Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00132-430

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Central Texas Veterans Health Care System Temple, Texas

July 27, 2015

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

AUD	alcohol use disorder
CBOC	community based outpatient clinic
EHR	electronic health record
EOC	environment of care
ER	emergency room
FY	fiscal year
HIV	human immunodeficiency virus
NM	not met
OIG	Office of Inspector General
OOC	other outpatient clinic
PACT	Patient Aligned Care Teams
RN	registered nurse
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 Central Texas Veterans 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 alcohol use disorder care, human immunodeficiency virus screening, outpatient documentation, and outpatient lab results management. We also randomly selected the Brownwood, TX, Community Based Outpatient Clinic as a representative site and evaluated the environment of care on April 15, 2015.

Review Results: We conducted five focused reviews and had no findings for the Human Immunodeficiency Virus Screening and Outpatient Documentation reviews. However, we made recommendations for improvement in the following three review areas:

Environment of Care: Ensure that:

- The staff at the Brownwood Community Based Outpatient Clinic receive regular information/updates on their responsibilities in emergency response operations.

Alcohol Use Disorder Care: Ensure that:

- Clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
- Clinic staff provide education and counseling for patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits.
- Clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
- Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.
- Providers in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Outpatient Lab Results Management: Ensure that:

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

Comments

The Acting Veterans Integrated Service Network and Facility Directors agreed with the Community Based Outpatient Clinic and other outpatient clinic review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 16–22, for the full text of the Directors' comments.) We will follow up on the planned actions for the open recommendations until they are completed.

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 requirements for AUD care.
- The CBOCs/OOCs are compliant with selected VHA requirements for HIV Screening.
- Healthcare practitioners at the CBOCs/OOCs comply with the requirements for outpatient documentation.
- The CBOCs/OOCs are compliant with VHA requirements for the patient notification and follow up of selected outpatient lab results.

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 five activities:

- EOC
- AUD Care
- HIV Screening
- Outpatient Documentation
- Outpatient Lab Results Management

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 AUD Care, HIV Screening, Outpatient Documentation, and Outpatient Lab Results Management focused reviews are noted in Table 1.

Table 1. CBOC/OOC Focused Reviews and Study Populations

Review Topic	Study Population
AUD Care	All CBOC and OOC patients screened within the study period of July 1, 2013, through June 30, 2014, and who had a positive AUDIT-C score;[2] and all licensed independent providers, RN Care Managers, and clinical associates assigned to PACT prior to October 1, 2013.
HIV Screening	All outpatients who had a visit in FY 2012 and had at least one visit at the parent facility's CBOCs and/or OOCs within a 12-month period during April 1, 2013, through March 31, 2014.
Outpatient Documentation	All patients new to VHA who had at least three outpatient encounters (face-to-face visits, telephonic/telehealth care, and telephonic communications) during April 1, 2013, through March 31, 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, 2014, through December 31, 2014.

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 primary care 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.
[2] The AUDIT-C is a brief alcohol screen that reliably identifies patients who are hazardous drinkers or have active alcohol use disorders. Scores range from 0–12.

Results and Recommendations

EOC

The purpose of this review was to evaluate 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 Brownwood CBOC. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Table 2. EOC

NM	Areas Reviewed	Findings	Recommendations
	The furnishings are clean and in good repair.		
	The CBOC is clean (walls, floors, and equipment are clean).		
	The CBOC's inventory of hazardous materials was reviewed for accuracy twice within the prior 12 months.		
	The CBOC's safety data sheets for chemicals are readily available to staff.		
	If safety data sheets are in electronic form, the staff can demonstrate ability to access the electronic version without coaching.		
	Employees received training on the new chemical label elements and safety data sheet format.		
	Clinic managers ensure that safety inspections of CBOC medical equipment are performed in accordance with Joint Commission standards.		
	Hand hygiene is monitored for compliance.		
	Personal protective equipment is readily available.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Sterile commercial supplies are not expired.		
	The CBOC staff members minimize the risk of infection when storing and disposing of medical (infectious) waste.		
	The CBOC has procedures to disinfect non-critical reusable medical equipment between patients.		
	There is evidence of fire drills occurring at least every 12 months.		
	Means of egress from the building are unobstructed.		
	Access to fire extinguishers is unobstructed.		
	Fire extinguishers are located in large rooms or are obscured from view, and the CBOC has signs identifying the locations of the fire extinguishers.		
	Exit signs are visible from any direction.		
	Multi-dose medication vials are not expired.		
	All medications are secured from unauthorized access.		
	The staff protects patient-identifiable information on laboratory specimens during transport.		
	Documents containing patient-identifiable information are not visible or unsecured.		
	Adequate privacy is provided at all times.		
	The women veterans' exam room is equipped with either an electronic or manual door lock.		
	The information technology network room/server closet is locked.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Access to the information technology network room/server closet is restricted to personnel authorized by Office of Information and Technology.		
	Access to the information technology network room/server closet is documented.		
	All computer screens are locked when not in use.		
	Information is not viewable on monitors in public areas.		
	The CBOC has an automated external defibrillator.		
	There is an alarm system and/or panic buttons installed and tested in high-risk areas (for example, mental health clinic), and the testing is documented.		
X	CBOC staff receive regular information/updates on their responsibilities in emergency response operations.	The CBOC staff at the Brownwood CBOC did not receive regular information/updates on their responsibilities in emergency response operations.	**1.** We recommended that the staff at the Brownwood CBOC receive regular information/updates on their responsibilities in emergency response operations.
	The staff participates in scheduled emergency management training and exercises.		

