Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Community Based Outpatient Clinic Reviews Smithville, MS and Memphis (Memphis-South), TN Knoxville, TN and Norton, VA Chattanooga and Nashville (Vine Hill), TN

Report No. 10-00627-174

June 16, 2010

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

Introduction

The VA OIG, Office of Healthcare Inspections conducted a review of six community-based outpatient clinics (CBOCs) during the week of March 15-19, 2010. The CBOCs reviewed in Veterans Integrated Service Network (VISN 9) were Smithville, MS and Memphis (Memphis-South), TN; Knoxville, TN and Norton, VA; and Chattanooga and Nashville (Vine Hill), TN. The parent facilities of these CBOCs are Memphis VA Medical Center (VAMC), Mountain Home VAMC, and Tennessee Valley Health Care System (HCS)-Nashville, respectively. The purpose of the review was to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care.

Results and Recommendations

The CBOC review covered five topics. In our review, we noted several opportunities for improvement and made recommendations to address all of these issues. The Director, VISN 9, in conjunction with the respective facility managers, should take appropriate actions on the following recommendations:

Memphis VAMC

- Ensure practitioners practicing under Scopes of Practice at the Smithville CBOC are monitored according to Veterans Health Administration (VHA) policy.
- Grant privileges that are consistent with the services provided at both the Smithville and Memphis-South CBOCs.
- Ensure the Infection Control program includes a hand hygiene component at both the Smithville and Memphis-South CBOCs.
- Require that medical record documentation at the Smithville CBOC be in compliance with VHA policy.
- Secure and protect all personally identifiable information at the Smithville CBOC.
- Ensure the local safety plan policy at both the Smithville and Memphis-South CBOCs is in compliance with VHA policy.
- Provide contract oversight and enforcement in accordance with the terms and conditions as stated in the contract for the Smithville CBOC and other contract CBOCs. Additionally, the Contracting Officer's Technical Representative should research the overpayments attributable to duplicate enrollees and seek refunds for those overpayments for Smithville.

- Make sure the Primary Care Management Module (PCMM) Coordinator performs in accordance with VHA Handbook 1101.02 to ensure accuracy of the data reported to the VAMC and to the VHA Support Service Center.

Mountain Home VAMC

- Ensure staff at the Knoxville CBOC receives education and training related to the panic alarm system.

Tennessee Valley HCS

- Maintain auditory privacy during the check-in process at the Chattanooga and Vine Hill CBOCs.
- Perform a vulnerability risk assessment at the Chattanooga and Vine Hill CBOCs to address potential workplace risks.
- Ensure that all patient care areas meet safety criteria at the Chattanooga and Vine Hill CBOCs.
- Require annual fire safety drills and inspections at the Vine Hill CBOC.
- Enforce the use of two patient identifiers in the blood drawing process at the Vine Hill CBOC.
- Ensure the Infection Control program includes a hand hygiene component at the Vine Hill CBOC.
- Require the Contractor inspects for cleanliness and performs needed repairs at the Vine Hill CBOC.
- Develop a local policy or standard operating procedure that reflects the current practice and capability for handling medical and mental health emergencies at the Vine Hill CBOC.
- Re-compete the contract if planning to continue to offer contracted primary care services.
- Draft a new contract to ensure compliance with terms during the re-compete process so as not to disrupt care to veterans. The duration of this contract should be no longer than appropriate for the re-compete process and less than one year.
- Provide contract oversight and enforcement in accordance with the terms and conditions as stated in the contract, specifically that a medical evaluation is performed at least once in 12 months and that Tennessee Valley HCS takes steps to recover overpayments on invoices prior to December 2009.
- Ensure that the PCMM Coordinator complies with the guidance in accordance with VHA Handbook 1101.02, specifically that steps are taken to reduce the number of patients assigned to more than one primary care provider.

Comments

The VISN and VAMC Directors agreed with the CBOC review findings and recommendations and provided acceptable improvement plans. (See Appendixes A–D, pages 23–36 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Part I. Introduction

Purpose

The VA Office of Inspector General (OIG) is undertaking a systematic review of the Veterans Health Administration's (VHA's) community-based outpatient clinics (CBOCs) to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care.

Background

The Veterans' Health Care Eligibility Reform Act of 1996 was enacted to equip VA with ways to provide veterans with medically needed care in a more equitable and cost-effective manner. As a result, VHA expanded the Ambulatory and Primary Care Services to include CBOCs located throughout the United States. CBOCs were established to provide more convenient access to care for currently enrolled users and to improve access opportunities within existing resources for eligible veterans not currently served.

Veterans are required to receive one standard of care at all VHA health care facilities. Care at CBOCs needs to be consistent, safe, and of high quality, regardless of model (VA-staffed or contract). CBOCs are expected to comply with all relevant VA policies and procedures, including those related to quality, patient safety, and performance. For additional background information, see the *Informational Report for the Community Based Outpatient Clinic Cyclical Reports*, 10-00627-124, issued April 6, 2010.

Scope and Methodology

Objectives. The purpose of this review is to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. The objectives of the review are to:

- Determine whether CBOC performance measure scores are comparable to the parent VA medical center (VAMC) outpatient clinics.
- Determine whether CBOC providers are appropriately credentialed and privileged in accordance to VHA Handbook 1100.19.[1]
- Determine whether CBOCs maintain the same standard of care as their parent facility to address the Mental Health (MH) needs of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) era veterans.
- Determine whether patients who are assessed to be high risk for suicide have safety plans that provide strategies that help mitigate or avert suicidal crises.

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

- Determine whether CBOCs are in compliance with standards of operations according to VHA Handbook 1006.1[2] in the areas of environmental safety and emergency planning.
- Determine whether the CBOC primary care and MH contracts were administered in accordance with contract terms and conditions.
- Determine whether primary care active panel management and reporting are in compliance with VHA Handbook 1101.02.[3]

Scope. We reviewed CBOC policies, performance documents, provider credentialing and privileging (C&P) files, and nurses' training records. For each CBOC, random samples of 50 patients with a diagnosis of diabetes mellitus (DM), 50 patients 50 years of age or older, and 30 patients with a service separation date after September 11, 2001, without a diagnosis of post-traumatic stress disorder (PTSD), were selected, unless fewer patients were available. We reviewed the medical records of these selected patients to determine compliance with VHA performance measures.

We conducted environment of care (EOC) inspections to determine the CBOCs' cleanliness and conditions of the patient care areas; conditions of equipment; adherence to clinical standards for infection control and patient safety; and compliance with patient data security requirements.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

In this report, we make recommendations for improvement.

[2] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics,* May 19, 2004.
[3] VHA Handbook 1101.02, *Primary Care Management Module (PCMM),* April 21, 2009.

Part II. CBOC Characteristics

Veterans Integrated Service Network (VISN) 9 has 7 VHA hospitals and 47 CBOCs. As part of our review, we inspected 6 CBOCs (4 VA-staffed and 2 with contracted staff). The CBOCs reviewed in VISN 9 were Smithville, MS and Memphis (Memphis-South), TN; Knoxville, TN and Norton, VA; and Chattanooga and Nashville (Vine Hill), TN. The parent facilities of these CBOCs are Memphis VA Medical Center (VAMC), Mountain Home VAMC, and Tennessee Valley Healthcare System (HCS)-Nashville, respectively.

We formulated a list of CBOC characteristics and developed an information request for data collection. The characteristics included identifiers and descriptive information for the CBOC evaluation.

In FY 2009, the average number of unique patients seen at the 4 VA-staffed CBOCs was 11,332 (range 1,180 to 21,665) and at the 2 contract CBOCs was 1,963 (range 686 to 3,240). Table 1 shows characteristics of the 6 CBOCs we reviewed to include size[4] and type of CBOC, rurality, number of full-time equivalent employees (FTE) primary care providers (PCPs), number of unique veterans enrolled in the CBOC, and number of veteran visits.

VISN Number	CBOC Name	Size of CBOC	CBOC Type	Urban/ Rural	Number of Clinical Providers (FTE)	Uniques	Visits
9	Smithville, MS	Mid-size	Contract	Rural	3.8	3,240	12,894
9	Memphis (Memphis-South),TN	Large	VA-Staffed	Urban	8.8	9,038	33,435
9	Knoxville, TN	Very Large	VA-Staffed	Urban	11.2	21,665	57,264
9	Norton, VA	Small	VA-Staffed	Rural	2.0	1,180	3,939
9	Chattanooga, TN	Very Large	VA-Staffed	Urban	11.7	13,445	77,039
9	Nashville (Vine Hill), TN	Small	Contract	Urban	0.4	686	1,551

Table 1 - CBOC Characteristics, FY 2010

Two of the six CBOCs provide specialty care services (Chattanooga and Knoxville), while the other four CBOCs refer patients to the parent facility. Norton also refers patients to non-VA fee-basis or contract care. Chattanooga provides cardiology, dental, and orthopedic services; and Knoxville provides services in optometry and audiology. Veterans have access to tele-retinal services at Memphis-South, Knoxville, Chattanooga, and Vine Hill.

