



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

Office of Healthcare Inspections

Report No. 15-00112-338

**Review of Community Based
Outpatient Clinics and Other
Outpatient Clinics
of
VA Puget Sound Health Care System
Seattle, Washington**

May 15, 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
EOC	environment of care
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 VA Puget Sound Health Care System and Veterans Integrated Service Network 20 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, and outpatient documentation. We also randomly selected the North Olympic Peninsula Community Based Outpatient Clinic, Port Angeles, WA, as a representative site and evaluated the environment of care on March 17, 2015.

Review Results: We conducted four focused reviews and had no findings for the outpatient documentation review. However, we made recommendations for improvement in the following three review areas:

Environment of Care: Ensure that:

- Managers' review of the hazardous materials inventory occurs twice within a 12-month period at the North Olympic Peninsula Community Based Outpatient Clinic.

Alcohol Use Disorder Care: Ensure that clinic:

- Staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
- Registered Nurse Care Managers receive motivational interviewing and health coaching training within 12 months of appointment to Patient Aligned Care Teams.
- Providers and clinical associates receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Human Immunodeficiency Virus Screening: Ensure that:

- The Facility Director develops policies and procedures that facilitate human immunodeficiency virus testing as part of routine medical care for patients.
- The Facility Director defines the requirements for communication of human immunodeficiency virus test results.
- Clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.

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 14–18, for the full text of the Directors' comments.) We will follow up on the planned actions 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.

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
- AUD Care
- HIV Screening
- Outpatient Documentation

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

¹ Each outpatient site selected for physical inspection was randomized from all primary care 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 October 1, 2014.

for the AUD Care, HIV Screening, and Outpatient Documentation 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.

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.

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 North Olympic Peninsula 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).		
X	The CBOC's inventory of hazardous materials was reviewed for accuracy twice within the prior 12 months.	The CBOC's inventory of hazardous materials and waste at the North Olympic Peninsula CBOC was not reviewed for accuracy twice within the prior 12 months.	1. We recommended that managers ensure review of the hazardous materials inventory occurs twice within a 12-month period at the North Olympic Peninsula CBOC.
	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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Personal protective equipment is readily available.		
	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.		
	CBOC staff receives 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 38 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 14 of 38 patients (37 percent) who had positive alcohol use screens.	2. We recommended that clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
	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.		
	Documentation reflects the offer of further treatment for 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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinic RN Care Managers have received motivational interviewing training within 12 months of appointment to PACT.	We found that 22 of 46 RN Care Managers (48 percent) did not receive MI training within 12 months of appointment to PACT.	3. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training within 12 months of appointment to Patient Aligned Care Teams.
X	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.	We found that 27 of 46 RN Care Managers (61 percent) did not receive health coaching training 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 42 of 61 providers (69 percent) did not receive health coaching training within 12 months of appointment to PACT.	4. We recommended that providers and clinical associates 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.	We found that 16 of 30 clinical associates (53 percent) did not receive health coaching training within 12 months of appointment of 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 32 EHRs and 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. HIV Screening

NM	Areas Reviewed	Findings	Recommendations
	The facility has a HIV Lead Clinician to carry out responsibilities as required.		
X	The facility has policies and procedures to facilitate HIV testing.	The facility had no policy and procedure addressing HIV testing as part of routine medical care.	5. We recommended that the Facility Director develops policies and procedures that facilitate human immunodeficiency virus testing as part of routine medical care for patients.
X	The facility had developed policies and procedures that include requirements for the communication of HIV test results.	The facility did not have a policy in place for communication of HIV test results.	6. We recommended that the Facility Director defines the requirements for communication of human immunodeficiency virus 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.	Clinicians did not document informed consent for HIV testing for two of eight patients.	7. We recommended that clinicians consistently document informed consent for HIV testing and that compliance is monitored.
	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 40 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.		

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.

