



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

**Office of Healthcare Inspections**

**Report No. 14-00908-194**

**Community Based Outpatient Clinic  
and Primary Care Clinic Reviews  
at  
Hampton VA Medical Center  
Hampton, Virginia**

**June 30, 2014**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**

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**(Hotline Information: [www.va.gov/oig/hotline](http://www.va.gov/oig/hotline))**

## Glossary

AUD	alcohol use disorder
CBOC	community based outpatient clinic
DWHP	designated women's health provider
EHR	electronic health record
EOC	environment of care
FY	fiscal year
MH	mental health
MM	medication management
NM	not met
OIG	Office of Inspector General
PACT	Patient Aligned Care Teams
PCC	primary care clinic
PCP	primary care provider
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH	women's health

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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 (CBOCs) and primary care clinics (PCCs) provide safe, consistent, and high-quality health care for our veterans. We conducted a site visit during the week of April 1, 2014, at the Albemarle CBOC, Elizabeth City, NC, which is under the oversight of the Hampton VA Medical Center and Veterans Integrated Service Network 6.

**Review Results:** We conducted four focused reviews and had no findings for the Designated Women's Health Providers' Proficiency review. However, we made recommendations in the following three review areas:

Environment of Care. Ensure that:

- The parent facility includes staff at the Albemarle CBOC in required education, training, planning, and participation in annual disaster exercises.
- The parent facility's Emergency Management Committee evaluates the Albemarle CBOC's emergency preparedness activities, participation in annual disaster exercises, and staff training/education relating to emergency preparedness requirements.

Alcohol Use Disorder. Ensure that CBOC/PCC:

- Staff consistently complete diagnostic assessments for patients with a positive alcohol screen.
- Staff provide education and counseling for patients with positive alcohol screens and drinking levels above National Institute on Alcohol Abuse and Alcoholism guidelines.
- Registered Nurse Care Managers receive motivational interviewing and health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Medication Management. Ensure that CBOC/PCC staff:

- Document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.
- Staff consistently provide written medication information that includes the fluoroquinolone.
- Staff provide medication counseling/education as required.

## Comments

The VISN and Facility Directors agreed with the CBOC and PCC review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 15–21, 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 PCC 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 PCC reviews are recurring evaluations of selected primary care operations that focus on patient care quality and the EOC. In general, our objectives are to:

- Determine whether the CBOCs are compliant with EOC requirements.
- Determine whether CBOCs/PCCs are compliant with VHA requirements in the care of patients with AUD.
- Determine compliance with requirements for the clinical oversight and patient education of fluoroquinolones for outpatients.
- Evaluate if processes are in place for DWHPs to maintain proficiency in WH.

### 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
- MM
- DWHP Proficiency

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

### Methodology

The onsite EOC inspection was only conducted at randomly selected CBOCs that had not been previously inspected.<sup>1</sup> Details of the targeted study populations for the AUD, MM, and DWHP Proficiency focused reviews are noted in Table 1.

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<sup>1</sup> Includes 93 CBOCs in operation before March 31, 2013.

**Table 1. CBOC/PCC Focused Reviews and Study Populations**

Review Topic	Study Population
AUD	All CBOC and PCC patients screened within the study period of July 1, 2012, through June 30, 2013, and who had a positive AUDIT-C score <sup>2</sup> and all providers and RN Care Managers assigned to PACT prior to October 1, 2012.
MM	All outpatients with an original prescription ordered for one of the three selected fluoroquinolones from July 1, 2012, through June 30, 2013.
DWHP Proficiencies	All WH PCPs designated as DWHPs as of October 1, 2012, and who remained as DWHPs until September 30, 2013.

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 done in accordance with OIG standard operating procedures for CBOC and PCC reviews.

<sup>2</sup> 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.<sup>a</sup>

We reviewed relevant documents and conducted a physical inspection of the Albemarle CBOC. 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
	The CBOC's location is clearly identifiable from the street as a VA CBOC.	
	The CBOC has interior signage available that clearly identifies the route to and location of the clinic entrance.	
	The CBOC is Americans with Disabilities Act accessible.	
	The furnishings are clean and in good repair.	
	The CBOC is clean.	
	The CBOC maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates.	
	An alarm system and/or panic buttons are installed and tested in high-risk areas (e.g., MH clinic).	
	Alcohol hand wash or soap dispenser and sink are available in the examination rooms.	
	Sharps containers are secured.	
	Safety needle devices are available.	
	The CBOC has a separate storage room for storing medical (infectious) waste.	
	The CBOC conducts fire drills at least every 12 months.	
	Means of egress from the building are unobstructed.	
	Access to fire alarm pull stations is unobstructed.	
	Access to fire extinguishers is unobstructed.	
	The CBOC has signs identifying the locations of fire extinguishers.	
	Exit signs are visible from any direction.	
	No expired medications were noted during the onsite visit.	
	All medications are secured from unauthorized access.	