Five CBOCs provide MH services onsite (Norton CBOC provides MH screening). MH services provided onsite at the CBOCs are displayed in Table 2.

[4] Based on the number of unique patients seen as defined by the VHA Handbook 1160.01, the size of the CBOC facility is categorized as very large (> 10,000), large (5,000-10,000), mid-size (1,500-5,000), or small (< 1,500).

CBOC Station Number	CBOC Name	CBOC Type	Substance Use Disorder	PTSD	MST	Homelessness	Psychosocial rehab
614GA	Smithville, MS	Contract	Yes	Yes	Yes	Yes	Yes
614GF	Memphis-South, Memphis, TN	VA-staffed	Yes	Yes	Yes	No	No
621BY	Knoxville, TN	VA-staffed	Yes	No	No	Yes	No
621GC	Norton, VA	VA-staffed	No	No	No	No	No
626GF	Chattanooga, TN	VA-staffed	Yes	No	No	No	No
626GI	Vine Hill, Nashville, TN	Contract	No	No	No	No	No

Table 2. Mental Health Services

The type of clinicians that provide MH services varied among the CBOCs to include PCPs, psychologists, psychiatrists, nurse practitioners (NPs), social workers, and addiction counselors. The two very large CBOCs had a suicide prevention coordinator onsite, as required by VHA policy.[5]

MH services are provided during evening hours (after normal business hours) at least one day per week and on weekends at the Chattanooga CBOC. Three CBOCs (Smithville, Memphis-South, and Chattanooga) have plans for responding to MH emergencies during times outside hours of operation. The plans identify at least one assessable VA or community-based emergency department where veterans are directed to seek emergent care when necessary.

Tele-mental health is available at three CBOCs (Smithville, Chattanooga, and Memphis-South). Tele-mental health is used for medication management at Chattanooga and Smithville. Smithville also uses tele-mental health for individual and group therapy, supervision or guidance to non-MH prescriptive providers, and consultation with other providers such as PCPs. Memphis-South uses tele-mental health with OEF/OIF veterans at outlying areas.

[5] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

Part III. Overview of Review Topics

The review topics discussed in this report include:

- Quality of Care Measures.
- C&P.
- EOC and Emergency Management.
- Suicide Safety Plans.
- CBOC Contracts.

The criteria used for these reviews are discussed in detail in the *Informational Report for the Community Based Outpatient Cyclical Reports*, 10-00627-124, issued April 6, 2010.

We evaluated the quality of care measures by reviewing 50 patients with a diagnosis of DM, 50 patients 50 years of age or older, and 30 patients with a service separation date after September 11, 2001 (without a diagnosis of PTSD), unless fewer patients were available. We reviewed the medical records of these selected patients to determine compliance with first (1st) quarter (Qtr), FY 2010 VHA performance measures.

We conducted an overall review to assess whether the medical center's C&P process complied with VHA Handbook 1100.19. We reviewed CBOC providers' C&P files and nursing staff personnel folders. We conducted EOC inspections at each CBOC, evaluating cleanliness, adherence to clinical standards for infection control and patient safety, and compliance with patient data security requirements. We evaluated whether the CBOCs had a local policy/guideline defining how health emergencies, including MH emergencies, are handled.

A previous OIG review of suicide prevention programs in VHA facilities[6] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in the review were that plans were not comprehensive (did not contain the above elements), not developed timely, or not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings. Therefore, we reviewed the records of 10 patients (unless fewer are available) assessed to be at high risk for suicide to determine if clinicians developed timely safety plans that included all required elements.

We evaluated whether the two CBOC contracts (Smithville and Vine Hill) provided guidelines that the contractor needed to follow in order to address quality of care issues. We also verified that the number of enrollees or visits reported was supported by collaborating documentation.

[6] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009*, Report No. 09-00326-223; September 22, 2009.

Part IV. Results and Recommendations

A. VISN 9, Memphis VAMC – Smithville and Memphis-South

Quality of Care Measures

The Smithville and Memphis-South CBOCs' quality measure scores were comparable to the parent facility for most measures. Both CBOCs met VHA target goals with the exception of Memphis-South that failed to meet the target goal for influenza vaccination, ages 65 or older. (See Appendix F.)

Credentialing and Privileging

We reviewed the C&P files of five providers and the personnel folders for three nurses at the Smithville CBOC and reviewed the files of five providers and four nurses at the Memphis-South CBOC. All providers possess a full, active, current, and unrestricted license. All nurses' licenses and education requirements were verified and documented. However, we identified the following areas that needed improvement:

Scope of Practice

Local criterion requires the chief of the clinical service assign a collaborating physician to monitor and evaluate the clinical activities of the NP. We found inconsistencies in the monitoring of the NP performance at the Smithville CBOC. We reviewed the C&P file and the Quality Profile and did not find evidence that the designated collaborating physician identified in the practitioners' Scopes of Practice[7] consistently monitored the performance.

Clinical Privileges

VHA Handbook 1100.19 requires that clinical privileges be granted based on the needs of the facility. The Professional Standards Board (PSB) granted providers clinical privileges for procedures that were not performed at both CBOCs. For example, all physicians were granted privileges to perform lumber puncture, paracenthesis,[8] and thoracenthesis.[9]

[7] "Scope of Practice" is a term used to describe activities that may be performed by health care workers, regardless of whether they are licensed independent healthcare providers. The scope of practice is specific to the individual and the facility involved.
[8] A procedure to remove fluid that has accumulated in the abdominal cavity (peritoneal fluid), a condition called ascites.
[9] An invasive procedure to remove fluid or air from the pleural space (body cavity that surrounds the lungs) for diagnostic or therapeutic purposes.

Privileging of Contract Providers

VHA Handbook 1100.19 states that clinical privileges granted to contractors may not extend beyond the contract period. Contract providers at the Smithville CBOC were privileged for a 2-year period while the contract was granted for a 1-year period. On April 13, 2010, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) issued a memorandum[10] stating that contract provider privileges can be granted to exceed the contract period, but cannot exceed a 2-year period, if the extension periods are clearly defined in the contract. Since the contract had a 4-year extension option, we made no recommendation.

Recommendation 1. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director requires that practitioners practicing under Scopes of Practice at the Smithville CBOC be monitored in accordance to VHA policy.

The VISN and VAMC Directors concurred with our finding and recommendation. A process and checklist have been created to ensure that practitioners practicing under Scopes of Practice will be monitored. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 2. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director requires that the PSB grant privileges consistent with the services provided at both the Smithville and Memphis-South CBOCs.

The VISN and VAMC Directors concurred with our finding and recommendation. Approved privileges have been changed to include only those privileges that are consistent with the services provided. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment and Emergency Management

Environment of Care

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, infection control, and general maintenance. Both CBOCs met most standards, and the environments were generally clean and safe. However, we identified the following areas that needed improvement:

Infection Control

We found that 3rd Qtr, FY 2009 hand hygiene data for the Smithville and Memphis-South CBOCs were collected; however, data for the 1st, 2nd, and 4th Qtrs of FY 2009 were not

[10] Deputy Under Secretary for Health for Operations and Management, *Privileges On-station Contracted Care* Memorandum, April 13, 2010.

collected. The facility's Infection Control (IC) policy outlines that hand hygiene be monitored and data be reported to the IC coordinator. The Joint Commission (JC), National Patient Safety Goals (NPSG), Center for Disease Control and Prevention (CDC),[11] and/or the World Health Organization (WHO)[12] recommend that healthcare facilities develop a comprehensive IC program with a hand hygiene component, which includes monitors, data analysis, and provider feedback. The intent is to foster a culture of hand hygiene compliance that ensures the control of infectious diseases.

Medical Record

We found the Smithville CBOC utilized a handwritten medical record, in addition to the computerized patient record (CPRS), to document the patients' care. Under further examination, we found the documentation for the visit varied in the clinical impression and medications.

According to VHA Handbook 1907.1:[13]

> VHA by Federal policy must maintain complete, accurate, timely, clinically pertinent, and readily accessible patient records, which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education, and research, facilitate VHA performance improvement processes, as well as fiscal operations and legal requirements.
>
> The record must be standardized with regard to content, creation, maintenance, management, processing, and expected quality measures. Electronic capture and storage of patient health information will be implemented to enhance access to patient data by health care practitioners and other authorized users. Electronically stored and/or printed patient information is subject to the same medical and legal requirements as handwritten information in the health record.

The use of two systems of recording medical care can potentially lead to adverse medical events.

