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

**Office of Healthcare Inspections**

**Report No. 16-00025-301**

# Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Carl Vinson VA Medical Center Dublin, Georgia

**May 12, 2016**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
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**(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 |
| NA | not applicable |
| NM | not met |
| OIG | Office of Inspector General |
| OOC | other outpatient clinic |
| PC | primary care |
| PTSD | post-traumatic stress disorder |
| VAMC | VA Medical Center |
| VHA | Veterans Health Administration |

# Table of Contents

# 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 Carl Vinson VA Medical Center and Veterans Integrated Service Network 7 provide safe, consistent, and high-quality health care. The review evaluated the clinic's compliance with selected requirements for home telehealth enrollment, outpatient lab results management, and post-traumatic stress disorder care. We also randomly selected the Milledgeville VA Clinic, Milledgeville, GA, as a representative site and evaluated the environment of care on February 23, 2016.

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

*Environment of Care:* Ensure that:

- Managers ensure that Milledgeville VA Clinic staff participate in emergency management training and exercises.
- The clinic manager ensures that Milledgeville VA Clinic and contracted employees receive the required hazardous communications training.
- The clinic manager ensures that there are no expired injectable medication vials.

*Outpatient Lab Results Management*: Ensure that:

- The Facility Director ensures that the facility's written policy for the communication of laboratory results includes all required elements.
- Clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.

*Post-Traumatic Stress Disorder Care*: Ensure that:

- Acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens.
- Further diagnostic evaluations are offered to patients with positive PTSD screens.

## 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 16–20, for the full text of the Directors' comments.) We consider recommendations 2 and 4 closed. 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 Milledgeville 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. Any items that did not apply to this facility are marked NA.

**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 |
|---|---|---|---|
| X | Clinic staff participated in regular emergency management training and exercises. | Two of 10 clinic employees did not participate in regular emergency management training and exercises. | **1.** We recommended that managers ensure that Milledgeville VA Clinic staff participate in 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. | | |
| NA | 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. | | |
| X | Clinic employees received training on the new chemical label elements and safety data sheet format. | Two of 12 VA clinic and contracted employees had not received any hazardous communications training on the new chemical label elements and safety data sheet format. | **2.** We recommended that the clinic manager ensures that Milledgeville VA Clinic and contracted employees receive the required hazardous communications training. |
| | 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. | | |
| | The clinic minimized the risk of infection when storing and disposing of medical waste. | | |
| | The clinic had unobstructed access to fire alarms/pull stations. | | |
| | The clinic had unobstructed access to fire extinguishers. | | |
| | For fire extinguishers located in large rooms or are obscured from view, the clinic identified the locations of the fire extinguishers with signs. | | |
| | The exit signs were visible from every direction. | | |
| | Exit routes from the building were unobstructed. | | |
| | Staff wore VA-issued identification badges. | | |
| | The clinic controlled access to and from areas identified as security sensitive. | | |
| NA | The clinic had an alarm system or panic buttons installed in high-risk areas. | | |
| | The clinic's inventory of hazardous materials was reviewed for accuracy twice within the prior 12 months. | | |
| | The clinic's safety data sheets for chemicals were readily available for the staff. | | |
| | The clinic provided visual and auditory privacy for veterans at check-in. | | |
| | The clinic provided visual and auditory privacy for patients in the interview areas. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Examination room doors were equipped with either an electronic or manual lock. | | |
| | A privacy sign was available for use to indicate that a telehealth visit was in progress. | | |
| | Documents containing patient-identifiable information were not visible or unsecured. | | |
| | Clinic staff locked computer screens when they were not in use. | | |
| | Information was not viewable on monitors in public areas. | | |
| | Window coverings, if present, provided privacy. | | |
| | Clinic staff protected patient-identifiable information to maintain patient privacy on laboratory specimens during transport. | | |
| | The clinic had examination room(s) for women veterans which were located in a space where they did not open into a public waiting room or a high-traffic public corridor. | | |
| | The clinic provided adequate privacy for women veterans in the examination rooms. | | |
| | The clinic provided feminine hygiene products in examination rooms where pelvic examinations were performed or in bathrooms within close proximity. | | |
| | Women's public restrooms had feminine hygiene products and disposal bins available for use. | | |
| X | Medication vials were not expired. | The Milledgeville VA Clinic had expired injectable medication vials. | **3**. We recommended that the Milledgeville VA Clinic manager ensures that there are no expired injectable medication vials. |
| | All medications were secured from unauthorized access. | | |
| | The information technology network room/server closet was secured/locked. | | |

| NM | Areas Reviewed (continued) | Findings | Recommendations |
|---|---|---|---|
| | Access to the information technology network room/server closet was restricted to personnel authorized by Office of Information and Technology, as evidenced by a list of authorized individuals. | | |
| | Access to the information technology network room/server closet was documented, as evidenced by the presence of a sign-in/sign-out log. | | |