Location	Station #	Rurality ⁶	Outpatient Workload / Encounters ⁴			Services Provided ⁵	
			PC	MH	Specialty Clinics ⁷	Specialty Care ⁸	Ancillary Services ⁹
Bellevue, WA	663GA	Urban	19,870	3,468	0	NA	NA
Bremerton, WA	663GB	Urban	8,035	2,147	335	Dermatology	Diabetic Retinal Screening HBPC Nutrition Pharmacy Social Work
Mount Vernon, WA	663GC	Urban	15,736	4,691	6,250	Dental Dermatology Optometry	Audiology Diabetic Retinal Screening MOVE! Program ¹⁰ Pharmacy Rehabilitation Services
Chehalis, WA	663GD	Rural	9,400	4,213	0	NA	Diabetic Retinal Screening

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.

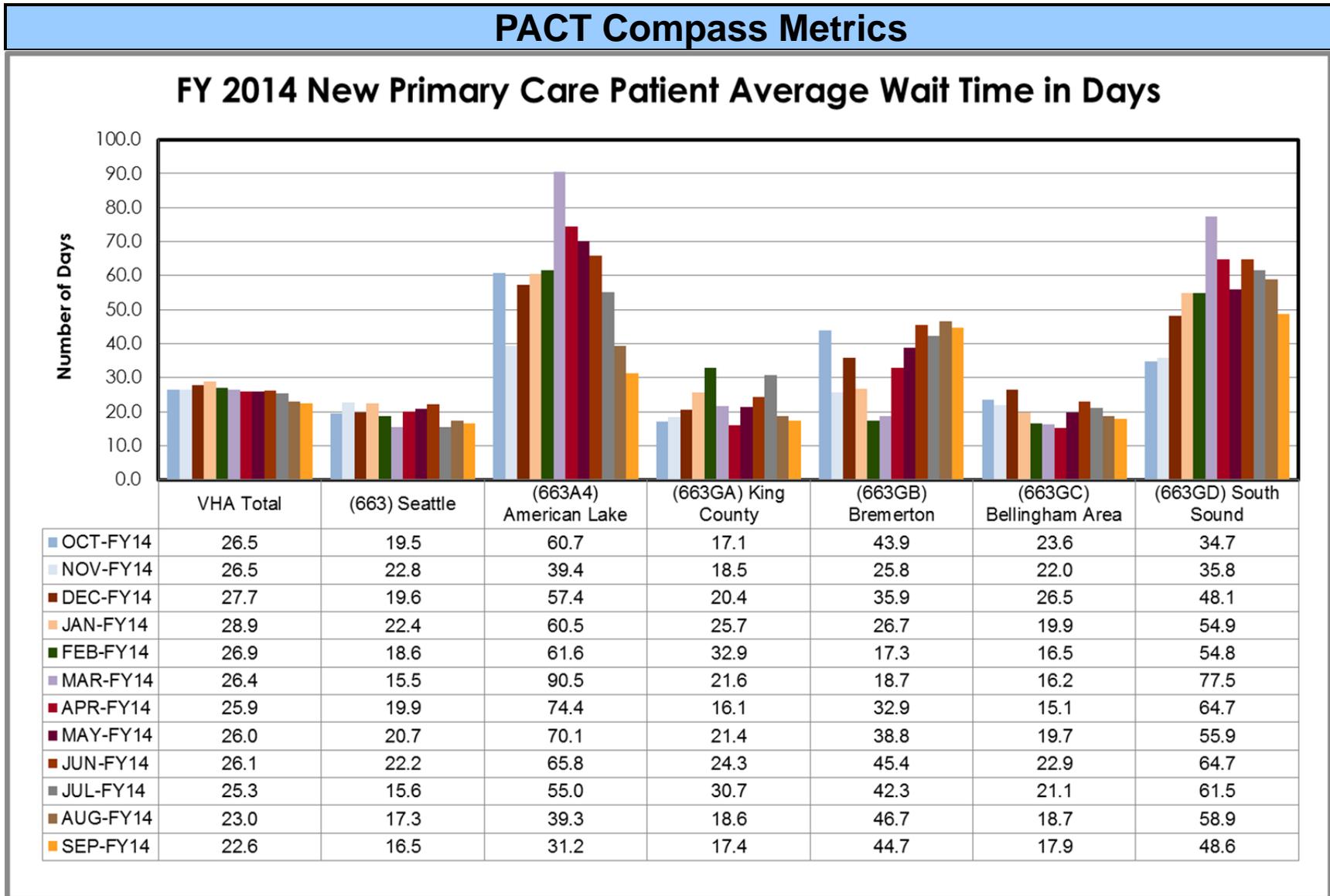
⁶ <http://vssc.med.va.gov/>

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.