NM	Areas Reviewed (cont.)	Findings
	Personally identifiable information is protected on laboratory specimens during transport so that patient privacy is maintained.	
	Adequate privacy is provided to patients in examination rooms.	
	Documents containing patient-identifiable information are not laying around, visible, or unsecured.	
	Window coverings provide privacy.	
	The CBOC has a designated examination room for women veterans.	
	Adequate privacy is provided to women veterans in the examination room.	
	The information technology network room/server closet is locked.	
	All computer screens are locked when not in use.	
	Staff use privacy screens on monitors to prevent unauthorized viewing in high-traffic areas.	
	EOC rounds are conducted semi-annually (at least twice in a 12-month period) and deficiencies are reported to and tracked by the EOC Committee until resolution.	
	The CBOC has an automated external defibrillator.	
	Safety inspections are performed on the CBOC medical equipment in accordance with Joint Commission standards.	
X	The parent facility includes the CBOC in required education, training, planning, and participation leading up to the annual disaster exercise.	The parent facility did not include the Albemarle CBOC in required education, training, planning, and participation leading up to the annual disaster exercises.
X	The parent facility's Emergency Management Committee evaluates CBOC emergency preparedness activities, participation in annual disaster exercise, and staff training/education relating to emergency preparedness requirements.	The parent facility's Emergency Management Committee did not evaluate the Albemarle CBOC's emergency preparedness activities, participation in annual disaster exercise, and staff training/education relating to emergency preparedness requirements.

**Recommendations**

1. We recommended that the parent facility include staff at the Albemarle CBOC in required education, training, planning, and participation in annual disaster exercises.
2. We recommended that the parent facility's Emergency Management Committee evaluate the Albemarle CBOC's emergency preparedness activities, participation in annual disaster exercises, and staff training/education relating to emergency preparedness requirements.

## AUD

The purpose of this review was to determine whether the facility's CBOCs and PCCs complied with selected alcohol use screening and treatment requirements.<sup>b</sup>

We reviewed relevant documents. We also reviewed 39 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 3. AUD**

NM	Areas Reviewed	Findings
	Alcohol use screenings are completed during new patient encounters, and at least annually.	
X	Diagnostic assessments are completed for patients with a positive alcohol screen.	Staff did not complete diagnostic assessments for 18 (46 percent) of 38 patients who had positive alcohol use screens.
X	Education and counseling about drinking levels and adverse consequences of heavy drinking are provided for patients with positive alcohol screens and drinking levels above National Institute on Alcohol Abuse and Alcoholism guidelines.	Staff did not provide education and counseling for two of eight patients who had positive alcohol use screens.
	Documentation reflects the offer of further treatment for patients diagnosed with alcohol dependence.	
	For patients with AUD who decline referral to specialty care, CBOC/PCC staff monitored them and their alcohol use.	
	Counseling, education, and brief treatments for AUD are provided within 2 weeks of positive screening.	
X	CBOC/PCC RN Care Managers have received motivational interviewing training within 12 months of appointment to PACT.	We found that all of the 20 RN Care Managers did not receive motivational interviewing training within 12 months of appointment to PACT.
X	CBOC/PCC 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 all of the 20 RN Care Managers did not receive health coaching training within 12 months of appointment to PACT.
	The facility complied with any additional elements required by VHA or local policy.	

## Recommendations

3. We recommended that CBOC/Primary Care Clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.

4. We recommended that CBOC/Primary Care Clinic staff provide education and counseling for patients with positive alcohol screens and drinking levels above National Institute on Alcohol Abuse and Alcoholism guidelines.
5. We recommended that CBOC/Primary Care Clinic Registered Nurse Care Managers receive motivational interviewing training and health coaching training within 12 months of appointment to Patient Aligned Care Teams.

**MM**

The purpose of this review was to determine whether appropriate clinical oversight and education were provided to outpatients prescribed oral fluoroquinolone antibiotics.<sup>c</sup>

We reviewed relevant documents. We also reviewed 40 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. Fluoroquinolones**

<b>NM</b>	<b>Areas Reviewed</b>	<b>Findings</b>
X	Clinicians documented the medication reconciliation process that included the fluoroquinolone.	We did not find documentation that medication reconciliation included the newly prescribed fluoroquinolone in 8 (20 percent) of 40 patients' EHRs.
X	Written information on the patient's prescribed medications was provided at the end of the outpatient encounter.	We did not find documentation that 5 (13 percent) of 40 patients received written information that included the fluoroquinolone.
X	Medication counseling/education for the fluoroquinolone was documented in the patients' EHRs.	We did not find documentation of medication counseling that included the fluoroquinolone in 5 (13 percent) of 40 patients' EHRs.
	Clinicians documented the evaluation of each patient's level of understanding for the education provided.	
	The facility complied with local policy.	

