Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-01322-215

Healthcare Inspection

Quality of Care and Staff Safety Concerns at the Huntsville Community Based Outpatient Clinic Huntsville, Alabama

July 17, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations concerning the quality of care provided by a primary care provider (PCP) and staff safety at the community based outpatient clinic (CBOC) located in Huntsville, AL. The CBOC is associated with the Birmingham VA Medical Center (facility).

We substantiated the PCP did not consistently document opioid medication management, did not consistently document and respond to patients' abnormal test results, and on one occasion, entered a derogatory comment in the electronic health record (EHR).

We reviewed 9 EHRs of the 10 patients referred to OIG by the complainant as examples of alleged inappropriate care provided by a Huntsville CBOC PCP. We were unable to identify 1 of the 10 patients because the complainant provided limited identifying information, and we were unable to identify the patient through interviews and record reviews. We did not substantiate that the PCP had made multiple medication errors, failed to respond to health care concerns appropriately, failed to refer a homicidal/suicidal patient, forced patients to receive vaccinations, and treated patients preferentially causing them to request a transfer of care to another PCP.

We did not substantiate that the PCP inappropriately instructed staff to shred patients' non-VA medical documents; however, we found that staff did not consistently follow facility policy for the management of non-VA medical records. We did not substantiate that the PCP yelled and became upset when a CBOC staff cautioned the PCP to not perform a procedure that was not approved for the CBOC setting. However, we found that the PCP had performed other CBOC-setting approved procedures for which he/she was not privileged to perform.

We did not substantiate that the facility did not respond to staff concerns about quality of care or safety. We substantiated that the CBOC did not initially have a mental health (MH) emergency standard operating procedure (SOP), and once developed, the SOP did not include all actions staff might take when addressing a MH emergency. We substantiated that the CBOC had non-functioning panic alarms.

During our inspection, we noted that the facility did not have a pain management policy as required and did not complete mandatory EHR quarterly quality reviews for outpatient programs.

We recommended that the Facility Director ensures that (1) documentation of treatment with opioid medications meets Veterans Health Administration (VHA) requirements, (2) staff consistently document responses to abnormal test results, (3) patients are notified of test results within the defined timeframe and that notification is documented in accordance with VHA requirements, (4) staff adhere to the facility policy for the management of non-VA medical records, (5) CBOC provider privileges are in accordance with VHA requirements, (6) MH SOP is updated to incorporate all

procedures available for management of a MH emergency at the CBOC, (7) CBOC panic alarms are functional, (8) a pain management policy is implemented, and (9) the quality of entries in the EHR is reviewed at least quarterly.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 12–16 for 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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations concerning quality of care and staff safety at the community based outpatient clinic (CBOC) located in Huntsville, AL.

Background

Huntsville CBOC. The CBOC is associated with the Birmingham VA Medical Center (facility), which is part of Veterans Integrated Service Network (VISN) 7, VA Southeast Network. It is located 100 miles from the facility and is the largest of the facility's nine CBOCs. During FY 2013, CBOC staff provided primary care and mental health (MH) services to 7,261 unique patients.

Pain Management. Opioids are narcotic medications that relieve moderate to severe pain; common medications include hydrocodone, oxycodone, and morphine.[1] The safe and effective use of opioid analgesics for the management of pain, particularly complex chronic pain conditions, requires special attention to personal and public health risks. A written opioid pain care agreement documents provider-patient discussion of potential risks and benefits of opioids, provider and patient responsibilities related to opioid use, and the parameters for continued use of opioids.[2] These written agreements are tools for educating patients and providers about the opioid treatment plan and documenting the patient's agreement to participate.[3]

Management of Tests Results. The Veterans Health Administration (VHA) requires that ordering practitioners document treatment actions in the patient's electronic health record (EHR) in response to critical, emergent, or abnormal test results.[4] VHA also requires that outpatient test results are communicated to patients no later than 14 calendar days from the date on which the results are available to the ordering practitioner. Significant abnormalities may require review and communication in shorter timeframes with 14 days representing the outer acceptable limit. For abnormalities that require immediate attention, the communication should occur in the timeframe that minimizes risk to the patient.[5]

Allegations. The OIG received an anonymous complaint concerning the quality of care provided by a CBOC primary care provider (PCP). The allegations concerning the quality of care are summarized below.

