



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

**Office of Healthcare Inspections**

**Report No. 16-00024-299**

**Review of Community Based  
Outpatient Clinics and Other  
Outpatient Clinics  
of  
James H. Quillen VA Medical Center  
Mountain Home, Tennessee**

**May 12, 2016**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**

**Telephone: 1-800-488-8244**

**E-Mail: [vaoighotline@va.gov](mailto:vaoighotline@va.gov)**

**(Hotline Information: [www.va.gov/oig/hotline](http://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 James H. Quillen VA Medical Center and Veterans Integrated Service Network 9 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 Jonesville VA Clinic, Jonesville, VA, as a representative site and evaluated the environment of care on March 15, 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:

- Providers sign Home Telehealth assessments and treatment plans.

Outpatient Lab Results Management: Ensure that:

- Clinicians consistently notify patients of their laboratory results within the timeframe set by local policy.

### 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 17–19, 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.<sup>1</sup> 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.

<sup>1</sup> 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.<sup>a</sup>

We reviewed relevant documents and conducted a physical inspection of the Jonesville VA Clinic. 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
<b>Document and Training Review</b>			
	Managers monitored clinic staff's hand hygiene compliance.		
	Clinic managers provided training for employees on the Exposure Control Plan for Blood borne 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.		
NA	The clinic had a policy/procedure for the cleaning and disinfection of telehealth equipment.		
<b>Physical Inspection</b>			
	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.		
	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.		
NA	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.		
NA	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.<sup>b</sup>

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 area marked as NM did not meet applicable requirements and needed improvement.

**Table 3. HT Enrollment**

NM	Areas Reviewed	Findings	Recommendations
	Clinicians entered a consult for HT services.		
	Clinicians completed the HT enrollment requests or "consults."		
	Clinicians documented contact with the patient to evaluate suitability for HT services.		
	Clinicians documented the patient or caregiver's verbal informed consent for HT services.		
	Clinicians documented assessments and treatment plans for HT patients.		
X	Providers signed HT assessments and treatment plans.	Providers did not sign 24 of 46 patient HT assessments and treatment plans (52 percent).	<b>1.</b> We recommended that providers sign Home Telehealth 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.<sup>c</sup>

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 area 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 10 of 49 patients (20 percent) of their lab results within the timeframe set by local policy.	<b>2.</b> We recommended that clinicians consistently notify patients of their laboratory results within the timeframe set by local policy.
	Clinicians documented in the EHR all attempts to communicate with the patients regarding their lab results.		
	Clinicians provided interventions for clinically significant abnormal lab results.		

## PTSD Care

The purpose of this review was to assess whether CBOCs/OOCs are compliant with selected VHA requirements for PTSD follow up in the outpatient setting.<sup>d</sup>

We reviewed relevant documents and 39 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

This review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.<sup>2</sup> 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.<sup>3</sup>

Location	Station #	Rurality	Outpatient Classification <sup>6</sup>	Outpatient Workload / Encounters <sup>4</sup>			Services Provided <sup>5</sup>		
				PC	Mental Health	Specialty Clinics <sup>7</sup>	Specialty Care <sup>8</sup>	Ancillary Services <sup>9</sup>	
Knoxville, TN	621BY	Urban	Multi-Specialty CBOC	30,900	25,219	5,900	Medicine Specialties Optometry	Audiology Diabetic Retinal Screening Diabetic Care Imaging Services Kinesiotherapy Laboratory	MOVE! Program <sup>10</sup> Nutrition Pharmacy Social Work Vascular Laboratory
Rogersville, TN	621GA	Rural	Primary Care CBOC	3,278	416	160	Pain Clinic	MOVE! Program	
Norton, VA	621GC	Rural	Primary Care CBOC	7,140	1,395	159	Pain Clinic	Diabetic Retinal Screening MOVE! Program	
Morristown, TN	621GG	Urban	Primary Care CBOC	5,879	1,171	84	NA	Diabetic Retinal Screening MOVE! Program Pharmacy	

<sup>2</sup> Includes all CBOCs in operation before August 15, 2015. We have omitted 621QA (Norton), 621QB (Marion), 621QC (Vansant), 621QD (Knoxville), and 621BU (Mountain Home) as no workload/encounters or services were reported.

