Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00028-337

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Amarillo VA Health Care System Amarillo, Texas

June 23, 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
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 Amarillo VA Health Care System and Veterans Integrated Service Network 17 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 Childress VA Clinic, Childress, TX, as a representative site and evaluated the environment of care on March 22, 2016.

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

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

- Managers minimize the risk of infection when storing and disposing of medical waste.
- Exit routes are unobstructed.
- An alarm system or panic buttons in high-risk areas are installed and used.
- Managers review the hazardous materials inventory twice within a 12-month period.
- Staff protect and secure patient-identifiable information.
- Access to the information technology server closet is maintained according to information technology safety and security standards.

Home Telehealth Enrollment: Ensure that:

- Clinicians document the Home Telehealth enrollment process prior to the entry of monthly monitoring notes.

Outpatient Lab Results Management: Ensure that clinicians:

- Consistently notify patients of their laboratory results within the timeframe set by local policy.
- Consistently document in the electronic health record all attempts to communicate with the patients regarding their laboratory results.
- Consistently provide and document interventions for clinically significant abnormal laboratory results.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Community Based Outpatient Clinic and other outpatient clinic review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 16–21, for the full text of the Directors' comments.) We will follow up on the planned actions for the open recommendations until they are completed.

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

Objectives, Scope, and Methodology

Objectives

The CBOC and OOC reviews are an element of the OIG's efforts to ensure that our Nation's veterans receive high-quality VA health care services. As such, the CBOC and OOC reviews are recurring evaluations of selected outpatient care activities that focus on patient care quality and the EOC. In general, our objectives are to determine whether:

- The selected CBOC is compliant with EOC requirements.
- The CBOCs/OOCs are compliant with selected VHA documentation requirements for the enrollment, assessment, and monitoring of HT patients.
- The CBOCs/OOCs are compliant with VHA requirements for the patient notification and follow up of selected outpatient lab results.
- The CBOCs/OOCs are compliant with selected VHA requirements related to PTSD screening, diagnostic evaluation, and treatment.

Scope

To evaluate for compliance with requirements related to patient care quality and the EOC, we conducted an onsite inspection, reviewed clinical and administrative records, and discussed processes and validated findings with managers and employees. The review covered the following four activities:

- EOC
- HT Enrollment
- Outpatient Lab Results Management
- PTSD Care

The scope of this review is limited to the established objectives. Issues and concerns that come to our attention but are outside the scope of this standardized inspection will be reviewed and referred accordingly.

Methodology

The onsite EOC inspection was conducted at a randomly selected outpatient site of care that had not been previously inspected.[1] Details of the targeted study populations for the HT Enrollment, Outpatient Lab Results Management, and PTSD Care focused reviews are noted in Table 1.

Table 1. CBOC/OOC Focused Reviews and Study Populations

Review Topic	Study Population
HT Enrollment	All CBOC and OOC patients screened within the study period of July 1, 2014, through June 30, 2015, who have had at least one "683" Monthly Monitoring Note and did not have Monthly Monitoring Notes documented before July 1, 2014.
Outpatient Lab Results Management	All patients who had outpatient (excluding emergency department, urgent care, or same day surgery orders) potassium and sodium serum lab test results during January 1 through December 31, 2014.
PTSD Care	All patients who had a positive PTSD screen at the parent facility's outpatient clinics during July 1, 2014, through June 30, 2015.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

The review was performed in accordance with OIG standard operating procedures for CBOC and OOC reviews.

[1] Each outpatient site selected for physical inspection was randomized from all PC CBOCs, multi-specialty CBOCs, and health care centers reporting to the parent facility and was operational and classified as such in VA's Site Tracking Database by August 15, 2015.

Results and Recommendations

EOC

The purpose of this review was to assess whether CBOC managers have established and maintained a safe and clean EOC as required.[a]

We reviewed relevant documents and conducted a physical inspection of the Childress VA Clinic. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 2. EOC