AUD Care

The purpose of this review was to determine whether the facility's CBOCs and OOCs complied with selected alcohol use screening and treatment requirements.[b]

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

Table 3. AUD Care

NM	Areas Reviewed	Findings	Recommendations
X	Diagnostic assessments are completed for patients with a positive alcohol screen.	Staff did not complete diagnostic assessments for 5 of 39 patients (13 percent) who had positive alcohol use screens.	**2**. We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
X	Education and counseling about drinking levels and adverse consequences of heavy drinking are provided for patients with positive alcohol screens and drinking levels above National Institute on Alcohol Abuse and Alcoholism guidelines.	Staff did not provide education and counseling for 3 of 27 patients who had positive alcohol use screens.	**3**. We recommended that clinic staff provide education and counseling for patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits.
X	Documentation reflects the offer of further treatment for patients diagnosed with alcohol dependence.	We did not find documentation of the offer of further treatment for 5 of 13 patients diagnosed with alcohol dependence.	**4**. We recommended that clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.
	For patients with AUD who decline referral to specialty care, clinic staff monitored them and their alcohol use.		
	Counseling, education, and brief treatments for AUD care are provided within 2 weeks of positive screening.		
X	Clinic RN Care Managers have received motivational interviewing training within 12 months of appointment to PACT.	We found that 29 of 29 RN Care Managers did not receive MI training within 12 months of appointment to PACT.	**5**. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinic RN Care Managers have received VHA National Center for Health Promotion and Disease Prevention-approved health coaching training (most likely TEACH for Success) within 12 months of appointment to PACT.		
X	Providers in the outpatient clinics have received VHA National Center for Health Promotion and Disease Prevention-approved health coaching training (most likely TEACH for Success) within 12 months of appointment to PACT.	We found that 7 of 44 providers (16.9 percent) did not receive health coaching training within 12 months of appointment to PACT.	6. We recommended that providers in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.
	Clinical associates in the outpatient clinics have received VHA National Center for Health Promotion and Disease Prevention-approved health coaching training (most likely TEACH for Success) within 12 months of appointment to PACT.		
	The facility complied with any additional elements required by VHA or local policy.		

HIV Screening

The purpose of this review was to determine whether CBOCs/OOCs are compliant with selected VHA requirements for HIV Screening.[c]

We reviewed the facility's self-assessment, VHA and local policies, and guidelines to assess administrative controls over the HIV screening process. We also reviewed 35 EHRs and 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 4. HIV Screening

NM	Areas Reviewed	Findings	Recommendations
	The facility has a HIV Lead Clinician to carry out responsibilities as required.		
	The facility has policies and procedures to facilitate HIV testing.		
	The facility had developed policies and procedures that include requirements for the communication of HIV test results.		
	Written patient educational materials utilized prior to or at the time of consent for HIV testing include all required elements.		
	Clinicians provided HIV testing as part of routine medical care for patients.		
	When HIV testing occurred, clinicians consistently documented informed consent.		
	The facility complied with additional elements as required by local policy.		

Outpatient Documentation

The purpose of this review was to determine whether healthcare practitioners at the CBOCs/OOCs comply with selected requirements for outpatient documentation.[d]

We reviewed relevant documents and 41 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. Outpatient Documentation

NM	Areas Reviewed	Findings	Recommendations
	A relevant history of the illness or injury and physical findings are documented when the patient is first admitted for VA medical care on an outpatient level.		
	Randomly selected progress notes contain the required documentation components in the EHR.		

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.[e]

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

Table 6. 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 patients of their lab results within the timeframe set by local policy.	**7**. We recommended that clinicians consistently notify patients of their laboratory results within the timeframe set by local policy.
	Clinicians documented in the electronic health record all attempts to communicate with the patients regarding their ab results.		
	Clinicians provided interventions for clinically significant abnormal lab results.		