<sup>3</sup> <http://vssc.med.va.gov/>

<sup>4</sup> 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.

<sup>5</sup> The denoted Specialty Care and Ancillary Services are limited to Primary Clinic Stops with a count  $\geq 100$  encounters during the October 1, 2014, through September 30, 2015, timeframe at the specified CBOC.

<sup>6</sup> VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

<sup>7</sup> The total number of encounters for the services provided in the "Specialty Care" column.

<sup>8</sup> Specialty Care Services refer to non-Primary Care and non-Mental Health services provided by a physician.

<sup>9</sup> Ancillary Services refer to non-Primary Care and non-Mental Health services that are not provided by a physician.

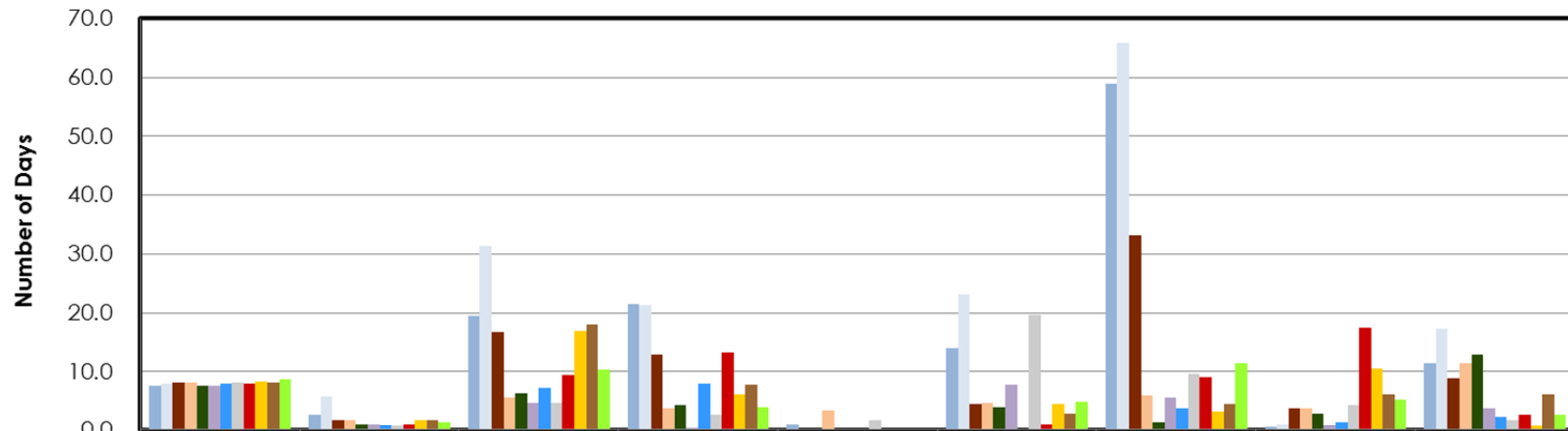
<sup>10</sup> VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.



Location (continued)	Station #	Rurality	Outpatient Classification	Outpatient Workload / Encounters			Services Provided	
				PC	Mental Health	Specialty Clinics	Specialty Care	Ancillary Services
Sevierville, TN	621GI	Rural	Primary Care CBOC	6,693	2,582	49	NA	Audiology Diabetic Retinal Screening
Bristol, VA	621GJ	Urban	Primary Care CBOC	8,886	2,714	386	Pain Clinic	Diabetic Retinal Screening MOVE! Program Pharmacy Social Work
Lafollette, TN	621GK	Rural	Other Outpatient Services	3,299	945	13	NA	Diabetic Retinal Screening

