Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00029-322

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Jesse Brown VA Medical Center Chicago, Illinois

June 9, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CBOC	community based outpatient clinic
EHR	electronic health record
EOC	environment of care
FY	fiscal year
HT	home telehealth
lab	laboratory
NA	not applicable
NM	not met
OIG	Office of Inspector General
OOC	other outpatient clinic
PC	primary care
PTSD	post-traumatic stress disorder
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 Jesse Brown VA Medical Center and Veterans Integrated Service Network 12 provide safe, consistent, and high-quality health care. The review evaluated the clinics' compliance with selected requirements for home telehealth enrollment, outpatient lab results management, and post-traumatic stress disorder care. We also randomly selected the Auburn Gresham VA Clinic, Chicago, IL, as a representative site and evaluated the environment of care on March 30, 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:

- The local policy is revised to include specific procedures for the identification of individuals entering the Community Based Outpatient Clinics.
- A safe work environment with adequate security coverage and incident responses is established and maintained at the Auburn Gresham VA Clinic.

Outpatient Lab Results Management: Ensure that:

- The facility's written policy for the communication of laboratory results includes all required elements.
- Clinicians consistently notify patients of their laboratory results as required by VHA.

Post-Traumatic Stress Disorder Care: Ensure that:

- The PTSD template is updated to accurately reflect providers' plans of care and disposition for patients with positive PTSD screens.

Comments

The Veterans Integrated Service Network and Acting 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 16–19, 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 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 made five 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 Auburn Gresham VA Clinic. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Table 2. EOC

NM	Areas Reviewed	Findings	Recommendations
Document and Training Review			
	Managers monitored clinic staff's hand hygiene compliance.		
	Clinic managers provided training for employees on the Exposure Control Plan for Bloodborne Pathogens within the past 12 months for those newly hired and annually for others.		
	The clinic had a policy/procedure for life safety elements.		
	The clinic had a policy for the management of clinical emergencies.		
	The clinic had a policy for the management of mental health emergencies.		
	The clinic had a documented Hazard Vulnerability Assessment to identify potential emergencies.		
	The Hazard Vulnerability Assessment was reviewed annually.		
	The clinic had a policy that requires staff to receive regular information on their responsibilities in emergency response operations.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinic staff participated in regular emergency management training and exercises.		
	The clinic conducted fire drills at least once every 12 months for the past 24 months with documented critiques of the drills.		
	The clinic had a policy/procedure for the identification of individuals entering the clinic.	The local policy did not address specific procedures for the identification of individuals entering the CBOCs.	**1**. We recommended that the facility revise the local policy to include specific procedures for the identification of individuals entering the CBOCs.
	The clinic had a Workplace Behavioral Risk Assessment in place.		
	The alarm system or panic buttons in high-risk areas were tested during the past 12 months.		
	The clinic had written procedures to follow in the event of a security incident.		
	Clinic employees received training on the new chemical label elements and safety data sheet format.		
	The clinic had a policy/procedure for the cleaning and disinfection of telehealth equipment.		
Physical Inspection			
	The clinic was clean.		
	The furnishings and equipment were safe and in good repair.		
	Hand hygiene facilities and product dispensers were working and readily accessible to employees.		
	Personal protective equipment was available.		
	Sharps containers were closable, easily accessible, and not overfilled.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinic staff did not store food and drinks in refrigerators or freezers or on countertops or other areas where there is blood or other potentially infectious materials.		
	Sterile commercial supplies were not expired.		
	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.		
	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.		
	Multi-dose medication vials were not expired.		
	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.		
X	Security coverage for the CBOC.	We found inadequate security coverage and response to a triggered alarm at the Auburn Gresham VA Clinic.	**2**. We recommended that the facility ensure a safe work environment with adequate security coverage and incident responses at the Auburn Gresham VA Clinic.

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 50 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 43 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 establish the process for the communication of emergent test results to another practitioner who can take action when the ordering and the surrogate practitioners are unavailable.	**3.** We recommend 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 13 of 43 patients (26 percent) of their lab results as required by VHA.	**4.** We recommended that clinicians consistently notify patients of their laboratory results 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 area marked as NM did not meet applicable requirements and needed improvement.