Clinic Profiles

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

			Outpatient Workload / Encounters[4]			Services Provided[5]			
Location	**Station #**	**Rurality[6]**	**PC**	**MH**	**Specialty Clinics[7]**	**Specialty Care[8]**		**Ancillary Services[9]**	
Austin, TX	674BY	Urban	50,212	66,226	46,264	Cardiology Chemotherapy Dental Dermatology Endocrinology ENT GI Gynecology Infectious Disease	Nephrology Neurology Oncology Ophthalmology Optometry Podiatry Pulmonary Rheumatology Surgery	Audiology Chiropractic Care Diabetes Care Diabetic Retinal Screening EKG HBPC Hypertension Imaging Services Kinesiotherapy	Laboratory Mammography MOVE! Program[10] Nutrition PFT Pharmacy Prosthetics/Orthotics Rehabilitation Services Respiratory Therapy Social Work Speech Pathology
Palestine, TX	674GA	Rural	7,295	3,516	71	N/A		Diabetic Retinal Screening EKG HBPC	Imaging Services MOVE! Program Pharmacy

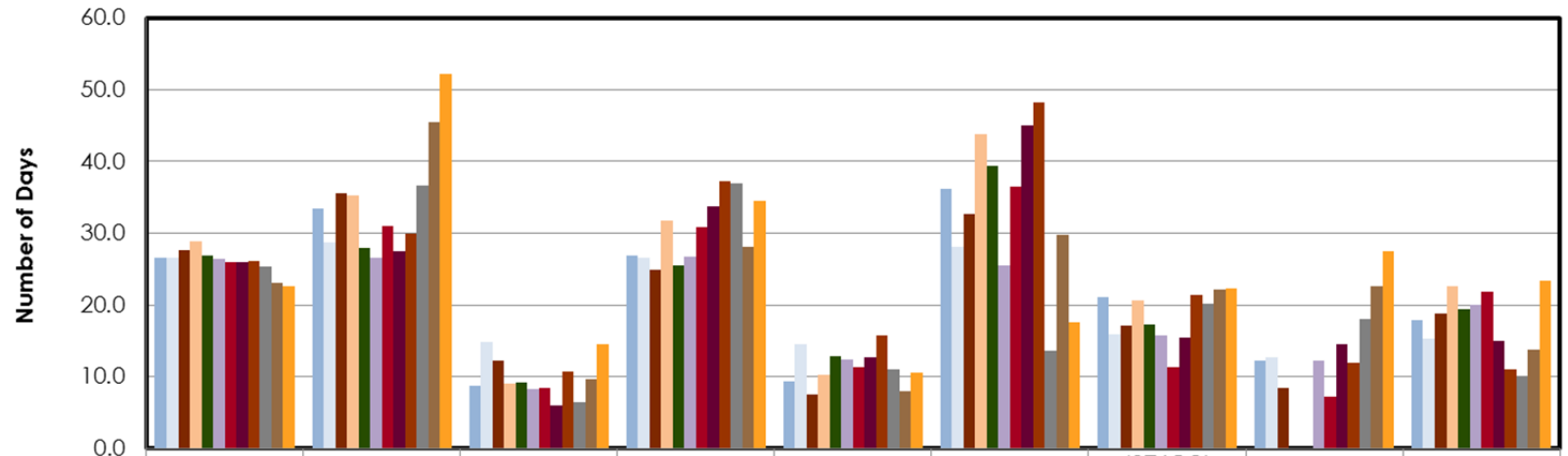
[3] Includes all CBOCs in operation before April 1, 2014.
[4] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting.
[5] The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

			Outpatient Workload / Encounters			Services Provided		
Location (continued)	**Station #**	**Rurality**	**PC**	**MH**	**Specialty Clinics**	**Specialty Care**	**Ancillary Services**	
Brownwood, TX	674GB	Rural	16,917	5,869	0	N/A	Diabetes Care EKG Imaging Services	Laboratory MOVE! Program Social Work
Bryan, TX	674GC	Urban	13,753	5,717	0	N/A	EKG Imaging Services	Laboratory Social Work
Cedar Park, TX	674GD	Urban	12,669	3,551	11	N/A	Diabetes Care Diabetic Retinal Screening EKG HBPC	Imaging Services Laboratory MOVE! Program Pharmacy Social Work
La Grange, TX	674HB	Rural	2,972	96	0	N/A	EKG	

EKG = Electrocardiography; ENT = Ear, Nose, & Throat; GI = Gastroenterology; HBPC = Home Based Primary Care; PFT = Pulmonary Function Test