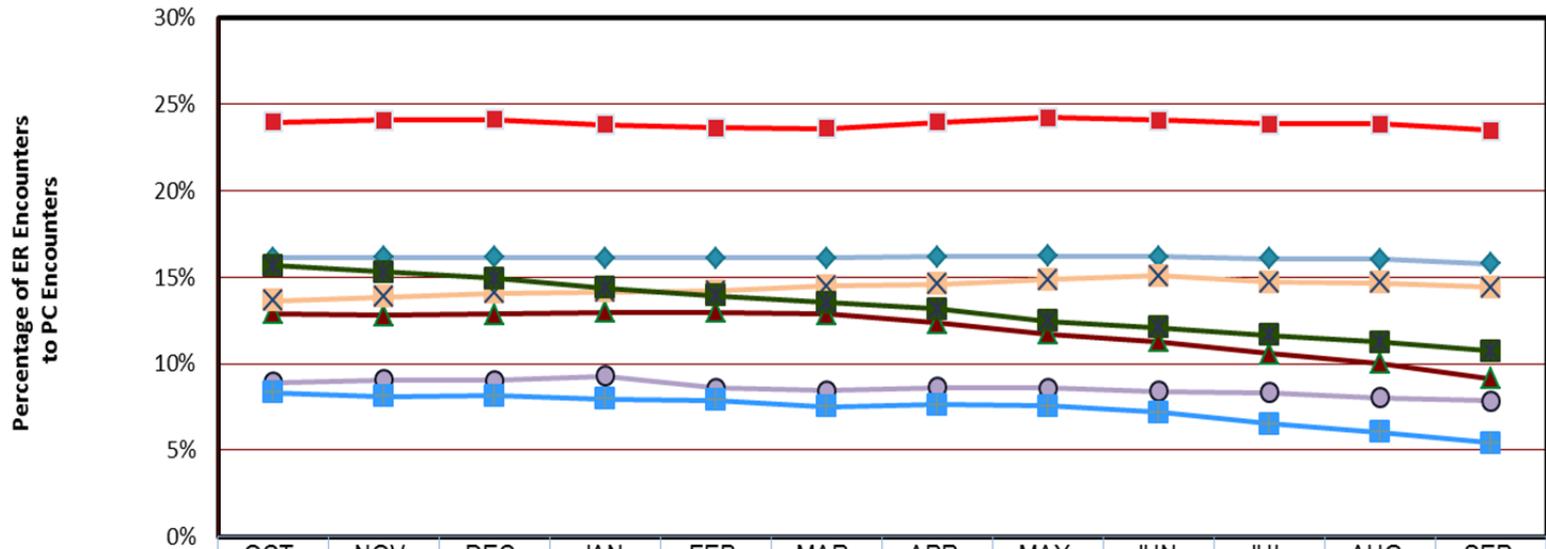
⁹ Ancillary Services refer to non-Primary Care and non-Mental Health services that are not provided by a physician.

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



Data Definition.^e 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.