## HT Enrollment

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

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 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. | | |
| | Documentation of HT enrollment (consult, screening, and/or initial assessment notes) was completed prior to the entry of monthly monitoring notes. | | |

## Outpatient Lab Results Management

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

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 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. | | |
| X | The facility has a written policy for the communication of lab results that included all required elements. | The facility's written policy for the communication of lab results did not require the communication of lab results to patients no later than 14 days from the date on which the results are available to the ordering practitioner. | **4**. We recommended that the Facility Director ensures that the facility's written policy for the communication of laboratory results includes all required elements. |
| X | Clinicians notified patients of their lab results. | Clinicians did not consistently notify 18 of 49 patients (37 percent) of their lab results within 14 days as required by VHA. | **5**. We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA. |
| | Clinicians documented in the EHR all attempts to communicate with the patients regarding their lab results. | | |
| | Clinicians provided interventions for clinically significant abnormal lab results. | | |

## PTSD Care

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

We reviewed relevant documents and 50 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 5. PTSD Care**

| NM | Areas Reviewed | Findings | Recommendations |
|---|---|---|---|
| X | Each patient with a positive PTSD screen received a suicide risk assessment. | Twelve of 50 patients (24 percent) with positive PTSD screens did not receive a suicide risk assessment. | **6.** We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens. |
| | 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. | | |
| X | Acceptable providers offered further diagnostic evaluations to patients with positive PTSD screens. | Acceptable providers did not offer patients with positive PTSD screens referrals for diagnostic evaluations in 6 of 29 EHRs. | **7**. We recommended that further diagnostic evaluations are offered 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

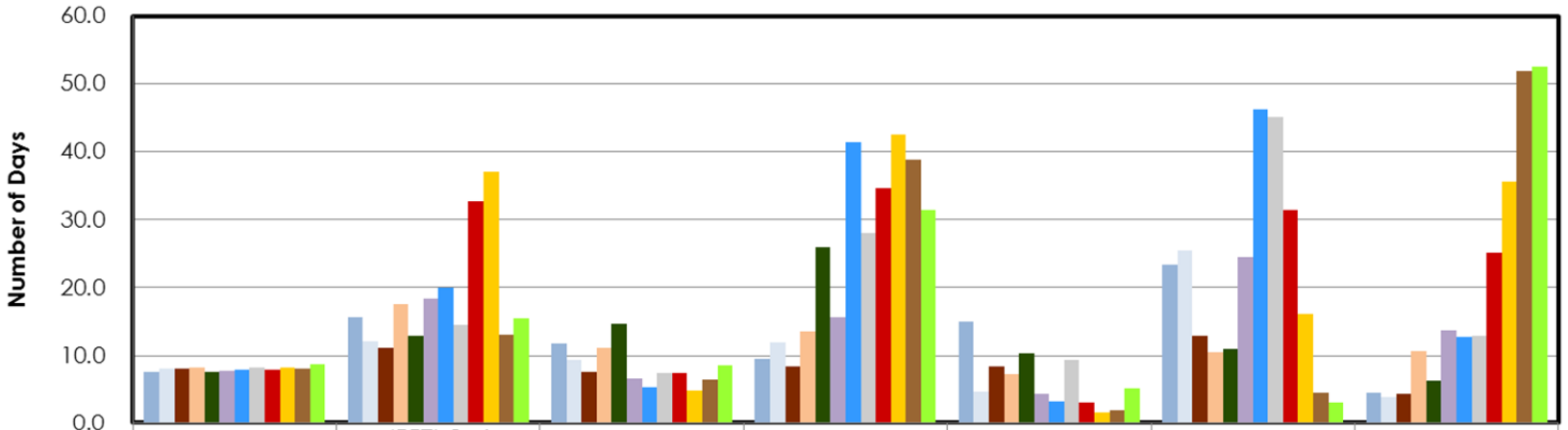
This review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[2] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. The following 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]** | |
| Macon, GA | 557GA | Urban | Primary Care CBOC | 12,544 | 6,571 | 191 | Dermatology | Diabetic Retinal Screening | MOVE! Program[10] Nutrition |
| Albany, GA | 557GB | Rural | Primary Care CBOC | 9,600 | 6,559 | 3,019 | Optometry Podiatry | Audiology Diabetic Retinal Screening | Pharmacy Rehabilitation Services |
| Milledgeville, GA | 557GC | Rural | Primary Care CBOC | 2,583 | 969 | 49 | NA | Home Based Primary Care | Social Work |
| Brunswick, GA | 557GE | Urban | Multi-Specialty CBOC | 6,759 | 2,965 | 3,023 | Dermatology Optometry Podiatry | Audiology Diabetic Retinal Screening | MOVE! Program Pharmacy Social Work |
| Kathleen, GA | 557HA | Urban | Primary Care CBOC | 4,216 | 2,655 | 2,654 | Dermatology Optometry | Diabetic Retinal Screening MOVE! Program | Nutrition Pharmacy Social Work |

