



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

Office of Healthcare Inspections

Report No. 16-03405-80

**Healthcare Inspection
Primary Care Provider's
Clinical Practice Deficiencies and
Security Concerns
Fort Benning VA Clinic
Fort Benning, Georgia**

January 30, 2018

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General conducted a healthcare inspection in 2016 in response to allegations of clinical practice concerns and a lack of security at the Fort Benning VA Clinic (Clinic), Fort Benning, GA, part of the Central Alabama Veterans Health Care System (system).

The complainant alleged that:

1. A Primary Care Provider (PCP X) did not:
 - Follow up on elevated prostate-specific antigen (PSA)¹ results,
 - Evaluate a patient's condition sufficiently,
 - Provide timely access to care for unscheduled (walk-in) and scheduled patients, and
 - Respond to patient requests for Veterans Health Administration (VHA) specialty care and pharmacy services.
2. The Clinic lacked VA Police presence and panic alarms.

We substantiated that PCP X did not follow up on elevated PSA test results, which resulted in a patient's (Patient 1) delay of prostate cancer diagnosis and treatment. PCP X routinely failed to notify patients of PSA test results or follow up on elevated values. We also found that system leaders did not monitor PCP X's performance consistently and did not take adequate administrative action to improve the delivery of quality care. During and following our June 2016 site visit, we notified system leaders of our concerns about PCP X's performance and compromised quality of care, including the care provided to specific patients. On June 21, 2016, we also informed Veterans Integrated Service Network 7 leaders of these concerns.

We did not substantiate that PCP X failed to evaluate a patient's (Patient 2) condition sufficiently. Through our interviews and electronic health record reviews, we found that PCP X provided appropriate evaluation and care for Patient 2's condition. However, we found issues with PCP X's documentation. Although PCP X documented a "pharyngitis/sinusitis" diagnosis and an appropriate treatment plan, PCP X's electronic health record note contained a "copy and paste" pre-populated normal examination template that did not accurately reflect the patient's condition. We found multiple instances in which PCP X's electronic health record documentation was inadequate and

¹ The PSA test measures the level of PSA, a protein produced by the prostate gland in a male's blood. Elevated PSA levels may be caused by prostate cancer or non-cancerous conditions such as prostatitis (inflammation of the prostate), benign prostatic hyperplasia (enlargement of the prostate), certain medications, and urinary tract infections. National Institute of Health, National Cancer Institute, <https://www.cancer.gov/types/prostate/psa-fact-sheet>. Accessed February 23, 2017.

erroneous.² PCP X's documentation was regularly inconsistent with patients' presenting conditions, diagnoses, and treatment plans. PCP X did not consistently submit appropriate consultations, follow up on consultant recommendations, or include relevant information to support consultations as required by VHA policy.

We substantiated that PCP X did not provide care for an unscheduled (walk-in) acutely ill patient; however, treatment was not delayed because another PCP provided the care. We substantiated that PCP X failed to provide timely access to care for two scheduled patients. We also found that PCP X's wait time for established patient visits was longer than the other Clinic PCPs. We also substantiated that PCP X did not respond to one of three complainant-identified patient requests for VHA specialty care. We did not substantiate that PCP X failed to respond to a patient's request for VHA pharmacy services.

We substantiated that there was a lack of VA Police presence at the Clinic; but, found that law enforcement personnel from the U.S. Army Garrison³ responded to calls for service. All properties located on the U.S. Army Garrison grounds, including the Clinic, are under the jurisdiction of the Department of Defense. Security and law enforcement services are provided by Department of Defense personnel.⁴ An agreement or Memorandum of Understanding detailing jurisdiction and authorities is required for VA Police to provide services on the grounds. While there were multiple attempts to execute a Memorandum of Understanding between the system and U.S. Army Garrison, an agreement was not finalized as of January 2017.

We substantiated that the Clinic did not have panic alarms. However, because the Workplace Behavioral Risk Assessment team assigned the Clinic a moderate (not high) risk, the panic alarms were not required. We found no evidence of prior incidents, which would have required a panic alarm, and there were no reported major incidents requiring Garrison police response. We also found that system managers did not provide Clinic staff with adequate Prevention and Management of Disruptive Behavior training. We also found that Clinic staff lacked general knowledge and information regarding emergency response management.

We recommended that the Veterans Integrated Service Network Director ensure that the System Director:

- Evaluates the care of the subject patient (Patient 1) and consults with the Office of General Counsel for disclosure to the patient, if appropriate.

² VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

³ The Clinic is located on the grounds of the U.S. Army Garrison at Fort Benning, GA.

⁴ Department of the Army, *Memorandum Of Agreement Between Martin Army Community Hospital (BMACH), Fort Benning, Georgia, U.S. Army Garrison (USAG), Fort Benning, Ga, and Central Alabama Veterans Health Care System (CAVHCS) Montgomery, Alabama.*

- Consults with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action(s), if any, for Primary Care Provider X and Primary Care Provider X's supervisors.

We recommended that the System Director ensure that:

- Providers notify patients of test values and follow up on clinical laboratory results as required.
- Providers accurately document patients' assessment, diagnosis, and treatment information into the electronic health record.
- Consults for VHA and non-VA care are entered and completed within time frames set by VHA.
- Employees receive training appropriate for the assigned Workplace Behavioral Risk Assessment risk level.
- Clinic employees are trained in emergency management procedures.
- Emergency procedures and contact information are posted and readily available to Clinic employees.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes B and C, pages 24–29 for the Directors' comments.) Based on information provided, we considered Recommendations 4 and 7 closed. For the remaining open recommendations, we will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations of clinical practice concerns and lack of security at the Fort Benning VA Clinic (Clinic), Fort Benning, GA, a community based outpatient clinic of the Central Alabama Veterans Health Care System (system).

Background

The system, part of Veterans Integrated Service Network (VISN) 7, is comprised of the Tuskegee VA Medical Center and the Montgomery VA Medical Center, five community based outpatient clinics (CBOC) with three in Alabama (Dothan, Monroeville, and Wiregrass); one in Columbus, GA; and the Clinic. This level 2 complexity⁵ system includes 71 inpatient beds, 160 community living center beds, and 73 residential care beds.

The Clinic is located on the grounds of the U.S. Army Garrison (Garrison) at Fort Benning, GA, and provides outpatient services, which include primary care (PC), dietary, social work, phlebotomy, and clinical pharmacy services. The Clinic supported nine Patient Aligned Care Teams (PACT) staffed by eight physicians and one physician assistant.⁶ In July 2015, the system opened the Clinic and transferred the majority of the Columbus CBOC PC services to the Clinic.⁷ Some PACTs remained at the Columbus CBOC for patients not permitted to access to Garrison. The system had a resource sharing agreement for health care services with Martin Army Community Hospital (MACH), also on the grounds of Garrison.⁸ The agreement provides referred Veterans Health Administration (VHA) patient services at MACH including immunology, behavioral health, cardiology, dermatology, gastroenterology, neurology, ophthalmology, optometry, sleep medicine, surgery, urology, and women's health. MACH also provides diagnostic imaging, pharmacy, and laboratory services.

PACTs and Panel Management

VHA provides PC services in the community using a patient centered, team based model implemented by PACTs, comprised of professionals who share responsibility to manage and coordinate the delivery of health care services. Each PACT includes a PC provider (PCP), a Registered Nurse Care Manager (RNCM), a Clinical Associate (licensed practical nurse, licensed vocational nurse, or medical or health technician),

⁵ VHA Office of Quality, Safety and Value, *2012 VHA Facility Quality and Safety Report*.

⁶ VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014 (Amended May 26, 2017).

⁷ Department of Veterans Affairs, *New VA Clinic Ribbon Cutting - Central Alabama Veterans Health Care System (CAVHCS)*. Accessed June 6, 2016.