**Recommendations**

6. We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.

7. We recommended that staff consistently provide written medication information that includes the fluoroquinolone.

8. We recommended that staff provide medication counseling/education as required.

## DWHP Proficiency

The purpose of this review was to determine whether the facility’s CBOCs and PCCs complied with selected DWHP proficiency requirements.<sup>d</sup>

We reviewed the facility self-assessment, VHA and local policies, Primary Care Management Module data, and supporting documentation for DWHPs’ proficiencies. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

**Table 5. DWHP Proficiency**

NM	Areas Reviewed	Findings
	CBOC and PCC DWHPs maintained proficiency requirements.	
	CBOC and PCC DWHPs were designated with the WH indicator in the Primary Care Management Module.	

## CBOC Profiles

This review evaluates the quality of care provided to veterans at all of the CBOCs under the parent facility's oversight.<sup>3</sup> The table below provides information relative to each of the CBOCs.

Location	State	Station #	Locality <sup>5</sup>	CBOC Size <sup>6</sup>	Uniques <sup>4</sup>				Encounters <sup>4</sup>			
					MH <sup>7</sup>	PC <sup>8</sup>	Other <sup>9</sup>	All	MH <sup>7</sup>	PC <sup>8</sup>	Other <sup>9</sup>	All
Norfolk-Virginia Beach	VA	590GB	Urban	Large	2,144	4,933	4,201	7,049	8,910	9,486	10,610	29,006
Albemarle	NC	590GC	Rural	Mid-Size	483	1,787	1,106	2,010	3,009	5,099	3,974	12,082

<sup>3</sup> Includes all CBOCs in operation before March 31, 2013.

<sup>4</sup> Unique patients and Total Encounters – Source: MedSAS outpatient files; completed outpatient appointments indicated by a valid stop code during the October 1, 2012, through September 30, 2013, timeframe at the specified CBOC.

<sup>5</sup> [http://vaww.pssg.med.va.gov/PSSG/DVDC/FY2013\\_Q1\\_VAST.xlsx](http://vaww.pssg.med.va.gov/PSSG/DVDC/FY2013_Q1_VAST.xlsx)

<sup>6</sup> Based on the number of unique patients seen as defined by VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, the size of the CBOC facility is categorized as very large (> 10,000), large (5,000-10,000), mid-size (1,500-5,000), or small (< 1,500).

<sup>7</sup> Mental Health includes stop codes in the 500 series, excluding 531 and 563, in the primary position.

<sup>8</sup> Primary Care includes the stop code list in the primary position: 323 – Primary Care; 322 – Women's Clinic; 348 – Primary Care Group; 350 – Geriatric Primary Care; 531 – MH Primary Care Team-Individual; 563 – MH Primary Care Team-Group; 170 – Home Based Primary Care (HBPC) Physician.

<sup>9</sup> All other non-Primary Care and non-MH stop codes in the primary position.

## CBOC Services Provided

In addition to primary care integrated with WH and MH care, the CBOCs provide various specialty care, ancillary, and tele-health services. The following table lists the services provided at each CBOC.<sup>10</sup>

CBOC	Specialty Care Services <sup>11</sup>	Ancillary Services <sup>12</sup>	Tele-Health Services <sup>13</sup>
Norfolk-Virginia Beach	Optometry Endocrinology Medicine Specialties	Pharmacy MOVE! Program <sup>14</sup> Diabetic Retinal Screening Nutrition Chaplain Diabetes Care	Tele Primary Care
Albemarle	Medicine Specialties	Pharmacy MOVE! Program	Tele Primary Care