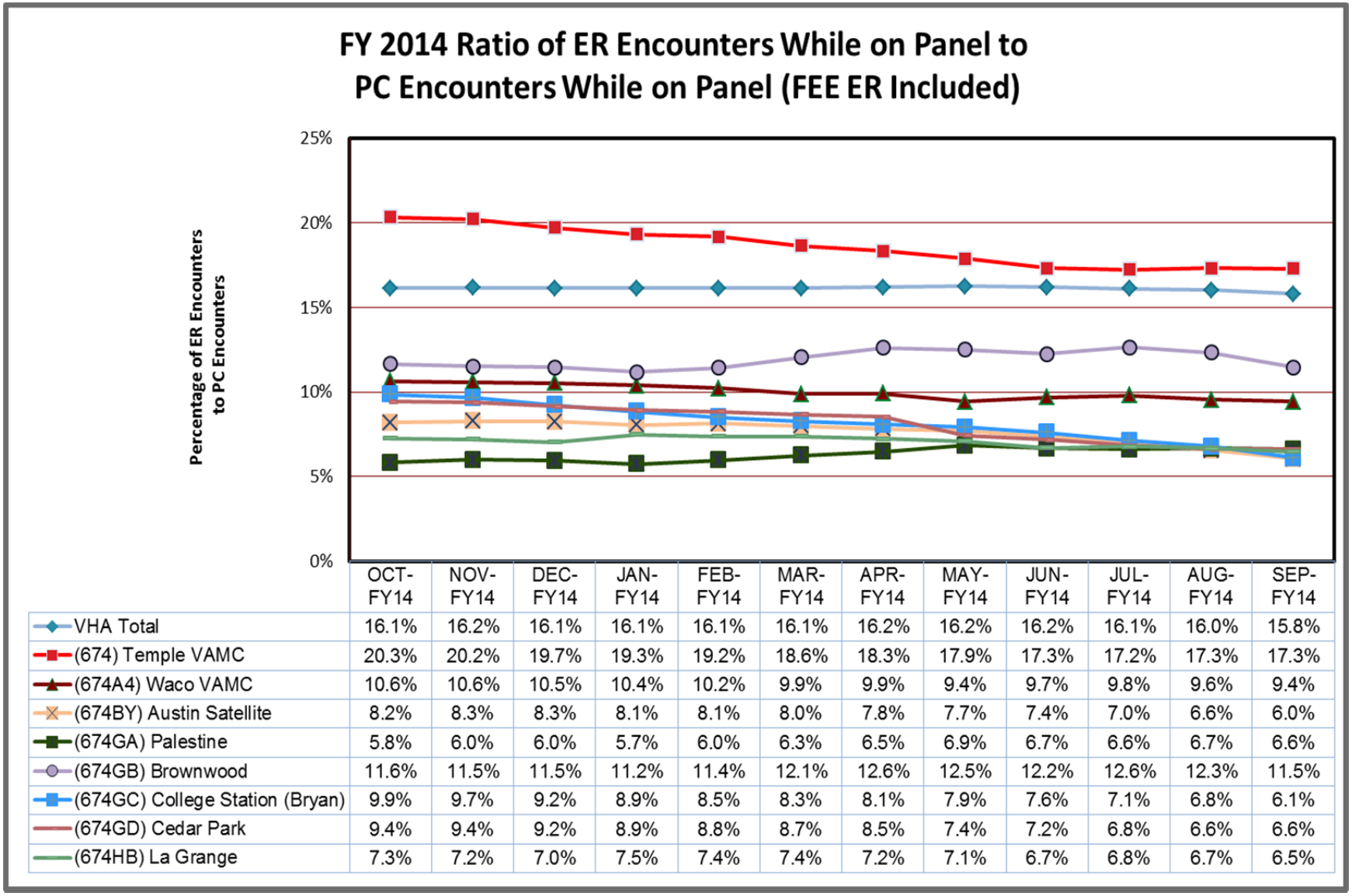
PACT Compass Metrics

FY 2014 New Primary Care Patient Average Wait Time in Days



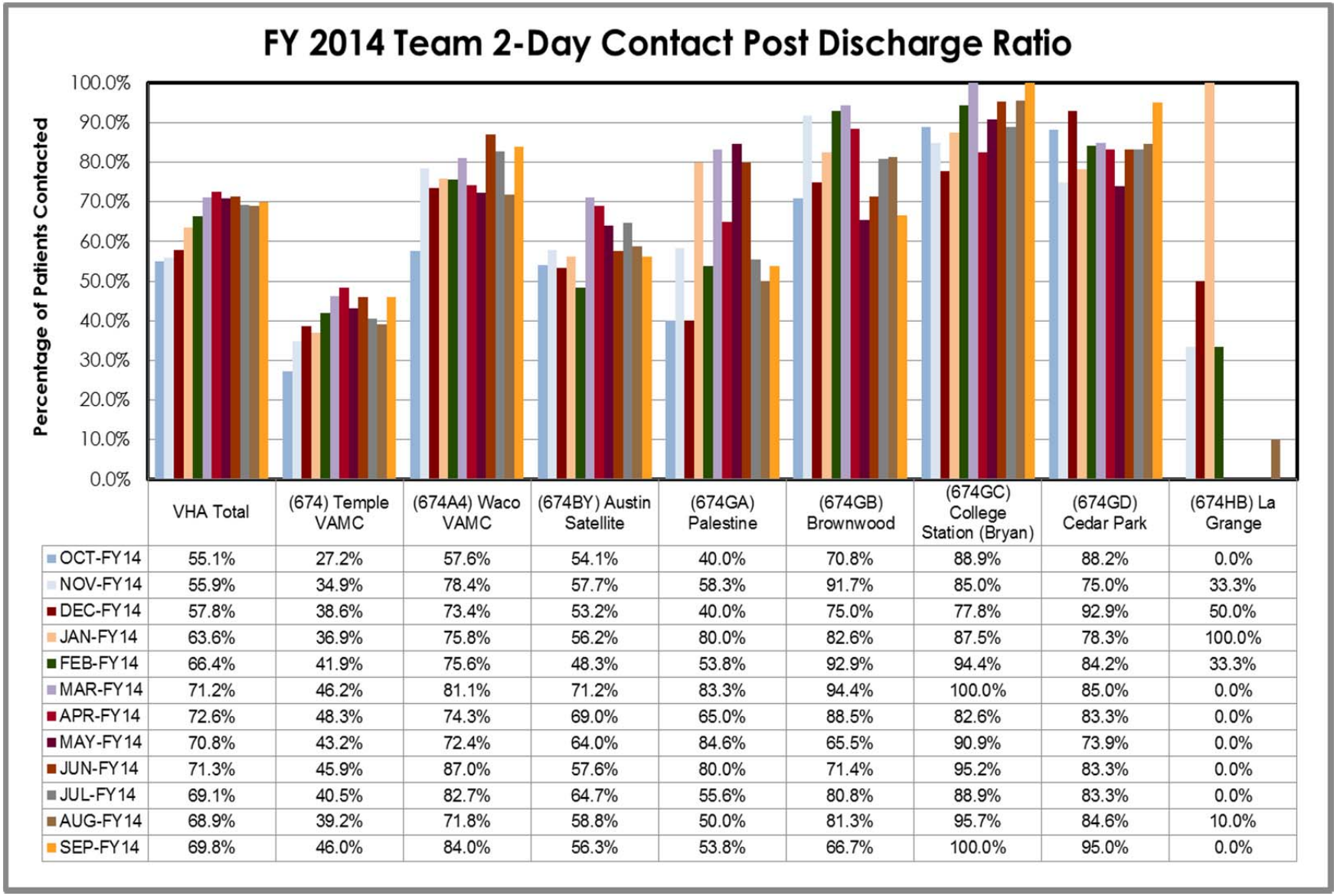
	VHA Total	(674) Temple VAMC	(674A4) Waco VAMC	(674BY) Austin Satellite	(674GA) Palestine	(674GB) Brownwood	(674GC) College Station (Bryan)	(674GD) Cedar Park	(674HB) La Grange
OCT-FY14	26.5	33.5	8.7	26.9	9.3	36.2	21.1	12.3	17.9
NOV-FY14	26.5	28.8	14.9	26.5	14.5	28.1	15.9	12.7	15.3
DEC-FY14	27.7	35.6	12.3	24.9	7.5	32.6	17.1	8.4	18.8
JAN-FY14	28.9	35.2	9.1	31.7	10.3	43.8	20.6	0.0	22.5
FEB-FY14	26.9	28.0	9.2	25.6	12.9	39.4	17.3	0.0	19.4
MAR-FY14	26.4	26.5	8.2	26.6	12.4	25.4	15.8	12.2	20.0
APR-FY14	25.9	31.0	8.3	30.9	11.3	36.4	11.3	7.2	21.9
MAY-FY14	26.0	27.5	6.0	33.7	12.7	45.0	15.5	14.5	14.9
JUN-FY14	26.1	30.0	10.7	37.2	15.8	48.2	21.3	12.0	11.0
JUL-FY14	25.3	36.6	6.5	37.0	11.0	13.6	20.2	18.0	9.9
AUG-FY14	23.0	45.5	9.6	28.0	8.0	29.8	22.2	22.6	13.7
SEP-FY14	22.6	52.1	14.5	34.5	10.5	17.5	22.3	27.4	23.3