[1] National Institute on Drug Abuse. "Prescription Drugs." http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/what-are-opioids. Accessed March 28, 2014.
[2] VHA Directive 2009-053, *Pain Management,* October 28, 2009.
[3] *VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain,* Version 2.0, 2010.
[4] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[5] VHA Directive 2009-019.

A primary care provider:

- Did not consistently document patient assessments when prescribing medications for chronic pain and made multiple medication errors.
- Failed to take appropriate action in response to patients' test results, failed to address patients' health concerns appropriately, failed to refer a homicidal/suicidal patient, forced patients to receive influenza vaccinations, and treated patients preferentially.
- Entered inappropriate comments in a patient's EHR and inappropriately instructed staff to shred documents pertaining to non-VA care.
- Wanted to perform a procedure that was outside the scope of the CBOC's services and yelled at staff when questioned.

In the report, we discuss the allegations pertaining to the PCP according to the specific patient care concerns identified by the complainant (see below Issues 1–4).

The complainant also alleged that facility leaders and CBOC managers did not respond to reports of concerns about quality of care and staff safety, that the CBOC is not properly staffed, and that staff have to work overtime and do not receive appropriate compensation.

During the course of our inspection, we received allegations that the CBOC had no MH standard operating procedures (SOP) for emergencies and that panic alarms were not working.

Scope and Methodology

We conducted a site visit January 13–15, 2014, and interviewed the Facility Director, Associate Chief of Staff of Primary Care, Director of Primary Care, Director of Quality Management, Nurse Manager of CBOCs, Chief of Police, and Suicide Prevention Coordinator. We also interviewed Business Management Service (BMS) staff, pharmacy staff, and CBOC administrative and clinical staff.

To evaluate the PCP's documentation of pain medication management, we reviewed the 205 prescriptions for oral or transdermal opioid medications (fentanyl, hydrocodone, methadone, morphine, and oxycodone[6]) that the PCP ordered July–September, 2013. We identified 14 patients who received oxycodone in preparations greater than 10 milligrams (mg) and/or any opioid in a quantity greater than 180 tablets. We considered these patients to be at higher risk for adverse medication effects and/or medication diversion than patients receiving lower doses or quantities. We then reviewed the 14 patients' EHRs for evidence of an in-person and/or telephone

[6] Prescriptions for acetaminophen/codeine and morphine 15 mg were not included in this review. Hydromorphone and meperidine were not prescribed.

encounter between a PCP and the patient during the week when an opioid was prescribed and in the prior 90 days.[7]

The complainant alleged instances of poor care involving 10 patients but provided only limited identification information. Through interviews and document review, we identified 9 of the 10 patients. We reviewed the EHRs of the identified patients. In this report, we refer to these patients as Patients 1–9.

We reviewed facility policies, VA and VHA handbooks and directives, credentialing and privileging information, and other relevant documents.

Allegations related to work schedules, staffing, overtime, and compensation were outside the scope of this review.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[7] *VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*, Version 2.0, 2010. "Patients who are on a stable dose of medication without evidence of adverse effects or adherence problems may be followed every 1–6 months." We selected the 90-day timeframe because patients at increased risk for adverse medication effects and/or medication diversion would generally require more frequent follow-up than every 6 months.