## Patient Aligned Care Team Compass Metrics

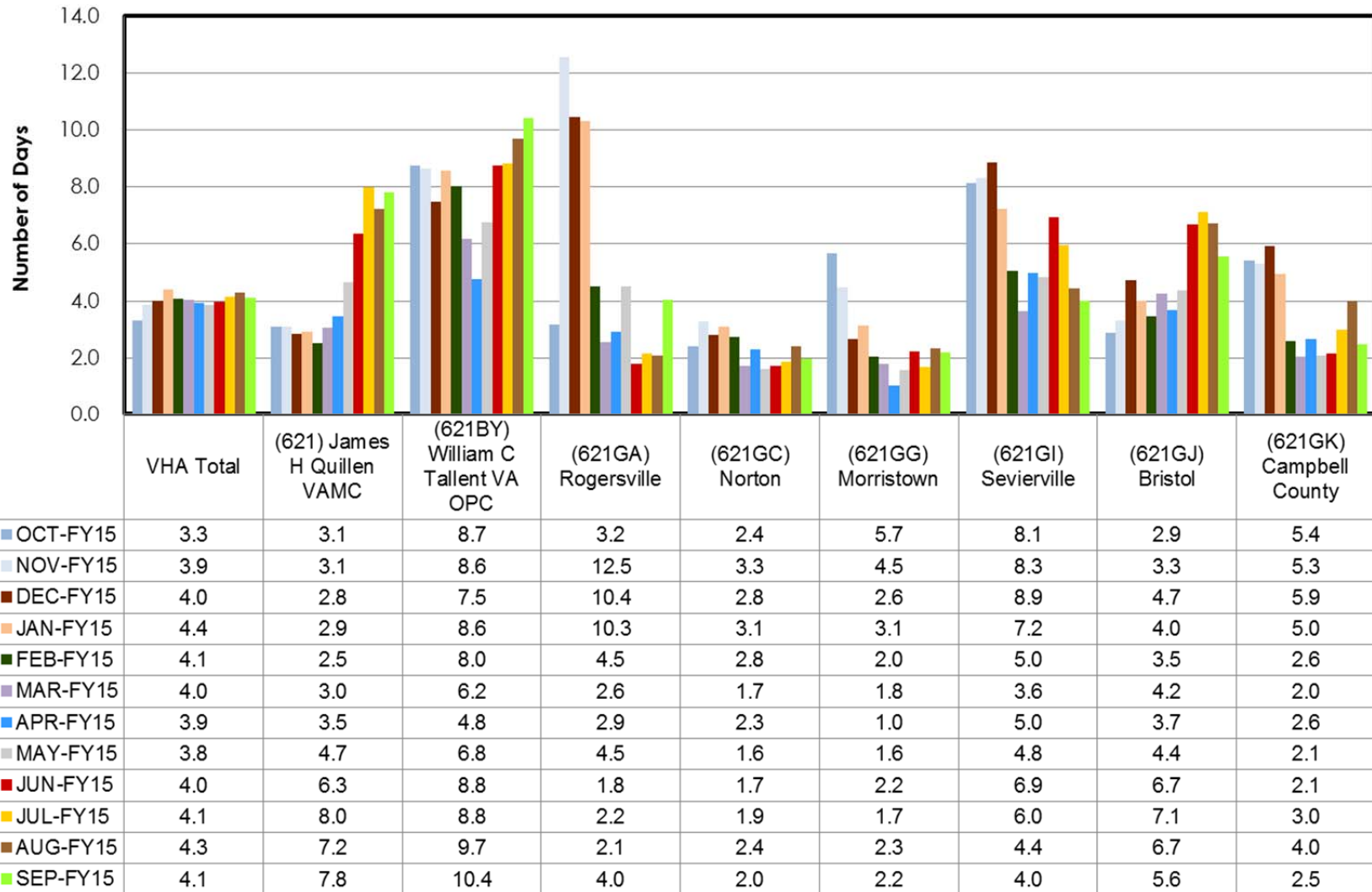
### FY 2015 New PC Patient Average Wait Time in Days



