Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-01296-203

Community Based Outpatient Clinics Summary Report

Evaluation of Alcohol Use Disorder Care at Community Based Outpatient Clinics and Other Outpatient Clinics

June 23, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a systematic review of the Veterans Health Administration's Community Based Outpatient Clinics and other outpatient clinics to evaluate for compliance with selected Veterans Health Administration requirements regarding alcohol use screening and follow-up in the primary care setting.

The objectives were to determine whether outpatient clinics (Community Based Outpatient Clinics, primary care clinics, and other outpatient clinics) complied with the requirements to provide:

- Further assessment of patients with a positive alcohol screen to determine the level of misuse.
- Education and counseling for patients who identified consumption exceeding National Institute on Alcohol Abuse and Alcoholism guidelines.
- Brief motivational counseling, referral to specialty providers, or other interventions for patients whose excessive alcohol use was persistent.
- Brief treatments for alcohol use disorder through face-to-face, tele-mental health, or phone encounters within 2 weeks of the time that the positive screen is completed.
- Patient Aligned Care Team clinical staff training in motivational interviewing and National Center for Health Promotion and Disease Prevention health coaching within 12 months of appointment to the Patient Aligned Care Team.

We performed this focused review of the outpatient clinics at 56 VA medical centers. Our initial electronic health records sample consisted of 2,088 patients who were screened within the study period of July 1, 2013, through June 30, 2014, and had a positive Alcohol Use Disorders Identification Test Consumption score ($\geq$5).

We estimated that:

- Staff completed further assessment of patients with a positive alcohol screen to determine the level of misuse in 84.4 percent of the electronic health records reviewed.
- Clinicians provided education and counseling to 94.5 percent of patients for their drinking levels and the adverse consequences of heavy drinking.
- Clinicians offered further treatment to 70 percent of patients diagnosed with alcohol dependence.
- Clinicians documented a plan for further monitoring for 82.9 percent of the patients who declined further treatment.

- Clinicians provided counseling, education, and brief treatments for alcohol use disorder to 93.3 percent of patients with excessive and persistent alcohol use.

- Clinic staff did not consistently complete required motivational interviewing and/or health coaching training within 12 months of appointment to Patient Aligned Care Teams.

We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that:

- Clinic staff complete diagnostic assessments for patients with a positive alcohol screen and that managers monitor for compliance.

- Clinic staff document the offer of further treatment to patients diagnosed with alcohol dependence and that managers monitor for compliance.

- Clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care and that managers monitor for compliance.

- Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.

- Clinic providers and clinical associates receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Comments

The Under Secretary for Health concurred with the findings and recommendations. (See Appendix B, pages 15–23, for the full text of the comments.) The implementation plans are acceptable, and we will follow up until all actions are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a systematic review of the Veterans Health Administration's (VHA's) Community Based Outpatient Clinics (CBOCs) and other outpatient clinics to evaluate for compliance with selected VHA requirements regarding alcohol use screening and follow-up in the primary care setting.

The objectives were to determine whether outpatient clinics (CBOCs, primary care clinics, and other outpatient clinics) complied with the requirements to provide:

- Further assessment of patients with a positive alcohol screen to determine the level of misuse.
- Education and counseling for patients who identified consumption exceeding National Institute on Alcohol Abuse and Alcoholism (NIAAA) guidelines.
- Brief motivational counseling, referral to specialty providers, or other interventions for patients whose excessive alcohol use was persistent.
- Brief treatments for alcohol use disorder (AUD) through face-to-face, tele-mental health, or phone encounters within 2 weeks of the time that the positive screen is completed.
- Patient Aligned Care Team (PACT) clinical staff training in motivational interviewing and National Center for Health Promotion and Disease Prevention health coaching.

Background

The United States Preventive Services Task Force has identified alcohol use screening as the third highest prevention priority for US adults.[1] For patients who screen positive, brief alcohol counseling interventions decrease drinking behaviors.[2,3] VHA policy requires alcohol misuse screening for new patients and a minimum of annual screenings for established patients.[4]

Specifically, VHA utilizes the Alcohol Use Disorders Identification Test Consumption (AUDIT-C) questions, an evidence-based unhealthy alcohol use screening tool. The AUDIT-C utilizes the first three questions of the World Health Organization AUDIT questionnaire. The three-item alcohol screen reliably identifies "positive" patients who are hazardous drinkers or have active alcohol use disorders.[5] The AUDIT-C is scored on a scale of 0–12, and VHA utilizes the positive score of 5 for both men and women to

[1] Quality Enhancement Research Initiative (QUERI) Audit-C Frequently Asked Questions, http://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-faqs.cfm

[2] Whitlock EP, Polen MR, Green CA, Orleans T, Klein J. Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2004; 140:557-568.

[3] Kaner E, Beyer F, Dickinson H, et al. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database Syst Rev*. 2007(2):CD004148.

[4] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

[5] AUDIT-C: http://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-faqs.cfm

identify patients "at risk" for alcohol misuse.[6] A score of 8 or above may indicate a diagnosable AUD.