Table 5. PTSD Care

NM	Areas Reviewed	Findings	Recommendations
	Each patient with a positive PTSD screen received a suicide risk assessment.		
	Suicide risk assessments for patients with positive PTSD screens are completed by acceptable providers.		
X	Acceptable providers established plans of care and disposition for patients with positive PTSD screens.	Acceptable providers did not document plans of care and disposition in 8 of 50 EHRs (16 percent) reviewed. The language in the facility's PTSD provider template appeared to be incongruent with the information on the initial screening.	**5.** We recommended that the facility update its template to ensure providers' plans of care and disposition are accurately documented for patients with positive PTSD screens.
	Acceptable providers offered further diagnostic evaluations to patients with positive PTSD screens.		
	Providers completed diagnostic evaluations for patients with positive PTSD screens.		
	Patients, when applicable, received mental health treatment.		

Clinic Profiles

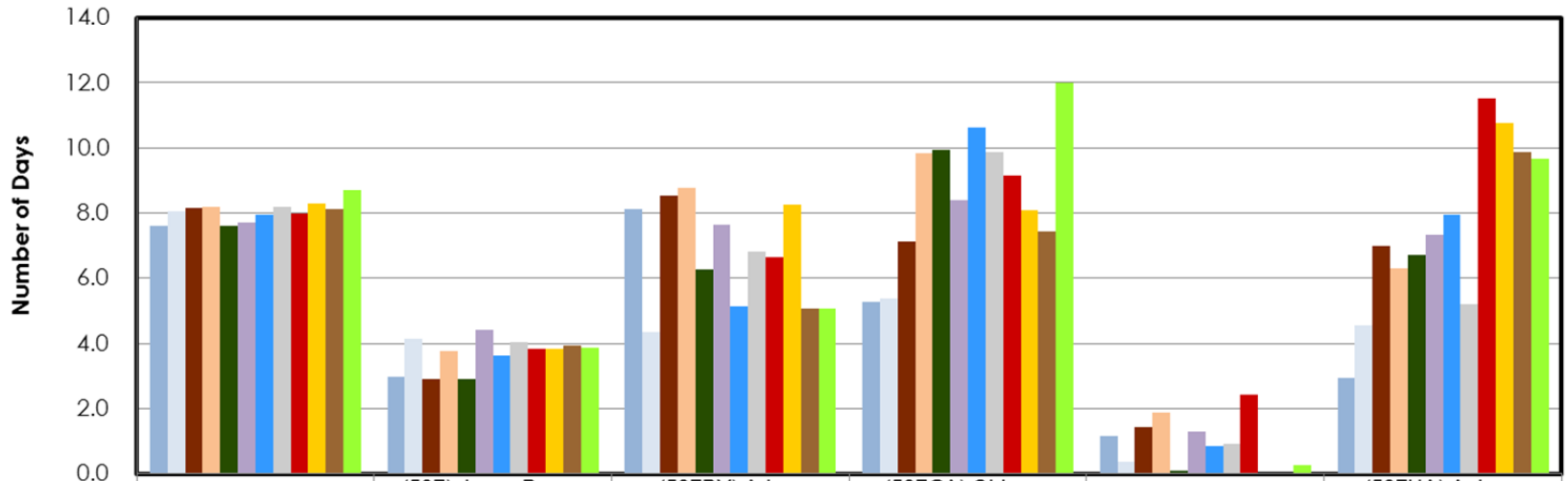
This review evaluates the quality of care provided to veterans at all of the outpatient clinics under the parent facility's oversight.[2] In addition to PC integrated with women's health, mental health, and tele-health services, the CBOCs provide various specialty care and ancillary services. The following table provides information relative to each of the outpatient clinics and lists the services provided at each location.[3]