Personally Identifiable Information

According to the Health Insurance Portability and Accountability Act (HIPAA)[14] regulations, control of the environment includes control of confidential patient

[11] CDC is one of the components of the Department of Health and Human Services that is responsible for health promotion; prevention of disease, injury and disability; and preparedness for new health threats.
[12] WHO is the directing and coordinating authority for health within the United Nations System.
[13] VHA Handbook 1907.01, *Health Management and Health Records*, issued August 25, 2006.
[14] The Health Insurance Portability and Accountability Act of 1996 (HIPAA), privacy rule's protection of the privacy of individually identifiable health information.

information. We found at the Smithville CBOC a room with built-in wall-to-wall open shelves that contained active medical records. We also found in an adjacent room six notebooks containing laboratory results dated from 1998 to 2003. The room was not locked and not under the direct oversight of staff. Hard copies of patients' personally identifiable information (PII) should be maintained in a locked desk, cabinet, or container when no security is present.

Recommendation 3. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director requires the IC program include a hand hygiene component at both the Smithville and Memphis-South CBOCs.

The VISN and VAMC Directors concurred with our finding and recommendation. A hand hygiene monitor and plan has been developed. The monthly data will be analyzed and reported on a quarterly basis to the Infection Control Committee and the Clinical Executive Board. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 4. We recommended that the VISN 9 Director ensure that the Memphis VA Medical Center Director requires that medical record documentation at the Smithville CBOC be in compliance with VHA policy.

The VISN and VAMC Directors concurred with our finding and recommendation. The contents of all medical records will be reviewed to ensure compliance with VHA policy. In addition, the Smithville CBOC is working toward elimination of all paper records, and all records will be recorded only in CPRS. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 5. We recommended that the VISN 9 Director ensure that the Memphis VA Medical Center Director requires that all PII is secured and protected at the Smithville CBOC.

The VISN and VAMC Directors concurred with our finding and recommendation. The room with medical records is now secured with a keypad lock. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical emergencies, including MH, are handled. Both CBOCs had policies that outlined management of medical and MH emergencies. Our interviews revealed staff at each facility articulated responses that accurately reflected the local emergency response guidelines.

Suicide Safety Plans

Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.[15]

We reviewed the medical records of two patients (one at Smithville and one at Memphis-South) assessed to be at high risk for suicide. We found no evidence to support that a copy of the safety plan had been provided to either patient. Furthermore, the local policy[16] does not require that the patient receive a copy of the safety plan. However, the DUSHOM requires that a copy of the safety plan be provided to the patient. The sole act of providing a copy of the safety plan does not guarantee that the patient will not engage in a self-injurious act; however, without a copy of the safety plan, adherence to the written arrangements in a time of crisis cannot be assured.

Recommendation 6. We recommended that the VISN 9 Director ensure that the Memphis VA Medical Center Director requires the local safety plan policy at both the Smithville and Memphis-South CBOCs is in compliance with VHA policy.

The VISN and VAMC Directors concurred with our finding and recommendation. The local suicide policy has been updated and is currently going through the approval process to ensure the policy is in compliance with VHA policy. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

CBOC Contract

Smithville

The contract for the Smithville CBOC is administered through the Memphis VAMC for delivery and management of primary and preventative medical care for all eligible veterans in VISN 9. The contract also provides for MH care services for the assessment, diagnosis, and treatment of patients in an individual, group, or telemedicine setting. Contracted services with Access Family Health Services, Inc. (Access) began on October 1, 2008, with option years extending through September 30, 2013. Access operates a private clinic at the same location. The contract terms state that the CBOC will have (1) a Mississippi-licensed physician to serve as medical director and (2) other PCPs to include Physicians Assistants (PAs) and NPs. MH services are to be provided by a physician board certified in psychiatry, licensed psychologist, licensed clinical social

[15] Deputy Under Secretary for Health for Operations and Management, *Patients at High-Risk for Suicide* Memorandum, April 24, 2008.
[16] Memphis VAMC Policy Memorandum, *Management of Patients at Risk for Suicide*, Number 116A-12, January 22, 2009.

worker, or other medical professionals with prior MH experience. There were 3.8 FTE PCPs for the 1st Qtr, FY 2010. The Contractor was compensated by the number of enrollees at a monthly capitated rate per enrollee. The CBOC had 1,299 MH encounters which included individual and telemedicine therapy sessions in FY 2009. The CBOC had 3,240 unique primary medical care enrollees with 12,894 visits as reported on the FY 2009 CBOC Characteristics report (see Table 1).

We reviewed the contract to determine the contract type, the services provided, the invoices submitted, and supporting information. We also performed inquiries of key Memphis VAMC and contractor personnel. Our review focused on documents and records for the 1st Qtr of FY 2010. We reviewed the methodology for tracking and reporting the number of enrollees in compliance with the terms of the contract. We reviewed capitation rates for compliance with the contract; form and substance of the contract invoices for ease of data analysis by the Contracting Officer's Technical Representative (COTR); and duplicate, missing, or incomplete social security numbers (SSNs) on the invoices.

The Primary Care Management Module (PCMM) Coordinator is responsible for maintaining currency of information in the PCMM database. The Memphis VAMC has approximately 40,000 active patients with approximately 3,300 being assigned to the Smithville CBOC. We performed inquiries of the PCMM Coordinator regarding frequency of PCMM updates and compliance with the latest service patch updates. We reviewed PCMM data reported by VHA Support Service Center (VSSC) and the Memphis VAMC and analyzed select data for compliance with VHA policies.

We noted the following regarding contract administration and oversight:

1. Analytical tests performed on the list of patients billed for the months of October, November and December 2009 resulted in identifying three, five, and four duplicate enrollees, respectively. The amount of overpayments attributable to these enrollees is approximately $600 for the period.

2. The COTR's review of Smithville's quarterly performance standards was not completed. The COTR is to quarterly assess contractor compliance with benchmarks, including access to care (appointment scheduling within 30 days), entry of medical data (within 24 hours), and potentially assess penalties for non-compliance. Based upon our review, we noted that one report for the month of July 2009 was completed for calendar year 2009.

3. In inquiries with the PCMM Coordinator, we noted that the Smithville PCMM panels were not being updated at least monthly as required by VHA Handbook 1101.02. Analysis of the list of active patients on the PCMM panel resulted in identifying approximately 165 out of 3,300 patients who had not received services in the prior 24 months and should be removed from the panels.

VHA HANDBOOK 1101.02, (12) Inactivation of Primary Care Patients from a PCMM Panel, specifies the following:

> C(2) - Patients appropriate for removal from a PCMM panel are identified and inactivated at least monthly, although more frequent updating of PCMM is encouraged.
>
> C(1) - "…..PCMM patients that have been assigned to a PC team for 12 months or longer and have not been seen within the last 23 months by a provider (assigned to the PCP or AP [assistant provider] positions assigned to the patient on that team) are to be given scheduled inactivation dates. After 30 days, these patients are inactivated from their Team and Position assignment if they have not been seen…."

Recommendation 7. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director provides contract oversight and enforcement in accordance with the terms and conditions as stated in the contract for the Smithville CBOC and other contract CBOCs. Additionally, the COTR should research the overpayments attributable to duplicate enrollees and seek refunds for those overpayments for Smithville.

The VISN and VAMC Directors concurred with our finding and recommendation. Monthly CBOC invoices are being checked for duplicate enrollees to ensure overpayments are deducted from the invoice total. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 8. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director ensures that the PCMM Coordinator performs in accordance with VHA Handbook 1101.02 to ensure accuracy of the data reported at the Memphis VAMC and to VSSC.

The VISN and VAMC Directors concurred with our finding and recommendation. The PCMM Coordinator will assure identification and inactivation is performed at least monthly for all patients assigned to a PCP. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

B. VISN 9, Mountain Home VAMC – Knoxville and Norton

Quality of Care Measures

The Knoxville and Norton CBOCs equaled or exceeded their parent facility's quality measure scores with the following exceptions: Knoxville CBOC scores were lower in the influenza, ages 50–64, and DM glycosylated hemoglobin molecule (HbgA1c) while the Norton CBOC scored lower in DM foot sensory examinations using monofilament (50 percent), annual retinal exams (74 percent), LDL-C measures, HbgA1c, and renal testing. (See Appendix G.)

The Norton CBOC was a contract facility until February 2009. The CBOC was established as a VA-staffed clinic in March 2009. Senior managers reported that during the time the Norton CBOC was under contract, provider compliance was substandard in performing and documenting DM exams. The quality measure scores have significantly improved since the CBOC became a VA-staffed clinic.

Credentialing and Privileging

We reviewed the C&P files of five providers and the personnel folders of four nurses at the Knoxville CBOC and reviewed the files of three providers and four nurses at the Norton CBOC. All providers possess a full, active, current, and unrestricted license and privileges were appropriate for services rendered. All nurses' licenses and education requirements were verified and documented.

Environment and Emergency Management

Environment of Care

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, infection control, and general maintenance. Both CBOCs met most standards, and the environments were generally clean and safe. However, we identified the following area that needed improvement at the Knoxville CBOC:

Panic Alarms

Staff provided documentation that the panic alarm system was tested monthly and regular maintenance was performed at the Knoxville CBOC. However, at the time of our visit, the panic alarm was not audible and did not illuminate on the panic alarm panel located in the check-in office area. Furthermore, when questioned, a check-in clerk could not articulate how the internal panic alarm system functioned or where the panic alarm panel was located. Staff notification and support would not readily be available in the event of an emergency if staff are unaware of the panic alarm warning.