The AUDIT-C identifies general drinking amounts; therefore, further assessment is necessary to determine the patient's drinking behaviors and whether the drinking amount is within recommended limits of use. VHA utilizes NIAAA guidelines on drinking limits. Men should not drink more than 4 drinks on any single day and no more than 14 drinks per week. Women should not drink more than three drinks on any single day and no more than seven drinks per week. To be low risk, a person must keep within applicable single-day and weekly limits.

VHA requires further diagnostic assessment, education, and counseling regarding NIAAA drinking limits for patients who have a positive AUDIT-C screen (over 5) within 14 days.[7] If the patient drinks above recommended limits, the clinician is required to provide a brief intervention to counsel the patient to abstain or cut down and review medical problems associated with alcohol use.[8]

An AUDIT-C score of 8 or above is potentially indicative of persistent excessive alcohol use and AUD. If the patient is drinking above recommended levels, VHA requires brief motivational counseling, referral to specialty providers, or other interventions as appropriate to address the patient's particular treatment needs at the time of assessment.

VHA utilizes a clinical reminder to support the alcohol misuse screening, assessment, education, and counseling of patients.[9] VHA developed a national clinical reminder template that many, but not all, facilities utilize. Some facilities made local modifications to the national template as well. The screening can be completed by trained staff members including clinical associates (licensed practical/licensed vocational nurses, health technicians, certified nursing assistants, and medical assistants). However, the assessment and provision of education and counseling need to be completed by a registered nurse or a provider (physicians, nurse practitioners, and physician assistants).

The national clinical reminder template includes a screen for patients who score 5, 6, or 7—this inquires about drinking limits and cues the provider to offer required feedback about impact of alcohol use on medical conditions and intervention (such as, to abstain or drink below NIAAA limits). For patients who score 8 or above, excessive and persistent alcohol use is likely, but the template does not offer the same cue to inquire about drinking limits. However, the assessment of level of misuse is still required per VHA policy, and the recommendation for the most appropriate intervention cannot be assumed based on the number of the screening score.[10]

[6] Quality Enhancement Research Initiative (QUERI) Audit-C Frequently Asked Questions, http://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-faqs.cfm#9.
[7] VHA Handbook 1160.01.
[8] http://www.queri.research.va.gov/tools/alcohol-misuse/alcohol-clinical-reminder-followup.cfm.
[9] Ibid.
[10] VHA Handbook 1160.01.

The provider may refer the patient to a specialty provider without assessing level of alcohol misuse, and this is an acceptable alternative. If this occurs, however, the specialty provider assessment must be completed within 2 weeks of the screening.

VHA recognized the role of identification and early interventions for AUD in primary care settings and requires specialized training for Patient-Aligned Care Team Registered Nurse care managers (RNCM). This includes the requirement for RNCMs to complete training for motivational interviewing (MI), the evidence-based clinical method to guide patients to make healthy choices by eliciting and supporting their own motivation to change, within 12 months of appointment to a PACT.[11,12,13]

Additionally, VHA focuses on the identification of and early interventions for AUD in primary care settings and requires National Center for Health Promotion and Disease Prevention (NCP) health coaching training for all health care team members within 12 months of appointment to a PACT.[14] This includes all providers, RNCMs, and clinical associates. "TEACH for Success" is the NCP-approved program designed to improve patient-centered communication, health education, health coaching, and partnership skills.[15,16] This is a 1-day program that is divided into five units (the titles of which create the program title acronym):

- **Unit T**—Tune into the Patient
- **Unit E**—Explore the Patient's Concerns, Preferences, and Needs
- **Unit A**—Assist the Patient with Behavior Changes
- **Unit C**—Communicate Effectively
- **Unit H**—Honor the Patient as a Partner.

Scope and Methodology

Scope. The Office of Healthcare Inspections conducted this inspection during CBOC reviews performed in fiscal year 2015. We considered all outpatients at the facility's CBOCs and other outpatient clinics who had positive scores of 5 and above on the AUDIT-C during July 1, 2013, through June 30, 2014, to assess the focused review objectives. We randomly selected 40 outpatients, unless fewer were available, to assess for the focused review objectives.

Methodology. We reviewed facility policies and procedures relevant to AUD screening, treatment, and referral. We also evaluated electronic health records (EHRs) to

[11] Miller WR, Rose, GS. Toward a Theory of Motivational Interviewing, *Am Psychol*.; 2009, September; 64(6): 527–537. http://motivationalinterview.org/Documents/nihms146933%20(1).pdf
[12] VHA National Center for Prevention (NCP). *NCP Training Resources*. http://vaww.infoshare.va.gov/sites/prevention/NCP_Training_Resources/Shared%20Documents/Forms/AllItems.aspx.
[13] Goldstein, M. Motivational Interviewing. *HealthPOWER!*, 2011, Summer; p.5–6. http://www.prevention.va.gov/healthpower/HealthPower2011SummerFinal.pdf.
[14] VHA Handbook 1101.10, *Patient Aligned Care Teams (PACT)*, February 5, 2014.
[15] VHA National Center for Prevention, T21 Implementation Guidance, Version 1.0, October 2012, Office of Healthcare Transformation, NCP_Training_Resources
[16] Ibid.

determine if the selected review elements were documented according to the applicable VHA policies. We requested the staff training dates and validation for clinicians assigned to primary care clinics to determine if they received MI and TEACH for Success training. For those clinicians assigned on or after July 5, 2012, we determined if their training occurred within 12 months of appointment in accordance with VHA policy.[17] For those clinicians assigned to PACT prior to July 5, 2012, we assessed if the training was completed by July 5, 2013, allowing a 1-year grace period for policy implementation. We then validated the findings with key managers and staff.