NM	Areas Reviewed	Findings	Recommendations
Document and Training Review			
	Managers monitored clinic staff's hand hygiene compliance.		
	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 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.		
X	The clinic minimized the risk of infection when storing and disposing of medical waste.	The Childress VA Clinic did not have a separate secured storage room/area or an acceptable alternative process for storing and disposing of medical waste.	**1.** We recommended that the clinic manager ensures the risk of infection is minimized when storing and disposing of medical waste at the Childress VA Clinic.
	The clinic had unobstructed access to fire alarms/pull stations.		
	The clinic had unobstructed access to fire extinguishers.		
	For fire extinguishers located in large rooms or are obscured from view, the clinic identified the locations of the fire extinguishers with signs.		
	The exit signs were visible from every direction.		
X	Exit routes from the building were unobstructed.	The exit route from the building was obstructed at the Childress VA Clinic.	**2.** We recommended that the clinic manager ensures that exit routes are unobstructed at the Childress VA Clinic.
	Staff wore VA-issued identification badges.		
	The clinic controlled access to and from areas identified as security sensitive.		
X	The clinic had an alarm system or panic buttons installed in high-risk areas.	The Childress VA Clinic did not have an alarm system or panic buttons installed in high-risk areas.	**3.** We recommended that the Facility Director ensures the installation and use of an alarm system or panic buttons in high-risk areas at the Childress VA Clinic.
X	The clinic's inventory of hazardous materials was reviewed for accuracy twice within the prior 12 months.	The Childress VA Clinic's inventory of hazardous materials and waste was not reviewed for accuracy twice within the prior 12 months.	**4.** We recommended that the clinic manager reviews the Childress VA Clinic's hazardous materials inventory twice within a 12-month period.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	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.		
X	Documents containing patient-identifiable information were not visible or unsecured.	EHR documents and laboratory specimens containing patient-identifiable information were visible and unsecured at the Childress VA Clinic.	**5.** We recommended that staff at the Childress VA Clinic protect and secure patient-identifiable information.
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		
	Access to the information technology network room/server closet was restricted to personnel authorized by Office of Information and Technology, as evidenced by a list of authorized individuals.		
X	Access to the information technology network room/server closet was documented, as evidenced by the presence of a sign-in/sign-out log.	The Childress VA Clinic did not document access to the information technology network room/server closet.	**6.** We recommended that the Childress VA Clinic manager ensures that the information technology server closet is maintained according to information technology safety and security standards.

HT Enrollment

The purpose of this review was to determine whether the facility's CBOCs and OOCs are compliant with selected VHA documentation requirements for the enrollment, assessment, and monitoring of HT patients.[b]

We reviewed relevant documents and 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 3. HT Enrollment

NM	Areas Reviewed	Findings	Recommendations
	Clinicians entered a consult for HT services.		
	Clinicians completed the HT enrollment requests or "consults."		
	Clinicians documented contact with the patient to evaluate suitability for HT services.		
	Clinicians documented the patient or caregiver's verbal informed consent for HT services.		
	Clinicians documented assessments and treatment plans for HT patients.		
	Providers signed HT assessments and treatment plans.		
	Monthly monitoring notes were documented for each month of HT program participation.		
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 13 of 49 EHRs (27 percent).	**7.** We recommended that clinicians document the Home Telehealth enrollment process prior to the entry of monthly monitoring notes.

Outpatient Lab Results Management

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

We reviewed relevant documents and 47 EHRs. We also validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 4. Outpatient Lab Results Management

NM	Areas Reviewed	Findings	Recommendations
	The facility has a written policy regarding communication of lab results from diagnostic practitioner to ordering practitioner.		
	The facility has a written policy for the communication of lab results that included all required elements.		
X	Clinicians notified patients of their lab results.	Clinicians did not consistently notify 38 of 47 patients (81 percent) of their lab results within the timeframe set by local policy.	**8.** We recommended that clinicians consistently notify patients of their laboratory results within the timeframe set by local policy.
X	Clinicians documented in the EHR all attempts to communicate with the patients regarding their lab results.	For the patients who could not be contacted regarding their results, clinicians did not document all communication attempts with any of the 37 (100 percent).	**9.** We recommended that clinicians consistently document in the electronic health record all attempts to communicate with the patients regarding their laboratory results.
X	Clinicians provided interventions for clinically significant abnormal lab results.	Clinicians did not consistently provide and document interventions for clinically significant abnormal lab results for four of eight patients.	**10.** We recommended that clinicians consistently provide and document interventions for clinically significant abnormal laboratory results.

PTSD Care

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

We reviewed relevant documents and 48 EHRs. We also validated findings with key managers and staff. The table below shows the areas reviewed for this topic. The 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.[2] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. The following table provides information relative to each of the outpatient clinics and lists the services provided at each location.[3]

