6%	85.6%	100.0%	83.3%	83.3%	100.0%	88.9%	100.0%			100.0%
JAN-FY15	68.0%	85.6%	100.0%	85.7%	100.0%	100.0%	83.3%	100.0%			100.0%
FEB-FY15	68.6%	85.6%	100.0%	85.7%	33.3%	100.0%	68.8%	66.7%			88.9%
MAR-FY15	70.4%	87.3%	100.0%	100.0%	100.0%	100.0%	90.9%	100.0%			100.0%
APR-FY15	70.1%	86.9%	100.0%	92.9%	87.5%	83.3%	100.0%	100.0%			100.0%
MAY-FY15	66.3%	82.1%	100.0%	80.0%	75.0%	100.0%	100.0%	66.7%			100.0%
JUN-FY15	68.2%	79.2%	100.0%	100.0%	60.0%	100.0%	92.9%	100.0%			100.0%
JUL-FY15	65.9%	81.0%	100.0%	100.0%	71.4%	100.0%	71.4%	83.3%			90.9%
AUG-FY15	69.4%	91.4%	100.0%	100.0%	62.5%	66.7%	100.0%	66.7%			85.7%
SEP-FY15	65.1%	82.2%	100.0%	100.0%	100.0%	80.0%	78.6%	100.0%			100.0%

Data Definition.[e] The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Blank cells indicate the absence of reported data.

Appendix C

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: March 24, 2016

From: Acting Director, Midwest Health Care Network (10N23)

Subject: **Review of CBOCs and OOCs of Fargo VA Health Care System, Fargo, ND**

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

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

Thank you for conducting a comprehensive review at the Fargo VA Health Care System.

I have reviewed the document and concur with the responses as submitted.

Patrick J. Kelly, FACHE

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 23, 2016

From: Director, Fargo VA Health Care System (437/00)

Subject: **Review of CBOCs and OOCs of Fargo VA Health Care System, Fargo, ND**

To: Acting Director, Midwest Health Care Network (10N23)

1. The Fargo VA HCS concurs with all recommendations. Please see the attached action plans for the recommendations identified from the recent review.

2. If you have any questions, please contact Ms. Joan Quick, Director, Quality, Safety & Value at (701) 239-3700 extension 3686.

LAVONNE LIVERSAGE, FACHE

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 clinicians document assessments and treatment plans for Home Telehealth patients.

Concur

Target date for completion: August 15, 2016

Facility response: All Veterans participating in Home Telehealth will have an assessment/treatment plan template completed. Training on the required documentation of assessment/treatment plans was completed on 3/17/16 for Home Telehealth RN's. Monthly audits will be completed with a compliance rate of 90% or greater for four consecutive months and then quarterly thereafter to ensure ongoing compliance. Audit results will be presented at the Quality, Safety and Value (QSV) Council.

Recommendation 2. We recommended that clinicians document the Home Telehealth enrollment process prior to the entry of monthly monitoring notes.

Concur

Target date for completion: August 15, 2016

Facility response: All Veterans participating in Home Telehealth will have an assessment/treatment plan template completed prior to the entry of a monthly monitor note. Training on the required documentation of assessment/treatment plans prior to entry of a monthly monitor note was completed on 3/17/16 for Home Telehealth RN's. Monthly audits will be completed with a compliance rate of 90% or greater for four consecutive months and then quarterly thereafter to ensure ongoing compliance. Audit results will be presented at the Quality, Safety and Value (QSV) Council.

Recommendation 3. We recommended that the Facility Director ensure that the facility's written policy for the communication of laboratory results includes all required elements.

Concur

Target date for completion: July 12, 2016

Facility response: The facility's written policy for the communication of laboratory results will be revised to include all required elements.

Recommendation 4. We recommended that clinicians consistently notify patients of their laboratory results within the timeframe required by VHA.

Concur

Target date for completion: August 15, 2016

Facility response: Clinicians will notify patients of their results within the timeframe required by the VHA. The Chief of Staff's office will provide training regarding the requirement. Monthly audits will be completed with a compliance rate of 90% or greater for four consecutive months and then quarterly thereafter to ensure ongoing compliance. Audit results will be presented at the Quality, Safety and Value (QSV) Council.

Recommendation 5. 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: August 15, 2016

Facility response: Clinicians will document in the electronic health record all attempts to communicate with the patient regarding their lab results. The Chief of Staff's office will provide training regarding the requirement. Monthly audits will be completed with a compliance rate of 90% or greater for four consecutive months and then quarterly thereafter to ensure ongoing compliance. Audit results will be presented at the Quality, Safety and Value (QSV) Council.

Office of Inspector General
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Endnotes

[a] References used for the EOC review included:

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- VHA Directive 2011-007, *Required Hand Hygiene Practices,* February 16, 2011.
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- 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.