We used a two-stage complex probability sample design to select patients from the study population for the EHR reviews. In the first stage of sampling, we statistically randomly selected 56 VA medical centers stratified by the 12 catchment areas of the OIG's Office of Healthcare Inspections regional offices. Then we compiled a list of eligible CBOC patients who were assigned to the parent facility for each of the selected 56 VA medical centers.[18]

In the second stage of sampling, we randomly selected 40 patients from each of the 56 patient lists for our EHR reviews. If a VA medical center had fewer than 40 eligible CBOC patients who met the criteria for the focused review, we reviewed all of the patients on the list.

Our randomly selected EHR sample consisted of 2,088 patients with a visit at the parent facility's outpatient clinics who had positive scores of 5 and above on the AUDIT-C during July 1, 2013, through June 30, 2014. We also reviewed the training records of 4,547 employees, which included providers,[19] RNCMs, and clinical associates[20] assigned to PACT teams at clinic settings in the community and the parent facility. The denominators for each issue presented varied based on the number of eligible records for each element assessed in the review.

Statistical Analysis. We estimated the VA compliant percentages for each of the review elements, taking into account the complexity of our multi-stage sample design. We used Horvitz-Thompson sampling weights (reciprocal of sampling probabilities) to account for unequal probability sampling and the Taylor expansion method to obtain the sampling errors for the estimates. We considered a VA medical center compliant with policy if at least 90 percent of its records reviewed met AUD screening, treatment, and referral requirements.

We presented 95 percent confidence intervals (CI) for the estimates of the true values (parameters) of the study population. A CI gives an estimated range of values (being calculated from a given set of sample data) that is likely to include an unknown population parameter. The 95% CI indicates that among all possible samples we could

[17] VHA Handbook 1120.02, Health *Promotion Disease Prevention (HPDP) Program*, July 5, 2012.
[18] Each outpatient site selected for physical inspection was randomized from all PC CBOCs, multi-specialty CBOCs, and heath care centers reporting to the parent facility and was operational and classified as such in VA's Site Tracking Database by October 1, 2014.
[19] Providers included physicians, nurse practitioners, and physician assistants.
[20] Clinical associates included licensed practical/vocational nurses, healthcare technicians, medical assistants, and certified nursing assistants.

have selected of the same size and design, 95 percent of the time the population parameter would have been included in the computed intervals.

Percentages can only take non-negative values from 0 to 100, but their logits can have unrestricted range so that the normal approximation can be used. Thus, we calculated the CIs for percentages on the logit scale and then transformed them back to the original scale to ensure that the calculated CIs contained only the proper range of 0 to 100 percent. All data analyses were performed using SAS statistical software, version 9.4 (TS1M0), SAS Institute, Inc. (Cary, North Carolina).

The Office of Healthcare Inspections conducted this inspection during CBOC reviews beginning October 1, 2014, through September 30, 2015. Facility-specific review results were reported in 56 CBOC reports. For this summary report, we aggregated and analyzed the data collected from the individual evaluations.

We conducted this inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Inspection Results

Issue 1: Further Assessment of Patients

Our sample included 2,088 EHRs, which included 2,012 male and 70 female patients with AUDIT-C scores ranging from 5 to 12. Table 1 below displays the positive AUDIT-C scores.

Table 1. Positive AUD Scores

Positive AUDIT-C Scores	Number of Patients	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
5	657	31.3	29.35	33.32
6	375	17.9	16.28	19.57
7	275	13.1	11.72	14.62
8	236	11.2	9.96	12.67
9	155	7.4	6.34	8.59
10	198	9.4	8.25	10.76
11	85	4.0	3.28	4.98
12	107	5.1	4.23	6.13

We estimated that staff completed diagnostic assessments in 84.4 percent EHRs reviewed; and, 95 percent of the time, the true compliance rate is between 82.76 and 85.88 percent. Thus, the compliance rate was statistically significantly below the 90 percent benchmark. Table 2 below displays the details.

Table 2. Completion of AUD Screenings

AUDIT-C Screenings	Number of Patients	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
Completed	1,762	84.4	82.76	85.88
Not Completed	326	15.6	14.12	17.24

For patients who received a diagnostic assessment, we collected data to report the frequency of the clinical disciplines which completed the assessment. We found that primary care providers completed 75.3 (95% CI: 73.18–77.22) percent of the assessments while Primary Care Mental Health Integration providers completed an additional 15.7 (95% CI: 14.04–17.44) percent. RNCMs and specialty clinic providers completed smaller proportions. Table 3 on the following page displays the details.