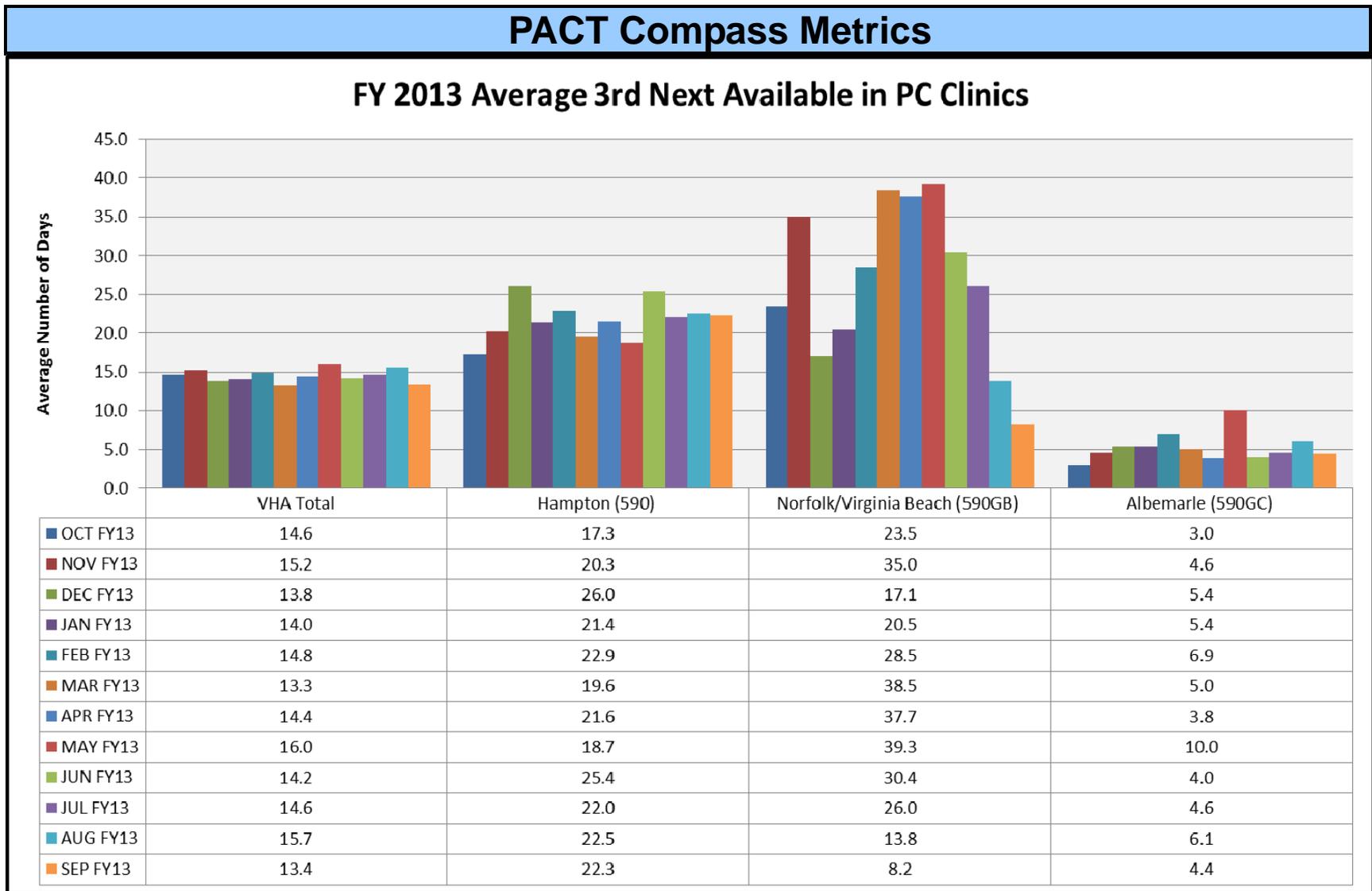
<sup>10</sup> Source: MedSAS outpatient files; the denoted Specialty Care and Ancillary Services are limited to Primary Clinic Stops with a count  $\geq 100$  encounters during the October 1, 2012, through September 30, 2013, timeframe at the specified CBOC.

<sup>11</sup> Specialty Care Services refer to non-Primary Care and non-MH services provided by a physician.

<sup>12</sup> Ancillary Services refer to non-Primary Care and non-MH services that are not provided by a physician.