[2] Includes all CBOCs in operation before August 15, 2015. We have omitted 557GF (Tifton), as no workload/encounters or services were reported.
[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.

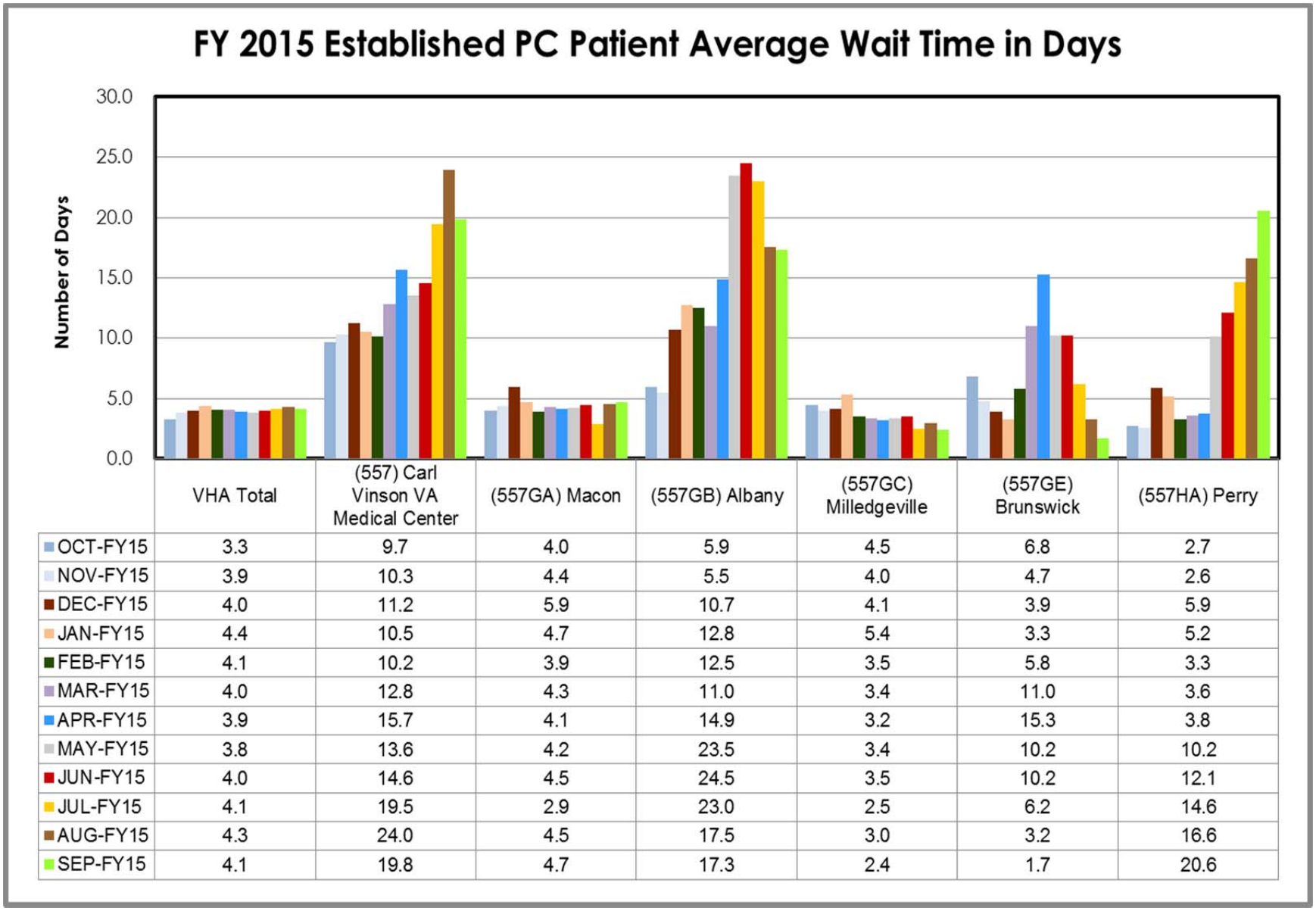
# PACT Compass Metrics

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



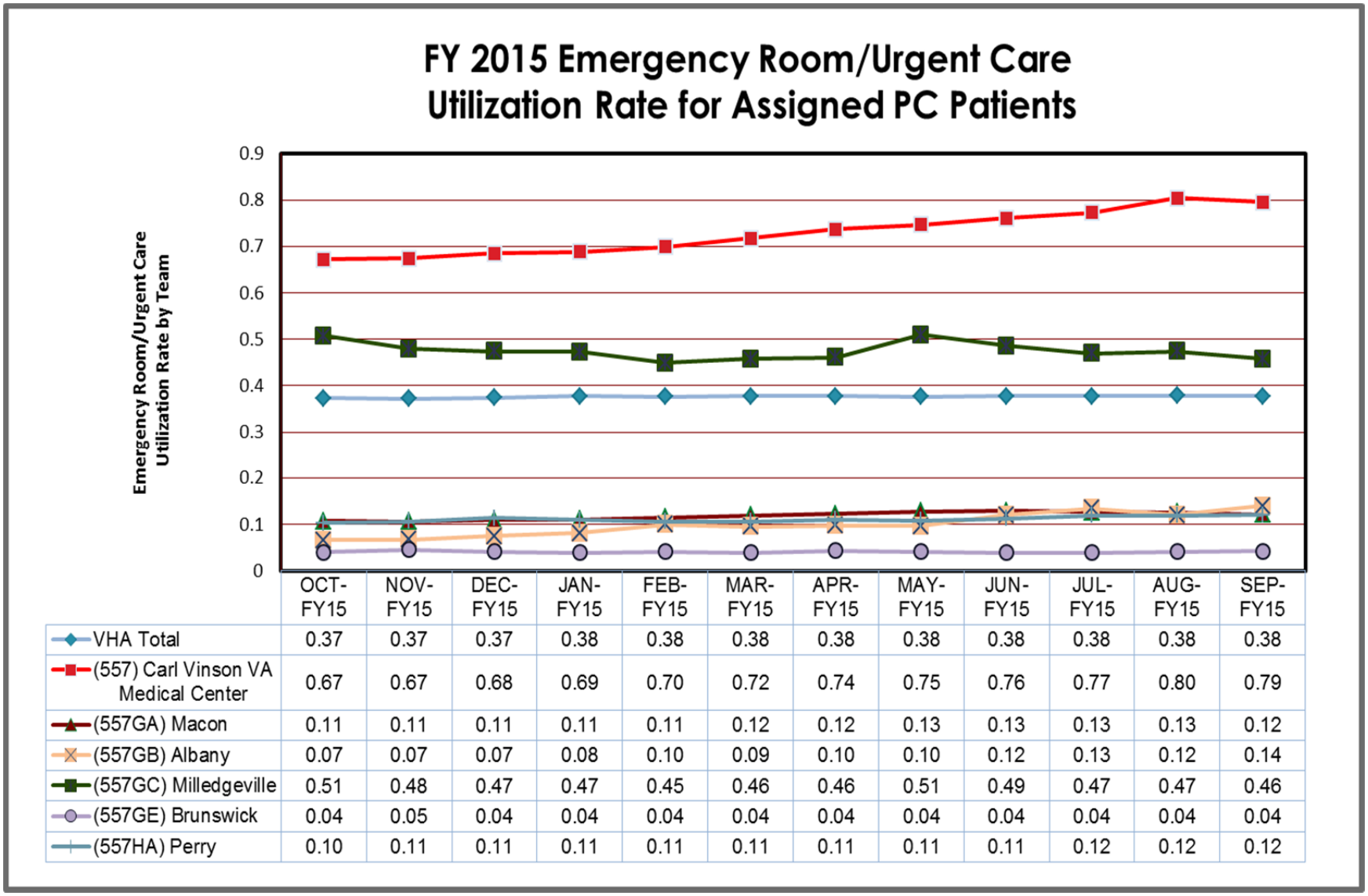

| | VHA Total | (557) Carl Vinson VA Medical Center | (557GA) Macon | (557GB) Albany | (557GC) Milledgeville | (557GE) Brunswick | (557HA) Perry |
|---|---|---|---|---|---|---|---|
| OCT-FY15 | 7.6 | 15.7 | 11.9 | 9.5 | 14.9 | 23.3 | 4.5 |