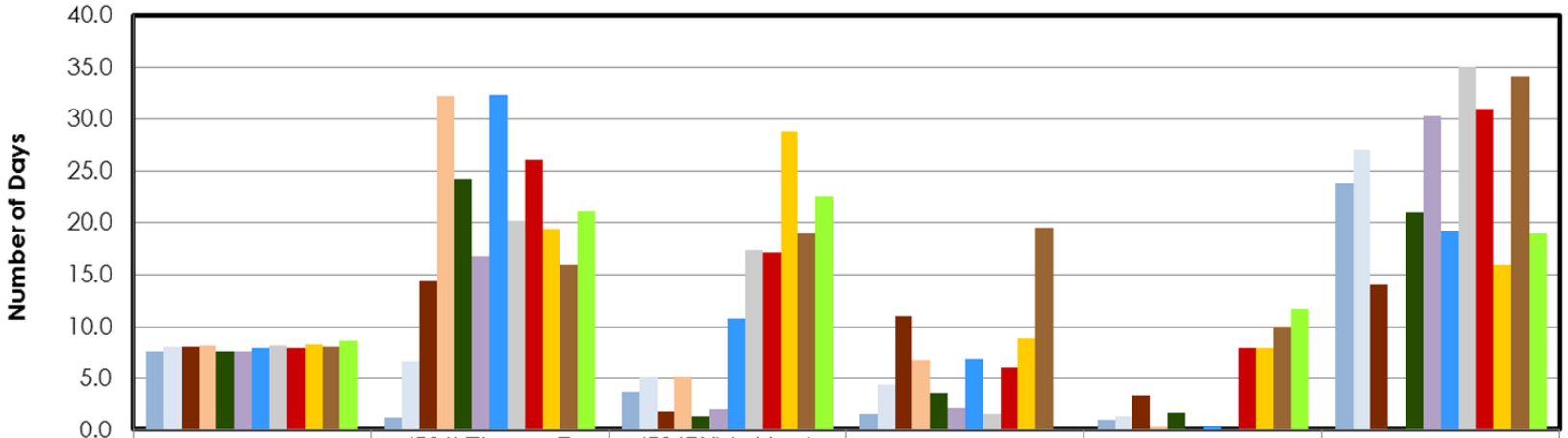
				Outpatient Workload / Encounters[4]			Services Provided[5]		
Location	**Station #**	**Rurality**	**Outpatient Classification[6]**	**PC**	**Mental Health**	**Specialty Clinics[7]**	**Specialty Care[8]**	**Ancillary Services[9]**	
Lubbock, TX	504BY	Urban	Multi-Specialty CBOC	17,314	13,008	14,339	Chemotherapy Dental Dermatology Nephrology Optometry Podiatry Rheumatology Urology	Diabetic Retinal Screening HBPC Imaging Services Laboratory MOVE! Program[10]	Nutrition Pharmacy Rehabilitation Services Social Work VIST
Clovis, NM	504BZ	Rural	Primary Care CBOC	2,848	3,367	189	Rheumatology	Pharmacy	
Childress, TX	504GA	Rural	Other Outpatient Services	732	112	0	NA	Pharmacy	
Dalhart, TX	504HB	Rural	Other Outpatient Services	367	15	5	NA	Pharmacy	

HBPC=Home Based Primary Care; VIST=Visual Impairment Services Team

[2] Includes all CBOCs in operation before August 15, 2015.
[3] http://vssc.med.va.gov/
[4] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting.
[5] The denoted Specialty Care and Ancillary Services are limited to Primary Clinic Stops with a count ≥ 100 encounters during the October 1, 2014, through September 30, 2015, timeframe at the specified CBOC.
[6] VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.
[7] The total number of encounters for the services provided in the "Specialty Care" column.
[8] Specialty Care Services refer to non-Primary Care and non-Mental Health services provided by a physician.
[9] Ancillary Services refer to non-Primary Care and non-Mental Health services that are not provided by a physician.
[10] VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.