	VHA Total	(621) James H Quillen VAMC	(621BY) William C Tallent VA OPC	(621GA) Rogersville	(621GC) Norton	(621GG) Morristown	(621GI) Sevierville	(621GJ) Bristol	(621GK) Campbell County
■ OCT-FY15	7.6	2.7	19.4	21.5	1.0	14.1	58.8	0.4	11.4
■ NOV-FY15	8.1	5.8	31.3	21.2	0.0	23.2	65.9	1.1	17.3
■ DEC-FY15	8.1	1.8	16.8	13.0	0.0	4.4	33.2	3.8	8.9
■ JAN-FY15	8.2	1.9	5.6	3.8	3.4	4.7	5.9	3.8	11.4
■ FEB-FY15	7.6	1.1	6.3	4.3	0.0	4.0	1.4	3.0	12.9
■ MAR-FY15	7.7	1.0	4.6	0.3	0.0	7.8	5.6	0.9	3.8
■ APR-FY15	7.9	0.9	7.2	8.0	0.1	0.0	3.7	1.4	2.4
■ MAY-FY15	8.2	0.7	4.7	2.8	1.7	19.6	9.6	4.3	1.8
■ JUN-FY15	8.0	1.1	9.4	13.3	0.0	1.1	9.1	17.4	2.8
■ JUL-FY15	8.3	1.8	16.9	6.1	0.0	4.5	3.3	10.5	0.7
■ AUG-FY15	8.1	1.8	17.9	7.8	0.0	2.9	4.5	6.1	6.2
■ SEP-FY15	8.7	1.4	10.3	4.0	0.0	4.8	11.4	5.3	2.8

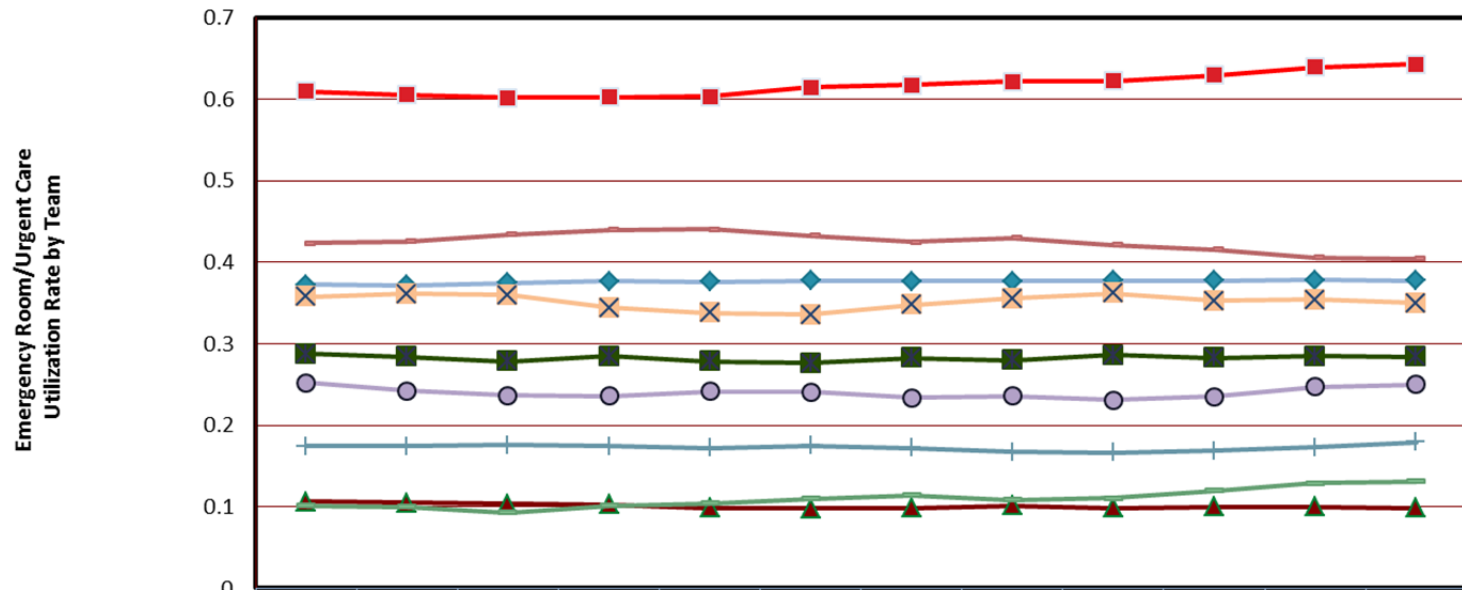
**Data Definition.**<sup>e</sup> The average number of calendar days between a New Patient’s PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by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