Table 3. Disciplines Completing Diagnostic Assessments

Disciplines Completing Diagnostic Assessments	Number of Clinicians	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
Primary Care Provider	1,326	75.3	73.18	77.22
Primary Care Mental Health Integration Provider	276	15.7	14.04	17.44
Registered Nurse Care Manager	100	5.7	4.69	6.86
Specialty Clinic Provider	42	2.4	1.77	3.21

Issue 2: Education and Counseling

We estimated that 72.4 percent (95% CI: 70.28–74.46) of the patients reviewed had documented drinking levels above NIAAA guidelines. We estimated that 94.5 percent (95% CI: 93.12–95.64) of these patients received education and counseling for their drinking levels and the adverse consequences of heavy drinking. Table 4 below displays the details.

Table 4. Education and Counseling

Education Provided	Number of Patients	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
Yes	1,206	94.5	93.12	95.64
No	70	5.5	4.36	6.88

Additionally, we estimated that the education was provided within 14 days as required by VHA policy in 98.0 percent (95% CI: 97.04–98.66) EHRs reviewed.[21] The compliance rate was not statistically significantly below the 90 percent benchmark. Table 5 below displays the details.

Table 5. Timeframe of Education and Counseling

Education Provided within 14 Days	Number of Patients	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
Yes	1,180	98.0	97.04	98.66
No	24	2.0	1.34	2.96

Issue 3: Brief Motivational Counseling, Referral to Specialty Providers, or Other Interventions

We estimated that an alcohol dependence diagnosis was documented for 24.3 percent (95% CI: 22.49–26.17) of the patients. We found that clinicians offered further treatment to 70 percent (95% CI: 65.87–73.86) of these patients. The compliance rate was statistically significantly below the 90 percent benchmark. Table 6 on the following page displays the details.

[21] VHA Handbook 1160.01.

Table 6. Patients with Alcohol Dependence Diagnosis

Alcohol Dependence	Number of patients	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
Yes	355	70.0	65.87	73.86
No	152	30.0	26.14	34.13

We estimated that 46.2 percent (95% CI: 41.05–51.43) of the patients then declined further treatment and that 82.9 percent (95% CI: 76.38–87.95) of the clinicians documented a plan for further monitoring for those patients. The compliance rate was statistically significantly below the 90 percent benchmark. Table 7 below displays the details.

Table 7. Plans to Monitor Patients Who Declined Further Treatment

Documented Plan For Monitoring	Number of Patients	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
Yes	136	82.9	76.38	87.95
No	28	17.1	12.05	23.62

Issue 4: Brief Treatments for Excessive and Persistent Alcohol Use

We estimated that 37.3 percent (95% CI: 35.26–39.41) of the patients had a documented AUDIT-C score of 8 or above with drinking levels above the NIAAA guidelines. Table 8 below displays the details.

Table 8. Patients with Excessive and Persistent Alcohol Use

Audit–C Score Above 8	Number of Patients	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
No	1, 309	62.7	60.59	64.74
Yes	779	37.3	35.26	39.41

We estimated that clinicians provided counseling, education, and brief treatments for AUD to 93.3 percent (95% CI: 91.22–94.89) of these patients with excessive and persistent alcohol use. Additionally, we estimated that clinicians provided counseling, education and treatment within 14 days as required by VHA policy for 98.1 percent (95% CI: 96.74–98.89) of the patients. The compliance rate was not statistically significantly below the 90 percent benchmark.[22]

Issue 5: PACT Clinical Staff Training

Table 9 displays the distribution of clinicians assigned to PACT teams. We estimated that 56.59 percent (95%CI: 55.14–58.02) of the staff were assigned to CBOCs, and

[22] Ibid.

0.68 percent (95%CI: 0.48–0.97) had dual assignments at both CBOCs and primary care clinics at the parent facility.

Table 9. Clinic Settings of PACT Teams

Assignment of PACT Clinical Staff	Number Clinicians	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
CBOC	2,573	56.59	55.14	58.02
Primary Care Clinic	1,943	42.73	41.30	44.18
CBOC and Primary Care Clinic	31	0.68	0.48	0.97

We estimated the clinical disciplines that received training for MI and/or TEACH for Success methods to care for patients with AUD. We estimated that 29.76 percent (95%CI: 28.45–31.11) were RNCMs, 29.24 percent (95%CI: 27.93–30.58) were licensed practical/vocational nurses, and 29.17 percent (95%CI: 27.87–30.51) were providers. Table 10 below displays the detailed results.

Table 10. PACT Clinicians Evaluated

PACT Clinical Disciplines	Number Clinicians	Estimated VA Compliance 95 Percent CI Limits		
		Percent	Lower	Upper
RNCM	1,354	29.76	28.45	31.11
Licensed Practical/Vocational Nurse	1,330	29.24	27.93	30.58
Providers	1,327	29.17	27.87	30.51
Nurse Practitioner	310	6.81	6.12	7.58
Healthcare Technician	90	1.98	1.61	2.43
Physician's Assistant	85	1.87	1.51	2.31
Medical Assistant	52	1.14	0.87	1.50
Certified Nursing Assistant	1	0.02	0.00	0.16

We estimated that 83.5 percent (95% CI: 79.82–86.58) of RNCMs assigned to PACT after July 5, 2012, received MI training, and 85.5 percent (95% CI: 83.05–87.71) of the RNCMs assigned to PACT prior to July 5, 2012, received MI training. Of those, we further estimated that 59.9 percent (95%CI: 54.94–64.66) completed the training during the 1-year policy implementation period. The compliance rate was statistically significantly below the 90 percent benchmark.