⁸ Department of the Army, *Memorandum Of Agreement Between Martin Army Community Hospital (MACH), Fort Benning, Georgia, U.S. Army Garrison (USAG), Fort Benning, Georgia, and Central Alabama Veterans Health Care System (CAVHCS) Montgomery, Alabama*.

and an administrative associate. The PCP may be a physician, advanced practice registered nurse, or physician assistant. The panel size for a full-time physician PCP is 1,000 to 1,400 patients. Non-physician PCPs are expected to manage a panel 75 percent of the full-time physician panel.⁹ The RNCM provides health education, preventative and therapeutic care, and coordinates care between VA and community services. Other professionals, including pharmacists, registered dietitians, and social workers, also support PACTs.¹⁰

Communication of Test Results

VHA requires facilities to develop local policies related to communication of test results and to comply with VHA requirements. The ordering provider must inform the patient of results requiring action within 7 days and of normal tests results within 14 days. The PCP may delegate other PACT members to inform patients of test results, but the PCP is responsible for “appropriate clinical actions” and follow-up. The PACT staff and the patient may communicate in person, by phone, in writing, or via secure messaging.¹¹ The PCP or designated staff must document the communications in the patient’s electronic health record (EHR) including notification from the laboratory to the ordering provider, and note any patient concerns.¹² System PCPs must document abnormal diagnostic results and actions taken in the EHR.¹³

System leaders must demonstrate periodic monitoring of communication of test results to both providers and patients.¹⁴ The Health Information Manager is responsible for monitoring “accurate, timely and complete health records,” and maintaining compliance with applicable laws and regulations.¹⁵ The Joint Commission 2015 National Patient Safety Goals included timely reporting of critical diagnostic values and auditing the “timeliness” of communication of critical diagnostic results.¹⁶

Prostate-Specific Antigen Diagnostic Testing

The prostate-specific antigen (PSA) test measures the level of PSA, a protein produced by the prostate gland in a male’s blood. Elevated PSA levels may be caused by prostate cancer or non-cancerous conditions such as prostatitis (inflammation of the

⁹ VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009. This handbook was in effect during the period of our review and was rescinded and replaced by VHA Directive 1406, *Primary Care Management Module (PCMM) for Primary Care*, June 20, 2017.

¹⁰ VHA Handbook 1101.10.

¹¹ My HealtheVet is an internet based portal which allows veterans to access their Personal Health Record, link to resources, and communicate with VHA providers. <https://www.myhealth.va.gov/>. Accessed July 7, 2017.

¹² VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

¹³ CVAHCS Memorandum No. 11-12-33, *Notification of Critical Test Results/Follow-Up Action*, August 20, 2015.

¹⁴ VHA Directive 1088.

¹⁵ VHA Handbook 1907.1, *Health Information Management and Health Records*, March 19, 2015.

¹⁶ The Joint Commission, *National Patient Safety Goals*, Effective January 1, 2015.

prostate), benign prostatic hyperplasia (enlargement of the prostate), certain medications, and urinary tract infections.¹⁷

Generally a PSA level of 4.0 nanograms/milliliter (ng/mL)¹⁸ and lower is considered normal; however, even men with levels in the normal range could have prostate cancer. The higher a PSA level, the more likely it is that the patient has prostate cancer. Further, a trending rise in PSA levels over time may also be a sign of prostate cancer.¹⁹

Sinusitis and Pharyngitis

Sinusitis is an inflammation of the sinus cavity(ies) which occurs when fluid builds up and allows infectious organisms to grow. Symptoms include headache, facial pain, runny nose, difficulty breathing through the nose, sore throat, fatigue, and coughing. Ninety percent of sinus infections are caused by viruses; and about 10 percent are caused by bacteria and can be treated with antibiotics.²⁰

Pharyngitis is an inflammation of the mucous membranes and other tissues of the pharynx (part of the throat) usually as a result of infection typically caused by viral or bacterial organisms. Common symptoms include a fever, tonsillar exudates (pus on the back of the throat), pain with swallowing, and congestion of the mucous membranes. A common treatment for pharyngitis is an antibiotic such as penicillin.²¹

Clinical Documentation

VHA requires that clinical documentation include accurate and current data relevant to the chief complaint(s), assessment, plan of care, diagnosis(es) treated during the encounter or that necessitate further treatment, medical rationale for ordering tests, consults, or changes to medication regimen, follow-up treatment, or patient instructions.²² The documentation must be consistent with The Joint Commission's standards regarding "maintaining complete and accurate clinical records."²³ Additionally, the system's Office of Health Information Management and Health Records

¹⁷ National Institute of Health, National Cancer Institute, <https://www.cancer.gov/types/prostate/psa-fact-sheet>. Accessed February 23, 2017.

¹⁸ PSA test results are reported as nanograms of PSA per milliliter (ng/mL) of blood. <https://www.cancer.gov/types/prostate/psa-fact-sheet>. Accessed February 23, 2017.

¹⁹ National Institute of Health, National Cancer Institute, <https://www.cancer.gov/types/prostate/psa-fact-sheet>. Accessed February 23, 2017.

²⁰ Centers for Disease Control and Prevention, Sinus Infection (Sinusitis). <https://www.cdc.gov/getsmart/community/for-patients/common-illnesses/sinus-infection.html>. Accessed August 14, 2017.

²¹ Centers for Disease Control and Prevention, Acute Pharyngitis in Adults. <https://www.cdc.gov/getsmart/community/materials-references/print-materials/hcp/adult-acute-pharyngitis.pdf>. Accessed August 14, 2017.

²² VHA Handbook 1907.01.

²³ The Joint Commission E-dition Program: *Ambulatory*, January 1, 2016. Chapter; Record of Care, Treatment, and Services.

leaders must have a protocol in place to audit and monitor the content of clinical documentation.²⁴

VHA considers the use of “copy and paste” functions in the EHR as “inappropriate documentation” and requires the system Director to conduct reviews and promote the “...elimination or judicious use of the “copy and paste” electronic functionality.”²⁵ The importation of text from other sources increases the risk of ethical and legal problems and “must be monitored, and where violations occur, findings must be reported to the appropriate Medical Staff Committee for disciplinary or other adverse action.”²⁶

Non-VA Care

VHA allows eligible patients to use non-VA Care when a VA facility cannot provide needed medical care due to the lack of a service or specialist, high demand for care, geographic inaccessibility, or other limiting factors. VHA provides non-VA community care through several programs, including the Patient-Centered Community Care Program (PC3) and the Veterans Choice Program (Choice).^{27,28} Both programs employ third party service contracts to provide care outside of the VA when required.²⁹ Health Net, the federal contractor authorized to manage non-VA care for VISN 7, administratively manages Choice provider enrollment and credentialing, and schedules patient appointments.³⁰

To initiate the process for a veteran to participate in a Community Care Program (CCP), the referring provider must enter a consult³¹ requesting non-VA care. A clinical issue that requires urgent or emergent attention is considered “STAT” and the consult should be completed within 24 hours.³² VHA requires that providers use the Computerized Patient Record System (CPRS) to initiate, manage, and communicate clinical

²⁴ VHA Handbook 1907.01.

²⁵ Ibid. “Copy and Paste: copy and paste means duplicating selected text or graphic(s) and inserting it in another location, leaving the original unchanged.”

²⁶ Ibid.

²⁷ VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013.

²⁸ VHA Office of Community Care- Community Care Programs Overview.

<https://www.va.gov/COMMUNITYCARE/programs/overview.asp>. Accessed January 31, 2017.

²⁹ VHA Handbook 1601C.01, *Requesting and Verifying Insurance Information from Third-Party Payers*, February 22, 2012. The term *third-party payer* means an entity responsible for the payment of medical expenses on behalf of a veteran through an insurance agreement or contract. The 2012 handbook was current at the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1910, *Patient Information Collection Management (PICM) Processes*, May 6, 2016.

³⁰ Health Net Federal Services, *Overview of Health Net Federal Services' VA Programs*.

<https://www.hnfs.com/content/hnfs/home/company/company-information/va.html>. Accessed May 7, 2017.