Recommendation 9. We recommended that the VISN 9 Director ensure that the Mountain Home VAMC Director requires that staff receive education and training related to the panic alarm system at the Knoxville CBOC.

The VISN and VAMC Directors concurred with our finding and recommendation. All staff at the Knoxville CBOC will receive education and training related to the panic alarm system. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical and MH emergencies are handled. Both CBOCs had local policies that outlined the management of medical and MH emergencies. Our interviews revealed clinical staff interviewed at both sites provided responses that were in compliance with their local policy.

Suicide Safety Plans

Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. They should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Safety plans must also include information about how patients can access professional help 24 hours a day, 7 days a week.

We reviewed the medical records of 17 patients (10 at Knoxville and 7 at Norton) assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support the patients and/or their families participated in the development of the plans.

C. VISN 9, Tennessee Valley HCS – Chattanooga and Vine Hill

Quality of Care Measures

Both the Chattanooga and Vine Hill CBOCs' quality measure scores equaled or exceeded the parent facility's scores with the following exceptions. The Chattanooga CBOC scored lower in influenza, both age groups; DM foot inspection; and PTSD screening with timely suicide ideation evaluation. The Vine Hill CBOC scored lower in the influenza, both age groups; and DM foot sensory exam using monofilament (37 percent) and retinal eye exam., and PTSD screening. (See Appendix H.)

Vine Hill management acknowledged previous problems meeting target indicators and past attempts to implement processes to increase physician compliance. During the exit interview, Tennessee Valley HCS management reported that all Vine Hill patients would be transitioned back to the parent facility for future care.

Credentialing and Privileging

We reviewed the C&P files of five providers and four nurses at the Chattanooga CBOC and three providers at the Vine Hill CBOC. There were no nurses on staff at the Vine Hill CBOC. All providers possess a full, active, current, and unrestricted license and privileges were appropriate for services rendered. All nurses' licenses and education requirements were verified and documented.

Environment and Emergency Management

Environment of Care

From July 2009 through February 2010, the VA patients seen at the Vine Hill CBOC were transitioned to the Parthenon Tower Clinic, also a satellite clinic of the University Community Health Services (UCHS), a former affiliate of the Contractor. Since VA patients were not seen at the Vine Hill Clinic at the time of our visit, we conducted a physical inspection of the Parthenon Tower Clinic. For the purpose of this report, we will refer to the Parthenon Tower Clinic as Vine Hill CBOC.

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, infection control, and general maintenance. Both clinics met most standards, and the environments were generally clean and safe. However, we found the following areas that needed improvement:

Auditory Privacy

Auditory privacy was inadequate for patients during the check-in process at the Chattanooga and Vine Hill CBOCs. There was no zone of audible privacy for patients at the check-in window; therefore, other patients waiting to check in for their appointment

could overhear confidential information provided to the check-in clerk. VHA policy[17] requires auditory privacy when individuals' identifiable health information is discussed.

Vulnerability Risk Assessment

Neither CBOC provided evidence of a vulnerability risk assessment (workplace analysis) as required per Occupational Safety and Health Administration (OSHA)[18] guidelines. MH services are provided at both CBOCs. The staff at both CBOCs indicated that if they felt threatened and needed assistance, they would call out for help or dial 911. The Chattanooga CBOC had some panic alarms in the clinics; however, the panic alarms were not strategically located where MH patients were triaged or treated. A vulnerability risk assessment addresses the steps (if any) the clinic should have in place based on the clinic's location and patient population.

Patient Safety

We found corded window blinds in the triage area at the Chattanooga CBOC and in the exam rooms and the MH office at the Vine Hill CBOC. The cords could potentially be used by patients to cause harm to self or others. The JC[19] requires organizations to identify and manage safety risks. Risks associated with the physical environment include those that might contribute to suicide or acts of violence.

Fire Drills and Inspections

We found no documentation of safety and fire inspections at the Vine Hill CBOC. National Fire Protection Association (NFPA)[20] requires outpatient clinics to conduct fire drills at least once a year. Management acknowledged they had not conducted the required fire drills or inspections. Without documented evidence of fire drills/strategies, management is not able to determine whether staff is competent to carry out fire emergencies.

Patient Identifiers

Staff at the Vine Hill CBOC could not articulate the use of two identifiers for patient identification in the blood drawing process. The NPSG requires staff to use two patient identifiers when drawing blood. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual.

[17] VHA Handbook 1605.1, *Privacy and Release of Information*, May 17, 2006.
[18] OSHA is a federal agency responsible to assure safe and healthful working conditions for working men and women.
[19] The JC Standard EC.02.01.01.
[20] NFPA 101 Life Safety Code 2006 6.1.11.1, A.6.1.11.1.

Hand Hygiene

We found no evidence that the Vine Hill CBOC was monitoring hand hygiene. The CDC recommends that healthcare facilities develop a comprehensive IC program with a hand hygiene component, which includes monitors, data analysis, and provider feedback. The parent facility's IC program did not include the Vine Hill CBOC as one of the locations reported in their reports.

Cleanliness

At the Vine Hill CBOC there were two exam rooms and a MH office that were generally well maintained; however, both exam rooms had cracked floors and ceiling tiles. A Tennessee Valley HCS engineer noted stained and broken ceiling tiles and a ceiling penetration around a smoke detector in the hallway leading to an exam room (memorandum dated March 11, 2010). We saw no evidence during our onsite visit that these deficiencies were being addressed.

Recommendation 10. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires auditory privacy be maintained during the check-in process at the Chattanooga and Vine Hill CBOCs.

The VISN and VAMC Directors concurred with our finding and recommendation. A plan has been implemented in an effort to establish an auditory privacy zone during the check-in process. In addition, construction projects are under review to improve the check-in privacy for patients. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires the Chattanooga and Vine Hill CBOCs perform a vulnerability risk assessment to address potential workplace risks.

The VISN and VAMC Directors concurred with our finding and recommendation. A workplace vulnerability assessment is planned to address the potential risks associated with the treatment of MH patients. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires that all patient care areas meet safety criteria at the Chattanooga and Vine Hill CBOCs.

The VISN and VAMC Directors concurred with our finding and recommendation. A MH EOC assessment will be conducted to identify and mitigate any potential physical safety threats to patients and staff. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 13. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires the Vine Hill CBOC conduct annual fire safety drills and inspections.

The VISN and VAMC Directors concurred with our finding and recommendation. The building owner completed the annual fire safety drills and inspections in April 2010. A copy of these records will be maintained by the CBOC supervisor. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 14. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires the use of two patient identifiers in the blood drawing process at the Vine Hill CBOC.

The VISN and VAMC Directors concurred with our finding and recommendation. The Patient Safety Officer will provide the CBOC staff with education concerning the use of two patient identifiers and also ensure the staff understands the NPSG. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 15. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires the IC program include a hand hygiene component at the Vine Hill CBOC.

The VISN and VAMC Directors concurred with our finding and recommendation. The appropriate IC education and monitoring tools will be provided to the staff at the Vine Hill CBOC. The CBOC will be required to report hand hygiene performance to the IC Committee. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 16. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires that the Contractor inspect the Vine Hill CBOC on a regular basis for cleanliness and perform needed repairs.

The VISN and VAMC Directors concurred with our finding and recommendation. Quarterly EOC building inspections will be conducted at the Vine Hill CBOC. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Management

The Vine Hill CBOC did not have a local policy or SOP defining how medical and MH emergencies are handled as required by VHA Handbook 1006.1. The SOP should describe the procedures the CBOC staff take in case of medical emergencies (cardiac arrest, severe hypoglycemic events, etc.) and what events/conditions would promote staff

to activate 911. The SOP should also address management of patients who present suicidal or with disruptive and/or violent behavior.

Recommendation 17. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires that Vine Hill CBOC managers develop a local policy or SOP that reflects the current practice and capability for handling medical and MH emergencies.

The VISN and VAMC Directors concurred with our finding and recommendation. CBOC management will develop an SOP to reflect the CBOC staff's capability and process for managing medical and MH emergencies. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Suicide Safety Plans

Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. Safety plans should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Additionally, safety plans must include information about how patients can access professional help 24 hours a day, 7 days a week.

We reviewed the medical records of three patients from the Chattanooga CBOC assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all required elements. We also found evidence to support that the patients and/or their families participated in the development of the plans.