We estimated that 87.8 percent (95% CI: 84.50–90.47) of RNCMs assigned to PACT after July 5, 2012, received TEACH for Success training, and 92.0 percent (95% CI: 90.02–93.61) of the RNCMs assigned to PACT prior to July 5, 2012, received TEACH for Success training. Of those, we further estimated that 86.25 percent (95%CI: 83.82–88.36) completed the training during the 1-year policy implementation period. The compliance rate was not statistically significantly below the 90 percent benchmark.

We estimated that 68.2 percent (95% CI: 63.56–72.45) of providers assigned to PACT after July 5, 2012, received TEACH for Success training, and 82.8 percent (95% CI: 80.63–84.74) of the providers assigned to PACT prior to July 5, 2012, received

TEACH for Success training. Of those, we further estimated that 15.1 percent (95%CI: 13.29–17.20) completed the training during the 1-year policy implementation period. The compliance rate was statistically significantly below the 90 percent benchmark.

We estimated that 80.1 percent (95% CI: 76.51–83.29) of clinical associates assigned to PACT after July 5, 2012, received TEACH for Success training, and 89.6 percent (95% CI: 87.45–91.37) of the clinical associates assigned to PACT prior to July 5, 2012, received TEACH for Success training. Of those, we further estimated that 12.0 percent (95%CI: 10.09–14.26) completed the training during the 1-year policy implementation period. The compliance rate was statistically significantly below the 90 percent benchmark.

Conclusions

We estimated that staff completed diagnostic assessments in 84.4 percent of the patients reviewed. We found that primary care providers completed 75.3 percent of the assessments while Primary Care Mental Health Integration providers completed an additional 15.7 percent.

We estimated that 72.4 percent of the patients reviewed had documented drinking levels above NIAAA guidelines. We found general compliance in the provision of education and counseling for these patients and that this was done in a timely manner.

We estimated that an alcohol dependence diagnosis was documented for 24.3 percent of the patients reviewed, and clinicians offered further treatment to 70.0 percent of these patients. We also estimated that for the patients who declined further treatment, clinicians documented a plan for further monitoring for 82.9 percent (95% CI: 76.38–87.95) of them. The compliance rates were statistically significantly below the 90 percent benchmark.

For patients with excessive and persistent alcohol use, we found general compliance with clinicians' provision of counseling, education, and brief treatments for AUD.

We estimated that 83.5 percent of RNCMs assigned to PACT after July 5, 2012, and 85.5 percent of the RNCMs assigned to PACT prior to July 5, 2012, received MI training. Of those in the latter group, we further estimated that 59.9 percent completed the training during the 1-year policy implementation period. The compliance rate was statistically significantly below the 90 percent benchmark.

We estimated that 87.8 percent of RNCMs, 68.2 percent of providers, and 80.1 percent of clinical associates assigned to PACT after July 5, 2012, received TEACH for Success training. We also estimated that 92.0 percent of the RNCMs, 82.8 percent of the providers, and 89.6 percent of the clinical associates assigned to PACT prior to July 5, 2012, received TEACH for Success training. Of those, we further estimated that 86.25 percent of the RNCMs, 15.1 percent of the providers, and 12.0 percent of the clinical associates completed the training during the 1-year policy implementation

period. The compliance rate was statistically significantly below the 90 percent benchmark for providers and clinical associates.

Recommendations

1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinic staff complete diagnostic assessments for patients with a positive alcohol screen and that managers monitor for compliance.

2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinic staff document the offer of further treatment to patients diagnosed with alcohol dependence and that managers monitor for compliance.

3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that that clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care and that managers monitor for compliance.

4. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.

5. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinic providers and clinical associates receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Parent Facilities Reviewed[23]