³¹ Taber's Cyclopedic Medical Dictionary, 22nd ed., F.A. Davis Company, (Philadelphia, Pennsylvania); 2013.

Consult: “To provide professional guidance to another health care professional in the care of a patient.”

³² VHA Directive 1232(1), *Consult Processes and Initiatives*, August 24, 2016, and as amended. The preceding consult policy, VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008, did not reflect these definitions. Direction was provided by the Deputy Under Secretary for Health on October 21, 2015.

consultations, including discussions between the referring provider and the consultant.³³ The referring provider is also required to document the reason for the requested consult, follow-up treatment, and patient instructions.³⁴

System CCP staff are to review the consult and perform the following steps:^{35,36}

- Determine administrative eligibility, clinical appropriateness, and secure authorization for care.
- Determine the patient's willingness to opt-in to use Choice.
- Send the consult to Health Net (third-party provider) for scheduling and follow up.

Health Net staff then contact the patient to schedule the appointment and notify CCP staff once the patient is scheduled. CCP staff track the consult to ensure that an appointment is scheduled with a clinically appropriate provider and that the patient attended the appointment. Additionally, CCP staff ensure that the consult records are scanned and the results are linked to the patient's EHR. System leaders must establish procedures to track and monitor consults, including identifying those for which no action has been taken within 7 days of the consult request.³⁷ If the patient declines to participate in Choice, or if no Choice provider is available, CCP staff coordinate the scheduling through the traditional fee basis process and send the consult, authorization, and supporting documents to a community provider for completion of the consultation and/or evaluation.

Access to Care

VHA requires that veterans have timely and convenient access to health care, including specialty care.^{38,39} This includes the ability to schedule appointments with a PCP within 30 days of request and with a specialist within 30 days of the Clinically Indicated Date (CID),⁴⁰ or Preferred Date.⁴¹

³³ VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010. This directive was in effect at the time of our review; it was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

³⁴ VHA Handbook 1907.01.

³⁵ Choice First Standard Operating Procedure (SOP) Non-VA Medical Care Consult/Referral Review Process, <http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/index.asp>. Accessed August 5, 2016

³⁶ VHA Chief Business Office, National Non-VA Medical Care Program Office, *Non-VA Medical Care Consult/Referral Management*, October 28, 2014.

³⁷ VHA Directive 2008-056.

³⁸ VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006.

³⁹ VHA Handbook 1101.10.

⁴⁰ VHA Directive 2010-027. The "Clinically Indicated Date" is the appointment date that a VA provider deemed clinically appropriate.

⁴¹ VHA Directive 2010-027. The "Preferred Date" is the date the veteran requests outpatient health care services.

Walk-in Patients

The VHA Scheduling Business Rules provide the framework for handling unscheduled visits and requests for appointments. When a patient arrives at the clinic for an unscheduled visit (referred to as a “walk-in”), the system clinical staff triages,⁴² and the provider or nurse, consistent with VHA and local policy, determines whether the patient can be seen at that time or scheduled for a later date.⁴³ System policy requires that Clinic staff direct all non-emergent walk-in patients to their assigned PACT.⁴⁴ The RNCM ensures emergent care or schedules stable patients with a same day appointment, or reschedules the patient to be seen within 72 hours. PACT members must discuss the care options and wait times with the patient.⁴⁵

Patient Advocacy Program

VHA requires that all facilities create and maintain a customer oriented patient advocacy program, and collect, trend, analyze, and report patients' concerns and feedback.⁴⁶ Patients submit complaints about quality of care, privacy violations, and discrimination directly to the system staff or VISN, veteran service organizations, congressional officers or the local patient advocate. The national and local patient advocates use the software platform Patient Advocate Tracking System (PATS) to collect and report data; aggregate information and trends; and provide insight into individual patient concerns. The system Director is responsible for ensuring that a patient advocacy program is in place, PATS information is analyzed, and the Patient Advocate provides quarterly reports to the system Director, Associate Director, Chief of Staff, Nurse Executive, and Quality Manager.

Clinic Security

VHA requires that leadership ensure the safety of employees, patients, and visitors in facilities and that all sexual assaults or other public safety incidents are appropriately reported, addressed, tracked, and monitored. Although the Clinic is located in a Department of Defense (DOD) building, “any location where a VHA employee is performing official duties” must comply with VHA security and law enforcement requirements.⁴⁷

⁴² Triage Definition(s): The screening and classification of casualties to make optimal use of treatment resources and to maximize the survival and welfare of patients. *Taber's Cyclopedic Medical Dictionary*, 22nd ed., F.A. Davis Company, (Philadelphia, Pennsylvania); 2013.

⁴³ VHA Directive 1230.

⁴⁴ Central Alabama Veterans Health Care System (CAVHCS) Memorandum 112-15-12, *Medical Ambulatory Care*, September 1, 2015.

⁴⁵ CAVHCS Memorandum 112-15-05, *Patient Aligned Care Team (PACT) Clinic Walk-Ins*.

⁴⁶ VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005. This VHA handbook was scheduled for recertification on or before the last working day of September 2010 but has not been updated.

⁴⁷ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012. This directive expired February 28, 2015 and has not been updated.

Security Assessments and Employee Training

VHA requires that the VA Police Service, Office of Security and Law Enforcement protect people and property in facilities within VA jurisdiction. A Physical Security Survey, a review of an individual program, location, or room, must be completed annually. A Vulnerability Assessment is completed every 2 years and addresses the “ability to deter threats, contain incidents, and respond or recover from a serious incident, such as attacks or weather disasters.”⁴⁸ VHA also requires that VISN and facility Directors ensure that a Workplace Behavioral Risk Assessment (WBRA) is conducted at each location to evaluate factors that may affect workplace safety, collect incident related data, and assign a risk level.⁴⁹

VHA requires that facility Directors ensure that all employees complete mandatory training on the policy and procedures related to security issues such as awareness, preparedness, precautions, and police assistance.⁵⁰ Based on the type, frequency, and severity of behavioral risk exposure in work areas as identified by the WBRA; VHA requires employees to complete one or more of the four levels of the Prevention and Management of Disruptive Behavior (PMDB) trainings. All employees are required to complete Level 1. Employees must complete additional levels of PMDB training based upon their working area's assigned risk level (low, moderate, or high risk).⁵¹

Panic Alarms

VHA requires VISN and facility Directors to implement and monitor appropriate physical security precautions and equipment as determined by the local risk assessments.⁵² The installation of panic alarms at VA facilities, including CBOCs, is not required unless the local risk assessment indicates a need for alarms.^{53,54} Per system policy, service chiefs must request panic alarms from the system's Chief of VA Police (Police Chief).⁵⁵ The Police Chief recommends panic alarm installation based upon the results of a Physical Security Survey(s) and a risk assessment.^{56,57}

⁴⁸ VA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013.

⁴⁹ VA Memorandum, *Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum*, November 7, 2013.

⁵⁰ VHA Directive 2012-026.

⁵¹ VA Memorandum, *Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum*. Level I minimal risk areas; Level II low risk areas (exposure to only verbal disruptive behaviors); Level III moderate risk areas (exposure to both verbal and physical disruptive behaviors); Level IV high risk areas (exposure to physically disruptive behaviors requiring therapeutic containment).

⁵² VHA Directive 2012-026.

⁵³ Occupational Safety and Health Administration, *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, 2016, <https://www.osha.gov/Publications/osha3148.pdf>. Accessed August 24, 2017.

⁵⁴ International Association for Healthcare Security and Safety, *Security Design Guidelines for Healthcare Facilities*, 2012, <http://nationaluasi.com/dru/Resources/Misc/designguidelines2012.pdf>, accessed August 24, 2017.

⁵⁵ The Police Chief is located at the system's Montgomery, AL campus.

⁵⁶ CAVHCS Memorandum 132-13-12, *Intrusion and Panic/Duress Alarms*, August 7, 2013.