Data Definition.[f] The average number of calendar days between a new patient's Primary Care appointment (clinic stops 322, 323, and 350), excluding compensation and pension appointments, and the earliest creation date.



	OCT-FY14	NOV-FY14	DEC-FY14	JAN-FY14	FEB-FY14	MAR-FY14	APR-FY14	MAY-FY14	JUN-FY14	JUL-FY14	AUG-FY14	SEP-FY14
VHA Total	16.1%	16.2%	16.1%	16.1%	16.1%	16.1%	16.2%	16.2%	16.2%	16.1%	16.0%	15.8%
(674) Temple VAMC	20.3%	20.2%	19.7%	19.3%	19.2%	18.6%	18.3%	17.9%	17.3%	17.2%	17.3%	17.3%
(674A4) Waco VAMC	10.6%	10.6%	10.5%	10.4%	10.2%	9.9%	9.9%	9.4%	9.7%	9.8%	9.6%	9.4%
(674BY) Austin Satellite	8.2%	8.3%	8.3%	8.1%	8.1%	8.0%	7.8%	7.7%	7.4%	7.0%	6.6%	6.0%
(674GA) Palestine	5.8%	6.0%	6.0%	5.7%	6.0%	6.3%	6.5%	6.9%	6.7%	6.6%	6.7%	6.6%
(674GB) Brownwood	11.6%	11.5%	11.5%	11.2%	11.4%	12.1%	12.6%	12.5%	12.2%	12.6%	12.3%	11.5%
(674GC) College Station (Bryan)	9.9%	9.7%	9.2%	8.9%	8.5%	8.3%	8.1%	7.9%	7.6%	7.1%	6.8%	6.1%
(674GD) Cedar Park	9.4%	9.4%	9.2%	8.9%	8.8%	8.7%	8.5%	7.4%	7.2%	6.8%	6.6%	6.6%
(674HB) La Grange	7.3%	7.2%	7.0%	7.5%	7.4%	7.4%	7.2%	7.1%	6.7%	6.8%	6.7%	6.5%