CBOC Contract

Vine Hill CBOC

The contract for the Vine Hill CBOC is administered through the Tennessee Valley HCS for delivery and management of primary and preventative medical care for all eligible veterans in VISN 9. Contracted services with Vanderbilt University School of Nursing (Vanderbilt) began August 1, 2006, for one base year plus one option year to extend the contract through July 31, 2008. Vanderbilt University School of Nursing was awarded a sole source contract under the provisions of the U.S. Code[21] or affiliated universities. The contract terms state that the CBOC will have (1) a physician that is licensed in Tennessee and board certified in Internal Medicine or Family Practice and (2) other PCPs to include PAs and NPs. There were 0.40 FTE PCPs for the 1st Qtr of FY 2010. The contractor was compensated by the number of enrollees at a monthly capitated rate per enrollee. The CBOC had 686 unique primary medical care enrollees with 1,551 visits as reported on the FY 2009 CBOC Characteristics report (see Table 1).

[21] 38 U.S.C. Section 8153, *Sharing of Health-care Resources.*

We reviewed the contract to determine the contract type, the services provided, the invoices submitted, and supporting information. We also performed inquiries of key personnel of Tennessee Valley HCS and UCHS. Our review focused on documents and records for the 1st Qtr of FY 2010. We reviewed the methodology for tracking and reporting the number of enrollees in compliance with the terms of the contract. We reviewed capitation rates for compliance with the contract; form and substance of the contract invoices for ease of data analysis by the COTR; and duplicate, missing, or incomplete SSNs on the invoices.

MH services were added to the statement of work at the Vine Hill Clinic; however, these services were never utilized by the veterans.

The PCMM Coordinator is responsible for maintaining currency of information in the PCMM database. Tennessee Valley HCS has 56,815 active patients with 825 being assigned to the Vine Hill clinic. We performed inquiries of the PCMM Coordinator regarding frequency of PCMM updates and compliance with the latest service patch updates. We reviewed PCMM data reported by VSSC and Tennessee Valley HCS and analyzed select data for compliance with VHA policies.

We noted the following regarding contract administration and oversight:

1. Vanderbilt was awarded a sole source contract as an affiliate university. In December 2006, UCHS filed an amendment to its corporate charter to sever its ties to Vanderbilt, effectively negating the contract with Tennessee Valley HCS. Since this contract was established between Tennessee Valley HCS and Vanderbilt with UCHS providing services, Vanderbilt had a responsibility to notify Tennessee Valley HCS of this change. However, Tennessee Valley HCS was not notified until March 2009. Upon notification, an amendment was processed crossing out Vanderbilt and replacing it with UCHS. When the contract was no longer with Vanderbilt University, the contract should have been resubmitted for competition.

2. The contractor in this agreement was Vanderbilt University School of Nursing, but payments for primary care services under this contract were made payable to the Vine Hill Community Clinic.

3. The contract contains a provision that states “the total duration of this contract, including the exercise of any options under this clause, shall not exceed 24 months”. The effective date of the contract was August 1, 2006. Therefore the contract should have ended on July 31, 2008. It was improper for the extension of the contract to July 31, 2010, which made the total duration of the contract 48 months.

4. Tennessee Valley HCS was not monitoring the length of time that passed between visits in accordance with the contract provision that requires the contractor to provide at least one detailed medical evaluation every 12 months. Tennessee Valley HCS

discovered this error in January 2010 during a detailed review of the December 2009 invoice, which resulted in the removal of 332 patients from the invoice and an adjustment in the amount of $5,146. Tennessee Valley HCS is in the process of calculating the overpayments for prior periods and has changed its process to monitor enrollees based on the length of time that has passed between visits.

5. The capitated rate was not reported on the monthly invoice, contrary to the contract requirements which require a description, quantity, unit of measure, unit price, and extended price of the items delivered.

6. The PCMM coordinator does not currently have a process in place to ensure that patients are assigned to only one PCP within the VA system. Patients are removed for dual enrollment purposes when the PCMM Coordinator receives notification from another facility that a patient has been seen at that facility. However, Tennessee Valley HCS also has a responsibility to determine if a patient is already assigned to another facility. On March 22, 2010, PCMM showed that more than 400 patients were assigned to more than one provider under Tennessee Valley HCS. VHA Handbook 1101.02, 11 Patient Assignment in PCMM, (b) 3 states: "…when assigning a new patient in PCMM, it must first be determined if a patient is already assigned in primary care (PC) at another facility. If the patient is enrolled in PC at another site of care, the decision whether to also assign the patient at the current site of care is made by the PC clinical leader, or designee."

Recommendation 18. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director re-compete the contract if they plan to continue to offer contracted primary care services in that area.

The VISN and VAMC Directors concurred with our finding and recommendation. The leadership at the Tennessee Valley HCS is evaluating the potential to reassign the CBOC patient population to one of the area VA clinics that is approximately 2.5 miles from the Vine Hill site. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 19. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director draft a new contract with UCHS to ensure compliance with terms during the re-compete process so as not to disrupt care to veterans. The duration of this contract should be no longer than appropriate for the re-compete process and less than one year.

The VISN and VAMC Directors concurred with our finding and recommendation. The Tennessee Valley HCS leadership acknowledges that any new CBOC contract arrangement will be competitive and not sole source. Due to veteran enrollee population densities, any new competitive contract may have the location moved to a more outlying county area that will be more convenient to dense Veteran population areas. The

improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 20. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director provides contract oversight and enforcement in accordance with the terms and conditions as stated in the contract, specifically that a medical evaluation is performed at least once in 12 months and that Tennessee Valley HCS takes steps to recover overpayments on invoices prior to December 2009.

The VISN and VAMC Directors concurred with our finding and recommendation. The Tennessee Valley HCS will review invoices and patient lists to ensure a medical evaluation is performed at least annually. In addition, the facility will continue to review invoices prior to December 2009 for inaccuracies and overpayments. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 21. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director ensure that the PCMM Coordinator complies with the guidance in accordance with VHA Handbook 1101.02, specifically that steps are taken to reduce the number of patients assigned to more than one PCP.

The VISN and VAMC Directors concurred with our finding and recommendation. The Tennessee Valley HCS will expand their efforts to monitor PCMM panels. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Appendix A

VISN 9 Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 19, 2010

From: Director, Veterans Integrated Service Network 9 (10N9)

Subject: **Healthcare Inspection – CBOC Reviews: Smithville, MS and Memphis (Memphis-South), TN; Knoxville, TN and Norton, VA; and Chattanooga and Nashville (Vine Hill), TN**

To: Director, CBOC/Vet Center Program Review, Office of Healthcare Inspections (54F)

1. Attached are the comments from the Memphis VAMC, Mountain Home VAMC, and Tennessee Valley HCS-Nashville on the OIG Draft Report: Healthcare Inspection of Community Based Outpatient Clinic Reviews: Smithville, MS and Memphis (Memphis-South), TN; Knoxville, TN and Norton, VA; and Chattanooga and Nashville (Vine Hill), TN.

2. Questions may be referred to Vincent Alvarez, MD, Chief Medical Officer or Pamela R. Kelly Staff Assistant to Network at 615-695-2200.

(original signed by:)
John Dandridge, Jr.
Network Director

Memphis VAMC Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 18, 2010

From: Director, Memphis VA Medical Center (614/00)

Subject: **Healthcare Inspection – CBOC Reviews: Smithville, MS and Memphis (Memphis-South), TN**

To: Director, Veterans Integrated Service Network 9 (10N9)

1. Attached are the Memphis VA Medical Center comments on the OIG Draft Report: Healthcare Inspection of Community Based Outpatient Clinic Reviews: Smithville, MS and Memphis (Memphis-South), TN.

2. Questions may be referred to Donna J. Savoy at 901-577-7545.

(original signed by:)

JAMES L. ROBINSON, III, Psy.D
Medical Center Director

Memphis VAMC Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director requires that practitioners practicing under Scopes of Practice at the Smithville CBOC be monitored in accordance to VHA policy.

Concur **Target Completion Date: July 28, 2010**

Midlevel practitioners at the VA Memphis have a Primary and Secondary collaborating physician sign their scopes of practice. The scope of practice requires 3 formalized chart reviews per month to be performed by the collaborating Physician and reviewed with the midlevel practitioner in order to provide feedback. A checklist has been created to standardize the process for each reviewed chart. The checklist is placed in the practitioner performance file. Additionally, the collaborating physicians are available for consultation on a case by case basis as needed during clinic hours.

By July 28, 2010, the Leadership at Smithville CBOC will be reeducated on the policy by the Chief of Primary Care Service or designee, and enforcement will be guaranteed by regular status checks by the COTR or designee, during routine Environment of Care inspections.

Recommendation 2. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director requires that the PSB grant privileges consistent with the services provided at both the Smithville and Memphis-South CBOCs.

Concur **Target Completion Date: Complete**

A new, specific Privilege request form for CBOCs has been developed, and the identified privileges have been removed. This form will be officially approved by the Clinical Privileges Committee on May 27, 2010, and by the Clinical Executive Board on May 28, 2010.

Recommendation 3. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director requires the IC program include a hand hygiene component at both the Smithville and Memphis-South CBOCs.

Concur **Target Completion Date: Complete**

The Medical Center Infection Control Nurse developed a Hand Hygiene Monitor and Plan on March 17, 2010, which required the CBOCs to provide the hand washing data to be faxed to the Infection Control Officer each month.