Inspection Results

Issue 1: Opioid Medication Management

Documentation

We substantiated that the PCP did not consistently document patient assessments when prescribing medications for chronic pain. VHA requires that when opioid analgesics are prescribed for regular use, providers periodically document treatment effectiveness, including pain control, function, and quality of life.[8]

To evaluate the PCP's opioid prescription documentation, we reviewed EHR documentation for the identified 14 high-risk patients for a 90-day period. Despite recurring prescriptions for opioids, three patients had no documented encounters and five patients had encounters with no documentation of an assessment of the effectiveness of the opioid medication. Three of the eight patients with absent pain assessments were also prescribed benzodiazepines, medications associated with an increased risk of morbidity and mortality when taken in combination with opioids.[9]

Medication Errors

We did not substantiate that the PCP made multiple medication errors. The complainant provided no specific patient information and the pharmacy staff stated the PCP was not an outlier among peers. The PCP's supervising physician reported that he had not received complaints of multiple medication errors.

Issue 2: Quality of Care

Management of Tests Results

We substantiated that the PCP did not consistently document treatment actions in response to abnormal test results, and did not consistently communicate the abnormal test results to patients (Patients 1–4).

Patient 1 had an abnormal platelet test result. In early December 2012, the patient's platelet count was 88,000 per cubic millimeter (mm^3) (normal, greater than 150,000). We found no documentation in the EHR that the patient was notified of the abnormal result within the required 14 days. Additionally, the PCP did not document discussing the abnormal platelet count with the patient when the patient returned for a clinic appointment in January 2013.

Patient 2 was a homebound individual with diabetes and a recent history of osteomyelitis (infection in the bone) and bacteremia (bacteria in the bloodstream). In

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[8] VHA Directive 2009-053.

[9] Gudin JA, Mogali S, Jones JD, Comer SD. *Risks, Management, and Monitoring of Combination Opioid, Benzodiazepines, and/or Alcohol Use*. Postgrad Med. 2013;125:115-30.

May 2013, staff documented in the patient's EHR that a white blood cell (WBC) test result of 13,280 per mm^3 (normal, less than 11,000) had been received from a home health agency. The PCP did not document a response to this abnormal test result.

Patient 3 had seven abnormal WBC test results between December 27, 2011 and July 24, 2013, ranging from 11,500 to 25,100 per mm^3. The PCP did not consistently document acknowledgement of or response to the abnormal results.

Patient 4 had abnormal platelet test results between June 2012 and January 2013, with platelet counts ranging from 96,000 to 110,000 per mm^3. During this time period, none of the PCP's five Huntsville Clinic notes indicated a response to the abnormal test results. In early August 2013, staff documented that the facility's Cardiology Service contacted the CBOC staff about the patient's plan of care for the abnormal test results. The PCP subsequently submitted a consult request to hematology.

PCP's Orders

We did not substantiate the allegations that the PCP would not order a chest x-ray for a patient (Patient 5) and would not order transportation to the local emergency department (ED) for another patient (Patient 6), who had a suspected deep vein thrombosis (DVT).[10]

Patient 5 had a history of asthma and sinusitis. During a visit to the CBOC in September 2013, the patient was described as having feverishness, cough, and chest pain. The PCP's assessment was that the patient had a viral syndrome with pleurisy.[11] Though not mentioned in the PCP's progress note, a chest x-ray was ordered to "R/O [rule-out] pneumonia."

Patient 6 had a history of DVTs and was being treated with warfarin to prevent further blood clots. In August 2013, the PCP documented that the patient had right leg pain for about a week which had worsened in the past 3 days. The PCP documented that the patient needed an ultrasound test at the local hospital to rule out a DVT. We were able to confirm that the patient went to the ED of a private medical center located one block from the CBOC on the same day as the visit to the CBOC but found no discussion in the EHR regarding how the patient was transported to the local ED.

MH Assessment

The complainant alleged that the PCP failed to document and write a consult for a patient who verbalized homicidal and suicidal thoughts, but no specific patient information was provided. The Suicide Prevention Coordinator reported no related incident involving the PCP.

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[10] A deep vein thrombosis is a blood clot that forms in deep rather than superficial veins, commonly, in the large veins in the lower leg and thigh.