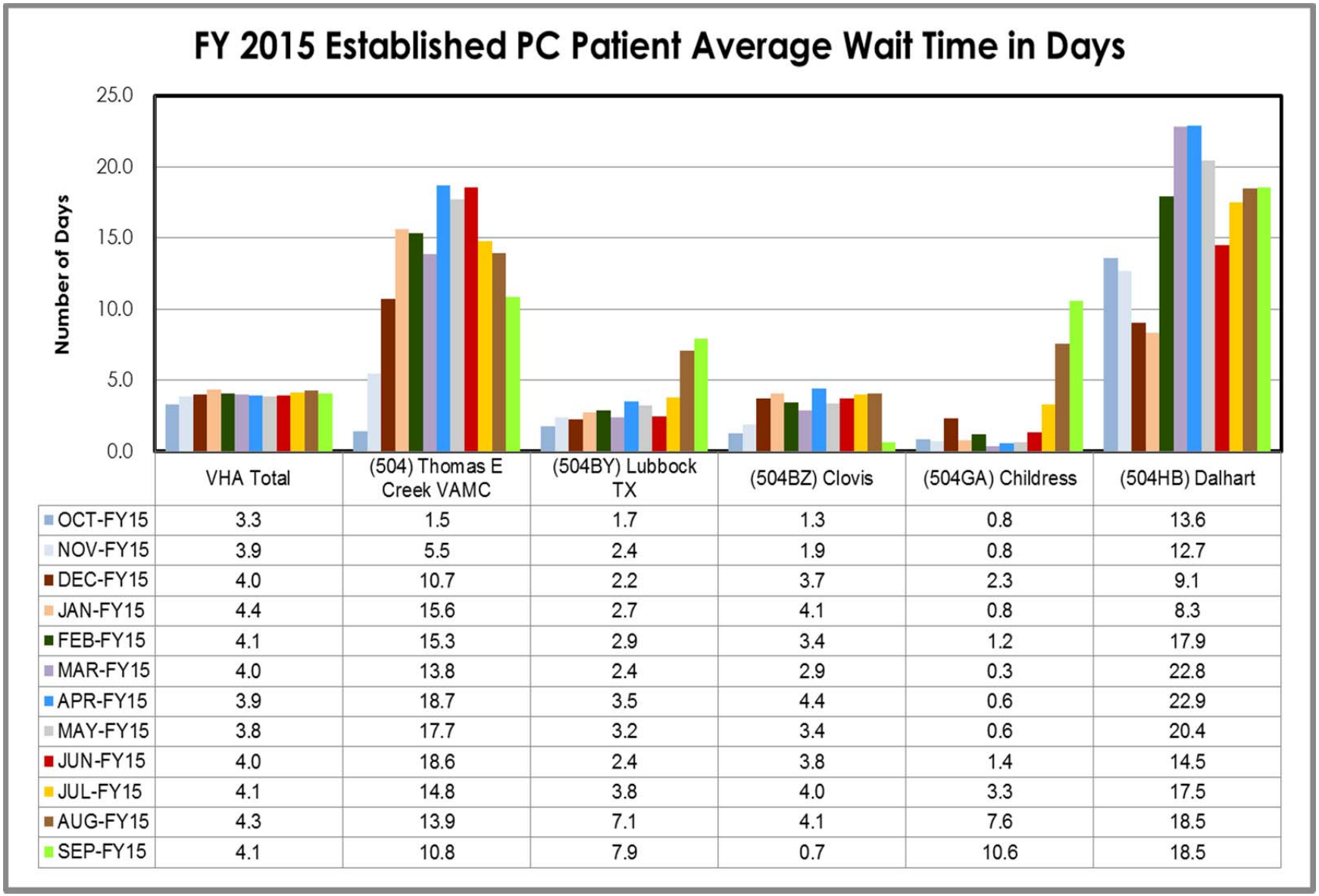
Patient Aligned Care Team Compass Metrics

FY 2015 New PC Patient Average Wait Time in Days



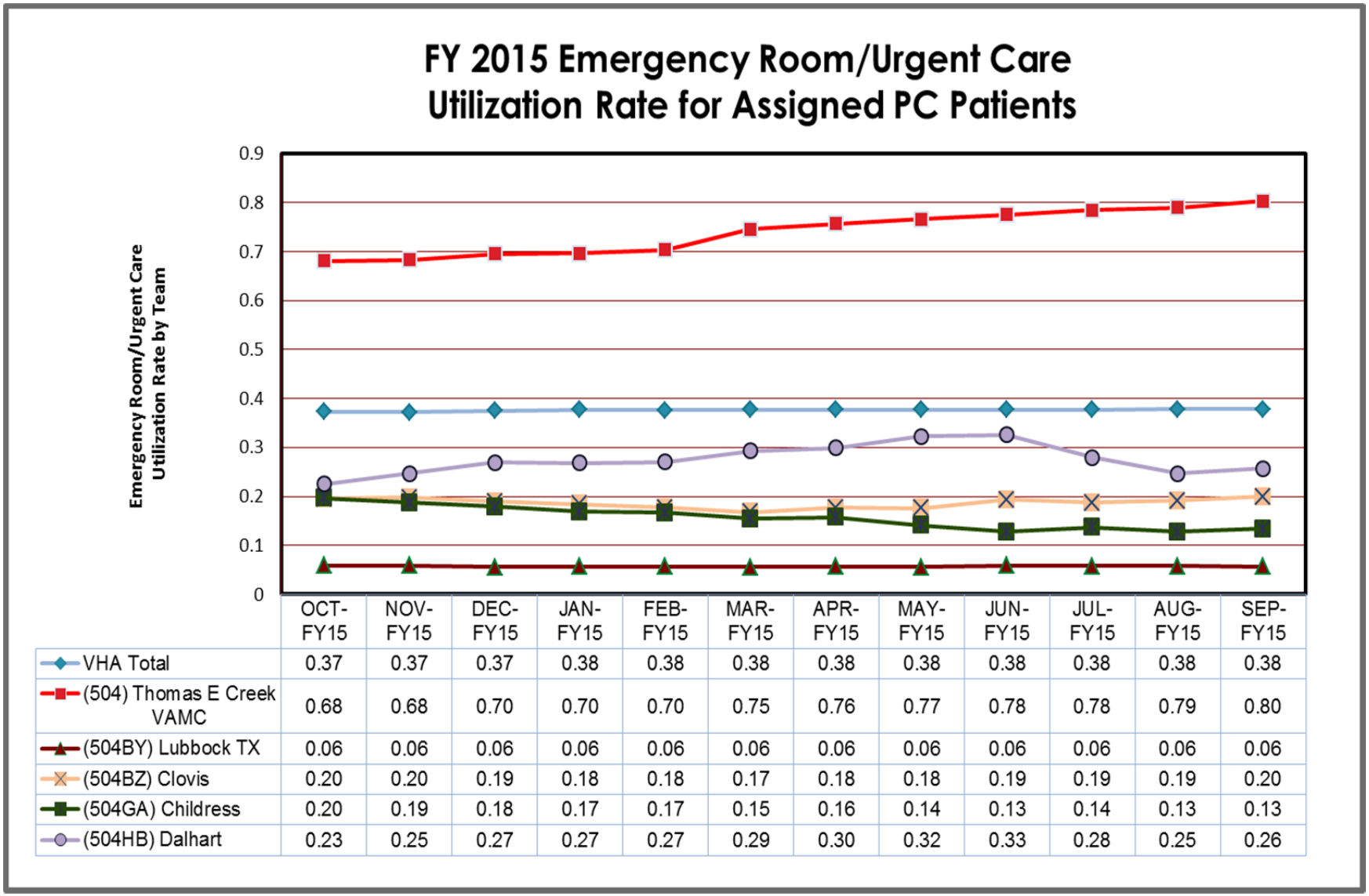
	VHA Total	(504) Thomas E Creek VAMC	(504BY) Lubbock TX	(504BZ) Clovis	(504GA) Childress	(504HB) Dalhart
OCT-FY15	7.6	1.3	3.7	1.6	1.0	23.8
NOV-FY15	8.1	6.6	5.2	4.4	1.4	27.0
DEC-FY15	8.1	14.3	1.8	11.0	3.4	14.0
JAN-FY15	8.2	32.2	5.2	6.7	0.3	
FEB-FY15	7.6	24.2	1.4	3.6	1.8	21.0
MAR-FY15	7.7	16.7	2.1	2.2	0.0	30.3
APR-FY15	7.9	32.4	10.8	6.9	0.3	19.3
MAY-FY15	8.2	20.2	17.4	1.5		35.0
JUN-FY15	8.0	26.1	17.2	6.1	8.0	31.0
JUL-FY15	8.3	19.5	28.8	8.9	8.0	16.0
AUG-FY15	8.1	15.9	19.0	19.5	10.0	34.2
SEP-FY15	8.7	21.1	22.6	0.0	11.7	19.0