The Infection Control Nurse provided education on the new process to CBOC Directors and Nursing Supervisors by March 31, 2010.

The Infection Control Officer conducts an analysis of the monthly data from both Smithville CBOC and Memphis-South CBOC, with a goal of greater than 60% compliance. The data will be reported to the Infection Control Committee and the Clinical Executive Board quarterly. The first report was to the Infection Control Committee on May 18th, 2010.

Recommendation 4. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director requires that medical record documentation at the Smithville CBOC be in compliance with VHA policy.

Concur **Target Completion Date: December 30, 2010**

The Privacy Officer and Health Information Manager will conduct a site visit at the Smithville CBOC to review the content of the handwritten medical record documents and all Medical Records for compliance with VHA policy. Removal of all handwritten documents will be enhanced by the installation of a Contingency Computer as a source of medical records when the CPRS system is not in operation.

A focused review will be performed to compare CPRS information with the handwritten documents to evaluate and document the differences. Results will be sent to Smithville CBOC, along with a list of requirements for changes to ensure compliance with VHA policy. Smithville CBOC has already started working toward elimination of all paper records. All Veteran records will be recorded in CPRS only.

Recommendation 5. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director requires that all PII is secured and protected at the Smithville CBOC.

Concur **Target Completion Date: July 1, 2010**

The room where the medical records are contained has physical security maintained via a Keypad Lock on both external doors to that area. To ensure that all staff understands the requirement of keeping the area secure and inaccessible to unauthorized persons, a Smithville clinical team meeting will be held on July 1, 2010. All staff signed a statement validating understanding of maintaining security at all times.

The six notebooks containing laboratory results were duplicates of data entered in CPRS and at the time of the inspection were being stored. At this time, all of the data from the six notebooks have been properly shredded, since the results were all already entered into CPRS. Point of care lab testing is no longer performed at the Smithville CBOC. As of March 29, 2010 all lab work is sent by courier to the Memphis VA for testing and direct entry into CPRS.

The Privacy Officer, Information Security Officer, and Health Information Manager will make a site visit to the Smithville CBOC by July 1, 2010 to ensure that all changes have occurred.

Recommendation 6. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director requires the local safety plan policy at the Smithville and Memphis-South CBOC is in compliance with VHA policy.

Concur **Target Completion Date: July 1, 2010**

The VA Medical Center Suicide Policy was updated in April 2010 and is currently going through the chain of command for approval to implement the changes. The Safety Plan CPRS Template was updated to document that the Veteran was given a copy of the Safety Plan and also that the Safety Plan was discussed with family members if appropriate. The Provider will document in CPRS that they have given the Veteran a copy of the Safety Plan and that the Safety Plan was reviewed with the Veteran patient. If appropriate, the safety plan can also be reviewed with the significant other or family member(s). The safety plan has the National Suicide Hotline number on it, so Veterans can access care 24 hours per day,

7 days per week. The Veterans are also informed that they can come into the VA Emergency Room.

Recommendation7. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director provides contract oversight and enforcement in accordance with the terms and conditions as stated in the contract for the Smithville CBOC and other contract CBOCs. Additionally, the COTR should research the overpayments attributable to duplicate enrollees and seek refunds for those overpayments for Smithville.

Concur **Target Completion Date: August 1, 2010**

The contract is regularly reviewed to ensure the Smithville CBOC provides appropriate care to our Veteran patients. While data is being collected for the Quality Assurance Surveillance Plan, the process of deducting a percentage of the monthly payment to the CBOC for failure to achieve Quality Performance Goals has not been implemented. Deductions will start with the June 2010 invoice for Smithville CBOC.

Monthly CBOC invoices are being checked for duplicate names as well as for deceased patients with all appropriate names being placed on the "not seen within 1 year" spreadsheet to ensure payment is deducted from the invoice total.

Duplicate names on the October, November, December 2009 Smithville CBOC will be identified by Fee Basis staff and sent to Patient Accounts to seek refund for the overpayments.

Recommendation 8. We recommended that the VISN 9 Director ensure that the Memphis VAMC Director ensures that the PCMM Coordinator performs in accordance with VHA Handbook 1101.02 to ensure accuracy of the data reported at the Memphis VAMC and to VSSC.

Concur **Target Completion Date: May 31, 2010**

Two additional Business Office staff have been allocated to consistently assist with panel management. These staff members, along with the PCMM Coordinator will assure identification and inactivation is performed at least monthly for all patients assigned to a primary care provider. Training for these staff members began May 17, 2010 and is ongoing. As it relates to Smithville Clinic, where 165 out of 3300 patients had not received care within the last 23 months, scrubbing of these patients will be completed by May 31, 2010.

Appendix C

Mountain Home VAMC Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 18, 2010

From: Director, Mountain Home VA Medical Center (621/00)

Subject: **Healthcare Inspection – CBOC Reviews: Knoxville, TN and Norton, VA**

To: Director, Veterans Integrated Service Network 9 (10N9)

1. Attached are the Mountain Home VA Medical Center comments on the OIG Draft Report: Healthcare Inspection of Community Based Outpatient Clinic Reviews: Knoxville, TN and Norton, VA.

2. Questions may be referred to Lora Hagen, Chief, Quality Management at (423) 979-3617.

(original signed by:)

Charlene Ehret
Medical Center Director

Mountain Home VAMC Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 9. We recommended that the VISN 9 Director ensure that the Mountain Home VAMC Director requires that staff receive education and training related to the panic alarm system at the Knoxville CBOC.

Concur **Target Completion Date: July 1, 2010**

All staff at the Knoxville CBOC will receive re-education and training related to the panic alarm system.

Appendix D

Tennessee Valley HCS-Nashville Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 18, 2010

From: Director, Tennessee Valley Healthcare System-Nashville (626/00)

Subject: **Healthcare Inspection – CBOC Review: Chattanooga and Nashville (Vine Hill), TN**

To: Director, Veterans Integrated Service Network 9 (10N9)

1. Attached are the Tennessee Valley Healthcare System Nashville comments on the OIG Draft Report: Healthcare Inspection of Community Based Outpatient Clinic Reviews: Chattanooga and Nashville (Vine Hill), TN.

2. Questions may be referred to Bob Davenport at 615-873-6065.

(original signed by:)

Juan A. Morales, RN, MSN
Health Systems Director

Tennessee Valley HCS-Nashville Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 10. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires auditory privacy be maintained during the check-in process at the Chattanooga and Vine Hill CBOCs.

Concur **Target Completion Date: June 30, 2010**

In effort to establish a zone of auditory privacy, the Vine Hill Clinic has asked patients to wait out in the lobby area, and one patient at a time enters the check in area. Chattanooga has a waiting area and has asked patients to maintain a 15 ft. distance from the check in counter with one client at a time. Construction projects are under review by engineering service to provide better privacy for patients during check in process at both facilities. This review will be completed by June 30, 2010.

Recommendation 11. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires the Chattanooga and Vine Hill CBOCs perform a vulnerability risk assessment to address potential workplace risks.

Concur **Target Completion Date: June 30, 2010**

A Hazard Vulnerability Assessment (HVA) is completed annually for both Davidson County and Hamilton County by the TVHS Emergency Preparedness Committee with help from external agencies. The last assessment was completed February 2010. Hamilton County (Chattanooga CBOC) also utilizes outside resources for this assessment using the Hamilton County Tennessee Emergency Management Agency (TEMA). A workplace vulnerability assessment (Mental Health Environment of Care Assessment) is planned to address the potential risks associated with the treatment of mental health patients**.**

Recommendation 12. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires that all patient care areas meet safety criteria at the Chattanooga and Vine Hill CBOCs.

Concur **Target Completion Date: June 30, 2010**

A Mental Health Environment of Care Assessment is scheduled to be conducted by TVHS Engineering Services, Patient Safety, and Mental Health Services. This assessment will identify and mitigate any potential safety threat to patients and staff posed by physical environment hazards.

Recommendation 13. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires the Vine Hill CBOC conduct annual fire safety drills and inspections.

Concur **Target Completion Date: June 15, 2010**

Annual fire safety drills and inspections are completed by the building owner, Parthenon Towers and were completed in April 2010. Records of these inspections are on file in the office at Parthenon Towers. A copy of these records will be maintained by the supervisor of the clinic for review and compliance monitoring.

Recommendation 14. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires the use of two patient identifiers in the blood drawing process at the Vine Hill CBOC.

Concur **Target Completion Date: June 30, 2010**

The Patient Safety Office will visit the Vine Hill clinic and provide the staff with education regarding *MCM 626-08-11-20 Patient Identification Policy* and its relationship to the National Patient Safety Goal requiring the use of two patient identifiers. Patient Safety specialist from the Nashville campus will be part of the May 19, 2010 Environmental Inspection Team inspection of the clinic. The specialist will provide education to the clinic staff regarding this issue and will ensure that the clinic staff has the appropriate NPSG information and reminders issued to them.