[11] Pleurisy is inflammation of the lining of the lungs and chest that leads to chest pain when a breath or cough occurs.

Influenza Vaccinations

We did not substantiate that the PCP forced patients to receive influenza vaccinations. The complainant provided no specific patient information.

VHA policy follows Centers for Disease Control and Prevention guidelines recommending routine annual influenza vaccinations.[12] Some staff reported that the PCP pressured patients to receive the influenza vaccinations; however, facility leaders stated that they expected all health care staff to encourage immunizations. The Patient Advocate Tracking System (PATS)[13] data did not contain complaints specific to immunizations.

Preferential Treatment

We did not substantiate that the PCP treated patients according to political beliefs, race, or socio-economic status. The complainant provided no specific information.

We reviewed the number of the CBOC patients requesting a transfer to a different provider. The PCP's rate of requests to transfer, from November 28, 2012 to January 6, 2014, was 4.23 patients per month. The rate of requests to transfer for the other providers in the CBOC ranged from 0.6 to 1.54 patients per month. We could not correlate the PCP's rate of patients requesting transfers to complaints of preferential treatment or patient satisfaction in general. Some CBOC staff reported they perceived the PCP treated patients differently, especially with regard to socio-economic status; however, others told us the PCP treated patients fairly and without regard to socio-economic status. The Patient Advocate had not recorded any complaints related to preferential treatment in PATS, and the PCP's FY 2013 patient satisfaction data revealed 99.4 percent of the patients who responded to the satisfaction survey were satisfied with their care. The PCP's satisfaction score was comparable to other CBOC providers.

Issue 3: Documentation Processes

Inappropriate Documentation

We substantiated that the PCP documented in a patient's EHR (patient 7) that the patient was "crazy." VHA policy prohibits derogatory or critical comments in the health record.[14]

Patient 7 had a history of stroke and schizophrenia. The patient also had a history of a benign liver hemangioma[15] and had a computed tomography (CT) scan of the abdomen in October 2008. In July 2013, the PCP wrote that the patient "has hardness on his

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[12] VHA Directive 2013-004, *Prevention and Control of Seasonal Influenza with Vaccines*, February 22, 2013.
[13] PATS is a program that tracks patient complaints and compliments at each medical center.
[14] VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
[15] A hemangioma is a tangle of blood vessels and is noncancerous.

right side and wants a CT of abd [abdomen] and he is crazy and bubbling about psychotic delusions about his health that make no sense."

Scanning and Shredding Medical Documents

We did not substantiate that the PCP inappropriately instructed staff to shred patients' non-VA medical documents. However, we found that staff did not consistently follow facility policy for the management of non-VA medical documents.

Facility policy specifies that documents received from non-VA health care organizations where the facility purchased services do not require review by a provider prior to scanning. These documents are to be routinely scanned by Health Information Management Section (HIMS) staff for inclusion in the EHR.[16] All other non-VA documents are to be sent to a provider for determination of clinical pertinence. After a determination is made, documents are sent to HIMS with a cover sheet signed by the provider and then scanned or shredded as directed.[17]

We reviewed the EHRs of patients 2 and 8 who had received facility-purchased non-VA care. The CBOC staff reported receipt of the patients' medical documentation from non-VA facilities. We found scanned copies of the documents in the patients' EHR.

The BMS staff confirmed that its scanning section did not consistently receive the cover letter with documents to be scanned into the EHR, as required by facility policy. The lack of a consistent process of using this cover letter may have led to staff confusion as to the disposition of non-VA medical documents.

Issue 4: CBOC Privileges

Staff stated that the PCP expressed the desire to perform a procedure on patient 9 at the CBOC for which the PCP was not privileged to perform and that was outside the scope of the CBOC's services. The PCP did not perform the procedure. We did not substantiate that the PCP yelled and became upset when a CBOC staff cautioned the PCP to not perform the procedure.