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.



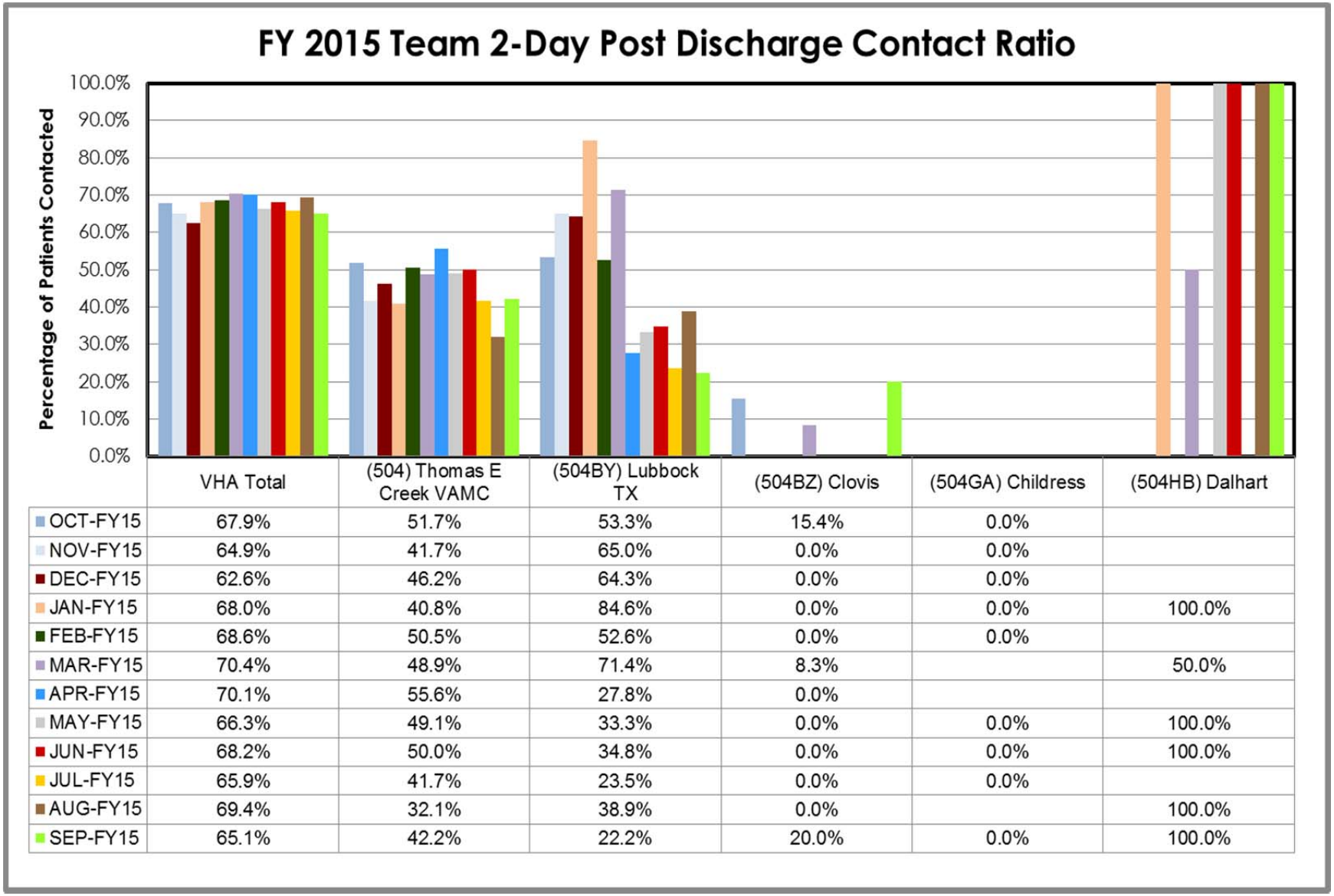
	VHA Total	(504) Thomas E Creek VAMC	(504BY) Lubbock TX	(504BZ) Clovis	(504GA) Childress	(504HB) Dalhart
OCT-FY15	3.3	1.5	1.7	1.3	0.8	13.6
NOV-FY15	3.9	5.5	2.4	1.9	0.8	12.7
DEC-FY15	4.0	10.7	2.2	3.7	2.3	9.1
JAN-FY15	4.4	15.6	2.7	4.1	0.8	8.3
FEB-FY15	4.1	15.3	2.9	3.4	1.2	17.9
MAR-FY15	4.0	13.8	2.4	2.9	0.3	22.8
APR-FY15	3.9	18.7	3.5	4.4	0.6	22.9
MAY-FY15	3.8	17.7	3.2	3.4	0.6	20.4
JUN-FY15	4.0	18.6	2.4	3.8	1.4	14.5
JUL-FY15	4.1	14.8	3.8	4.0	3.3	17.5
AUG-FY15	4.3	13.9	7.1	4.1	7.6	18.5
SEP-FY15	4.1	10.8	7.9	0.7	10.6	18.5

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



	OCT-FY15	NOV-FY15	DEC-FY15	JAN-FY15	FEB-FY15	MAR-FY15	APR-FY15	MAY-FY15	JUN-FY15	JUL-FY15	AUG-FY15	SEP-FY15
VHA Total	0.37	0.37	0.37	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38
(504) Thomas E Creek VAMC	0.68	0.68	0.70	0.70	0.70	0.75	0.76	0.77	0.78	0.78	0.79	0.80
(504BY) Lubbock TX	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06	0.06
(504BZ) Clovis	0.20	0.20	0.19	0.18	0.18	0.17	0.18	0.18	0.19	0.19	0.19	0.20
(504GA) Childress	0.20	0.19	0.18	0.17	0.17	0.15	0.16	0.14	0.13	0.14	0.13	0.13
(504HB) Dalhart	0.23	0.25	0.27	0.27	0.27	0.29	0.30	0.32	0.33	0.28	0.25	0.26

Data Definition.[e] The total Emergency Room/Urgent Care encounters for assigned PC patients in the last 12 months divided by the Team Assignments. VHA Emergency Room/Urgent Care encounters are defined as encounters with a Primary Stop Code of 130 or 131 in either the primary or secondary position, excluding encounters with a Secondary Stop Code of 107, 115, 152, 311, 333, 334, 999, 474, 103, 430, 328, 321, 329, or 435 and the encounter was with a licensed independent practitioner (MD, DO, RNP, PA).