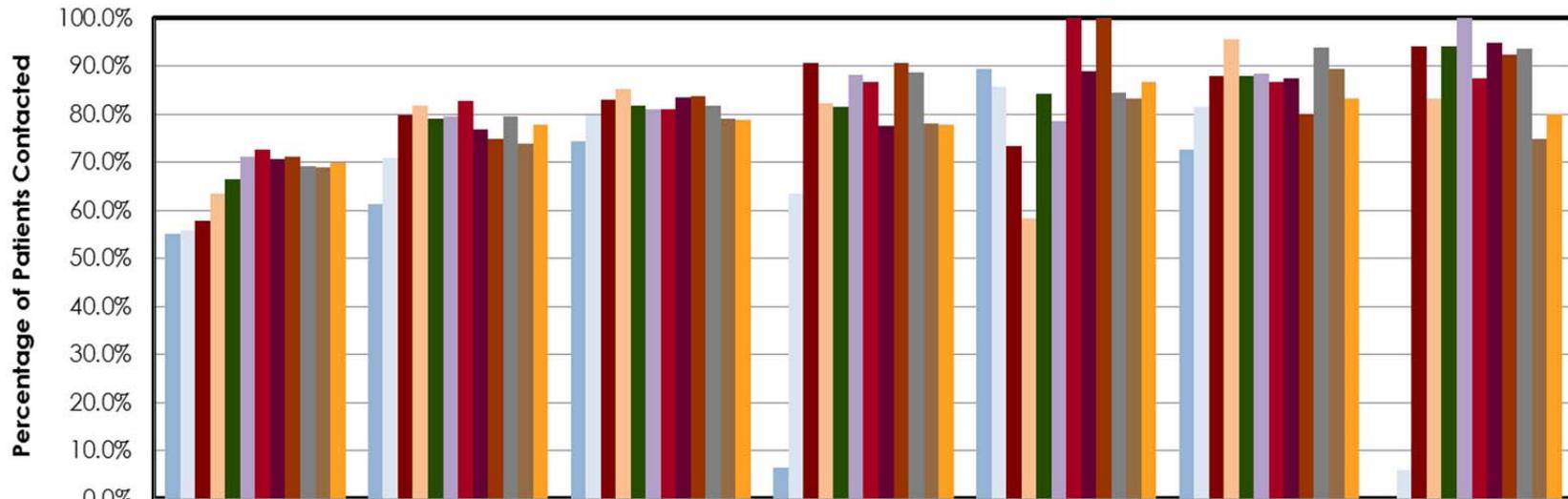
FY 2014 Ratio of ER Encounters While on Panel to PC Encounters While on Panel (FEE ER Included)



	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%
■ (663) Seattle	24.0%	24.1%	24.1%	23.8%	23.6%	23.6%	24.0%	24.2%	24.1%	23.9%	23.9%	23.5%
▲ (663A4) American Lake	12.9%	12.8%	12.9%	13.0%	13.0%	12.9%	12.4%	11.7%	11.3%	10.6%	10.0%	9.1%
× (663GA) King County	13.7%	13.9%	14.1%	14.2%	14.2%	14.5%	14.6%	14.9%	15.1%	14.7%	14.7%	14.4%
■ (663GB) Bremerton	15.7%	15.3%	14.9%	14.4%	14.0%	13.5%	13.2%	12.5%	12.1%	11.7%	11.2%	10.7%
● (663GC) Bellingham Area	8.9%	9.1%	9.0%	9.3%	8.6%	8.4%	8.6%	8.6%	8.4%	8.3%	8.0%	7.9%
■ (663GD) South Sound	8.3%	8.1%	8.1%	8.0%	7.9%	7.5%	7.6%	7.5%	7.2%	6.5%	6.1%	5.4%

Data Definition.⁶ 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.

FY 2014 Team 2-Day Contact Post Discharge Ratio



	VHA Total	(663) Seattle	(663A4) American Lake	(663GA) King County	(663GB) Bremerton	(663GC) Bellingham Area	(663GD) South Sound
■ OCT-FY14	55.1%	61.2%	74.3%	6.4%	89.5%	72.7%	0.0%
■ NOV-FY14	55.9%	70.9%	79.8%	63.5%	85.7%	81.5%	5.9%
■ DEC-FY14	57.8%	79.8%	83.0%	90.8%	73.3%	88.0%	94.1%
■ JAN-FY14	63.6%	81.7%	85.3%	82.2%	58.3%	95.7%	83.3%
■ FEB-FY14	66.4%	79.2%	81.8%	81.5%	84.2%	88.0%	94.1%
■ MAR-FY14	71.2%	79.6%	81.0%	88.2%	78.6%	88.5%	100.0%
■ APR-FY14	72.6%	82.7%	81.0%	86.7%	100.0%	86.8%	87.5%
■ MAY-FY14	70.8%	77.0%	83.5%	77.6%	88.9%	87.5%	95.0%
■ JUN-FY14	71.3%	75.0%	83.9%	90.8%	100.0%	80.0%	92.3%
■ JUL-FY14	69.1%	79.7%	81.8%	88.7%	84.6%	93.9%	93.8%
■ AUG-FY14	68.9%	73.9%	79.2%	78.1%	83.3%	89.5%	75.0%
■ SEP-FY14	69.8%	77.8%	78.9%	77.8%	86.7%	83.3%	80.0%