VHA policy requires that providers' clinical privileges are accurate and detailed and that providers perform only those procedures for which they have privileges.[18] VHA also requires that privileges be provider- and setting-specific.[19]

We reviewed the PCP's CBOC privileges and noted approval for one procedure, arthrocentesis.[20] We reviewed the EHRs of two patients referred to us during interviews

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[16] Medical Center Memorandum 136-04, *Document Scanning/Document Removal in the Computerized Patient Record System,* March 13, 2013.
[17] Medical Center Memorandum 136-04.
[18] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[19] VHA Handbook 1100.19.
[20] An arthrocentesis involves the use of a syringe to collect synovial fluid from a joint capsule. Arthrocentesis is an approved procedure for this CBOC.

and found the PCP had performed skin biopsies and a skin tag removal. Although these procedures were within the scope of services offered at the CBOC, the PCP was not privileged to perform them.

Issue 5: Staff Concerns and Facility Leadership Responsiveness

Staff Quality of Care Concerns

We substantiated that CBOC staff had reported to facility leaders their concerns about the quality of care the PCP provided; however, we did not substantiate that facility leaders did not respond to the concerns. We found that facility leaders reviewed the staff's quality of care concerns in July 2013 and addressed the concerns with the PCP and CBOC staff.

Safety Concerns

We substantiated that CBOC staff had notified facility leaders about concerns of staff safety; however, we did not substantiate that facility leaders did not respond to the staff safety concerns.

VHA requires that each CBOC have a local policy or SOP defining how medical and MH emergencies are handled.[21] On August 7, 2013, CBOC staff sent an email to facility leaders voicing workplace safety concerns and the lack of a MH emergency policy. On August 8, the facility's Chief of Police completed a safety and security assessment that included findings and recommendations.

In response to the report, facility staff assessed the CBOC's check-in work stations to determine if protective barriers and mirrors could be installed in the waiting area to allow staff the ability to view the CBOC entrance. At the time of our review, the facility was negotiating with the owner of the building to install window tint on a back door to ensure patient privacy.

Issue 6: Additional Findings

CBOC MH Emergency Policy

We substantiated the allegation we received on-site that the CBOC did not previously have a MH emergency policy that defined MH SOP as required by VHA.[22] The CBOC staff reported the lack of a MH emergency policy in the August 2013 email addressed to facility leaders.

On November 29, 2013, the facility implemented a MH emergency SOP for the CBOC.[23] The SOP instructs CBOC primary care staff to contact Primary Care MH Integration

[21] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.
[22] VHA Handbook 1006.1.
[23] SOP 521-116-01, *Management of Mental Health Emergencies*, November 29, 2013.

staff to assess MH emergencies. CBOC staff also stated they would use the panic alarm system and call 911 during a MH emergency. These responses to a MH emergency were not reflected in the SOP.

Panic Alarms

We substantiated the allegation received on-site that panic alarms were not working. VHA requires that appropriate physical security precautions and equipment are implemented, used, and tested in the facility, and The Joint Commission requires that equipment is in good repair.[24] The CBOC uses a computer keyboard activated panic alarm system, and the alarm can be activated from multiple computer stations. Facility documents showed that not all the panic alarm stations were functional. Non-functioning panic alarms potentially compromise staff safety.

Pain Management Policy

Although not an allegation, we found the facility did not have a local pain management policy. VHA requires that all facilities within the VISN establish and implement current pain management policies.[25]

EHR Quarterly Quality Review

During the course of this review, we found the facility did not complete EHR quarterly quality reviews for outpatient programs as required.[26]

Conclusions

We substantiated the PCP did not consistently document opioid medication management, did not consistently document and respond to patients' abnormal test results, and on one occasion, entered a derogatory comment in the EHR.