				Outpatient Workload / Encounters[4]			Services Provided[5]		
Location	**Station #**	**Rurality**	**Outpatient Classification[6]**	**PC**	**Mental Health**	**Specialty Clinics[7]**	**Specialty Care[8]**	**Ancillary Services[9]**	
Crown Point, IN	537BY	Urban	Multi-Specialty CBOC	20,317	29,392	11,676	Cardiology Dental Endocrinology Gastroenterology Optometry Pain Clinic Podiatry	Audiology Diabetes Care Imaging Services Laboratory MOVE! Program[10] Nutrition	Pharmacy Rehabilitation Services Sleep Medicine Social Work
Chicago Heights, IL	537GA	Urban	Primary Care CBOC	3,392	3,890	92	NA	MOVE! Program	Pharmacy
Chicago, IL	537GD	Urban	Primary Care CBOC	12,013	206	1	NA	Pharmacy	Social Work
Chicago, IL	537HA	Urban	Primary Care CBOC	3,602	4,126	50	NA	Pharmacy	MOVE! Program

[2] Includes all CBOCs in operation before August 15, 2015. We have omitted 537QA (Chicago), 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.

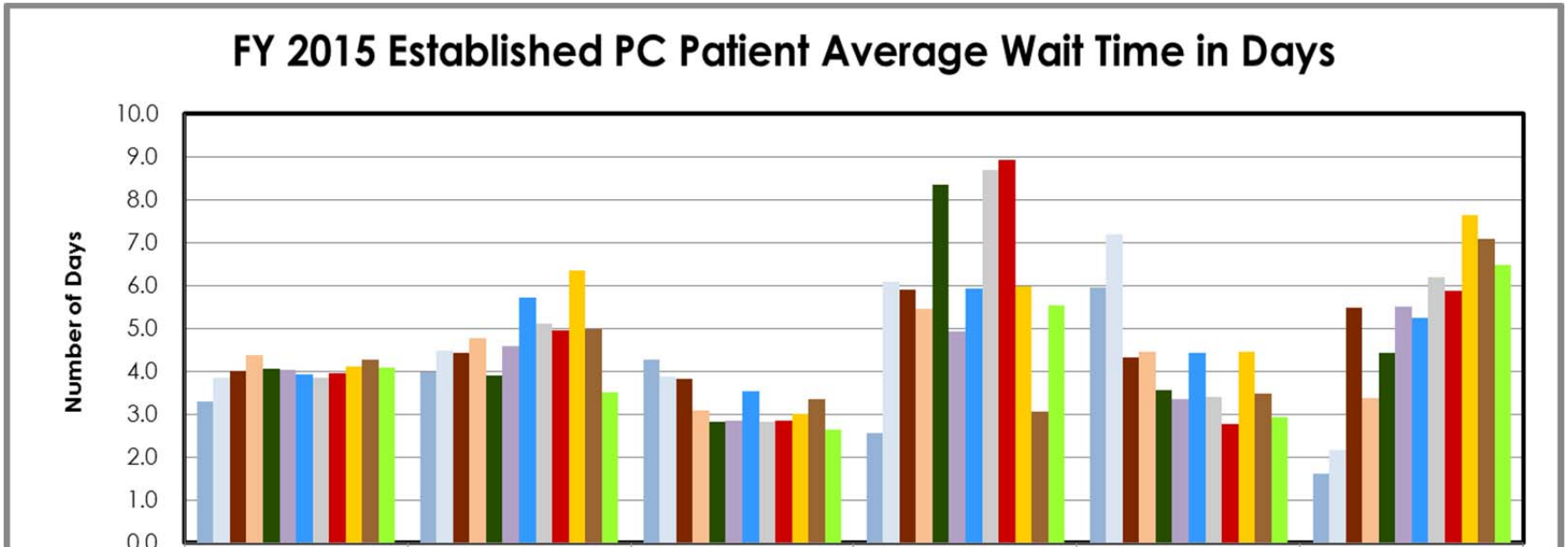
Patient Aligned Care Team Compass Metrics