| NOV-FY15 | 8.1 | 12.1 | 9.4 | 12.0 | 4.6 | 25.5 | 3.9 |
| DEC-FY15 | 8.1 | 11.1 | 7.6 | 8.4 | 8.4 | 12.9 | 4.4 |
| JAN-FY15 | 8.2 | 17.6 | 11.1 | 13.6 | 7.3 | 10.5 | 10.6 |
| FEB-FY15 | 7.6 | 12.9 | 14.7 | 26.0 | 10.3 | 11.1 | 6.4 |
| MAR-FY15 | 7.7 | 18.4 | 6.6 | 15.7 | 4.3 | 24.5 | 13.8 |
| APR-FY15 | 7.9 | 20.0 | 5.4 | 41.5 | 3.3 | 46.3 | 12.7 |
| MAY-FY15 | 8.2 | 14.5 | 7.4 | 28.1 | 9.3 | 45.1 | 12.9 |
| JUN-FY15 | 8.0 | 32.8 | 7.4 | 34.6 | 3.2 | 31.4 | 25.1 |
| JUL-FY15 | 8.3 | 37.1 | 4.8 | 42.6 | 1.6 | 16.2 | 35.6 |
| AUG-FY15 | 8.1 | 13.1 | 6.5 | 38.8 | 2.0 | 4.6 | 51.8 |
| SEP-FY15 | 8.7 | 15.5 | 8.6 | 31.4 | 5.2 | 3.1 | 52.5 |