We reviewed 9 EHRs of the 10 patients referred to OIG by the complainant as examples of alleged inappropriate care provided by a Huntsville CBOC PCP. We were unable to identify 1 of the 10 patients because the complainant provided limited identifying information, and we were unable to identify the patient through interviews and record reviews. We did not substantiate that the PCP had made multiple medication errors, failed to respond to health care concerns appropriately, failed to refer a homicidal/suicidal patient, forced patients to receive vaccinations, and treated patients preferentially causing them to request a transfer of care to another PCP.

We did not substantiate that the PCP inappropriately instructed staff to shred patients' non-VA medical documents; however, we found that staff did not consistently follow

[24] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
[25] VHA Directive 2009-053.
[26] VHA Handbook 1907.01.

facility policy for the management of non-VA medical records. We did not substantiate that the PCP yelled and became upset when a CBOC staff cautioned the PCP to not perform a procedure that was not approved for the CBOC setting. However, we found that the PCP had performed other CBOC-setting approved procedures for which he/she was not privileged to perform.

We did not substantiate that the facility did not respond to staff concerns about quality of care or safety. We substantiated that the CBOC did not initially have a MH emergency SOP, and once developed, the SOP did not include all actions staff might take when addressing a MH emergency. We substantiated that the CBOC had non-functioning panic alarms.

During our inspection, we noted that the facility did not have a pain management policy as required and did not complete mandatory EHR quarterly quality reviews for outpatient programs.

Recommendations

Recommendation 1. We recommended that the Facility Director ensures that documentation of treatment with opioid medications meets Veterans Health Administration requirements.

Recommendation 2. We recommended that the Facility Director ensures that staff consistently document responses to abnormal test results.

Recommendation 3. We recommended that the Facility Director ensures that patients are notified of test results within the defined timeframe and that notification is documented in accordance with Veterans Health Administration requirements.

Recommendation 4. We recommended that the Facility Director ensures that staff adhere to the facility policy for the management of non-VA medical records.

Recommendation 5. We recommended that the Facility Director ensures that Community Based Outpatient Clinic provider privileges are in accordance with Veterans Health Administration requirements.

Recommendation 6. We recommended that the Facility Director ensures the mental health standard operating procedure is updated to incorporate all procedures available for management of a mental health emergency at the Community Based Outpatient Clinic.

Recommendation 7. We recommended that the Facility Director ensures that Community Based Outpatient Clinic panic alarms are functional.

Recommendation 8. We recommended that the Facility Director ensures that a pain management policy is implemented.

Recommendation 9. We recommended that the Facility Director ensures that the quality of entries in the electronic health record is reviewed at least quarterly.

Appendix A

VISN Director Comments

Department of
Veterans Affairs Memorandum

Date: June 11, 2014

From: Director, VA Southeast Network (10N7)

Subject: **Healthcare Inspection – Quality of Care and Staff Safety Concerns Huntsville Community Based Outpatient Clinic, Huntsville, AL**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

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

1. I have reviewed the OIG Draft Report and the facility's responses. I am assured that the corrective actions are underway with identified target completion dates. The VISN office will provide support and oversight to ensure that these actions are completed and sustained.

2. If you have questions or need additional information, please contact Robin Hindsman, QMO 678-924-5700.

(original signed by:)

Charles E. Sepich, FACHE

Appendix B

Facility Director Comments

Department of
Veterans Affairs Memorandum

Date: June 9, 2014

From: Director, Birmingham VA Medical Center (521/00)

Subject: **Healthcare Inspection – Quality of Care and Staff Safety Concerns Huntsville Community Based Outpatient Clinic, Huntsville, AL**

To: Director, VA Southeast Network (10N7)

1. The Birmingham VA Medical Center has reviewed the OIG Report and has provided comments to the recommendations. Corrective actions are underway with identified target completion dates.

2. If you have questions or need additional information, please contact my office at (205) 933-4515.

(original signed by:)

Thomas C. Smith, III, FACHE

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 Facility Director ensures that documentation of treatment with opioid medications meets Veterans Health Administration requirements.