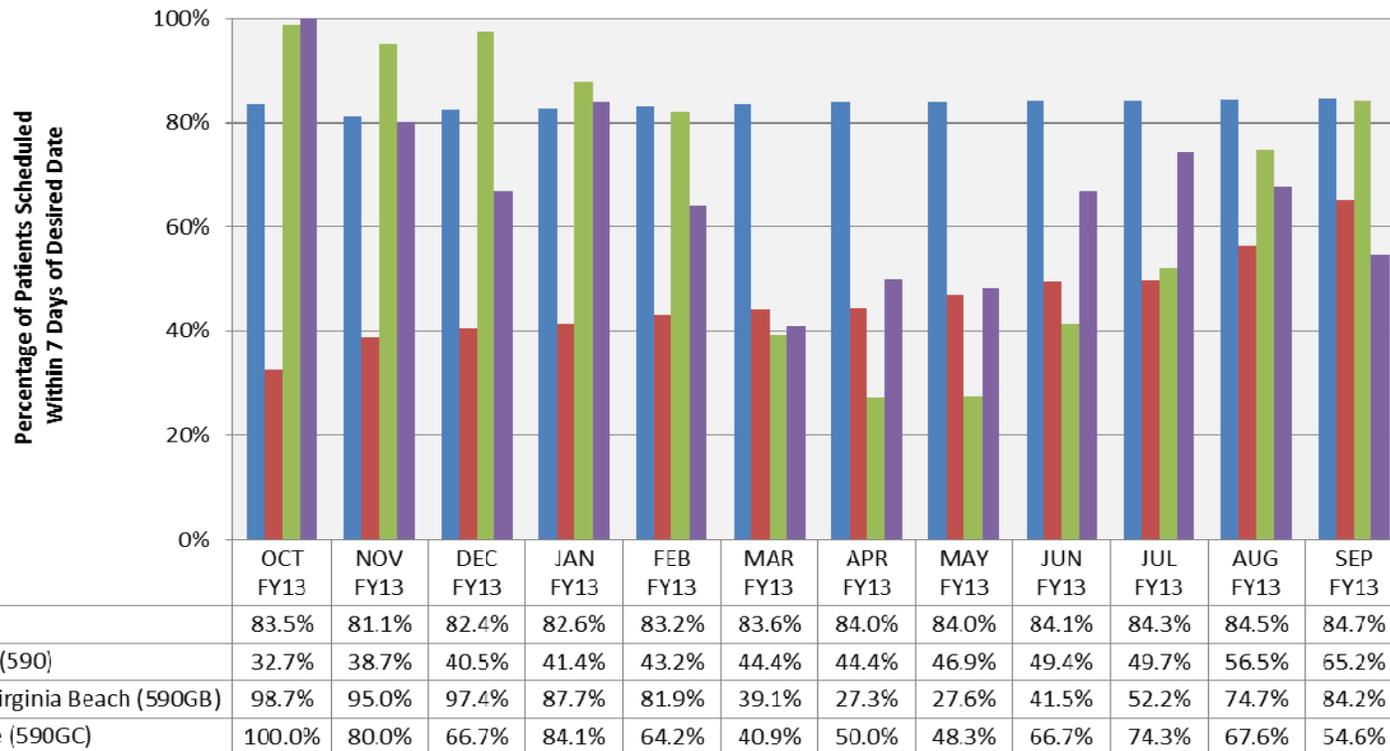
<sup>13</sup> Tele-Health Services refer to services provided under the VA Telehealth program (<http://www.telehealth.va.gov/>)

<sup>14</sup> VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.



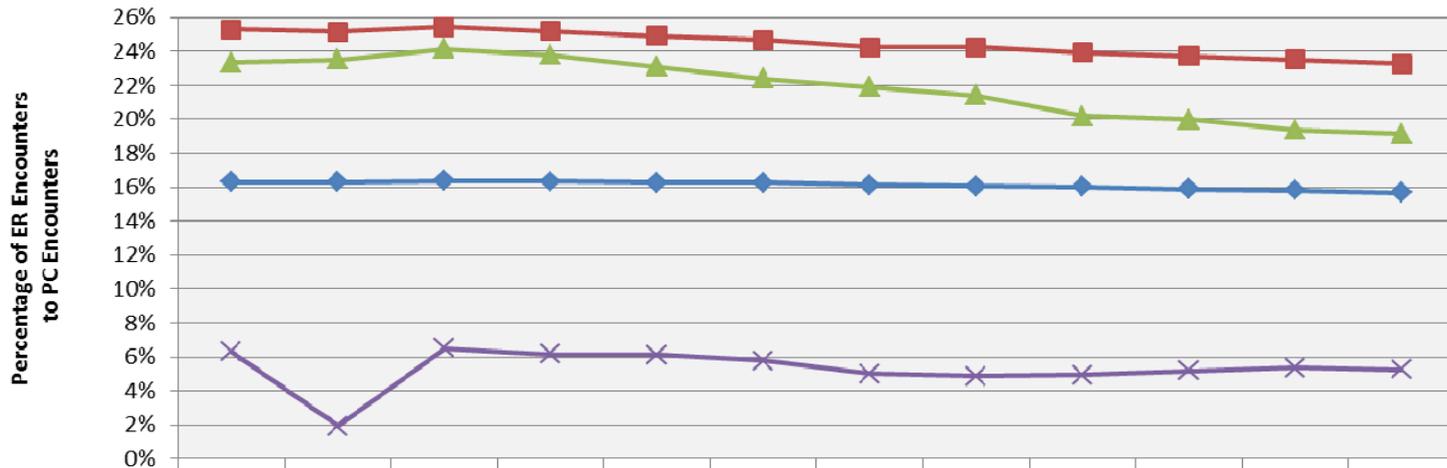
**Data Definition.**<sup>6</sup> The average waiting time in days until the next third open appointment slot for completed primary care appointments in stop code 350. Completed appointments in stop code 350 for this metric include completed appointments where a 350 stop code is in the primary position on the appointment or one of the telephone stop codes is in the primary position, and 350 stop code is in the secondary position. The data is averaged from the national to the division level.