**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.*



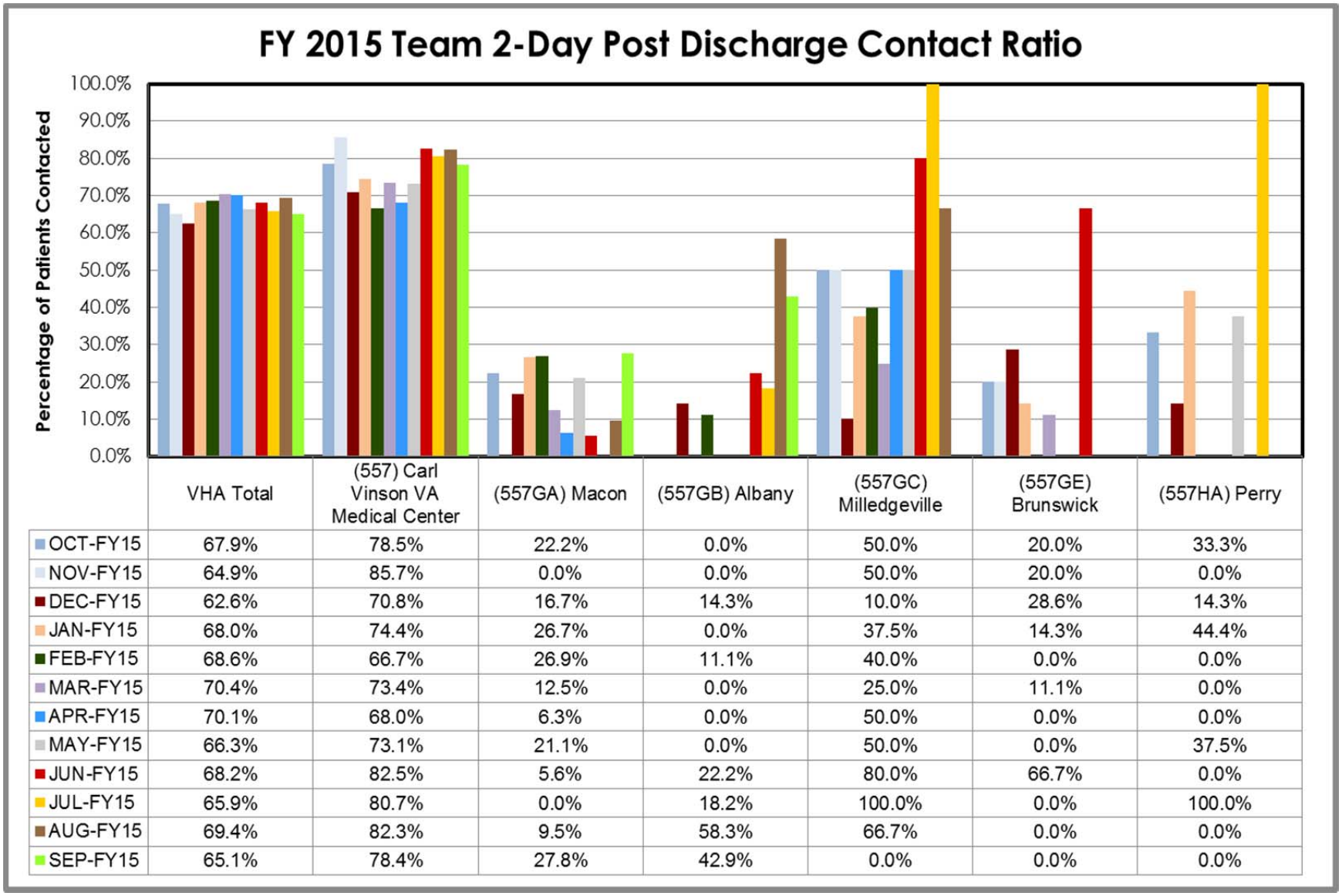

| | VHA Total | (557) Carl Vinson VA Medical Center | (557GA) Macon | (557GB) Albany | (557GC) Milledgeville | (557GE) Brunswick | (557HA) Perry |
|---|---|---|---|---|---|---|---|
| OCT-FY15 | 3.3 | 9.7 | 4.0 | 5.9 | 4.5 | 6.8 | 2.7 |
| NOV-FY15 | 3.9 | 10.3 | 4.4 | 5.5 | 4.0 | 4.7 | 2.6 |
| DEC-FY15 | 4.0 | 11.2 | 5.9 | 10.7 | 4.1 | 3.9 | 5.9 |
| JAN-FY15 | 4.4 | 10.5 | 4.7 | 12.8 | 5.4 | 3.3 | 5.2 |
| FEB-FY15 | 4.1 | 10.2 | 3.9 | 12.5 | 3.5 | 5.8 | 3.3 |
| MAR-FY15 | 4.0 | 12.8 | 4.3 | 11.0 | 3.4 | 11.0 | 3.6 |
| APR-FY15 | 3.9 | 15.7 | 4.1 | 14.9 | 3.2 | 15.3 | 3.8 |
| MAY-FY15 | 3.8 | 13.6 | 4.2 | 23.5 | 3.4 | 10.2 | 10.2 |
| JUN-FY15 | 4.0 | 14.6 | 4.5 | 24.5 | 3.5 | 10.2 | 12.1 |
| JUL-FY15 | 4.1 | 19.5 | 2.9 | 23.0 | 2.5 | 6.2 | 14.6 |