Data Definition.[f] This is a measure of where the patient receives his primary care and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care/FEE ER encounters while on panel (including FEE ER visits) divided by the number of Primary Care encounters while on panel with the patient's assigned primary care (or associate) provider plus the total VHA ER/Urgent Care/FEE ER encounters (including FEE ER visits) while on panel plus the number of Primary Care encounters while on panel with a provider other than the patient's Primary Care Provider/Associate Provider.



	VHA Total	(674) Temple VAMC	(674A4) Waco VAMC	(674BY) Austin Satellite	(674GA) Palestine	(674GB) Brownwood	(674GC) College Station (Bryan)	(674GD) Cedar Park	(674HB) La Grange
OCT-FY14	55.1%	27.2%	57.6%	54.1%	40.0%	70.8%	88.9%	88.2%	0.0%
NOV-FY14	55.9%	34.9%	78.4%	57.7%	58.3%	91.7%	85.0%	75.0%	33.3%
DEC-FY14	57.8%	38.6%	73.4%	53.2%	40.0%	75.0%	77.8%	92.9%	50.0%
JAN-FY14	63.6%	36.9%	75.8%	56.2%	80.0%	82.6%	87.5%	78.3%	100.0%
FEB-FY14	66.4%	41.9%	75.6%	48.3%	53.8%	92.9%	94.4%	84.2%	33.3%
MAR-FY14	71.2%	46.2%	81.1%	71.2%	83.3%	94.4%	100.0%	85.0%	0.0%
APR-FY14	72.6%	48.3%	74.3%	69.0%	65.0%	88.5%	82.6%	83.3%	0.0%
MAY-FY14	70.8%	43.2%	72.4%	64.0%	84.6%	65.5%	90.9%	73.9%	0.0%
JUN-FY14	71.3%	45.9%	87.0%	57.6%	80.0%	71.4%	95.2%	83.3%	0.0%
JUL-FY14	69.1%	40.5%	82.7%	64.7%	55.6%	80.8%	88.9%	83.3%	0.0%
AUG-FY14	68.9%	39.2%	71.8%	58.8%	50.0%	81.3%	95.7%	84.6%	10.0%
SEP-FY14	69.8%	46.0%	84.0%	56.3%	53.8%	66.7%	100.0%	95.0%	0.0%

Data Definition.[f] The percent of discharges (VHA inpatient discharges) for the reporting timeframe for assigned Primary Care patients where the patient was contacted by a member of the Patient Aligned Care Team the patient is assigned to within 2 business days post discharge. Discharges resulting in death and discharges where a patient is readmitted within 2 days of discharge are excluded from this metric.

Appendix C

Acting Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: June 29, 2015

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

Subject: **Review of CBOCs and OOCs of Central Texas Veterans Health Care System, Temple, TX**

To: Director**,** Dallas Office of Healthcare Inspections (54DA)

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

1. Thank you for allowing me to respond to this CBOC Review for the Central Texas Veterans 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.

Wendell Jones, MD
Acting Director, VA Heart of Texas Health Care Network (10N17)

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: June 29, 2015

From: Acting Director, Central Texas Veterans Health Care System (674/00)

Subject: **Review of CBOCs and OOCs of Central Texas Veterans Health Care System, Temple, TX**

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

1. On behalf of Central Texas Veterans Health Care System, I would like to take this opportunity to express my sincere appreciation to the Office of the Inspector General (OIG), Community Based Outpatient Clinics (CBOCs) review team for their professionalism, consultative approach, and excellent feedback provided to our staff during the review conducted the week of April 13, 2015.

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. Central Texas Veterans Health Care System 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 any questions or require additional information, please do not hesitate to contact Sylvia Tennent, Chief of Quality Management and Improvement Service at (254)-743-0719.

Russell E. Lloyd

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 staff at the Brownwood CBOC receive regular information/updates on their responsibilities in emergency response operations.