Names	Locations
Samuel S. Stratton VA Medical Center	Albany, NY
Alaska VA Healthcare System	Anchorage, AK
VA Ann Arbor Healthcare System	Ann Arbor, MI
Charles George VA Medical Center	Asheville, NC
VA Maine Healthcare System	Augusta, ME
Battle Creek VA Medical Center	Battle Creek, MI
Beckley VA Medical Center	Beckley, WV
Edith Nourse Rogers Memorial Veterans Hospital	Bedford, MA
Gulf Coast Veterans Health Care System	Biloxi, MS
VA Boston Healthcare System	Boston, MA
Ralph H. Johnson VA Medical Center	Charleston, SC
Chillicothe VA Medical Center	Chillicothe, OH
Cincinnati VA Medical Center	Cincinnati, OH
Louis A. Johnson VA Medical Center	Clarksburg, WV
William Jennings Bryan Dorn VA Medical Center	Columbia, SC
VA North Texas Health Care System	Dallas, TX
VA Illiana Health Care System	Danville, IL
Dayton VA Medical Center	Dayton, OH
Durham VA Medical Center	Durham, NC
VA New Jersey Health Care System	East Orange, NJ
Erie VA Medical Center	Erie, PA
Veterans Health Care System of the Ozarks	Fayetteville, AR
North Florida/South Georgia Veterans Health System	Gainesville, FL
VA Pacific Islands Health Care System	Honolulu, HI
Iowa City VA Health Care System	Iowa City, IA
G.V. (Sonny) Montgomery VA Medical Center	Jackson, MS
VA Southern Nevada Healthcare System	North Las Vegas, NV
VA Central Western Massachusetts Healthcare System	Leeds, MA
Central Arkansas Veterans Healthcare System	Little Rock, AR
Robley Rex VA Medical Center	Louisville, KY
William S. Middleton Memorial Veterans Hospital	Madison, WI
Manchester VA Medical Center	Manchester, NH
Marion VA Medical Center	Marion, IL
Martinsburg VA Medical Center	Martinsburg, WV
Memphis VA Medical Center	Memphis, TN
VA Hudson Valley Health Care System	Montrose, NY
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
Northport VA Medical Center	Northport, NY
Oklahoma City VA Health Care System	Oklahoma City, OK
VA Nebraska-Western Iowa Health Care System	Omaha, NE
VA Palo Alto Health Care System	Palo Alto, CA
Phoenix VA Health Care System	Phoenix, AZ
VA Pittsburgh Healthcare System	Pittsburgh, PA
John J. Pershing VA Medical Center	Poplar Bluff, MO
VA Sierra Nevada Health Care System	Reno, NV
VA Roseburg Healthcare System	Roseburg, OR
Salem VA Medical Center	Salem, VA
VA San Diego Healthcare System	San Diego, CA

[23] This report refers to the CBOCs for these randomly selected parent facilities.

San Francisco VA Health Care System	San Francisco, CA
VA Puget Sound Health Care System	Seattle, WA
Mann-Grandstaff VA Medical Center	Spokane, WA
St. Cloud VA Health Care System	St. Cloud, MN
VA St. Louis Health Care System	St. Louis, MO
Central Texas Veterans Health Care System	Temple, TX
Tomah VA Medical Center	Tomah, WI
West Palm Beach VA Medical Center	West Palm Beach, FL

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: May 24, 2016

From: Under Secretary for Health (10)

Subject: **Office of Inspector General (OIG) Draft Report, Community Based Outpatient Clinics (CBOC) Summary Report: Evaluation of Alcohol Use Disorder Care Fiscal Year 2015 (Project No. 2015-01296-HI-0405) (VAIQ 7675338)**

To: Assistant Inspector General for Health Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report, Evaluation of Alcohol Use Disorder Care Fiscal Year 2015. The Veterans Health Administration (VHA) is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the Department of Veterans Affairs (VA) health care system. VHA is using the input from the VA's Office of Inspector General, and other advisory groups to identify root causes and to develop critical actions. As VHA implements corrective measures, we will ensure our actions are meeting the intent of the recommendations. VHA is dedicated to sustained improvement in the high risk areas.

2. The recommendations in this report apply to GAO high risk areas 1, 2 and 4. VHA's actions will serve to address ambiguous policies, inconsistent processes, inadequate oversight and accountability, and inadequate training for VA staff.

3. I have reviewed the draft report, and provide the attached action plan to address the report's recommendation 1-5.

4. If you have any questions, please email Karen M. Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

David J. Shulkin, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, CBOC Summary Report – Evaluation of Alcohol Use Disorder Care Fiscal Year 2015

Date of Draft Report: May 10, 2016

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinic staff complete diagnostic assessments for patients with a positive alcohol screen and that managers monitor for compliance.

VHA Comments: Concur in Principle

VHA concurs that Veterans should receive indicated interventions for at-risk alcohol use consistent with current evidence-base guidelines. This OIG audit took place prior to a recent revision in the VA-DoD Clinical Practice Guideline for Management of Substance Use Disorders (CPG-SUD); full text available at: http://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf).

A systematic review of the clinical evidence in this area is reflected in the recently revised CPG-SUD. There is no empiric basis to support the practice of performing a diagnostic assessment on everyone with a positive alcohol screen. Rather, the CPG-SUD (page 31, Section B "Brief Alcohol Intervention"/Discussion/paragraph 1) recommends brief alcohol intervention (BAI) as a universally indicated intervention for those who screen positive with the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C). VA requires annual AUDIT-C screening and BAI among those with AUDIT-C scores of five or greater based on the strength of this evidence. The CPG also recommends (page 31) that individuals who are higher risk for alcohol use disorder (AUD), which includes those with an AUDIT-C score ≥8, be considered for further treatment (i.e., evaluation and evidence-based care; see response to Recommendation 2 regarding reliable documentation of an offer for these services).