Data Definition.^e 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.

Veterans Integrated Service Network Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 17, 2015

From: Director, VA Northwest Network (10N20)

Subject: Review of CBOCs and OOCs of VA Puget Sound Health Care System, Seattle, WA

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

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

1. Thank you for the opportunity to provide responses to the findings from the Community Based Outpatient Clinic and Other Outpatient Clinics at VA Puget Sound Health Care System, Seattle, Washington.
2. Attached please find the facility concurrence and response to the findings from the review.
3. If you have additional questions or need further information, please contact Susan Green, Survey Coordinator, VISN 20 at (360) 567-4678.


Lawrence H. Carroll

Health Care System Director Comments

**Department of
Veterans Affairs**

Memorandum

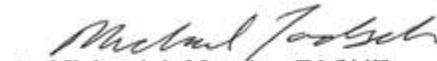
Date: April 15, 2015

From: Director, VA Puget Sound Health Care System, Seattle, WA (663/00)

Subject: **Review of CBOCs and OOCs of VA Puget Sound Health Care System, Seattle, Washington**

To: Director, VA Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the recommendations from the Community Based Outpatient Clinics and Other Outpatient Clinics Review of VA Puget Sound Health Care System Seattle, Washington.
2. Attached please find the facility responses to each of the findings from the review.
3. If you have questions or need additional information, please contact Jane Penny, Director Quality Improvement at (206) 764-5522 or via e-mail Jane.Penny@va.gov.


Michael J. Murphy, FACHE

Attachment

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 managers ensure review of the hazardous materials inventory occurs twice within a 12-month period at the North Olympic Peninsula CBOC.

Concur

Target date for completion: July 31, 2015

System response: The master agreement between the Department of Veterans Affairs and the American Federation of Government Employees (AFGE) has been reviewed to clarify bi-annual hazard materials inventory requirements. The North Olympic Peninsula CBOC hazardous materials inventory was last updated in January 2015. A new reporting schedule now reflects an additional check during the month of July. The CBOC manager will perform hazardous materials inventory audit January and July of each year, document findings and ensure a copy of the report is sent to the facility Industrial Hygienist. The General Medicine Service Quality Manager monitors North Olympic Peninsula hazardous materials inventory records and will report compliance to Leadership through the facility Safety Committee.

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

Concur

Target date for completion: October 31, 2015

System response: A multidisciplinary committee including General Medical Service, Mental Health Service, CAC, and QM has been formed to update the CPRS Audit C template. Template updates will include National Institute on Alcohol Abuse and Alcoholism (NIAAA) "[Rethinking Drinking](#)" interview and motivational strategies for patients having a positive alcohol use score. Quality Management will monitor for three consecutive months those Veteran diagnostic assessments with a positive alcohol screen to ensure 90% compliance by clinical staff. Template changes will be reviewed with Primary Care staff monthly during all-staff meeting and via other communication modes until 90% of staff has been made aware of template changes. Compliance will be reported to Leadership at Leadership Quality Management Review (LQMR) in August 2015.

Recommendation 3. We recommended that Clinic Registered Nurse Care Managers receive motivational interviewing and health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target date for completion: November 30, 2015

System response: GMS has implemented a twelve month tracking spreadsheet which includes the date of the employee's appointment to PACT, the type and date of training received and a date for training completion. Each CBOC Manager will ensure all RN Care Managers currently employed have completed MI and Health Coaching training and all newly hired staff will complete the afore mentioned training within 12 months of appointment to Patient Aligned Care Teams (PACT).