Prior OIG Reviews

In the VA OIG report, *Deficient Consult Management, Contractor, and Administrative Practices*, July 29, 2015, OIG substantiated leadership transitions that impacted continuity of actions and CBOC staffing shortages. OIG recommended that the interim system leaders:^{58,59}

- Begin, and permanent leadership continue, to make systemic improvements to the Non-VA Care Coordination consult process, to include ensuring that patients receive services timely; that the backlog is resolved; that staff comply with business rules governing the process; and that the program is provided with adequate staffing, training, and a consistent leadership structure.
- Develop processes to ensure that Human Resource tracking and reporting is accurate and that the system either has adequate staffing to meet patient care needs in a timely manner or adequate processes to ensure patients receive timely care in the community.

In a 2014 VA OIG report, *Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama, November 25, 2014*, OIG found that 22 percent of patients who had a positive colorectal cancer screening did not receive further diagnostic testing within the required time frame. Additionally, 90 percent of the patients requiring further diagnostic testing through non-VA care did not receive this care within the required time frame. OIG also found a lack of oversight regarding clinicians' EHR documentation and recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed. In July 2016, OIG closed this recommendation in response to compliance data provided by the system leaders. OIG also recommended that processes be strengthened to ensure that patients with positive colorectal cancer screening test results receive diagnostic testing within the required timeframe and that compliance be monitored.⁶⁰ In December 2016, OIG closed this recommendation in response to compliance data provided by the system leaders.

See Appendix A for other relevant OIG reports published in the past 3 years.

⁵⁷ VA Handbook 0730/4.

⁵⁸ *Healthcare Inspection - Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama*, (Report No. 14-04530-452, July 29, 2015).

⁵⁹ Ibid.

⁶⁰ *Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery Alabama*, (Report No. 14-02079-10, November 25, 2014).

Allegations

On March 31, 2016, OIG received allegations regarding the clinical practice of one PCP (PCP X) and lack of security at the Clinic.

The complainant alleged that:

1. PCP X did not:
 - Follow up on elevated laboratory results,
 - Evaluate a patient's condition sufficiently,
 - Provide timely access to care for two unscheduled (walk-in) and two scheduled patients, and
 - Respond to patient requests for VHA specialty care and pharmacy services.
2. The Clinic lacked VA Police presence and panic alarms.

The complainant also alleged that PCP X had threatening behavior. This allegation was reviewed and addressed by the system; beyond the scope of this healthcare review; and referred to OIG Office of Investigations.

Scope and Methodology

We initiated our inspection in June 2016 and conducted a site visit from June 13, 2016 through June 15, 2016.

We interviewed the system's Acting Director, Deputy Chief of Staff, Assistant Chief of Staff of Ambulatory Services, Administrative Officer of the Clinic, Clinic providers and staff, the Patient Advocate, Police Chief, VA police officers, non-VHA care staff, and a Nurse Practitioner.

We reviewed VHA and system documents related to PACTs, critical laboratory value reporting, security, safety, training records associated with safety and security, patient complaints, Patient Advocate reports, PATS reports, relevant Memorandums of Understanding (MOU), and applicable EHRs. We reviewed proficiency reports, Ongoing Professional Practice Evaluations,⁶¹ Focused Professional Practice Evaluations,⁶² and data specific to diagnoses of sinusitis/pharyngitis and elevated PSA levels.

We reviewed issues related to physician practice; clinical documentation; access to timely care; communication of laboratory results; and security at the Clinic from July 8, 2015 through August 15, 2017. Additionally, we reviewed physician practices

⁶¹ VHA Handbook 1100.19.

⁶² Ibid.

and access to care pertaining to the Columbus CBOC (Columbus, GA) from January 1, 2015 through July 8, 2015 because the majority of the patients and staff involved in this review transferred from the Columbus CBOC to the Clinic in July 2015.

We evaluated the system's processes for reviewing clinical documentation within the context of Federal standards for control activities. These standards emphasize the need for management to establish processes to reliably evaluate performance against requirements and address noncompliance in a timely manner.⁶³

Three policies cited in this report were expired or beyond the certification date:

1. VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006 (expired June 30, 2011).
2. VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012 (expired February 28, 2015).
3. VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005 (recertification due date September 2010).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum (amended on January 11, 2017) to supplement policy provided by VHA Directive 6330(1),⁶⁴ the VA Under Secretary for Health (USH) mandated the "...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."⁶⁵ The USH also tasked the Principal Deputy USH and Deputy USH with ensuring "...the timely rescission or recertification of policy documents over which their program offices have primary responsibility."⁶⁶

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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.

⁶³ United States Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO Report No. 14-704G 10.01–10.08, September 2014).

⁶⁴ VHA Directive 6330, *Controlled National Policy/Directives Management System*, June 24, 2016.

⁶⁵ VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016 (Amended January 11, 2017).

⁶⁶ *Ibid.*

Inspection Results

Issue 1. Follow-Up on Elevated PSA Test Results

We substantiated that PCP X did not follow up on elevated PSA findings, which resulted in a patient's (Patient 1) delay in prostate cancer diagnosis and treatment. We found that PCP X routinely failed to notify patients of PSA test results or follow up on elevated values.⁶⁷ We also found that system leaders did not monitor PCP X's performance consistently and did not take adequate administrative action to improve the delivery of quality care.

We found that as a result of PCP X's inaction, Patient 1 had a delay in diagnosis and treatment of prostate cancer. PCP X did not address Patient 1's 2011 and 2014 elevated PSA test values until 2015. Patient 1's 2016 prostate biopsy took place approximately 5 years from the first elevated PSA in 2011; 21 months from the second elevated PSA in 2014; and 14 months from a third elevated PSA in 2015.

Patient 1. From 2007–2009, Patient 1, a male in his late 50s, had PSA values within normal range. In 2011, PCP X⁶⁸ ordered a PSA test and results indicated an elevated value > 6 ng/mL. Although the elevated value was not mentioned in the EHR note, PCP X documented that he reviewed “laboratory results.”

In 2014, PCP X saw Patient 1 for a routine visit. PCP X did not document new complaints that day but noted “labs ordered—will f/u [follow-up] results.” PCP X ordered a PSA test and results indicated an elevated value of > 16 ng/mL. At the next scheduled routine visit in spring 2015, PCP X documented a “Plan” that included “labs ordered—will follow-up results.” PCP X's note stated that “laboratory results” were “reviewed” but did not include information about the elevated PSA results from either 2011 or 2014. PCP X obtained another PSA value that day that revealed an elevated level of > 19 ng/mL. PCP X did not follow-up with Patient 1.

In late 2015, at Patient 1's next routine appointment, an RNCM noted the elevated spring 2015 PSA value. The RNCM sent an electronic request for PCP X's signature on that note and advised Patient 1 to “discuss a Urology Consult referral/ treatment options” with PCP X “this visit.” PCP X's note again contained the phrasing “reviewed laboratory results.” However, PCP X did not document discussion about the PSA values with Patient 1. That same day, PCP X signed the nurse's note, submitted a urology consult request, and entered orders for a PSA test. Patient 1's PSA values were further elevated at > 23 ng/mL.

In late fall 2015, Patient 1 met with a system physician assistant for an initial urology consultation. They discussed options to address the elevated PSA and the patient was given an early 2016 date for the prostate biopsy. Two days before the scheduled

⁶⁷ VHA Directive 1088.