### FY 2013 Established PC Prospective Wait Times 7 Days



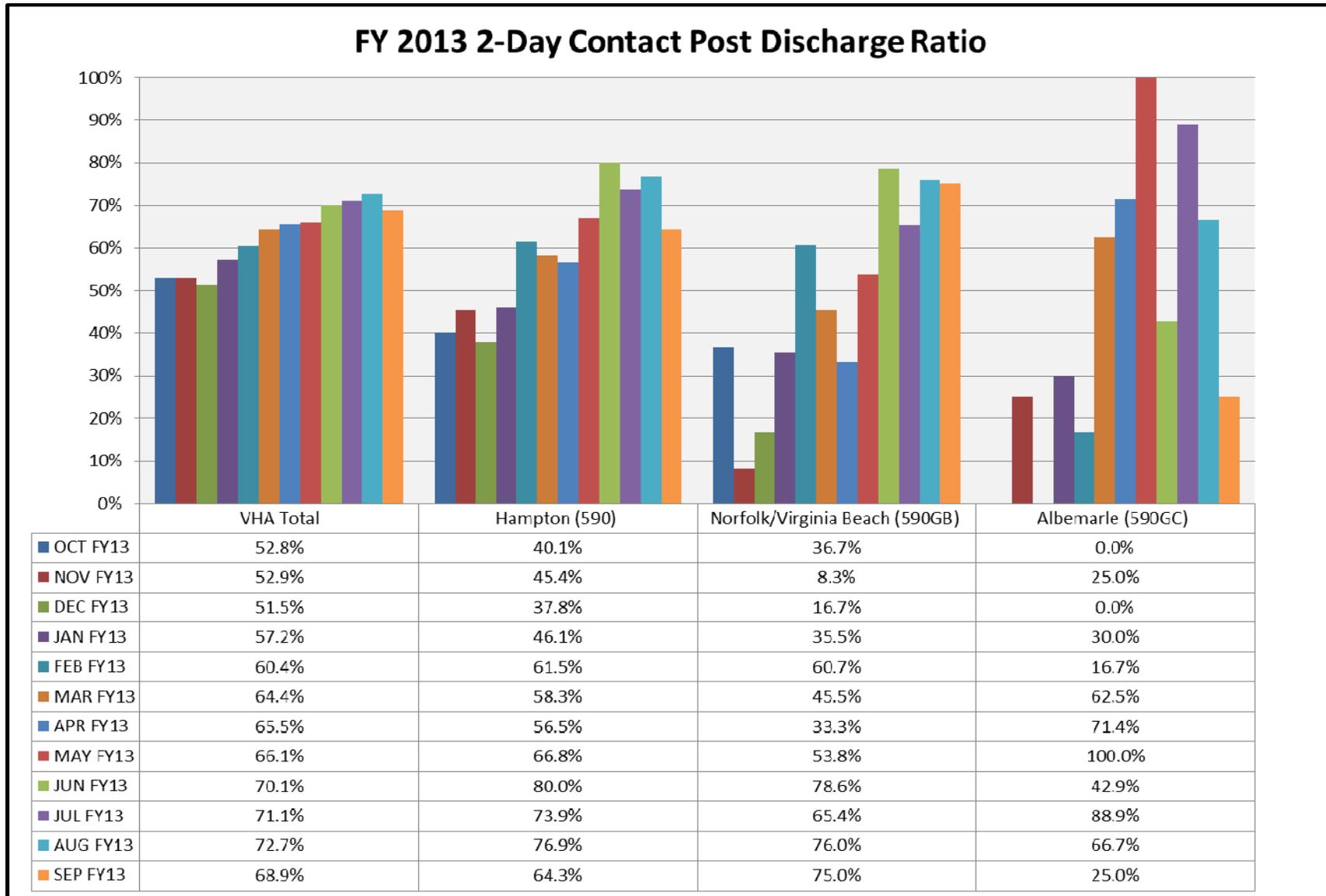
**Data Definition.**<sup>c</sup> The percent of patients scheduled within 7 days of the desired date. Data source is the Wait Times Prospective Wait Times measures. The total number of scheduled appointments for primary care-assigned patients in primary care clinics 322, 323 and 350. Data is collected twice a month on the 1<sup>st</sup> and the 15<sup>th</sup>. Data reported is for the data pulled on the 15<sup>th</sup> of the month. There is no FY to date score for this measure.

### FY 2013 Ratio of ER Encounters While on Panel to PC Encounters While on Panel (FEE ER Included)



—●— VHA Total	OCT FY13	NOV FY13	DEC FY13	JAN FY13	FEB FY13	MAR FY13	APR FY13	MAY FY13	JUN FY13	JUL FY13	AUG FY13	SEP FY13
—■— Hampton (590)	25.3%	25.2%	25.5%	25.2%	24.9%	24.7%	24.3%	24.2%	23.9%	23.7%	23.5%	23.3%
—▲— Norfolk/Virginia Beach (590GB)	23.3%	23.5%	24.1%	23.8%	23.1%	22.4%	21.9%	21.4%	20.2%	20.0%	19.4%	19.1%
—×— Albemarle (590GC)	6.3%	1.9%	6.5%	6.2%	6.1%	5.8%	5.0%	4.9%	4.9%	5.2%	5.4%	5.2%

**Data Definition.**<sup>6</sup> This is a measure of where the patient receives his or her primary care and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care/FEE ER Encounters WOP (including FEE ER visits) *divided by* the number of primary care encounters WOP with the patient’s assigned primary care (or associate) provider plus the total VHA ER/Urgent Care/FEE ER Encounters (including FEE ER visits) WOP plus the number of primary care encounters WOP with a provider other than the patient’s PCP/AP.