Concur

Target date for completion: July 31, 2015

Facility response: To ensure that the staff at the Brownwood CBOC receives regular information/updates regarding their responsibilities in response operations, the following corrective actions were initiated by the Associate Chief Nurse, Ambulatory Care:

- The Brownwood CBOC Emergency Response Plan will be reviewed and updated to reflect specific actions/responsibilities required by individual staff members during an emergency response situation.

- 100% staff assigned to the Brownwood CBOC will be educated on the updated Emergency Response Plan to include individual, specific actions/responsibilities.

- For sustainment, CBOC reporting on Emergency Response Plan and staff education will be an annual action item for Primary Care Council.

Recommendation 2. We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.

Concur

Target date for completion: December 30, 2015

Facility response: To ensure that the clinic staff consistently completes diagnostic assessments for patients with a positive alcohol screen the Associate Chief of Staff, (ACOS) Ambulatory Care initiated the following corrective actions:

- The Positive National Audit C clinical reminder completed by nursing staff triggers activation of (national) V17 P/RN Eval+ Alcohol Screen reminder. This reminder has components of further discussion of Medical problems associated with alcohol use in which the provider has options to choose the various medical problems. Additionally, the clinical reminder has options to provide counselling.

- The re-education to complete the positive Audit C screen was conducted at Primary Care Council meeting by the ACOS of Ambulatory Care on May 19, 2015, and Clinic Directors and Nurse Managers throughout CTVHCS attended the meeting. The information was also shared by the ACOS of Ambulatory Care with all Primary Care providers in an email on June 10, 2015.

- Monthly service level review of 10% of medical records with positive AUDIT C reminder will be conducted to assess for compliance. Reports will be shared at Primary Care council (bi-monthly meetings) and submitted to the CEC, the oversight Council.

- Additionally, monthly reports will be submitted to the Executive Leadership Board (ELB).

Recommendation 3. We recommended that clinic staff provide education and counseling for patients with positive alcohol screens and alcohol consumption above National Institute on Alcohol Abuse and Alcoholism limits.

Concur

Target date for completion: December 30, 2015

Facility response: To ensure that clinic staff provides education and counseling for patients with positive alcohol screens and alcohol consumption above the National Institute on Alcohol Abuse and Alcoholism (NIAAA) limits, the ACOS Ambulatory Care initiated the following corrective actions:

- The re-education regarding use of (national) V17 P/RN Eval+ Alcohol Screen reminder was conducted at Primary Care Council meeting on May 19, 2015, where Clinic Directors and Nurse Managers from all CTXVHCS campuses attend the meeting. This reminder has components of further discussion of Medical problems associated with alcohol use in which the provider has options to choose the various medical problems. Additionally, the clinical reminder has additional choice to provide counselling. The information was also shared with all Primary Care providers in an email on June 10, 2015.

- Ongoing sharing of the education at all staff meetings will also include monthly staff meeting at each locations including the CBOCs.

- Monthly service level review of 10% of medical records with positive AUDIT C reminder will be conducted to assess for compliance. Reports will be shared at Primary Care council (bi-monthly meetings) and submitted to the CEC, the oversight Council.

- Additionally, monthly reports will be submitted to the Executive Leadership Board (ELB).

Recommendation 4. We recommended that clinic staff consistently document the offer of further treatment to patients diagnosed with alcohol dependence.

Concur

Target date for completion: December 30, 2015

Facility response: To ensure that clinic staff consistently documents the offer of further treatment to patients diagnosed with alcohol dependence, the ACOS Ambulatory Care initiated the following corrective actions:

- The Positive National Audit C reminder conducted by nursing staff, triggers activation of (national) V17 P/RN Eval+ Alcohol Screen reminder. This reminder has components of further discussion of medical problems associated with alcohol use in which the provider has options to choose the various medical problems. The clinical reminder has additional choices to provide counselling, and for choosing interventions as well. The component of choosing options is "optional" with the National reminder. One June 18, 2015, CTVHCS has added a mandatory component that documents consult to Mental Health/Substance Abuse Treatment Program (MH/SATP) or declination.

- This information was shared at the Primary Care Council meeting on May 19, 2015, that Clinic Directors and Nurse Managers throughout CTVHCS attended. The ACOS Ambulatory Care also shared this information with all Primary Care providers in an email on June 16, 2015.

- The re-education regarding additional change/addition to National reminder is being shared with providers in email communication and will be reinforced at upcoming staff meetings in coming weeks.

- Consults will be monitored for individual cases by providers with comments coming back to them. The Consult Management Committee monitors all consults for completion in a timely manner in accordance with CTVHCS policy.

- The Veterans declining consults will be reviewed annually through the use of AUDIT C reminder.

Recommendation 5. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target date for completion: March 31, 2016

Facility response: The ACNS, Ambulatory Care has initiated the following corrective actions:

- A tracking process has been developed to monitor timely completion of Motivational Interviewing training within 12 months for all Clinic Registered Nurse Case Managers currently employed and all newly hired Case Managers within 12 months of appointment to the Patient Aligned Care Teams (PACT).

- Motivational Interviewing training to include both sessions will be offered at least quarterly.