⁶⁸ PCP X became Patient 1's PCP beginning in 2008.

biopsy, a nurse telephoned Patient 1 for pre-operative planning. However, the system's CCP⁶⁹ staff were not informed of the appointment and; therefore, the non-VA care provider was not scheduled to perform the procedure. On the day that the biopsy was supposed to take place, PCP X entered the non-VA Care consult and it was approved the same day. Five days later, a system employee noted that Patient 1 was enrolled in Choice First and that clinical documentation was sent to Health Net, VHA's contracted scheduler. For 4 months in early 2016, CCP staff attempted multiple times to schedule Patient 1 for a biopsy but they were unsuccessful due to Health Net's delayed response.⁷⁰

In early spring 2016, a nurse practitioner ordered a PSA test that resulted in a further elevated level of > 34 ng/mL. The nurse practitioner "alerted the Urology Department" about Patient 1's progressively increasing PSA results and his missed biopsy appointment. The nurse practitioner also sent Patient 1 a letter that encouraged him to follow up with PCP X regarding his elevated PSA levels. The next month, CCP staff scheduled an initial evaluation with a fee-based⁷¹ provider for early summer at which time the biopsy was scheduled for the following month. Patient 1 underwent a prostate biopsy in mid-summer 2016, almost 5 years after the first system PSA test elevation. The biopsy revealed prostate cancer. Patient 1 began chemotherapy treatment the following week. As of July 2017, a system urologist continued to monitor Patient 1.

Additional Patients Reviewed

We reviewed 27 EHRs for additional patients for whom PCP X ordered PSA tests that resulted in elevated levels during Quarters (Qs) 1 and 2, Fiscal Year (FY) 2016 and Q1 FY 2017. We found that PCP X:

- Did not timely notify 17 patients of elevated PSA values.
- Did not provide 17 patients with timely follow-up evaluations.
- Provided nine patients with appropriate follow-up care.

System Leader Actions

We found that from 2013 through 2016, PCP X's clinical supervisors and PCP X discussed unsatisfactory/marginal performance pertaining to professionalism, clinical competency and judgement, assessments, documentation, and patient relations. The system leaders monitored PCP X's practice through Ongoing Professional Practice Evaluations. In early 2016, the supervisor documented "Recommend

⁶⁹ VHA Office of Community Care, *Community Care Programs for Veterans*, <https://www.va.gov/COMMUNITYCARE/programs/overview.asp>, accessed July 23, 2017.

⁷⁰ *Healthcare Inspection—Deficient Consult Management, Contractor, and Administrative Practices Central Alabama VA Health Care System Montgomery, Alabama*, Report No. 14-04530-452, July 29, 2015. This report highlighted problems with federal contractor scheduling of non-VA care appointments.

⁷¹ CCP staff scheduled the appointment with a fee-based provider outside of the Health Net contract due to delay in care and poor communication from the Health Net contractor.

mentoring/proctoring with lead physician and report of progress to committee every quarter for 12 months.” In early summer 2016, PCP X’s supervisor issued a Focused Professional Practice Evaluation that cited “inappropriate performance” and recommended a performance improvement plan. We found no evidence of a performance improvement plan or supervisory follow-up. During and following the site visit, we notified system leaders of our concerns about PCP X’s performance and compromised quality of care, including the care provided to Patient 1. On June 21, 2016, we also informed VISN 7 leaders of these concerns. In early 2017, PCP X transferred to another VISN 7 facility.

Issue 2. Evaluation of a Patient’s Condition

We did not substantiate that PCP X failed to evaluate a patient’s (Patient 2) condition sufficiently. Through our interviews and EHR reviews, we found that PCP X provided appropriate evaluation and care for Patient 2’s condition. However, we found issues with PCP X’s documentation. Although PCP X documented a “pharyngitis/sinusitis” diagnosis and an appropriate treatment plan. PCP X’s EHR note contained a “copy and paste” pre-populated normal examination template that did not accurately reflect the patient’s condition. We found that PCP X’s EHR documentation was inadequate and erroneous.⁷² PCP X’s documentation was regularly inconsistent with patients’ presenting conditions, diagnoses, and treatment plans. PCP X did not consistently submit appropriate consultations, follow up on consultant recommendations, or include relevant information to support consultations as required by VHA policy.

Patient 2. The complainant alleged that PCP X treated Patient 2 without examining or touching the patient. In fall 2015, Patient 2 presented for an unscheduled PACT visit with PCP X. Patient 2, whose medical history included allergic rhinitis⁷³ and asthma, complained of a 3-week history of “fever, sore throat, and frontal sinus pressure”. The RNCM noted that the patient’s voice was “hoarse.” PCP X’s note included a history of “sore throat and sinus congestion;” and diagnosed “pharyngitis/sinusitis.”^{74,75} However, PCP X documented a normal physical examination: “nasal: no discharge, no tenderness of sinuses,” and “pharynx: no inflammation, no tonsillar exudate.” These physical examination results were inconsistent with PCP X’s “pharyngitis/sinusitis” diagnosis and plan to treat with amoxicillin and cetirizine. In an OIG interview, PCP X confirmed that the fall 2015 note contained a pre-populated, templated normal examination and was not an accurate reflection of the patient’s condition.

⁷²VHA Handbook 1907.01.

⁷³ Allergic rhinitis is an allergic reaction of the nasal mucosa.

⁷⁴ Sinusitis is inflammation of a sinus that may be infectious.

⁷⁵ Pharyngitis is inflammation of the pharynx causing pain with swallowing, congestion of the mucus membranes, and fever.

Additional Sinusitis/Pharyngitis Patient EHR Reviews

We identified 16 patients diagnosed and treated by PCP X for sinusitis/pharyngitis in Q1 FY 2016 and Q1–2 FY 2017. In 15 of the 16 patients' EHRs, we found that PCP X's physical examination documentation did not correspond with the patient's presenting complaints or signs and symptoms as noted in the RNCM note. In all 16 EHRs, PCP X documented a normal physical examination using a pre-populated, templated normal examination that was copied and pasted from a prior EHR entry. PCP X's documentation was regularly inconsistent with patients' presenting conditions, diagnoses, and treatment plans.

Documentation and Follow-Up Care Concerns

We reviewed a total of 34 EHRs comprised of patients identified by the complainant or Clinic staff, and patients who submitted a complaint about PCP X's care including follow-up to specialty consultation needs.⁷⁶ We found instances in which PCP X's documentation of a Clinic visit note was a copy of documentation ("copy and paste") from a previous encounter note. Twelve of the 34 EHRs contained unedited, pre-populated (templated) text that was inconsistent with the patients' presenting complaint, physical examination, and plan of care. In the EHRs of two female patients, PCP X documented the review of male genitalia, a prostate exam, and ordering a PSA level. For nine patients, PCP X either did not submit appropriate consultation or follow up on consultant recommendations. In eight patients' EHRs, PCP X ordered a consultation but did not include documentation of patient concerns, observations, or physical exam findings to support the consult. PCP X did not include reasons for consults, follow-up treatment, or patient instructions as required by VHA policy.⁷⁷

Issue 3. Timely Access to Care

We substantiated that PCP X did not provide care for one (Patient 3) of two unscheduled (walk-in) patients. However, another PCP provided Patient 3 with timely care so there was no delay in treatment. We substantiated that PCP X failed to provide timely access to care for two complainant-identified patients (Patients 5 and 6).

Walk-In Patient

Patient 3. In fall 2015, Patient 3's spouse brought the veteran for an unscheduled (walk-in) appointment to the Clinic with mental status alterations, poor nutritional intake, and hallucinations. Patient 3 was assigned to PCP X's panel and the RNCM informed PCP X of Patient 3's condition. According to the complainant, PCP X refused to see the patient. The complainant reported that PCP X said that Patient 3 should see another PCP (Patient 3 was already scheduled with this other PCP for the following month). On this same day, PCP X saw 12 scheduled patients, slightly above PCP X's fall 2015

⁷⁶ We identified these patients through PATS data.

⁷⁷ VHA Handbook 1907.01

average of 10.5 patient visits per day. Another PCP evaluated Patient 3 that day and transferred him to a non-VA community hospital.

Patient 4. Patient 4 presented as a walk-in to the Clinic mid-summer 2015. Patient 4 reported that recent imaging studies revealed a chest wall mass and bone lesion and that a non-VA provider advised a bone biopsy to aid in establishing a diagnosis. PCP X instructed Patient 4 to schedule the next available appointment for the following Monday. PCP X saw Patient 4 as scheduled and ordered an urgent interventional radiology follow-up, which was completed in late summer. Although we did not find a delay in Patient 4's follow-up care, we found that PCP X's use of template documented information was inconsistent with Patient 4's subjective report and known conditions.