| AUG-FY15 | 4.3 | 24.0 | 4.5 | 17.5 | 3.0 | 3.2 | 16.6 |
| SEP-FY15 | 4.1 | 19.8 | 4.7 | 17.3 | 2.4 | 1.7 | 20.6 |

**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 |
| (557) Carl Vinson VA Medical Center | 0.67 | 0.67 | 0.68 | 0.69 | 0.70 | 0.72 | 0.74 | 0.75 | 0.76 | 0.77 | 0.80 | 0.79 |
| (557GA) Macon | 0.11 | 0.11 | 0.11 | 0.11 | 0.11 | 0.12 | 0.12 | 0.13 | 0.13 | 0.13 | 0.13 | 0.12 |
| (557GB) Albany | 0.07 | 0.07 | 0.07 | 0.08 | 0.10 | 0.09 | 0.10 | 0.10 | 0.12 | 0.13 | 0.12 | 0.14 |
| (557GC) Milledgeville | 0.51 | 0.48 | 0.47 | 0.47 | 0.45 | 0.46 | 0.46 | 0.51 | 0.49 | 0.47 | 0.47 | 0.46 |
| (557GE) Brunswick | 0.04 | 0.05 | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 | 0.04 |
| (557HA) Perry | 0.10 | 0.11 | 0.11 | 0.11 | 0.11 | 0.11 | 0.11 | 0.11 | 0.11 | 0.12 | 0.12 | 0.12 |