### FY 2015 Established PC Patient Average Wait Time in Days



**Data Definition.**<sup>e</sup> 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.

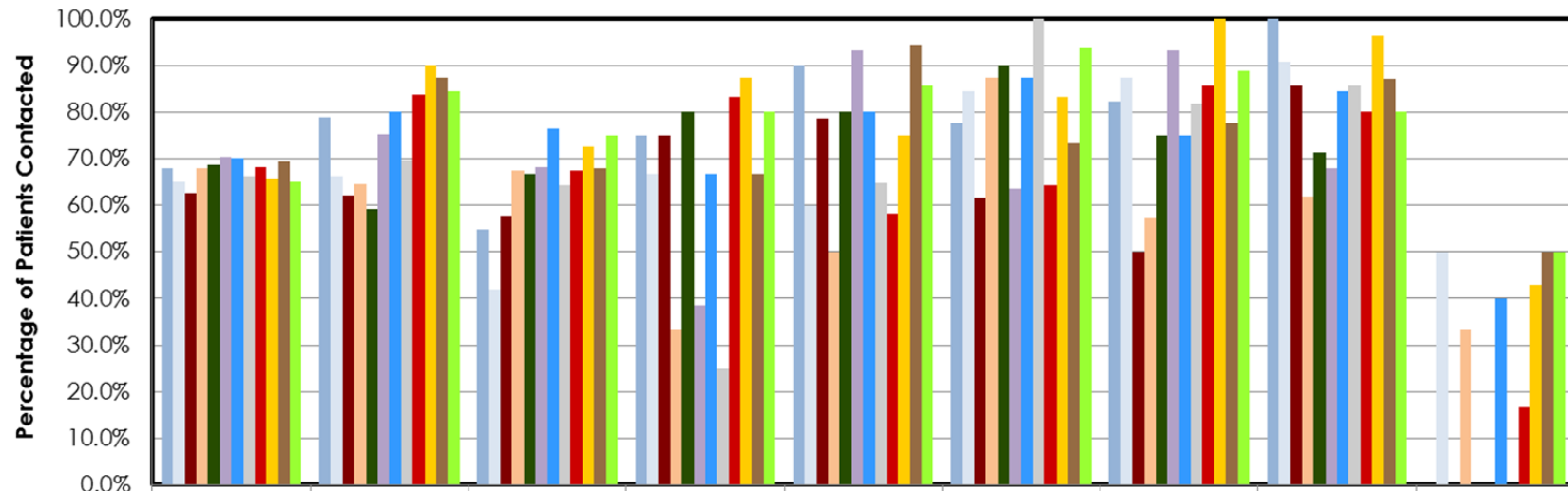
### FY 2015 Emergency Room/Urgent Care Utilization Rate for Assigned PC Patients



	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
■ (621) James H Quillen VAMC	0.61	0.61	0.60	0.60	0.60	0.61	0.62	0.62	0.62	0.63	0.64	0.64
▲ (621BY) William C Tallent VA OPC	0.11	0.11	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10
× (621GA) Rogersville	0.36	0.36	0.36	0.34	0.34	0.34	0.35	0.36	0.36	0.35	0.35	0.35
■ (621GC) Norton	0.29	0.28	0.28	0.28	0.28	0.28	0.28	0.28	0.29	0.28	0.28	0.28
● (621GG) Morristown	0.25	0.24	0.24	0.24	0.24	0.24	0.23	0.24	0.23	0.24	0.25	0.25
+ (621GI) Sevierville	0.17	0.17	0.18	0.17	0.17	0.18	0.17	0.17	0.17	0.17	0.17	0.18
— (621GJ) Bristol	0.42	0.43	0.43	0.44	0.44	0.43	0.43	0.43	0.42	0.42	0.41	0.40
— (621GK) Campbell County	0.10	0.10	0.09	0.10	0.10	0.11	0.11	0.11	0.11	0.12	0.13	0.13