Recommendation 15. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires the IC program include a hand hygiene component at the Vine Hill CBOC.

Concur **Target Completion Date: June 30, 2010**

TVHS Infection Control program will provide the Vine Hill CBOC with the appropriate education and monitoring tools. TVHS leadership will require quarterly reporting of hand hygiene performance to its Infection Control Committee.

Recommendation 16. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires that the Contractor inspect the Vine Hill CBOC on a regular basis for cleanliness and perform needed repairs.

Concur **Target Completion Date: June 30, 2010**

TVHS Engineering Services will coordinate with the Vine Hill Clinic for quarterly Environment of Care (EOC) building inspections.

Recommendation 17. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director requires that Vine Hill CBOC managers develop a local policy or SOP that reflects the current practice and capability for handling medical and MH emergencies.

Concur **Target Completion Date: May 28, 2010**

TVHS Nursing Service will assist Vine Hill management staff to develop a standard operating procedure (SOP) that reflects their capability and process for managing medical and psychiatric emergencies.

Recommendation 18. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director re-compete the contract if they plan to continue to offer contracted primary care services in that area.

Concur **Target Completion Date: June 30, 2010**

TVHS leadership is evaluating the potential to reassign this patient population to one of the area VA clinics that is approximately 2.5 miles from the Vine Hill site. The small number of enrollees could easily and more efficiently be managed by one of the recently established comprehensive primary and specialty care areas**.**

Recommendation 19. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director draft a new contract with UCHS to ensure compliance with terms during the re-compete process so as not to disrupt care to veterans. The duration of this contract should be no longer than appropriate for the re-compete process and less than one year.

Concur **Target Completion Date: June 30, 2010**

In addition to the service evaluation noted above, to transfer Veterans to nearby VA clinics, TVHS leadership acknowledges that any new CBOC contract arrangement will be competitive and not sole source. Due to veteran enrollee population densities, any new competitive contract may have the location moved to a more outlying county area, but more convenient to dense Veteran population areas.

Recommendation 20. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director provides contract oversight and enforcement in accordance with the terms and conditions as stated in the contract, specifically that a medical evaluation is performed at least once in 12 months and that Tennessee Valley HCS takes steps to recover overpayments on invoices prior to December 2009.

Concur **Target Completion Date: July 30, 2010**

The Business Office Program Assistant (PA) will review invoices and Patient Lists provided by Administrative Officer (AO), Primary Care to ensure that a Level 3 exam is performed at least annually. For those who do not meet the contract requirement, no payment will be processed. This process has already begun. The Business Office (PA) and AO (Primary Care) will continue to review invoices prior to December 2009 for inaccuracies and overpayments. Charge backs and bill collection will be processed for any overpayments.

Recommendation 21. We recommended that the VISN 9 Director ensure that the Tennessee Valley HCS Director ensure that the PCMM Coordinator complies with the guidance in accordance with VHA

Handbook 1101.02, specifically that steps are taken to reduce the number of patients assigned to more than one PCP.

Concur **Target Completion Date: June 30, 2010**

This has been an ongoing process and a basic function of the PCMM program. TVHS will expand efforts to include assistance from PSA of clinical sections. This will give additional capacity for cleanup and monitoring PCMM panels.

Appendix E

CBOC Characteristics

CBOC Station Number	CBOC Name	Parent VA	Specialty Care	Cardiology	Dental	Orthopedics	Optometry	Audiology
614GA	Smithville, MS	Memphis, TN	No	No	No	No	No	No
614GF	Memphis-South, Memphis, TN	Memphis, TN	No	No	No	No	No	No
621BY	Knoxville, TN	Mountain Home, TN	Yes	No	No	No	Yes	Yes
621GC	Norton, VA	Mountain Home, TN	No	No	No	No	No	No
626GF	Chattanooga, TN	Tennessee Valley HCS	Yes	Yes	Yes	Yes	No	No
626GI	Vine Hill, Nashville, TN	Tennessee Valley HCS	No	No	No	No	No	No

Specialty Care Services

CBOC Station Number	CBOC Name	Parent VA	Laboratory (draw blood)	Radiology	Onsite Pharmacy	EKG
614GA	Smithville, MS	Memphis, TN	Yes	No	No	Yes
614GF	Memphis-South, Memphis, TN	Memphis, TN	Yes	No	No	Yes
621BY	Knoxville, TN	Mountain Home, TN	Yes	Yes	No	Yes
621GC	Norton, VA	Mountain Home, TN	Yes	No	No	No
626GF	Chattanooga, TN	Tennessee Valley HCS	Yes	Yes	No	Yes
626GI	Vine Hill, Nashville, TN	Tennessee Valley HCS	Yes	No	No	Yes

Onsite Ancillary Services

CBOC Station Number	CBOC Name	Internal Medicine Physician	Primary Care Physician	Nurse Practitioner	Physician Assistant	Psychiatrist	Psychologist	Licensed Clinical Social Worker	Others
614GA	Smithville, MS	No	Yes	Yes	No	Yes	No	Yes	No
614GF	Memphis-South, Memphis, TN	Yes	No	Yes	No	Yes	Yes	No	Yes
621BY	Knoxville, TN	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
621GC	Norton, VA	Yes	Yes	Yes	No	No	No	No	No
626GF	Chattanooga, TN	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
626GI	Vine Hill, Nashville, TN	Yes	No	Yes	No	No	No	No	No

Providers Assigned to the CBOC

CBOC Station Number	CBOC Name	Parent VAs	Mental Health Care Services	Primary Care Physicians	Psychologist	Psychiatrist	Nurse Practitioner	Licensed Clinical Social Worker	Addiction Counselor
614GA	Smithville, MS	Memphis, TN	Yes	Yes	No	Yes	Yes	Yes	No
614GF	Memphis-South, Memphis, TN	Memphis, TN	Yes	Yes	Yes	Yes	Yes	Yes	Yes
621BY	Knoxville, TN	Mountain Home, TN	Yes	Yes	Yes	Yes	Yes	Yes	No
621GC	Norton, VA	Mountain Home, TN	Yes	Yes	No	No	Yes	No	No
626GF	Chattanooga, TN	Tennessee Valley HCS	Yes	No	Yes	Yes	Yes	Yes	Yes
626GI	Vine Hill, Nashville, TN	Tennessee Valley HCS	Yes	No	No	No	Yes	No	No

Mental Health Clinicians

CBOC Station Number	CBOC Name	Parent VA	Miles to Parent Facility
614GA	Smithville, MS	Memphis, TN	125
614GF	Memphis-South, Memphis, TN	Memphis, TN	8
621BY	Knoxville, TN	Mountain Home, TN	118
621GC	Norton, VA	Mountain Home, TN	70
626GF	Chattanooga, TN	Tennessee Valley HCS	125
626GI	Vine Hill, Nashville, TN	Tennessee Valley HCS	3

Miles to Parent Facility

Quality of Care Measures
Memphis VAMC[22] – Smithville and Memphis-South Clinic

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 50-64	**66**	**National**	**4,843**	**6,973**	**69**
	66	614 Memphis	39	54	**72**
		614GA Smithville	14	14	**100**
		614GF Memphis-South	22	33	**67**

Influenza Vaccination, 50-64 Years of Age, 4th Qtr, FY 2009

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 65 or older	**83**	**National**	**5,460**	**6,499**	**84**
	83	614 Memphis	33	39	**85**
		614GA Smithville	25	29	**86**
		614GF Memphis-South	12	15	**80**

Influenza Vaccination, Age 65 or Older, 4th Qtr, FY 2009

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Outpatient Foot Inspection	**National**	**4,321**	**4,651**	**93**
	614 Memphis	58	59	**99**
	614GA Smithville	44	48	**92**
	614GF Memphis-South	48	49	**96**

DM Foot Inspection, FY 2010

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr1 Percentage*
DM - Outpatient - Foot Pedal Pulses	**National**	**4,208**	**4,651**	**90**
	614 Memphis	58	59	**99**
	614GA Smithville	44	48	**100**
	614GF Memphis-South	48	49	**96**

Foot Pedal Pulse, FY 2010

[22] http://vaww.pdw.med.va.gov/MeasureMaster/MMReport.asp Note: Scores are weighted. The purpose of weighting is to correct for the over-representation of cases from small sites and the under-representation of cases from large sites. It corrects for the unequal number of available cases within each organizational level (i.e., CBOC, facility) and protects against the calculation of biased or inaccurate scores. Weighting can alter the raw measure score (numerator/denominator) in different ways, particularly measures with small "N"(s). Raw scores can go up or down depending on which cases pass or fail a measure. Sometimes the adjustment can be quite significant.