Concur

Facility Action: Quarterly reviews will be conducted by Primary Care and reported through the Health Systems Council.

Target date for completion: October 1, 2014

Recommendation 2. We recommended that the Facility Director ensures that staff consistently document responses to abnormal test results.

Concur

Facility Action: Re-educate staff on required responses and documentation of abnormal test results as referenced in Medical Center Memorandum 11-11, Ordering and Reporting Test Results. Primary Care management to send Medical Center Memorandum 11-11 to all staff via email and incorporate education in staff meetings at all locations. Monthly audit results will be reported through the Ongoing Professional Practice Evaluation process through the Health System Council to the Facility Leadership Board.

Target date for completion: June 30, 2014

Recommendation 3. We recommended that the Facility Director ensures that patients are notified of test results within the defined timeframe and that notification is documented in accordance with Veterans Health Administration requirements.

Concur

Facility Action: Re-educate staff regarding notification of test results as outlined in Medical Center Memorandum 11-11, Ordering and Reporting Test Results. Primary Care management to send Medical Center Memorandum 11-11 to all staff via email and incorporate education in staff meetings at all locations. Monthly audit results will be reported through the Ongoing Professional Practice Evaluation process through the Health System Council to the Facility Leadership Board.

Target date for completion: June 30, 2014

Recommendation 4. We recommended that the Facility Director ensures that staff adhere to the facility policy for the management of non-VA medical records.

Concur

Facility Action: Re-educate staff on the facility policy Medical Center Memorandum 136-04, Document Scanning/Document Removal in the Computerized Patient Record System. Primary Care management to send Medical Center Memorandum 136-04 to all staff via email and incorporate education in staff meetings at all locations.

Target date for completion: June 30, 2014

Recommendation 5. We recommended that the Facility Director ensures that Community Based Outpatient Clinic provider privileges are in accordance with Veterans Health Administration requirements.

Concur

Facility Action: Reviewed privileges of provider in question. Provider is Board Certified in Family Practice Medicine and the procedure in question is included in the core privileges for Board Certified Family Practice providers. Core privileges for Board Certified Family Practice Medicine providers will be updated to include a listing of the approved procedures.

Target date for completion: August 30, 2014

Recommendation 6. We recommended that the Facility Director ensures the mental health standard operating procedure is updated to incorporate all procedures available for management of a mental health emergency at the Community Based Outpatient Clinic.

Concur

Facility Action: The Mental Health Standard Operating Procedure was updated to incorporate all procedures available for management of a mental health emergency at the Community Based Outpatient Clinic. Staff were notified and educated via email on June 3, 2014.

Target date for completion: June 3, 2014

Recommendation 7. We recommended that the Facility Director ensures that Community Based Outpatient Clinic panic alarms are functional.

Concur

Facility Action: All panic alarms in the Community Based Outpatient Clinics are currently operational. Monthly testing is occurring via Lynx software and by the computer end user. This process is being overseen by the VA Police Physical Security

Analysis. On June 3, 2014, Chief of Police confirmed that all panic alarms were operational.

Target date for completion: June 3, 2014

Recommendation 8. We recommended that the Facility Director ensures that a pain management policy is implemented.

Concur

Facility Action: The Pain Policy has been updated and is currently being routed through the Executive Leadership Team for approval.

Target date for completion: June 13, 2014

Recommendation 9. We recommended that the Facility Director ensures that the quality of entries in the electronic health record is reviewed at least quarterly.

Concur

Facility Action: Task group being developed through Business Management Service to implement quarterly reviews of the Computerized Patient Record System. Quarterly audits will be coordinated by Business Management Service and reported through Medical Records Committee.

Target date for completion: October 30, 2014

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Larry Selzler, MSPT, Team Leader Stephanie Hensel, RN Jerome Herbers, MD James Seitz, RN, MBA

Appendix D

Report Distribution

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Director, Birmingham VA Medical Center (521/00)

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