**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 | (557) Carl Vinson VA Medical Center | (557GA) Macon | (557GB) Albany | (557GC) Milledgeville | (557GE) Brunswick | (557HA) Perry |
|---|---|---|---|---|---|---|---|
| OCT-FY15 | 67.9% | 78.5% | 22.2% | 0.0% | 50.0% | 20.0% | 33.3% |
| NOV-FY15 | 64.9% | 85.7% | 0.0% | 0.0% | 50.0% | 20.0% | 0.0% |
| DEC-FY15 | 62.6% | 70.8% | 16.7% | 14.3% | 10.0% | 28.6% | 14.3% |
| JAN-FY15 | 68.0% | 74.4% | 26.7% | 0.0% | 37.5% | 14.3% | 44.4% |
| FEB-FY15 | 68.6% | 66.7% | 26.9% | 11.1% | 40.0% | 0.0% | 0.0% |
| MAR-FY15 | 70.4% | 73.4% | 12.5% | 0.0% | 25.0% | 11.1% | 0.0% |
| APR-FY15 | 70.1% | 68.0% | 6.3% | 0.0% | 50.0% | 0.0% | 0.0% |
| MAY-FY15 | 66.3% | 73.1% | 21.1% | 0.0% | 50.0% | 0.0% | 37.5% |
| JUN-FY15 | 68.2% | 82.5% | 5.6% | 22.2% | 80.0% | 66.7% | 0.0% |
| JUL-FY15 | 65.9% | 80.7% | 0.0% | 18.2% | 100.0% | 0.0% | 100.0% |
| AUG-FY15 | 69.4% | 82.3% | 9.5% | 58.3% | 66.7% | 0.0% | 0.0% |
| SEP-FY15 | 65.1% | 78.4% | 27.8% | 42.9% | 0.0% | 0.0% | 0.0% |

**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.

# Veterans Integrated Service Network Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** April 7, 2016

**From:** Director, VA Southeast Network (10N7)

**Subject:** **Review of CBOCs and OOCs of Carl Vinson VA Medical Center, Dublin, GA**

**To:** Director**,** Atlanta Office of Healthcare Inspections (54AT)

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

1. Thank you for this opportunity to review the draft report: Review of CBOCs and OOCs of Carl Vinson VA Medical Center, Dublin, GA.

2. I have reviewed and concur with the recommendations and the facility's action corrective action plan.

3. If you have any additional questions or need further information, please contact Donna Schnider, VISN 7 Quality Management Officer at (678) 924-5723 or Madonna.schnider@va.gov.

Robin E. Jackson, PhD. LCSW

Deputy Network Director

Attachment

# Facility Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** April 4, 2016

**From:** Director, Carl Vinson VA Medical Center (557/00)

**Subject:** **Review of CBOCs and OOCs of Carl Vinson VA Medical Center, Dublin, GA**

**To:** Director, VA Southeast Network (10N7)

1. I concur with the recommendations presented in the Review of CBOCS and OOCS of the Carl Vinson VA Medical Center.

2. Thank you for this opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendations.

3. If you have additional questions or need further information, please contact me at (478) 272-1210, ext. 2901.

Maryalice Morro, RN, MSN
Director, Carl Vinson VA Medical Center (557/00)

# 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 managers ensure that Milledgeville VA Clinic staff participate in emergency management training and exercises.

Concur

Target date for completion: June 30, 2016

Facility response: The CBOC Nurse Manager is responsible for ensuring that CBOC staff completes emergency management training as required by facility guidelines for employment and ensures that assigned CBOC staff participates in exercises. The Nurse Manager will audit staff training on a monthly basis and report to the Quality Leadership Team. Auditing will occur until compliance of 100% or greater for 3 consecutive months will be demonstrated and reported to the QLT.

**Recommendation 2.** We recommended that the clinic manager ensures that Milledgeville VA Clinic and contracted employees receive the required hazardous communications training.