**Data Definition.**<sup>e</sup> 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).

### FY 2015 Team 2-Day Post Discharge Contact Ratio



	VHA Total	(621) James H Quillen VAMC	(621BY) William C Tallent VA OPC	(621GA) Rogersville	(621GC) Norton	(621GG) Morristown	(621GI) Sevierville	(621GJ) Bristol	(621GK) Campbell County
OCT-FY15	67.9%	79.0%	54.7%	75.0%	90.0%	77.8%	82.4%	100.0%	0.0%
NOV-FY15	64.9%	66.2%	41.9%	66.7%	60.0%	84.6%	87.5%	90.9%	50.0%
DEC-FY15	62.6%	62.1%	57.8%	75.0%	78.6%	61.5%	50.0%	85.7%	0.0%
JAN-FY15	68.0%	64.6%	67.6%	33.3%	50.0%	87.5%	57.1%	61.8%	33.3%
FEB-FY15	68.6%	59.2%	66.7%	80.0%	80.0%	90.0%	75.0%	71.4%	0.0%
MAR-FY15	70.4%	75.3%	68.1%	38.5%	93.3%	63.6%	93.3%	68.0%	0.0%
APR-FY15	70.1%	80.2%	76.6%	66.7%	80.0%	87.5%	75.0%	84.4%	40.0%
MAY-FY15	66.3%	69.6%	64.3%	25.0%	64.7%	100.0%	81.8%	85.7%	0.0%
JUN-FY15	68.2%	83.7%	67.4%	83.3%	58.3%	64.3%	85.7%	80.0%	16.7%
JUL-FY15	65.9%	90.1%	72.6%	87.5%	75.0%	83.3%	100.0%	96.4%	42.9%
AUG-FY15	69.4%	87.5%	68.0%	66.7%	94.4%	73.3%	77.8%	87.1%	50.0%
SEP-FY15	65.1%	84.5%	75.0%	80.0%	85.7%	93.8%	88.9%	80.0%	50.0%

**Data Definition.<sup>e</sup>** 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:** April 15, 2016

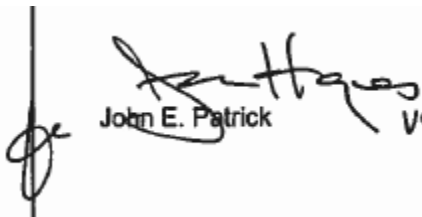
**From:** Director, VA Mid South Healthcare Network (10N9)

**Subject:** **Review of CBOCs and OOCs of James H. Quillen VA Medical Center, Mountain Home, TN**

**To:** Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. I concur with the findings and recommendation of this Office of Inspector General Community Based Outpatient Clinic Review of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, as well as the action plan developed by the facility.
2. If you have questions or need additional information from the Network, please do not hesitate to contact me at 615-695-2206.

  
John E. Patrick V&DND 4/21/16

## Acting Facility Director Comments

**Department of  
Veterans Affairs**

# Memorandum


**Date:** April 11, 2016

**From:** Acting Director, James H. Quillen VA Medical Center (621/00)

**Subject: Review of CBOCs and OOCs of James H. Quillen VA Medical Center, Mountain Home, TN**

**To:** Director, VA Mid South Healthcare Network (10N9)

1. On behalf of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, I concur with the findings and recommendations of this Office of Inspector General report.
2. Included herein is an outline of improvement actions taken, in progress, or planned in response to these findings. We believe these changes will further enhance key systems and processes throughout our healthcare system.



Daniel Snyder, P.E., 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 providers sign Home Telehealth assessments and treatment plans.

Concur

Target date for completion: September 30, 2016

Facility response: The Home Telehealth providers are responsible for signing Home Telehealth assessments and treatment plans, and the Coordinator or designee is responsible for 100 percent record review to determine whether the provider signature is present. The monitoring will be recorded and be reported to Documentation and Standards Committee on a monthly basis with a target of 100 percent compliance.

**Recommendation 2.** We recommended that clinicians consistently notify patients of their laboratory results within the timeframe set by local policy.

Concur

Target date for completion: September 30, 2016

Facility response: Clinicians are responsible for consistently notifying patients of laboratory results timely. Clinicians were re-educated in February 2016 regarding the requirements for timely notification. The notification of timely laboratory results will be monitored by the Chief of HIMS or designee to determine compliance. The results will be reported to Documentation and Standards committee with a target of 100 percent compliance.



## Office of Inspector General Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the OIG at (202) 461-4720.
<b>Inspection Team</b>	Martha A. Kearns, MSN, FNP, Team Leader Darlene Conde-Nadeau, MSN, ARNP Carol Torczon, MSN, ACNP
<b>Other Contributors</b>	Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Anita Pendleton, AAS Jennifer Reed, RN, MSHI Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, RN, MSN Jarvis Yu, MS

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## Endnotes

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<sup>e</sup> Reference used for Patient Aligned Care Team Compass data graphs:

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