The CBOC and PCC Nurse Managers will report training data monthly to the Health Promotion Disease Prevention coordinator and the Health Behavior Coordinator until each of 7 CBOC's and 2 PCCs reach 100% of the required Health Coaching and MI training. The GMS Quality Manager will monitor training compliance and report progress quarterly to the Leadership Quarterly Management Review (LQMR).

Recommendation 4. We recommended that providers and clinical associates in the outpatient clinics receive health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target date for completion: November 30, 2015

System response: GMS has implemented a twelve month tracking spreadsheet which includes the date of the employee's appointment to PACT, the type and date of training received, and a date for training completion. Each VHA and contract PACT Nurse Manager will ensure all Provider and Clinical Associate Health Coaching training is completed and documented for current employees and within 12 months of appointment to PACT for new hires.

The CBOC and PCC Nurse Managers will report data monthly to the Health Promotion Disease Prevention coordinator and the Health Behavior Coordinator until each of the 9 PACT areas reach 100% of the required PACT training. The GMS Quality Manager will monitor training compliance and report progress quarterly to the Leadership Quarterly Management Review (LQMR).

Recommendation 5. We recommended that the Facility Director develops policies and procedures that facilitate human immunodeficiency virus testing as part of routine medical care for patients.

Concur

Target date for completion: August 31, 2015

System response: A comprehensive policy and procedure has been developed to ensure provisions are in place to facilitate ordering of HIV testing as part of routine medical care for patients. The policy concurrence review period is complete and approved for publication by the VA Puget Sound Health Care System PENTAD. Responsibility for the implementation of the policy called Testing for Human Immunodeficiency Virus (HIV) will be carried out by the HIV Lead Clinician. Quality Management will audit for effectiveness to ensure 90% of patients have orders for HIV testing included as part of routine medical care. Data will be reported in May and August 2015 to the Leadership Quarterly Management Review (LQMR).

Recommendation 6. We recommended that the Facility Director defines the requirements for communication of human immunodeficiency virus test results.

Concur

Target date for completion: August 31, 2015

System response: The facility Director has defined the requirements for communication of human immunodeficiency virus test results in VA Puget Sound policy called Testing for Human Immunodeficiency Virus (HIV). HIV test results will be communicated to the patient forty-eight hours from receipt of RNA confirmation of a positive HIV antibody test by the ordering or surrogate practitioner. Negative test results will be reported to the patient within 14 calendar days. Compliance will be audited by the General Medicine Service Quality Manager for three consecutive months to ensure 90% of newly ordered and completed HIV tests have met policy standards. Compliance data will be reported in May and August 2015 to the Leadership Quarterly Management Review (LQMR).

Recommendation 7. We recommended that clinicians consistently document informed consent for human immunodeficiency virus testing and that compliance is monitored.

Concur

Target date for completion: August 31, 2015

System response: Clinicians will consistently document the required informed consent for HIV testing through two methods:

1. The current method embedded in the CPRS template
2. A "quick link" has been added to the HIV laboratory test order reminding clinicians of the required informed consent. This link embeds the required informed consent language into the provider note.

Quality Management will monitor newly tested Veterans for three consecutive months to ensure 90% compliance with the informed consent requirement. Compliance will be reported in May and August 2015 to the Leadership Quarterly Management Review (LQMR).

Office of Inspector General Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. Senate: Maria Cantwell, Patty Murray
U.S. House of Representatives: Jamie Herrera Beutler, Suzan DelBene, Denny Heck,
Derek Kilmer, Rick Larsen, Jim McDermott, Dan Newhouse, David G. Reichert,
Cathy McMorris Rodgers, Adam Smith

This report is available at www.va.gov/oig.

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 Manual*, July 1, 2014.
- US Department of Health and Human Services, Health Insurance Portability and Accountability Act, *The Privacy Rule*, February 16, 2006.
- US Department of Labor, Occupational Safety and Health Administration, *Laws and Regulations, 1910 General Industry Standards*.
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