FY 2015 New PC Patient Average Wait Time in Days



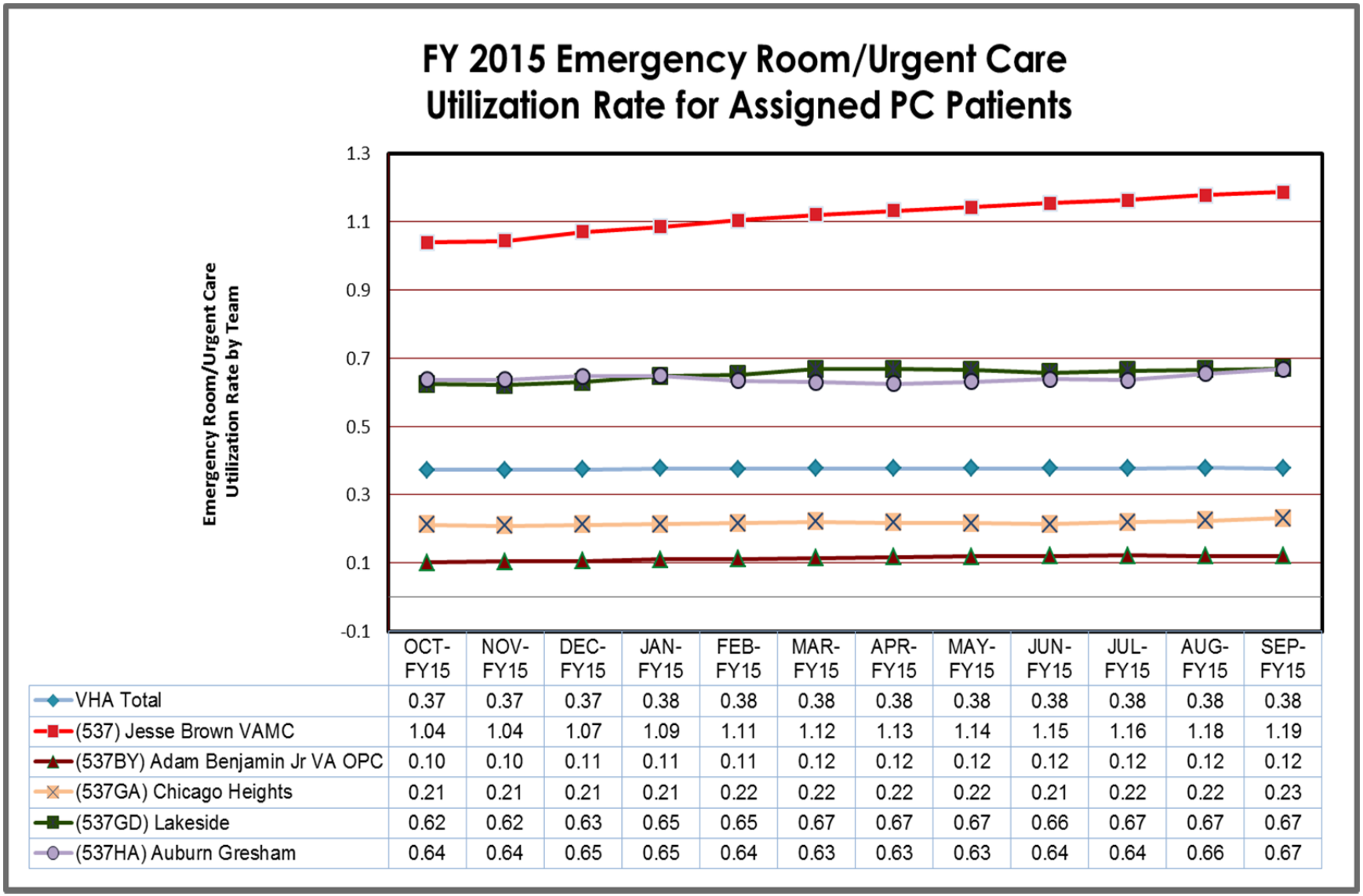
	VHA Total	(537) Jesse Brown VAMC	(537BY) Adam Benjamin Jr VA OPC	(537GA) Chicago Heights	(537GD) Lakeside	(537HA) Auburn Gresham
OCT-FY15	7.6	3.0	8.1	5.3	1.2	2.9
NOV-FY15	8.1	4.1	4.3	5.4	0.4	4.5
DEC-FY15	8.1	2.9	8.5	7.1	1.4	7.0
JAN-FY15	8.2	3.8	8.8	9.8	1.9	6.3
FEB-FY15	7.6	2.9	6.3	9.9	0.1	6.7
MAR-FY15	7.7	4.4	7.6	8.4	1.3	7.3
APR-FY15	7.9	3.6	5.1	10.6	0.8	7.9
MAY-FY15	8.2	4.0	6.8	9.9	0.9	5.2
JUN-FY15	8.0	3.8	6.6	9.1	2.4	11.5
JUL-FY15	8.3	3.8	8.2	8.1	0.0	10.8
AUG-FY15	8.1	3.9	5.1	7.4	0.0	9.9
SEP-FY15	8.7	3.9	5.1	12.0	0.3	9.7