**Data Definition.**<sup>e</sup> Total Discharges Included in 2-day Contact Post Discharge Ratio: The total VHA and FEE Inpatient Discharges for assigned primary care patients for the reporting timeframe. Discharges resulting in death and discharges where a patient is readmitted within 2 days of discharge are excluded from this metric.

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** June 9, 2014

**From:** Director, VISN (10N6)

**Subject:** **CBOC and PCC Reviews of the Hampton VA Medical Center, Hampton, VA**

**To:** Director, Washington, DC Office of Healthcare Inspections (54DC)

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

1. Attached is the action plan developed by the Hampton VA Medical Center in response to the recommendations received during their recent OIG review.
2. The facility concurs with the findings and will ensure the corrective action plan is implemented.
3. If you have any questions and/or concerns, please contact Lisa Shear, VISN 6 QMO, at (919) 956-5541.

(original signed:)

DANIEL F. HOFFMANN, FACHE

## Facility Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** June 3, 2014  
**From:** Director, Hampton VA Medical Center (590/00)  
**Subject:** **CBOC and PCC Reviews of the Hampton VA Medical Center, Hampton, VA**  
**To:** Director, VISN 6 (10N6)

1. Thank you for the opportunity to review the OIG report on the Review of Hampton VA Medical Center. We concur with the recommendations, and will ensure completion as described in the implementation plan.
2. Please find attached our responses to each recommendation provided in the attached plan.
3. If you have any questions regarding the response to the recommendations, feel free to call me at (757) 722-9961, extension 3100.

(original signed by:)

MICHAEL H. DUNFEE, MHA

## Comments to OIG's Report

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

### **OIG Recommendations**

**Recommendation 1.** We recommended that the parent facility include staff at the Albemarle CBOC in required education, training, planning, and participation in annual disaster exercises.

Concur

Target date for completion: October 31, 2014

Facility response:

Emergency Management Education and Training  
The following actions have been initiated:

All APOC staff will complete the Emergency Preparedness Management Program in Talent Management System (TMS) by June 2014.

Members of the Emergency Management Incident Command Team are required to complete the following two (2) specialized Emergency Management Trainings:

1. FEMA's National Incident Management System (NIMS) ICS 100, 200, 700, 800 (TMS)
2. FEMA's National Incident Management System (NIMS) ICS 300 (off site course)

The next scheduled offsite course is October 2014.

All assigned Emergency Management training by staff identified above will be completed by October 31, 2014.

TMS Emergency Preparedness Management Program training status will be tracked in TMS. The TMS reports will be reported monthly to Administrative Executive Board for Leadership oversight through the Emergency Management Committee until closure.

Emergency Management Planning

The APOC/CBOC Service Specific plans were reviewed and approved by the Emergency Management Committee in January 2012.

Emergency Management Participation:

The next scheduled Facility Emergency Management Exercise is a Tornado Warning Exercise, and will occur NLT July 31, 2014. This exercise will be inclusive of both the APOC and the parent facility. The tornado scenario will involve a series of tornado

touchdowns in the Hampton Roads (parent facility geographic area) and Elizabeth City (APOC geographic area). The After Action Report (AAR) of the Tornado Warning Exercise will document the parent facility and APOC participation in this severe weather event. The AAR will be reported to the August Administrative Executive Board through the Emergency Management Committee for Leadership oversight.

**Recommendation 2.** We recommended that the parent facility's Emergency Management Committee evaluate the Albemarle CBOC's emergency preparedness activities, participation in annual disaster exercises, and staff training/education relating to emergency preparedness requirements.

Concur

Target date for completion: August 31, 2014

Facility response:

The next scheduled Facility Emergency Management Exercise is a Tornado Warning Exercise, and will occur NLT July 31, 2014. This exercise will be inclusive of both the APOC and the parent facility. The tornado scenario will involve a series of tornado touchdowns in the Hampton Roads (parent facility geographic area) and Elizabeth City (APOC geographic area). The After Action Report (AAR) of the Tornado Warning Exercise will document the evaluation of this severe weather event. The AAR will be reported to the August Administrative Executive Board through the Emergency Management Committee for Leadership oversight until closure.