To respond to this recommendation, Primary Care Services will reiterate and update guidance to the field through a memorandum, noting the requirement for annual alcohol use screening and BAI when indicated, further advising the field regarding the recently revised CPG, and requiring an action plan and two quarters of follow-up for those facilities whose External Peer Review Program (EPRP) FY2015 performance on completion of BAI was greater than one standard deviation below the national average.

Additional support to the field will include national educational teleconferences for Patient Aligned Care Team providers on the updated CPG-SUD, and targeted outreach to facilities to assist in their action planning and quality improvement efforts.

To close this recommendation, Primary Care Services will submit the following:

1. Memorandum noted above, disseminated by the Deputy Undersecretary for Health for Operations and Management.
2. Two quarters of data from EPRP monitoring of compliance for annual alcohol use screening and completion of BAI when required.

Status:	Target Completion Date:
In process	January 2017

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinic staff document the offer of further treatment to patients diagnosed with alcohol dependence and that managers monitor for compliance.

VHA Comments: Concur

VHA concurs that Veterans who are at higher risk for alcohol use disorder (AUD) including those with an active diagnosis of alcohol dependence should be offered further treatment and that managers should monitor to ensure compliance with documentation.

Mental Health Services endorses the evidence-based practices contained in the recently revised VA-DoD Clinical Practice Guideline for Substance Use Disorders (CPG-SUD); full text available at http://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf). The CPG (see page 31, Section B "Brief Alcohol Intervention"/Discussion/paragraph 1) recommends that individuals who are higher risk for AUD, which includes those with an AUDIT-C score ≥8, be considered for further treatment (i.e., evaluation and evidence-based care).

The Office of Mental Health informatics staff will explore and implement modifications to the current design of the alcohol positive screen follow-up clinical reminder. This will effectively support reliable clinical documentation of an offer of further treatment to patients at higher risk for alcohol use disorder. It will also effectively support those with an active diagnosis of alcohol dependence, consistent with the recommendations of the CPG-SUD.

To close this recommendation, Primary Care Services will provide:

1. A copy of the modified clinical reminder, and require all facilities to certify its installation to their VISN director or to provide an alternative method for reliably assuring this documentation.

Status:	Target Completion Date:
In process	February 2017

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that that clinic staff document a plan to monitor the alcohol use of patients who decline referral to specialty care and that managers monitor for compliance.

VHA Comments: Concur

VHA concurs that documentation of a plan for monitoring alcohol use in patients who decline the offer of referral for specialized SUD services is an important part of care. Furthermore, annual alcohol use screening presents an opportunity for follow-up in all instances where BAI was previously indicated. As noted above, the Office of Mental Health informatics staff will explore and implement modifications to the current design of the alcohol positive screen follow-up clinical reminder that can effectively support reliable documentation of a plan to monitor alcohol use in patients who decline the offer of referral for specialized SUD services.

To close this recommendation, Primary Care Services will provide:

1. A copy of the modified clinical reminder, and require all facilities to certify its installation to their VISN director or to provide an alternative method for reliably assuring this documentation.

Status:	Target Completion Date:
In process	February 2017

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.

VHA Comments: Concur

This is supported by policy, VHA Handbook 1120.02, Health Promotion and Disease Prevention Core Program Requirements:

"(1) The Registered Nurse Care Manager (RNCM) (or equivalent from Special Population PACT) from each PACT must complete National Center for Prevention

(NCP)-approved training in health coaching (i.e., TEACH or an alternative program approved by NCP) and NCP-approved training in MI within 12 months of hire or appointment to a PACT."

While the VHA Handbook 1101.10 Patient Aligned Care Team (PACT) Handbook does not list a timeframe for completion, it does require RNCM to receive motivational interviewing.

"(b) PACT staff performing the responsibilities of the RNCM must complete NCP-approved communication and coaching skills training (i.e., TEACH or an alternative program approved by NCP) and in motivational interviewing. Training of additional PACT staff in Motivational Interviewing and complementary training in whole health coaching (offered by the Office of Patient Centered Care and Cultural Transformation) is encouraged to further enhance communication and coaching skills."

The findings presented in the OIG report indicate that 83.5 percent of PACT RNCMs assigned to PACT after July 5, 2012, and 85.5 percent of RNCMs assigned to PACT before July 5, 2015**,** completed Motivational Interviewing (MI) training, though smaller percentages completed MI training within the timeframe specified in VHA Handbook 1120.02 (within 12 months of PACT assignment). It should be noted that those RNCMs who received MI training more than 12 months post assignment to PACT, can never meet the, within 12 month of PACT assignment, requirement. Thus, only the small percent of current PACT RNCMs who have yet to complete MI training, as well as those who will be assigned the role of PACT RNCM in the future, will be targeted in the response to recommendation 4. The following steps will be taken to insure that PACT RNCMs receive MI training within 12 months of assignment to PACT:

1. NCP will continue to offer at least one annual MI Facilitator training to insure that each facility can meet these program requirements. As noted in the Report, the National Center for Health Promotion and Disease Prevention (NCP) (10P4N) offers training in MI for PACT staff by NCP-trained MI Facilitators, who are usually in the facility-based role of Health Behavior Coordinator. VHA Handbook 1120.02 specifies that each VHA facility maintain at least one NCP-trained MI Facilitator. At the end of FY 15, 90 percent of VHA facilities reported that they met VHA Handbook 1120.02 requirements for having NCP-trained MI and TEACH Facilitators available to conduct local training. NCP plans to conduct a MI Facilitator Training program in FY 2016.