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.*



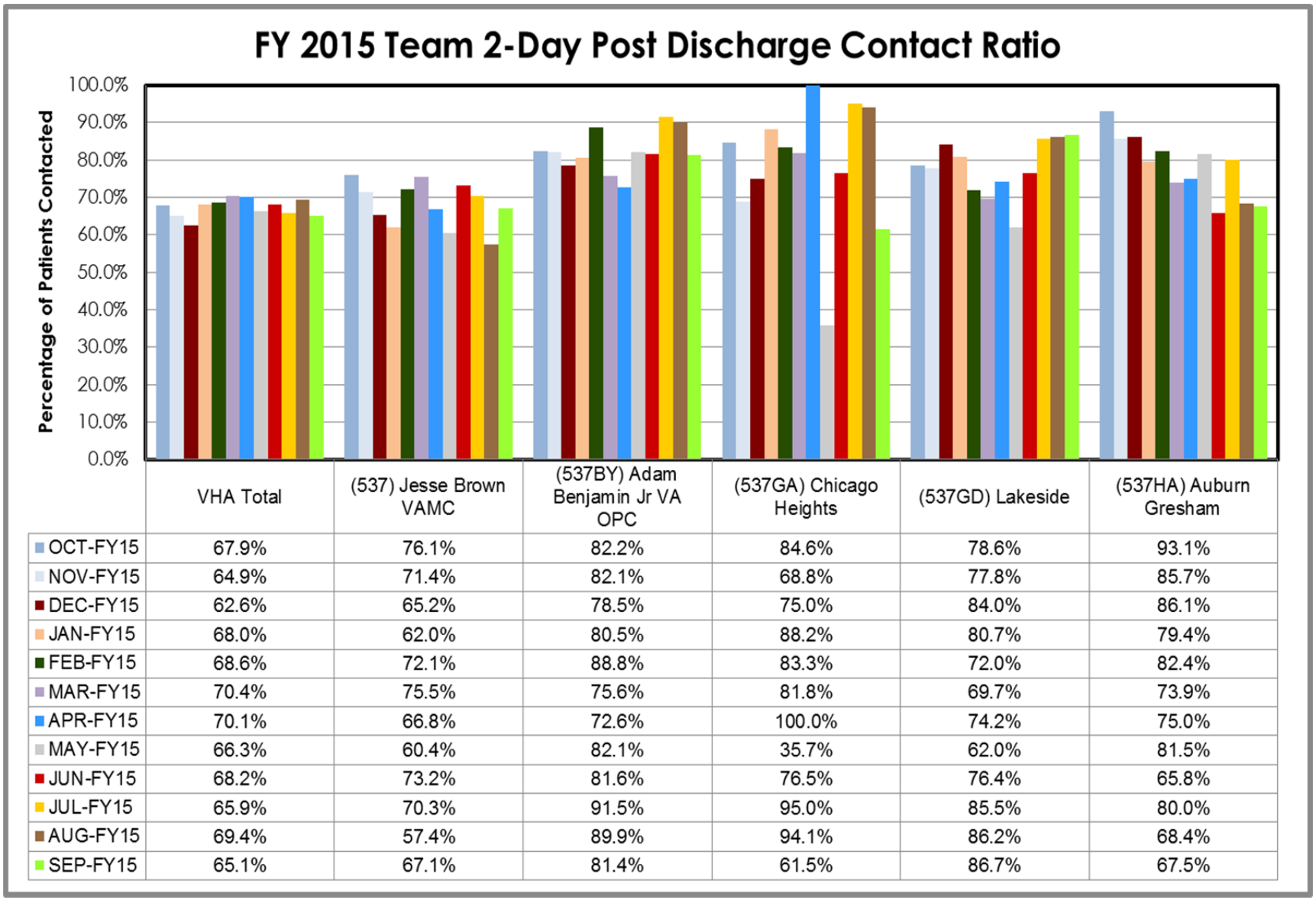
	VHA Total	(537) Jesse Brown VAMC	(537BY) Adam Benjamin Jr VA OPC	(537GA) Chicago Heights	(537GD) Lakeside	(537HA) Auburn Gresham
OCT-FY15	3.3	4.0	4.3	2.6	6.0	1.6
NOV-FY15	3.9	4.5	3.9	6.1	7.2	2.2
DEC-FY15	4.0	4.4	3.8	5.9	4.3	5.5
JAN-FY15	4.4	4.8	3.1	5.4	4.5	3.4
FEB-FY15	4.1	3.9	2.8	8.4	3.6	4.4
MAR-FY15	4.0	4.6	2.8	4.9	3.4	5.5
APR-FY15	3.9	5.7	3.5	5.9	4.4	5.2
MAY-FY15	3.8	5.1	2.8	8.7	3.4	6.2
JUN-FY15	4.0	5.0	2.9	8.9	2.8	5.9
JUL-FY15	4.1	6.3	3.0	6.0	4.5	7.6
AUG-FY15	4.3	5.0	3.4	3.1	3.5	7.1
SEP-FY15	4.1	3.5	2.6	5.5	2.9	6.5