Scheduled Patients

Patient 5. In fall 2015, Patient 5 reported opioid withdrawal symptoms from a morphine prescription for pain control. The RNCM noted Patient 5's elevated blood pressure and "positive depression screen and verbalized intent to harm self." The RNCM documented that PCP X was "informed" of these findings. PCP X met with Patient 5 and refilled the morphine prescription. However, we found that PCP X did not document any discussion of potential opioid withdrawal symptoms/signs such as Patient 5's elevated blood pressure. Additionally, PCP X did not address Patient 5's positive depression screen or self-harm statements, as required by VHA.⁷⁸ Although PCP X did not document a comprehensive assessment or plan of care consistent with Patient 5's conditions, we did not identify any adverse events related to this visit. We found that PCP X prescribed Patient 5 morphine from spring 2014 through early 2016 without delay.

Patient 6. During Patient 6's April 2015 MACH admission, computerized tomography scan results indicated a "probable renal cyst" on in his left kidney and a "low probability malignancy" right lung nodule. The MACH provider recommended a 6-month follow-up including a computerized tomography scan of the kidney and right lung. Patient 6 requested PCP X provide follow-up referrals and/or plan of care information on two days in July and September 2015. At Patient 6's PC visit in mid-October 2015, PCP X ordered a non-VA urology consult and also placed a Montgomery VAMC urology consult in October 2015 for follow-up of a renal cyst. Patient 6 attended the Montgomery VAMC appointment scheduled for early 2016 and received treatment as needed. However, PCP X did not follow up on Patient's 6's lung nodule identified in spring 2015. In summer 2017, a new PCP referred Patient 6 for a pulmonary function evaluation.

Clinic PACT Access

In FY 2016, Clinic staff scheduled PC appointments for established patients within 30 days of the requested date at a rate of 89.6 percent and new patients at

⁷⁸ VA VistA Clinical Reminders, Version 2.0, User Manual, December 2007.

79.4 percent. The FY 2016 VHA national average for established and new patients was 96.8 percent and 92 percent, respectively. In FY 2016, PCP X's PACT had an average wait time of 25.07 days for an established patient visit, while the wait time for other Clinic PACTs ranged from 3.11 to 15.39 days. The VHA national average was 4.38 days.

Although Clinic PCPs reported panel sizes of approximately 1600 patients, FY 2015 and FY 2016 data show panel sizes were consistent with VHA's limitations of 1000–1400 patients for non-specialized PC panels. The Clinic appointments were scheduled from 8:00 a.m. through 3:30 p.m. Staff scheduled established patients for 30 minutes and new patients received 60-minute appointments. PCP schedules did not include open slots for unscheduled patients. Consistent with the 2015 VA OIG report findings of demanding system PCP work schedules,⁷⁹ Clinic PCPs told us that they managed their schedules by working through lunch, longer hours, and on weekends.

Issue 4. Patients' Requests for VHA Specialty Care and Pharmacy Services

We substantiated that PCP X did not respond to one (Patient 7) of three complainant-identified patients' (Patients 7, 8, and 9) requests for VHA specialty care. We did not substantiate that PCP X did not respond to a patient's (Patient 10) request for VHA pharmacy services.

Specialty Care

Patient 7. In 2008, Patient 7 had a carotid stent⁸⁰ placement. According to the patient, the surgeon advised annual carotid ultrasound studies as follow-up. From 2009 through 2012, Patient 7's previous PCP ordered annual carotid ultrasound studies which indicated no significant change to the stent or right carotid artery. Per RNCM notes, Patient 7 requested that PCP X order carotid ultrasound studies on three separate dates (summer 2013, summer 2014, and fall 2014). PCP X did not document any discussion regarding Patient 7's request for carotid ultrasound studies or any physical examination of the carotid arteries. In late fall 2014, Patient 7 transferred to another PACT, and the new PCP ordered the carotid ultrasound at the first clinic visit.

Patient 8. Patient 8 had a history of colon polyps prior to a 2006 colonoscopy⁸¹ that did not find polyps. The 2006 surgeon did not specify a timeframe for repeating the procedure. In summer 2014, Patient 8 requested that PCP X place an order for a repeat colonoscopy because of his history of polyps. PCP X did not submit an order. However, Patient 8 did not complain of symptoms that would have warranted a repeat colonoscopy at that time. In fall 2015, Patient 8's new PCP ordered a colonoscopy visit in response to Patient 8's complaint of abdominal pain and intermittent vomiting over

⁷⁹ VA OIG Report No. 14-04530-452, *Healthcare Inspection—Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama*, July 29, 2015.

⁸⁰ Carotid stent is a rod-like or threadlike device used to provide support for the principle artery in the neck.

⁸¹ Colonoscopy is a procedure that uses a flexible endoscope to permit visual examination of the entire colon.

the prior 2 weeks. In late 2015, Patient 8 had one polyp removed during the colonoscopy.

Patient 9. The complainant alleged that on a fall 2015 visit, PCP X denied Patient 9's request for VA urology care. However, PCP X reportedly provided Patient 9 with "a list of local urologists... and advised [Patient 9] to seek care from them." PCP X also entered a Montgomery facility urology consult 8 days later.

Pharmacy Services

Patient 10. Patient 10 requested information about pharmacy and audiology services from PCP X and an RNCM during the patient's initial fall 2015 visit. PCP X and RNCM notes contained documentation of the request for VA pharmacy services. The RNCM referred the patient to a Clinic pharmacist. We found no delay in provision of pharmacy services for Patient 10.

Issue 5. VA Police Presence and Panic Alarms

VA Police Presence

We substantiated that there was a lack of VA Police presence at the Clinic. However Garrison law enforcement personnel responded to Clinic calls for service. We also found that an MOU between the system and the Garrison to grant VA Police law enforcement jurisdiction at the Clinic was not finalized as of January 2017.

All properties located on the Garrison grounds, including the Clinic, are under the jurisdiction of DOD Security and law enforcement services are provided by DOD personnel.⁸² As such, no VA Police were stationed at the Clinic. An agreement or MOU detailing jurisdiction and authorities is required for VA Police to provide services on the grounds. While there were multiple attempts to execute an MOU, no formalized agreement was finalized as of January 2017.⁸³

In an April 2015 VA issue brief, *Columbus/Fort Benning Clinic Expansion*, it was documented that the action item "officers allowed to work on base" was completed; however, no further information was provided.⁸⁴ In 2015, for a period of 2–3 months one VA Police Officer, from the Columbus CBOC, was stationed at the Clinic several hours per day reportedly "as a presence" but with no law enforcement authority. Upon his return to a permanent duty station at the Columbus CBOC, the system leaders did not replace him with another officer. The Police Chief described a positive relationship between Fort Benning military police and the VA Police Service.

⁸² Department of the Army, *Memorandum Of Agreement Between Martin Army Community Hospital (BMACH), Fort Benning, Georgia, U.S. Army Garrison (USAG), Fort Benning, Ga, and Central Alabama Veterans Health Care System (CAVHCS) Montgomery, Alabama.*

⁸³ VA Memorandum *Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum*, November 7, 2013.

⁸⁴ Fort Benning Issue Brief, *Columbus/Fort Benning Clinic Expansion Project*, April 27, 2015.

He also said he preferred to have a permanent and established presence at the Clinic to include shared law enforcement jurisdiction/authority with Garrison police. We found that there were few reported incidents at the Clinic requiring police response, and that there was a military police presence available when necessary.

In July 2015, VA Regional Counsel approved the MOU as legally sufficient. During July 2015–June 2016, the Police Chief attempted unsuccessfully to execute the MOU between the system and the Garrison to establish VA Police services at the Clinic:

- July 7, 2015 - VA Regional Counsel provided legal clearance for the MOU.
- July 14, 2015 - MOU was signed by the system Interim Director and the Police Chief but not by DOD representatives.
- June 17, 2016 - MOU was signed by the new system Interim Director and the Police Chief but not by DOD representatives.
- June 22, 2016 - MOU was signed by the designees for the new system Interim Director and the Police Chief but not by DOD representatives.