	VHA Total	(504) Thomas E Creek VAMC	(504BY) Lubbock TX	(504BZ) Clovis	(504GA) Childress	(504HB) Dalhart
OCT-FY15	67.9%	51.7%	53.3%	15.4%	0.0%	
NOV-FY15	64.9%	41.7%	65.0%	0.0%	0.0%	
DEC-FY15	62.6%	46.2%	64.3%	0.0%	0.0%	
JAN-FY15	68.0%	40.8%	84.6%	0.0%	0.0%	100.0%
FEB-FY15	68.6%	50.5%	52.6%	0.0%	0.0%	
MAR-FY15	70.4%	48.9%	71.4%	8.3%		50.0%
APR-FY15	70.1%	55.6%	27.8%	0.0%		
MAY-FY15	66.3%	49.1%	33.3%	0.0%	0.0%	100.0%
JUN-FY15	68.2%	50.0%	34.8%	0.0%	0.0%	100.0%
JUL-FY15	65.9%	41.7%	23.5%	0.0%	0.0%	
AUG-FY15	69.4%	32.1%	38.9%	0.0%		100.0%
SEP-FY15	65.1%	42.2%	22.2%	20.0%	0.0%	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.

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 19, 2016

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **Review of CBOCs and OOCs of Amarillo VA Health Care System, Amarillo, TX**

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

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

1. Thank you for allowing me to respond to this CBOC Review for the Amarillo VA Health Care System.

2. I have reviewed and concur with the findings of this report. Specific corrective actions have been provided for the recommendations.

3. Should you have any questions, please contact Denise Elliott, VISN 17 Quality Management Officer at 817-385-3734.

for Joseph Dalpiaz
Network Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 19, 2016

From: Director, Amarillo VA Health Care System (504/00)

Subject: **Review of CBOCs and OOCs of Amarillo VA Health Care System, Amarillo, TX**

To: Director, VA Heart of Texas Health Care Network (10N17)

1. On behalf of AVAHCS, I would like to take this opportunity to express my sincere appreciation to the Office of the Inspector General (OIG), Community Based Outpatient Clinics and Other Outpatient Clinic (CBOC) review team for their professionalism, consultative approach, and excellent feedback provided to our staff during the review conducted the week of March 21, 2016.

2. The recommendations were reviewed and I concur with the findings. Our comments and implementation plan are delineated below. Corrective action plans have been developed or executed for continual monitoring. AVAHCS welcomes the external perspective provided, which we will utilize to further strengthen the quality of care we provide to our Veterans.

3. Should you have questions or require additional information, please do not hesitate to contact Leslie Whitaker, Chief of Quality, Safety, and Value at 806-355-9703, extension 7007.

Michael L. Kiefer, MHA, FACHE

Director, Amarillo VA Health Care System (504/00)

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 the clinic manager ensures the risk of infection is minimized when storing and disposing of medical waste at the Childress VA Clinic.

Concur

Target date for completion: May 13, 2016

Facility response: Infection Control performed an on-the-spot risk assessment and determined placement of medical waste bin in exam room cabinet was deemed acceptable. Completed.

Recommendation 2. We recommended that the clinic manager ensures that exit routes are unobstructed at the Childress VA Clinic.

Concur

Target date for completion: May 13, 2016

Facility response: The obstruction was removed in March 2016 while surveyors were on site. EOC rounds will be performed as scheduled to ensure compliance. Chief, Engineering will review EOC reports. EOC rounds were completed May 6, 2016 to verify. Completed.

Recommendation 3. We recommended that the Facility Director ensures the installation and use of an alarm system or panic buttons in high-risk areas at the Childress VA Clinic.

Concur

Target date for completion: May 31, 2016

Facility response: A panic button has been purchased and is scheduled to be installed by 5/31/16. Once installed, those panic alarms will be placed on a regular testing schedule.

Recommendation 4. We recommended that the clinic manager reviews the Childress VA Clinic's hazardous materials inventory twice within a 12-month period.

Concur

Target date for completion: August 31, 2016

Facility response: Environmental Protection Specialist developed process and created a spreadsheet for tracking to ensure the inventory of hazardous materials and waste for accuracy. This inventory process will be performed twice within 12 months. On April 14, 2016, Chief, Engineering conducted an inventory of hazardous materials and waste for Childress CBOC Clinic. Next review scheduled for August 2016. Progress of actions to be reported to Continuous Readiness committee, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

Recommendation 5. We recommended that staff at the Childress VA Clinic protect and secure patient-identifiable information.

Concur

Target date for completion: August 31, 2016

Facility response: A new scientific refrigerator has been ordered for Childress CBOC lab specimens containing PII and will include a lock to secure patient information. A privacy screen was applied to the computer monitor. On May 6, 2016, the Privacy Officer reeducated staff on requirements to secure PII/PHI. Compliance will be monitored during leadership monthly visits. If noncompliance is identified, the staff member is notified. A review of expectations with applicable staff was completed, and staff trending will be used to identify further actions. Progress of actions is to be reported at least monthly to Continuous Readiness committee, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability. Compliance will be monitored until sustainment has been demonstrated for 3 consecutive months.

Recommendation 6. We recommended that the Childress VA Clinic manager ensures that the information technology server closet is maintained according to information technology safety and security standards.