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



	OCT-FY15	NOV-FY15	DEC-FY15	JAN-FY15	FEB-FY15	MAR-FY15	APR-FY15	MAY-FY15	JUN-FY15	JUL-FY15	AUG-FY15	SEP-FY15
VHA Total	0.37	0.37	0.37	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38	0.38
(537) Jesse Brown VAMC	1.04	1.04	1.07	1.09	1.11	1.12	1.13	1.14	1.15	1.16	1.18	1.19
(537BY) Adam Benjamin Jr VA OPC	0.10	0.10	0.11	0.11	0.11	0.12	0.12	0.12	0.12	0.12	0.12	0.12
(537GA) Chicago Heights	0.21	0.21	0.21	0.21	0.22	0.22	0.22	0.22	0.21	0.22	0.22	0.23
(537GD) Lakeside	0.62	0.62	0.63	0.65	0.65	0.67	0.67	0.67	0.66	0.67	0.67	0.67
(537HA) Auburn Gresham	0.64	0.64	0.65	0.65	0.64	0.63	0.63	0.63	0.64	0.64	0.66	0.67

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	(537) Jesse Brown VAMC	(537BY) Adam Benjamin Jr VA OPC	(537GA) Chicago Heights	(537GD) Lakeside	(537HA) Auburn Gresham
OCT-FY15	67.9%	76.1%	82.2%	84.6%	78.6%	93.1%
NOV-FY15	64.9%	71.4%	82.1%	68.8%	77.8%	85.7%
DEC-FY15	62.6%	65.2%	78.5%	75.0%	84.0%	86.1%
JAN-FY15	68.0%	62.0%	80.5%	88.2%	80.7%	79.4%
FEB-FY15	68.6%	72.1%	88.8%	83.3%	72.0%	82.4%
MAR-FY15	70.4%	75.5%	75.6%	81.8%	69.7%	73.9%
APR-FY15	70.1%	66.8%	72.6%	100.0%	74.2%	75.0%
MAY-FY15	66.3%	60.4%	82.1%	35.7%	62.0%	81.5%
JUN-FY15	68.2%	73.2%	81.6%	76.5%	76.4%	65.8%
JUL-FY15	65.9%	70.3%	91.5%	95.0%	85.5%	80.0%
AUG-FY15	69.4%	57.4%	89.9%	94.1%	86.2%	68.4%
SEP-FY15	65.1%	67.1%	81.4%	61.5%	86.7%	67.5%

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.