System leaders could not recall why the MOU was not finalized, and they were unable to provide us with an anticipated completion date.

Panic Alarms

We substantiated that the Clinic did not have panic alarms. However, because the WBRA team assigned the Clinic a moderate (not high) risk, the panic alarms were not required. The Police Chief told us that a request for panic alarms was not received, as required by system policy. One staff member reported being unaware of the process for requesting alarms but did not believe there was a need for additional security measures. Staff told us that they recalled no incidents which would have required a panic alarm, and there were no reported major incidents requiring Garrison police response during our period of review.

Clinic Employee Security Training

We found that system managers did not provide Clinic staff appropriate training relative to the WBRA. The WBRA team assigned the Clinic a moderate risk level indicating that staff should receive PMDB Levels I, II, and III training.⁸⁵ However, we found that Clinic staff received only Level I training.

Clinic staff also lacked general knowledge and information related to emergency response management. We interviewed seven Clinic staff members; and all of them were uncertain if there was a specific phone to use to contact law enforcement, what phone number to use, and which police service would respond (VA or DOD). Although

⁸⁵ VA Memorandum, *Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum*, November 7, 2013.

a VA Police Officer told us that informational posters are part of staff emergency management education, we did not observe any posted emergency contact information. During our site visit, we discussed concerns with the Interim System Director about security issues and emphasized emotional and physical well-being concerns of staff secondary to absence of a coherent emergency plan.

Conclusions

We substantiated that PCP X did not follow up on elevated PSA test results, which resulted in a patient's (Patient 1) delay of prostate cancer diagnosis and treatment. We found that PCP X routinely failed to notify patients of PSA test results or follow up on elevated values. We also found that system leaders did not monitor PCP X's performance consistently and did not take adequate administrative action to improve the delivery of quality care. During and following our June 2016 site visit, we notified system leaders of our concerns about PCP X's performance and compromised quality of care, including the care provided to patients. On June 21, 2016, we also informed the VISN 7 leaders of these concerns.

We did not substantiate that PCP X failed to evaluate a patient's (Patient 2) condition sufficiently. Through our interviews and EHR reviews, we found that PCP X provided appropriate evaluation and care for Patient 2's condition. However, we found issues with PCP X's documentation. Although PCP X documented a "pharyngitis/sinusitis" diagnosis and an appropriate treatment plan, PCP X's EHR note contained a "copy and paste" pre-populated normal examination template that did not accurately reflect the patient's condition. We found that PCP X's EHR documentation was inadequate and erroneous. PCP X's documentation was regularly inconsistent with patients' presenting condition, diagnoses, and treatment plans. PCP X did not consistently submit appropriate consultations, follow up on consultant recommendations, or include relevant information to support consultations as required by VHA policy.

We substantiated that PCP X did not provide care for an unscheduled acutely ill patient (Patient 3); however, treatment was not delayed because another PCP provided the care. We substantiated that PCP X failed to provide timely access to care for two scheduled patients (Patients 5 and 6). We also found that PCP X's wait time for established patient visits was longer than the other Clinic PCPs. We also substantiated that PCP X did not respond to one (Patient 7) of three complainant-identified patient requests for VHA specialty care. We did not substantiate that PCP X did not respond to a patient's (Patient 10) request for VHA pharmacy services.

We substantiated that there was a lack of daily VA Police presence at the Clinic; but, found that law enforcement personnel from the Garrison responded to calls for service. We also determined that an MOU between the system and the Garrison to grant VA Police law enforcement jurisdiction at the Clinic was not finalized as of January 2017.

We substantiated that the Clinic did not have panic alarms. However, because the WBRA team assigned the Clinic a moderate (not high) risk, the panic alarms are not required. We found no evidence of prior incidents which would have required a panic alarm, and there were no reported major incidents requiring Garrison police response. We also determined that system managers did not provide Clinic staff with adequate PMDB training, and Clinic staff lacked general knowledge and information regarding emergency response management.

Recommendations

Recommendation 1. We recommended that the Veterans Integrated Service Network Director ensure that the System Director evaluates the care of the subject patient (Patient 1) and consults with the Office of General Counsel for disclosure to the patient, if appropriate.

Recommendation 2. We recommended that the Veterans Integrated Service Network Director ensure that the System Director consults with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action(s), if any, for Primary Care Provider X and Primary Care Provider X's supervisors.

Recommendation 3. We recommended that the System Director ensure that providers notify patients of test values and follow up on clinical laboratory results as required.

Recommendation 4. We recommended that the System Director ensure that providers accurately document patients' assessment, diagnosis, and treatment information into the electronic health record.

Recommendation 5. We recommended that the System Director ensure that consults for VHA and non-VA care are entered and completed within time frames set by Veterans Health Administration.

Recommendation 6. We recommended that the System Director ensure that employees receive training appropriate for the assigned Workplace Behavioral Risk Assessment risk level.

Recommendation 7. We recommended that the System Director ensure that Clinic employees are trained in emergency management procedures.

Recommendation 8. We recommended that the System Director ensure that emergency procedures and contact information are posted and readily available to Clinic employees.

Prior OIG Reports November 25, 2014–August 14, 2017

System Reports

Healthcare Inspection – Magnetic Resonance Imaging Patient Safety Screening, Central Alabama VA Health Care System, Montgomery, Alabama

8/14/2017 | 15-02993-339

Healthcare Inspection – Alleged Manipulation of Outpatient Appointments, Central Alabama VA Health Care System, Montgomery, Alabama

9/21/2016 | 15-03942-392

Healthcare Inspection – Emergency Department Concerns, Central Alabama VA Health Care System, Montgomery, Alabama

1/14/2016 | 14-04530-41

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Central Alabama Veterans Health Care System, Montgomery, Alabama

12/4/2014 | 14-00930-14

Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama

11/25/2014 | 14-02079-10

Topic Related Reports

Choice Access

Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6

3/2/2017 | 16-02618-424

Healthcare Inspection - Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care

8/1/2017 | 17-01846-316

Follow-Up Care Deficiencies

Healthcare Inspection – Poor Follow-Up Care and Incomplete Assessment of Disability, VA San Diego Healthcare System San Diego, California

1/5/2016 | 15-00827-68

Healthcare Inspection – Alleged Staffing, Quality of Care, and Administrative Deficiencies, Amarillo VA Health Care System, Amarillo, Texas

7/6/2017 | 14-03822-289

Prior OIG Reports November 25, 2014–August 14, 2017

Healthcare Inspection—Quality of Care Concerns at Two Veterans Integrated Service Network 23 Facilities and a Veterans Readjustment Counseling Center
7/17/2017 | 15-00509-301

Healthcare Inspection – Delays in the Evaluation and Care of a Patient with Lung Cancer, VA Southern Nevada Health Care System, Las Vegas, NV
5/23/2017 | 15-01301-242

Healthcare Inspection – Restraint Use, Failure to Provide Care, and Communication Concerns, Bay Pines VA Healthcare System, Bay Pines, Florida
4/13/2016 | 15-01432-264

Clinical Documentation

Healthcare Inspection – Restraint Use, Failure to Provide Care, and Communication Concerns, Bay Pines VA Healthcare System, Bay Pines, Florida
4/13/2016 | 15-01432-264

Combined Assessment Program Review of the VA Roseburg Healthcare System, Roseburg, Oregon
3/4/2015 | 14-04222-141

Healthcare Inspection - Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care
8/1/2017 | 17-01846-316

Security

Healthcare Inspection—Clinical Activities, Staffing, and Administrative Practices, Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma
7/10/2017 | 16-02676-297

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Maryland Health Care System, Baltimore, Maryland
2/23/2016 | 15-05164-139

Staffing

Healthcare Inspection – Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii
9/22/2016 | 15-04655-347

OIG reports are available on our website at www.va.gov/oig

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 22, 2017

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

Subj: Healthcare Inspection—Primary Care Provider's Clinical Practice Deficiencies and Security Concerns at Fort Benning VA Clinic, Fort Benning, Georgia

To: Director, Baltimore Office of Healthcare Inspections (54BA)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have had the opportunity to review the *Healthcare Inspection—Primary Care Provider's Clinical Practice Deficiencies and Security Concerns at Fort Benning VA Clinic, Fort Benning, Georgia*.
2. Central Alabama VA Healthcare System submits the attached draft report concurring with recommendations 1–8. I concur with the Draft Report *Primary Care Provider's Clinical Practice Deficiencies and Security Concerns at Fort Benning VA Clinic, Fort Benning, Georgia*.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer at (678) 924-5700.