2. NCP will continue to encourage NCP-trained facility-based MI Facilitators to collaborate with facility PACT leaders to ensure that all PACT RNCMs have access to MI training within a year of assignment to PACT.

3. NCP will continue to consider approving alternatives to NCP-developed MI training when these programs meet NCP standards for MI training.

4. NCP-trained facility-based MI Facilitators, or their designee, will monitor and document PACT RNCM completion of MI training or an approved alternative to NCP-provided MI training, at each facility.

To close this recommendation, National Center for Prevention will provide:

1. Documents demonstrating completion of a NCP-led MI Facilitator Training in FY 2016.
2. A report indicating the percentage of PACT RNCMs who have received NCP-approved MI training.

Status:	Target Completion Date:
In process	November 2016

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinic providers and clinical associates receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

VHA Comments: Concur

This is supported by policy, VHA Handbook 1120.02, Health Promotion and Disease Prevention Core Program Requirements:

"(2) The Clinical Associate (or equivalent from Special Population PACT) and Primary Care Provider from each PACT must complete NCP-approved training in health coaching (i.e., TEACH for Success (TEACH) or an alternative program approved by NCP) within 12 months of hire or appointment to a PACT."

In addition, VHA Handbook 1101.10 Patient Aligned Care Team (PACT) Handbook encourages health coaching training, but does not mandate this and does not list a timeframe:

"(c) VA medical facilities and Veterans Integrated Service Networks (VISNs) may, and are encouraged to, require NCP-approved training in patient-centered communication skills for all PACT staff (e.g., discipline-specific team members). NOTE: Training in patient-centered communication is available to VA employees through programs delivered by TEACH facilitators and NCP-approved motivational interviewing facilitators. Additional resources to support training in patient-centered communication are available through the Talent Management System."

The findings presented in the OIG report indicate that 87.8 percent of PACT RNCMs assigned to PACT after July 5, 2012, and 92 percent of RNCMs assigned to PACT before July 5, 2015, completed NCP-supported TEACH for Success (TEACH) training. The report also indicated that 68.2 percent of PACT Providers assigned to PACT after July 5, 2012, and 82.8 percent of Providers assigned to PACT before July 5, 2015,

completed TEACH training. Among PACT clinical associates, 80.1 percent of PACT clinical associates assigned to PACT after July 5, 2012, and 89.6 percent of clinical associates assigned to PACT before July 5, 2015, completed TEACH training. As also noted in the report, smaller percentages of RNCMs, Providers and clinical associates completed TEACH training within the timeframe specified in VHA Handbook 1120.02 (within 12 months of PACT assignment). It should be noted that those RNCMs, Providers and clinical associates who completed TEACH training more than 12 months post assignment to PACT can never meet the within 12 month of assignment requirement. Thus, only the small percent of current PACT RNCMs who have yet to complete MI training, as well as those who will be assigned a clinical PACT role in the future, will be targeted in the response to recommendation 5.

The following steps will be taken to assure that PACT RNCMs, Providers and clinical associates receive TEACH training within 12 months of assignment to PACT:

1. NCP will continue to offer at least one annual TEACH Facilitator training to insure that each facility can meet these program requirements. As noted in the Report, the National Center for Health Promotion and Disease Prevention offers training in TEACH by NCP-trained TEACH Facilitators. Facility-based Veterans Health Education Coordinators usually serve as the lead facilitator for TEACH and Health Behavior Coordinators serve as the co-lead with assistance from the Health Promotion Disease Prevention Program Managers who also serve as TEACH facilitators at many facilities. VHA Handbook 1120.02 specifies that each VHA facility maintain at least one NCP-trained TEACH Facilitator. At the end of FY 15, 90 percent of VHA facilities reported that they met VHA Handbook 1120.02 requirements for having NCP-trained MI and TEACH Facilitators available to conduct local training. NCP plans to conduct a TEACH Facilitator Training program in FY 2016.

2. NCP will continue to encourage NCP-trained facility-based TEACH Facilitators to collaborate with facility PACT leaders to insure that all PACT RNCMs, Providers and clinical associates have access to TEACH training within a year of assignment to PACT.

3. NCP will continue to consider approving alternatives to TEACH training when these programs meet NCP standards for TEACH training.

4. NCP-trained facility-based TEACH Facilitators, or their designee, will be monitor and document PACT RNCM, Provider and clinical associate completion of TEACH training, or an approved alternative to TEACH training, at each facility.

To close this recommendation, National Center for Prevention will provide:

1. Documents demonstrating completion of NCP-led TEACH Facilitator Training in FY 2016.
2. A report indicating the percentage of PACT RNCMs, Providers and Clinical Associates who have received NCP-approved TEACH training.

Status:	Target Completion Date:
In process	November 2016

Office of Inspector General
Contact and Staff Acknowledgments

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