Concur

Target date for completion: Completed

Facility response: VA and contracted employees that clean the Milledgeville Clinic received training on hazardous communications during March 2016. New employees receive hazardous communications training during new employee orientation. We request this recommendation be closed since training has been completed.

**Recommendation 3.** We recommended that the Milledgeville VA Clinic manager ensures that there are no expired injectable medication vials.

Concur

Target date for completion: June 30, 2016

Facility response: The CBOC Nurse Manager will ensure monthly medication room inspections are performed by designated staff in a timely manner and submitted monthly. The report will be presented to Pharmacy & Therapeutics Committee (P&T) monthly. Audit results will be reported monthly to P&T Committee until 90% or greater compliance is achieved for 3 consecutive months. Audit results will then be reported quarterly and as performance indicates.

**Recommendation 4.** We recommended that the Facility Director ensures that the facility's written policy for the communication of laboratory results includes all required elements.

Concur

Target date for completion: Completed

Facility response: The OIG CAP CBOC and Other Outpatient Clinics Review for Carl Vinson VA Medical Center occurred during the week of February 22 – 26, 2016. MCM 11-339, Ordering and Reporting Patient Test Results, was revised in January 2016 to include all required elements as required by VHA Directive 1088, Communicating Test Results to Providers and Patients. VHA Handbook 2009-019, Ordering and Reporting Test Results, March 24, 2009 was rescinded as a result. The facility's MCM was not made available to the inspectors for review as requested. The MCM is now published in the appropriate electronic directory and staff is notified as new documents are posted. We request closure of this recommendation based on the evidence provided.

**Recommendation 5.** We recommended that clinicians consistently notify patients of their laboratory results within 14 days as required by VHA.

Concur

Target date for completion: June 30, 2016

Facility response: The facility will perform monthly audits for all CBOCs to ensure compliance with reporting of laboratory results within 14 days for providers. This audit is performed on a monthly basis. This is presented to the Quality Leadership Team for appropriate follow-up and further action if required. Compliance is demonstrated with 90% of test results reported to the patient within 14 days for 3 consecutive months.

**Recommendation 6.** We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens.

Concur

Target date for completion: June 30, 2016

Facility response: The CBOC Nurse Manager will review positive PTSD screens on a daily basis via the PTSD Screen Report to ensure that acceptable providers performed and documented suicide risk assessments. Any incidence of an incomplete assessment will be reported daily to the appropriate provider for timely completion of the suicide risk assessment. Results will be reported on a monthly basis to the Quality Leadership Team for appropriate follow-up and further action as necessary. Compliance is determined to be 100% for 3 consecutive months.

**Recommendation 7.** We recommended that further diagnostic evaluations are offered to patients with positive PTSD screens.

Concur

Target date for completion: June 30, 2016

Facility response: Using the same data set from Recommendation 6, the patients with positive PTSD screens and completed suicide risk assessments will be reviewed to ensure that further appropriate diagnostic evaluations/referrals were offered to appropriate patients. Any incidence of non-compliance will be reported daily to the responsible provider for timely completion. Results will be reported on a monthly basis to the Quality Leadership Team for appropriate follow-up and further action as necessary. Compliance is determined to be 100% referral or evaluation for 3 consecutive months.

# Office of Inspector General
# Contact and Staff Acknowledgments

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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 Manua*l, July 1, 2015.
- National Fire Protection Association (NFPA), *NFPA 10: Installation of Portable Fire Extinguishers,* 2013.
- National Fire Protection Association (NFPA), *NFPA 101: Life Safety Code,* 2015.
- US Department of Health and Human Services, *Health Information Privacy: The Health Insurance Portability and Accountability Act (HIPAA) Enforcement Rule*, February 16, 2006.
- US Department of Labor, Occupational Safety and Health Administration (OSHA), *Fact Sheet: Hazard Communication Standard Final Rule,* n.d.
- US Department of Labor, Occupational Safety and Health Administration (OSHA), *Regulations (Standards – 29 CFR), 1910 General Industry Standards, 120 Hazardous Waste Operations and Emergency Response,* February 8, 2013.
- US Department of Labor, Occupational Safety and Health Administration (OSHA), *Regulations (Standards – 29 CFR), 1910 General Industry Standards, 1030 Bloodborne Pathogens,* April 3, 2012.
- 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.