Beginning with the August 2014 Emergency Management Committee meeting: TMS Emergency Preparedness Management Program training status, attendance, and participation in Emergency Management exercises will be tracked, monitored, and documented monthly in the Emergency Management Committee. This report will be reported monthly to Administrative Executive Board through the Emergency Management Committee for Leadership oversight until closure.

**Recommendation 3.** We recommended that CBOC/Primary Care Clinic staff consistently complete diagnostic assessments for patients with a positive alcohol screen.

Concur

Target Date for completion: September 30, 2014

Facility response:

Members of the Clinical Champions Workgroup thoroughly analyzed the process to complete the AUDIT-C clinical reminder. We identified technical opportunities with the AUDIT-C Clinical Reminder that hinders consistent completion of the positive clinical reminder.

Staff have been re-educated on the correct process to activate the Positive AUDIT-C and to use verbal communication as a means to alert the Provider and/or Primary Care Mental Health Integration (PCMHI) Team of a positive reminder requiring action.

Starting in June 2014, the monthly Alcohol Clinical Reminder completion report will be reported to Executive Leadership Board through Quality Executive Council for Leadership oversight until closure.

**Recommendation 4.** We recommended that CBOC/Primary Care Clinic staff provide education and counseling for patients with positive alcohol screens and drinking levels above National Institute on Alcohol Abuse and Alcoholism guidelines.

Concur

Target Date for completion: September 30, 2014

Facility response:

If the alcohol screen is noted to be positive, the Provider completes a diagnostic assessment and documents the education and counseling provided to the Veteran during that visit. Additionally, if the AUDIT-C screen is positive, the provider does a warm hand-off to the Primary Care Mental Health Integration (PCMHI) team member(s) to facilitate patient education and counseling on substance use and screening for other co-morbid conditions.

Starting in June 2014, the monthly Alcohol Clinical Reminder completion report will be reported to Executive Leadership Board through Quality Executive Council for Leadership oversight until closure.

**Recommendation 5.** We recommended that CBOC/Primary Care Clinic Registered Nurse Care Managers receive motivational interviewing training and health coaching training within 12 months of appointment to Patient Aligned Care Teams.

Concur

Target Date for completion: September 30, 2014

Facility response:

A facility needs assessment was performed to identify staff that have not completed Motivational Interviewing and Health Coaching training. A newly hired Health Behavioral Coach is registered to attend and complete the Motivational Interviewing and Health Coaching training by July 30, 2014. Upon completion of the training, the Health Behavioral Coach will provide additional classes to support the effort of 100% of staff receiving Motivational Interviewing training within twelve months of appointment to a Patient Aligned Care Team (PACT). Training completion is tracked in the VA Talent Management System (TMS). Monthly TMS training reports will be reported to Medical

Executive Leadership Board (MEB) through Primary Care Staff Meeting for Leadership oversight until closure.

**Recommendation 6.** We recommended that staff document that medication reconciliation was completed at each episode of care where the newly prescribed fluoroquinolone was administered, prescribed, or modified.

Concur

Facility response:

Target Date for completion: September 30, 2014

The Chief of Staff re-educated clinical service chiefs on the expectation that medication reconciliation will be completed per VHA Directive 2011-012 and local policy. Beginning in June 2014, random chart audits will be performed to validate compliance with medication reconciliation for outpatients prescribed fluoroquinolones. The results of the chart audits will be reported monthly to Medical Executive Board through Medical Records Committee for Leadership oversight until closure.

**Recommendation 7.** We recommended that staff consistently provide written medication information that includes the fluoroquinolone.

Concur

Target Date for completion: September 30, 2014

Written medication education is provided to patients receiving fluoroquinolones. Clinical staff were trained to document that they provided this written education. Beginning in June 2014, random chart audits will be performed to validate compliance with documentation of providing written medication information for outpatients prescribed fluoroquinolones. The results of the chart audits will be reported monthly to Medical Executive Board through Medical Records Committee for Leadership oversight until closure.

Facility response:

**Recommendation 8.** We recommended that staff provide medication counseling/education as required.

Concur

Target Date for completion: September 30, 2014

Clinical staff were educated to document counseling/education specific to key areas (e.g. side effects, drug interactions, etc.) in CPRS. Beginning in June 2014, random chart audits will be performed to validate compliance with documentation of providing counseling/education specific to key areas (e.g. side effects, drug interactions, etc.) for

outpatients prescribed fluoroquinolones. The results of the chart audits will be reported monthly to Medical Executive Board through Medical Records Committee for Leadership oversight until closure.

## OIG Contact and Staff Acknowledgments

<b>Contact</b>	For more information about this report, please contact the OIG at (202) 461-4720.
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## **Report Distribution**

### **VA Distribution**

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Veterans Health Administration  
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Scott, Robert Wittiman

This report is available at [www.va.gov/oig](http://www.va.gov/oig).

## Endnotes

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