- Completion of each Motivational Interviewing session will be documented in the Training Management System (TMS).

- Training on deficiencies will be completed and documented by October 31, 2015. We are in the process of selecting a Health Promotion and Disease Prevention (HPDP) Coordinator, and the target compliance date is March 31, 2016.

- Compliance monitoring of training data will be submitted to the Primary Care Council and the CEC until full compliance is achieved. Additionally, reports will be submitted to the ELB.

Recommendation 6. We recommended that providers in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target date for completion: March 31, 2016

Facility response: The ACOS, Ambulatory Care has initiated the following corrective actions:

- A tracking process has been developed to monitor timely completion of all the providers currently employed and all newly hired in the outpatient clinics receive health coaching training within 12 months of appointment to the PACTs.

- Identified providers received TEACH training on May 11, 2015.

- TEACH training will be offered quarterly at minimum.

- Completion of TEACH training will be documented in TMS.

- Training for remaining providers will be completed and documented by October 31, 2015. We are in the process of selecting a HPDP Coordinator. The target compliance date is March 31, 2016.

- Compliance monitoring of training data will be submitted to the Primary Care Council and the CEC until full compliance is achieved. Additionally, reports will be submitted to the ELB.

Recommendation 7. We recommended that clinicians consistently notify patients of their laboratory results within the timeframe set by local policy.

Concur

Target date for completion: December 30, 2015

Facility response: To ensure that the clinicians consistently notify patients of their laboratory results within the timeframes established by local policy, the ACOS Ambulatory Care initiated the following corrective actions:

- Updated clinic note template to reflect notation of discussion of available test results. The update requires the provider to enter applicable information. The process of notification of test results includes Patient Aligned Care Teams (PACT) staff.

- Staff re-education regarding the template was conducted on May 11, 2015, to the Primary Care Clinic Directors via conference call. Primary Care Providers were educated at staff meeting on May 19, 2015. Additionally, e-mail communication was submitted to all providers on June 10, 2015. There will be ongoing reinforcements through email communications and discussion/feedback at staff meetings at all locations of Ambulatory care.

- Random sampling method will be used in which a sample size of 75 medical records of primary care visits will be audited monthly, with a minimum compliance rate of 90% or >.

- Compliance will be monitored by the ACOS Ambulatory Care Service with results reported monthly to the Primary Care Council, and the CEC.

- Additionally, monthly reports will be submitted to the ELB.

Office of Inspector General
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Endnotes

[a] References used for the EOC review included:
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- Joint Commission, *Joint Commission Comprehensive Accreditation and Certification Manua*l, July 1, 2014.
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- VA Directive 0059, *VA Chemicals Management and Pollution Prevention,* May 25, 2012.
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- 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 1330.01, *Health Care Services for Women Veterans,* May 21, 2010.

[b] References used for the AUD Care review included:
- VHA Handbook 1101.10, *Patient Aligned Care Teams (PACT),* February 5, 2014.
- VHA Handbook 1120.02, *Health Promotion Disease Prevention (HPDP) Program*, July 5, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.
- VHA National Center for Health Promotion and Disease Prevention (NCP), HealthPOWER Prevention News, *Motivational Interviewing,* Summer 2011. Accessed from:
- http://www.prevention.va.gov/Publications/Newsletters/2011/HealthPOWER_Prevention_News_Summer_2011.asp
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[c] References used for the HIV Screening review included:
- Centers for Disease Control and Prevention, *Testing in Clinical Settings*, June 25, 2014. http://www.cdc.gov/hiv/testing/clinical/ Accessed July 18, 2014.
- VHA Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, *VAIQ #741734 – Documentation of Oral Consent for Human Immunodeficiency Virus (HIV) Testing*, January 10, 2014.
- VHA Directive 2008-082, *National HIV Program,* December 5, 2008.
- VHA Directive 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.
- VHA Directive 2009-036, *Testing for Human Immunodeficiency Virus in Veterans Health Administration Facilities*, August 14, 2009.
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA National Center for Health Promotion and Disease Prevention (NCP), *Screening for HIV*, June 23, 2014. http://vaww.prevention.va.gov/Screening_for_HIV.asp Accessed July 18, 2014.
- VHA Under Secretary for Health Information, *Letter IL 10-2010-006, Use of Rapid Tests for Routine Human Immunodeficiency Virus Screening*, February 16, 2010.

[d] References used for the Outpatient Documentation review included:
- VHA Handbook 1907.01, *Health Information Management and Health Records,* September 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records,* July 22, 2014.

[e] References used for the Outpatient Lab Results Management review included:
- VHA Handbook 2009-019, *Ordering and Reporting Test Results,* March 24, 2009.
- VHA, *Communication of Test Results Toolkit*, April 2012.

[f] Reference used for PACT Compass data graphs:
- Department of Veterans' Affairs, *Patient Aligned Care Teams Compass Data Definitions*, June 24, 2014.