Concur

Target date for completion: August 31, 2016

Facility response: Chief, OI&T is to provide a sign-in log to document visitors accessing our portion of the Server Rack in the contracted space at Childress Fox Clinic. We have prepared a Sign-in Book with VELCRO Strips to attach the Sign-in Book to the Server Rack, and the new Sign-In process will be deployed by May 20, 2016. A two-tech team will review and report progress on security of the closet at that time. Progress of actions is to be reported at least monthly to Continuous Readiness committee, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

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

Concur

Target date for completion: August 31, 2016

Facility response: The Telehealth Manager identified the process as problematic before the OIG visit with corrective actions already accomplished. The Telehealth Manager is to perform chart audits monthly to ensure compliance. Randomly selected chart audits of 30 records per month will be conducted until 90% compliance is sustained for three consecutive months. When noncompliance is identified, the staff member is notified. A review of expectations with applicable staff was completed, and staff trending will be used to identify further actions. Progress of actions is to be reported at least monthly to Continuous Readiness committee, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

Recommendation 8. We recommended that clinicians consistently notify patients of their laboratory results within the timeframe set by local policy.

Concur

Target date for completion: August 31, 2016

Facility response: Chief, Ambulatory Care provided re-education to providers on notifying patients of their lab results within the timeframe set by local policy. Chief, Ambulatory Care to perform monthly chart audits to ensure compliance. Randomly selected chart audits of 30 records per month will be conducted until 90% compliance is sustained for three consecutive months. When noncompliance is identified, staff member is notified. Progress of actions is to be reported at least monthly to Continuous Readiness committee, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

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

Concur

Target date for completion: August 31, 2016

Facility response: Chief, Ambulatory Care provided re-education to providers on documenting all communication attempts regarding lab results. Chief, Ambulatory Care to perform monthly chart audits to ensure compliance. Randomly selected chart audits of 30 records per month will be conducted until 90% compliance is sustained for three consecutive months. When noncompliance is identified, the staff member is notified. Progress of actions is to be reported at least monthly to Continuous Readiness

committee, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

Recommendation 10. We recommended that clinicians consistently provide and document interventions for clinically significant abnormal laboratory results.

Concur

Target date for completion: August 31, 2016

Facility response: Chief, Ambulatory Care provided re-education to providers on documentation of interventions for clinically significant abnormal lab results. Chief, Ambulatory Care, or designee, is to perform monthly chart audits to ensure compliance. Randomly selected chart audits of 30 records per month will be conducted until 90% compliance is sustained for three consecutive months. When noncompliance is identified, the staff member is notified. Progress of actions is to be reported at least monthly to Continuous Readiness committee, then ultimately up to the leadership committee of Executive Health Care Committee (EHCC) to address accountability.

Office of Inspector General
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Endnotes

[a] References used for the EOC review included:

- International Association of Healthcare Central Services Materiel Management, *Central Service Technical Manual*, 7th ed.
- Joint Commission, *Joint Commission Comprehensive Accreditation and Certification Manua*l, July 1, 2015.
- National Fire Protection Association (NFPA), *NFPA 10: Installation of Portable Fire Extinguishers,* 2013.
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- US Department of Health and Human Services, *Health Information Privacy: The Health Insurance Portability and Accountability Act (HIPAA) Enforcement Rule*, February 16, 2006.
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- VA Directive 0059, *VA Chemicals Management and Pollution Prevention,* May 25, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program,* March 10, 2015.
- VHA Center for Engineering, Occupational Safety, and Health (CEOSH), *Emergency Management Program Guidebook*, March 2011.
- VHA Directive 2011-007, *Required Hand Hygiene Practices,* February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults & Other Defined Public Safety Incidents in VHA Facilities,* September 27, 2012.
- VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics,* May 19, 2004.
- VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans,* May 21, 2010.
- VHA Handbook 1605.1, *Privacy and Release of Information*, May 17, 2006.
- VHA Handbook 1907.01, *Health Information Management*, July 22, 2014.
- VHA Telehealth Services, *Clinic Based Telehealth Operations Manual,* July 2014.

[b] References used for the HT Enrollment review included:

- *VHA Office of VHA Telehealth Services Home Telehealth Operations Manual*, April 13, 2015. Accessed from: http://vaww.telehealth.va.gov/pgm/ht/index.asp.

[c] References used for the Outpatient Lab Results Management review included:

- VHA, *Communication of Test Results Toolkit*, April 2012.
- VHA Handbook 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.

[d] References used for the PTSD Care review included:

- Department of Veterans Affairs Memorandum, *Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 2015.
- *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, Version 2.0, October 2010.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.
- *VHA Technical Manual – PTSD*, VA Measurement Manual PTSD-51.

[e] Reference used for Patient Aligned Care Team Compass data graphs:

- Department of Veterans' Affairs, *Patient Aligned Care Teams Compass Data Definitions*, accessed: June 25, 2015.