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – Outpatient Foot Sensory Exam Using Monofilament	**National**	**4,126**	**4,630**	**89**
	614 Memphis	58	59	**99**
	614GA Smithville	44	48	**92**
	614GF Memphis-South	47	49	**94**

Foot Sensory, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – Retinal Eye Exam	**70**	**National**	**3,181**	**3,510**	**91**
	70	614 Memphis	44	47	**99**
		614GA Smithville	44	48	**92**
		614GF Memphis-South	46	49	**92**

Retinal Exam, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – LDL-C	**88**	**National**	**3,413**	**3,511**	**97**
	88	614 Memphis	46	47	**100**
		614GA Smithville	47	48	**98**
		614GF Memphis-South	48	49	**98**

Lipid Profile, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – HbgA1c	**93**	**National**	**3,452**	**3,512**	**98**
	93	614 Memphis	46	47	**100**
		614GA Smithville	48	48	**100**
		614GF Memphis-South	49	49	**100**

HbgA1c Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Renal Testing	**88**	**National**	**3,371**	**3,512**	**95**
	88	614 Memphis	46	47	**100**
		614GA Smithville	48	48	**100**
		614GF Memphis-South	45	49	**92**

Renal Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
Patient Screen with PC-PTSD	**95**	**National**	**9,761**	**10,006**	**98**
	95	614 Memphis	70	76	**97**
		614GA Smithville	14	14	**100**
		614GF Memphis-South	14	14	**100**

PTSD Screening, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
***Patient Screen with PC-PTSD with* timely Suicide Ideation/Behavior Evaluation**	**75**	**National**	**239**	**379**	**64**
	75	614 Memphis	4	6	**86**
		614GA Smithville	2	2	**100**
		614GF Memphis-South	3	3	**100**

PTSD Screening with Timely Suicide Ideation/Behavior Evaluation, FY 2010

Quality of Care Measures
Mountain Home VAMC[23] – Knoxville and Norton

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 50-64	**66**	**National**	**4,843**	**6,973**	**69**
	66	621 Mountain Home	35	52	**67**
		621BY Knoxville	12	19	**63**
		621GC Norton	20	23	**87**

Influenza Vaccination, 50-64 Years of Age, 4th Qtr, FY 2009

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 65 or older	**83**	**National**	**5,460**	**6,499**	**84**
	83	621 Mountain Home	39	45	**87**
		621BY Knoxville	27	30	**90**
		621GC Norton	24	24	**100**

Influenza Vaccination, Age 65 or Older, 4th Qtr, FY 2009

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Outpatient Foot Inspection	**National**	**4,321**	**4,651**	**93**
	621 Mountain Home	22	27	**78**
	621BY Knoxville	48	50	**96**
	621GC Norton	49	50	**98**

DM Foot Inspection, FY 2010

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr1 Percentage*
DM - Outpatient - Foot Pedal Pulses	**National**	**4,208**	**4,651**	**90**
	621 Mountain Home	22	27	**78**
	621BY Knoxville	44	50	**88**
	621GC Norton	49	50	**98**

Foot Pedal Pulse, FY 2010

[23] http://vaww.pdw.med.va.gov/MeasureMaster/MMReport.asp Note: Scores are weighted. The purpose of weighting is to correct for the over-representation of cases from small sites and the under-representation of cases from large sites. It corrects for the unequal number of available cases within each organizational level (i.e., CBOC, facility) and protects against the calculation of biased or inaccurate scores. Weighting can alter the raw measure score (numerator/denominator) in different ways, particularly measures with small "N"(s). Raw scores can go up or down depending on which cases pass or fail a measure. Sometimes the adjustment can be quite significant.

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – Outpatient Foot Sensory Exam Using Monofilament	**National**	**4,126**	**4,630**	**89**
	621 Mountain Home	21	27	**77**
	621BY Knoxville	44	50	**88**
	621GC Norton	25	50	**50**

Foot Sensory, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – Retinal Eye Exam	**70**	**National**	**3,181**	**3,510**	**91**
	70	621 Mountain Home	19	23	**91**
		621BY Knoxville	48	50	**96**
		621GC Norton	37	50	**74**

Retinal Exam, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – LDL-C	**88**	**National**	**3,413**	**3,511**	**97**
	88	621 Mountain Home	22	23	**92**
		621BY Knoxville	47	50	**94**
		621GC Norton	44	50	**88**

Lipid Profile, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – HbgA1c	**93**	**National**	**3,452**	**3,512**	**98**
	93	621 Mountain Home	22	23	**100**
		621BY Knoxville	49	50	**98**
		621GC Norton	48	50	**96**

HbgA1c Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Renal Testing	**88**	**National**	**3,371**	**3,512**	**95**
	88	621 Mountain Home	23	23	**100**
		621BY Knoxville	50	50	**100**
		621GC Norton	49	50	**98**

Renal Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
Patient Screen with PC-PTSD	**95**	**National**	**9,761**	**10,006**	**98**
	95	621 Mountain Home	84	84	**100**
		621BY Knoxville	26	26	**100**
		621GC Norton	18	18	**100**

PTSD Screening, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
***Patient Screen with PC-PTSD with* timely Suicide Ideation/Behavior Evaluation**	**75**	**National**	**239**	**379**	**64**
	75	621 Mountain Home	1	2	**52**
		621BY Knoxville	2	3	**67**
		621GC Norton	2	3	**67**

PTSD Screening with Timely Suicide Ideation/Behavior Evaluation, FY 2010

Quality of Care Measures
Tennessee Valley HCS[24] – Chattanooga and Vine Hill

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 50-64	**66**	**National**	**4,843**	**6,973**	**69**
	66	626 Nashville	31	50	**62**
		626GF Chattanooga	15	28	**54**
		626GI Vine Hill	10	24	**42**

Influenza Vaccination, 50-64 Years of Age, 4th Qtr, FY 2009

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 65 or older	**83**	**National**	**5,460**	**6,499**	**84**
	83	626 Nashville	36	42	**86**
		626GF Chattanooga	10	14	**71**
		626GI Vine Hill	10	18	**56**

Influenza Vaccination, Age 65 or Older, 4th Qtr, FY 2009

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Outpatient Foot Inspection	**National**	**4,321**	**4,651**	**93**
	626 Nashville	49	50	**97**
	626GF Chattanooga	41	44	**93**
	626GI Vine Hill	35	35	**100**

DM Foot Inspection, FY 2010

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr1 Percentage*
DM - Outpatient - Foot Pedal Pulses	**National**	**4,208**	**4,651**	**90**
	626 Nashville	45	50	**91**
	626GF Chattanooga	40	44	**91**
	626GI Vine Hill	35	35	**100**

Foot Pedal Pulse, FY 2010

[24] http://vaww.pdw.med.va.gov/MeasureMaster/MMReport.asp Note: Scores are weighted. The purpose of weighting is to correct for the over-representation of cases from small sites and the under-representation of cases from large sites. It corrects for the unequal number of available cases within each organizational level (i.e., CBOC, facility) and protects against the calculation of biased or inaccurate scores. Weighting can alter the raw measure score (numerator/denominator) in different ways, particularly measures with small "N"(s). Raw scores can go up or down depending on which cases pass or fail a measure. Sometimes the adjustment can be quite significant.

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – Outpatient Foot Sensory Exam Using Monofilament	**National**	**4,126**	**4,630**	**89**
	626 Nashville	39	50	**79**
	626GF Chattanooga	37	44	**84**
	626GI Vine Hill	13	35	**37**

Foot Sensory, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – Retinal Eye Exam	**70**	**National**	**3,181**	**3,510**	**91**
	70	626 Nashville	31	36	**84**
		626GF Chattanooga	37	44	**84**
		626GI Vine Hill	28	35	**80**

Retinal Exam, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – LDL-C	**88**	**National**	**3,413**	**3,511**	**97**
	88	626 Nashville	34	36	**94**
		626GF Chattanooga	44	44	**100**
		626GI Vine Hill	35	35	**100**

Lipid Profile, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – HbgA1c	**93**	**National**	**3,452**	**3,512**	**98**
	93	626 Nashville	36	36	**100**
		626GF Chattanooga	44	44	**100**
		626GI Vine Hill	32	35	**91**

HbgA1c Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Renal Testing	**88**	**National**	**3,371**	**3,512**	**95**
	88	626 Nashville	32	36	**81**
		626GF Chattanooga	43	44	**98**
		626GI Vine Hill	35	35	**100**

Renal Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
Patient Screen with PC-PTSD	**95**	**National**	**9,761**	**10,006**	**98**
	95	626 Nashville	207	222	**98**
		626GF Chattanooga	21	21	**100**
		626GI Vine Hill	0	1	**0**

PTSD Screening, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
***Patient Screen with PC-PTSD with* timely Suicide Ideation/Behavior Evaluation**	**75**	**National**	**239**	**379**	**64**
	75	626 Nashville	12	12	**100**
		626GF Chattanooga	2	2	**100**
		626GI Vine Hill	*	*	*

PTSD Screening with Timely Suicide Ideation/Behavior Evaluation, FY 2010

Null values are represented by *, indicating no eligible cases.

OIG Contact and Staff Acknowledgments

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Appendix J

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