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date; 11 May 2016

From: Director, VA Great Lakes Health Care System (10N12)

Subject: CBOC and OOC Review of the Jesse Brown VA Medical Center, Chicago, IL

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. I have reviewed the response from the Jesse Brown VA Medical Center Chicago and concur with the response.

2. If you have any questions or concerns, please contact Chris Lacovetti, Acting QMO VISN 12 (708)492-3918.

(*original signed by:)*

Denise M. Deitzen
Director, VISN 12 VA Great Lakes Health Care System

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: 11 May 2016

From: Acting Director, Jesse Brown VA Medical Center (537/00)

Subject: CBOC and OOC Review of the Jesse Brown VA Medical Center, Chicago, IL

To: Director, VA Great Lakes Health Care System (10N12)

1. We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

2. I concur with the findings and recommendations of the OIG CBOC Survey Team. The importance of this review is acknowledged as we continually strive to provide the best possible care.

3. If you have any questions, please contact Deborah J. Barker RN, Chief Performance Improvement at (312)569-6194.

(*original signed by:)*

Annette P. Walker, MSHA, BSN
Acting Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendation

Recommendation 1. We recommended that the facility revise the local policy to include specific procedures for the identification of individuals entering the CBOCs.

Concur

Target date for completion: August 1, 2016

Facility response: The medical center policy is being revised and will include the process of identifying all individuals entering the CBOCs.

Recommendation 2. We recommended that the facility ensure a safe work environment with adequate security coverage and incident responses at the Auburn Gresham VA Clinic.

Concur

Target date for completion: July 1, 2016

Facility response: To ensure adequate security response two-way radios are being purchased for Security Personnel and identified staff members. This will allow for security coverage and continuous communication ability through the hours of operation in the clinic.

Recommendation 3. We recommend 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: June 1, 2016

Facility response: The medical center memorandum for communication of test results including critical test results will be updated to ensure compliance with all elements of VHA Directive 1088. The policy will also include provisions for surrogate assignment when ordering provider is unavailable, and a call cascade for reporting of test results

Recommendation 4. We recommended that clinicians consistently notify patients of their laboratory results as required by VHA.

Concur

Target date for completion: September 1, 2016

Facility response: The ordering provider or surrogate will be responsible for notifying the patient of test results. Random sample of medical records will be reviewed monthly to ensure compliance with of communication of test results. This monitor will be continued until sustainment of 3 months of 90% compliance.

Recommendation 5. We recommended that the facility update its template to ensure providers' plans of care and disposition are accurately documented for patients with positive PTSD screens.

Concur

Target date for completion: June 15, 2016

Facility response: The Mental Health Staff worked with the CPRS team to revise the positive PTSD screen clinical reminder. This template is planned for completion June 15, 2016. Once implemented a random sample of medical records will be reviewed monthly to ensure documentation requirements for positive PTSD screens. This monitor will be continued until sustainment of 3 months of 90% compliance.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Yoonhee Kim, PharmD, Team Leader Kathryn Arnett, LCSW Daisy Arugay-Rittenberg, MT John Barnes, BS, NREMT Stacy DePriest, LCSW Kathleen Shimoda, RN
Other Contributors	Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Jackelinne Melendez, MPA Jennifer Reed, RN, MSHI Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, RN, MSN Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Great Lakes Health Care System (10N12)
Acting Director, Jesse Brown VA Medical Center (537/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Daniel Coats, Joe Donnelly, Richard J. Durbin, Mark Kirk
U.S. House of Representatives: Danny K. Davis, Bob Dold, Tammy Duckworth, Bill Foster, Luis Gutierrez, Randy Hultgren, Robin Kelly, Adam Kinzinger, Daniel Lipinski, Mike Quigley, Peter J. Roskam, Bobby L. Rush, Jan Schakowsky, Peter Visclosky

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.