Robert R. Norvel Jr., MD
Deputy Chief Medical Officer

Comments to OIG Report

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

OIG Recommendations

Recommendation 1. We recommended that the Veterans Integrated Service Network Director ensure that the System Director evaluates the care of the subject patient (Patient 1) and consults with the Office of General Counsel for disclosure to the patient, if appropriate.

Concur

Target date for completion: November 30, 2017

VISN response: Process to ensure direct oversight of the Facility Director by the VISN7 Network Director has been implemented to complete an assessment of care and consultation with the Office of General Counsel for disclosure as appropriate.

OIG Comment: We do not consider this recommendation closed and will follow up on the recently implemented actions provided by the Network Director to ensure that corrective actions have been effective and sustained.

Recommendation 2. We recommended that the Veterans Integrated Service Network Director ensure that the System Director consults with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action(s), if any, for Primary Care Provider X and Primary Care Provider X's supervisors.

Concur

Target date for completion: January 30, 2018

VISN response: Process to ensure direct oversight of the Facility Director by the VISN 7 Network Director has been implemented to ensure consultation with the Office of Human Resources and Office of General counsel to determine and implement appropriate administrative action(s) as appropriate.

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 21, 2017

From: Acting Director, Central Alabama Veterans Health Care System (619/00)

Subj: Healthcare Inspection—Primary Care Provider's Clinical Practice Deficiencies and Security Concerns at Fort Benning VA Clinic, Fort Benning, Georgia

To: Director, VA Southeast Network (10N7)

1. I have reviewed and concur with the findings and recommendations in the OIG report, *Healthcare Inspection—Primary Care Provider's Clinical Practice Deficiencies and Security Concerns at Fort Benning VA Clinic, Fort Benning, Georgia*.
2. Attached please find the facility actions, progress in the reviewed areas, and plans for continued compliance.
3. Thank you for your support as we continue to improve the services and processes at CAVHCS for the best outcomes for our Veterans.

Thomas B. Huettemann 395558
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Thomas B.
Huettemann 395558
Date: 2017.11.21
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Thomas Huettemann, MPA
Acting Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 3. We recommended that the System Director ensure that providers notify patients of test values and follow up on clinical laboratory results as required.

Concur

Target date for completion: May 31, 2018

System response: Central Alabama Veterans Health Care System has established a process for communicating test results to patients. Quality Management will conduct a monthly review of the timely provider notification of patients of test results and follow-up. The report will be reported to the Medical Executive Committee to ensure 90 percent compliance is achieved and sustained.

Recommendation 4. We recommended that the System Director ensure that providers accurately document patients' assessment, diagnosis, and treatment information into the electronic health record.

Concur

Target date for completion: Completed August 31, 2017

System response: Health Information Management Service (HIMS) monitors records for copy and paste compliance guidelines from the VHA, Joint Commission, local policy, and directives. Monthly record reviews are conducted using random sampling method. The findings are reported in Medical Records Committee and forwarded to the appropriate Service Chief to provide education and training to their staff. In 2017, HIMS added three additional Health Information Technician positions to review records for medical record delinquencies to include copy and paste. From January 2017 to August 2017, compliance rate average was 96.5 percent.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 5. We recommended that the System Director ensure that consults for VHA and non-VA care are entered and completed within time frames set by Veterans Health Administration.

Concur

Target date for completion: Completed October 18, 2017

System response: Central Alabama Veterans Health Care System ensures that consults for VHA and Non-VHA are entered and completed within the time frames as set by VHA. Consults (pending, active, and scheduled) are tracked daily. A consult report is presented daily during the facility leadership morning report. The Acting Chief of Staff reviews the consult performance and identifies processes to improve facility consult performance and outcomes. A detailed consult report is presented weekly to the Executive Leadership Team during the morning meeting.

The Acting Chief of Staff has instructed all sending providers to adhere to Care Coordination Agreements and to review and act on the results of completed clinical consults. Each service is tasked to review consult templates to ensure needed documentation is properly designated as required fields. The diagnosis, reason for request, and other information (depending on specialty) are required fields to submit a consult.

Central Alabama Veterans Health Care System is implementing the One Consult Model as required by VHA. The One Consult Model requires each consult to have relevant information to support the consultation, such as a diagnosis and reason for consultation.

OIG Comment: We do not consider this recommendation closed and will follow up on the recently implemented actions provided by the System Director to ensure that corrective actions have been effective and sustained.

Recommendation 6. We recommended that the System Director ensure that employees receive training appropriate for the assigned Workplace Behavioral Risk Assessment risk level.

Concur

Target date for completion: May 31, 2018

System response: The Workplace Behavioral Risk Assessment identifies the levels of Prevention and Management of Disruptive Behavior training required for employees based on their assigned work area designations. The Level I training module is part of the "New Employee Orientation." Additional training will occur as required for assigned risk areas within 90 days of hire and will be documented in the VA Talent Management System (TMS). The Education Department has a notification escalation process for employees and managers to facilitate compliance. Monitoring will continue to ensure compliance.

In August 2016, CAVHCS CBOC remote sites were targeted as priority for Management of Disruptive Behavior training. The Ft. Benning Clinic completed 100 percent of the mandatory training and is valid for 2 years.

Recommendation 7. We recommended that the System Director ensure that Clinic employees are trained in emergency management procedures.

Concur

Target date for completion: Completed October 31, 2017

System response: Emergency Management training is conducted as part of the new employee orientation and required yearly through the VA Talent Management System (TMS) Emergency Management course. The Safety and Emergency Management also conducts a yearly Safety Fair and training. As of October 31, 2017, 94 percent of staff completed the Emergency Management training.

In 2017, Safety and Emergency Management in conjunction with Patient Safety conducted the Safety Fair and training at all CAVHCS CBOCs with a focus on the following areas: Safety, Life Safety, Industrial Hygiene, Green Environmental Management System (GEMS), Emergency Management, Patient Safety, Infection Control, Safe Patient and Handling, and Security. This event was conducted at Ft. Benning Primary Care and Columbus Mental Health on February 3, 2017.

OIG Comment: The System provided sufficient supporting documentation, and we consider this recommendation closed.

Recommendation 8. We recommended that the System Director ensure that emergency procedures and contact information are posted and readily available to Clinic employees.

Concur

Target date for completion: Completed May 31, 2017

System response: Safety and Emergency Management revised the CAVHCS Emergency Codes and Response Guide handout in March 2017; the handout was distributed during training and was also sent via email to all CAVHCS supervisors to dispense to their employees. A desktop shortcut named CAVHCS Policies located in the facility policy drive was created for easy accessibility of policies. Central Alabama Veterans Health Care System Memo 002S-17-03, *Emergency Management Plan (EMP)*, dated April 30, 2017, is accessible in this policy folder.

OIG Comment: We do not consider this recommendation closed and will follow up on the recently implemented actions provided by the System Director to ensure that corrective actions have been effective and sustained.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Alison Loughran, JD, BSN, Team Leader Thomas Jamieson, MD Terri Julian, PhD
Other Contributors	Nicholas DiTondo, BA Laura Dulcie, BSEE Trina Rollins, PA-C Larry Ross, MS Michelle Wilt, MBA, BSN

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