VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

# Veterans Health Administration

*Audit of Community-Based Outpatient Clinic Management Oversight*

**July 28, 2010**
**09-02093-211**

# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| CAPRI | Compensation and Pension Records Interchange |
| CBOC | Community-Based Outpatient Clinic |
| CPRS | Computerized Patient Record System |
| DSS | Decision Support System |
| DUSHOM | Deputy Under Secretary for Health for Operations and Management |
| EPRP | External Peer Review Program |
| MST | Military Sexual Trauma |
| NPR | Network Performance Review |
| OEF/OIF | Operation Enduring Freedom/Operation Iraqi Freedom |
| OMHS | Office of Mental Health Services |
| OQP | Office of Quality and Performance |
| PCMM | Primary Care Management Module |
| PSSG | Planning Systems Support Group |
| PCP | Primary Care Provider |
| TBI | Traumatic Brain Injury |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |
| VistA | Veterans Health Information Systems and Technology Architecture |
| VSSC | VHA Support Service Center |

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# Report Highlights: Audit of VHA's Community-Based Outpatient Clinic Management Oversight

## Why We Did This Audit

Community-based outpatient clinics (CBOCs) are a key part of the Veterans Health Administration's (VHA's) health care delivery system because they increase veterans' access to care and allow veterans to receive care closer to their homes and communities. Based on the best available VA data, VHA spent over $2.9 billion to provide services to about 2.8 million patients at 783 VA- and contractor-staffed CBOCs in FY 2009.

This audit evaluated the effectiveness of VHA's management oversight of CBOCs. The audit objectives were to evaluate VHA CBOC monitoring and evaluation policies and processes and examine CBOC management controls related to the Primary Care Management Module (PCMM) and the completion of required traumatic brain injury (TBI) and military sexual trauma (MST) screenings.

## What We Found

VHA lacks a comprehensive CBOC management control system with which to effectively evaluate and manage CBOC performance and address operational problems. As a result, VHA lacks reasonable assurance that CBOCs adhere to VHA's one standard of care and provide consistent, quality care in accordance with VA policies, regulations, and procedures. Problems identified during our evaluation of CBOC PCMM data and the completion of TBI and MST screenings at CBOCs demonstrate the need for VHA to establish CBOC-specific monitors and evaluations that can identify systemic problems and deviations from the standard of care.

We found that CBOC PCMM data maintained by medical facility and CBOC staff and used to make VHA budgetary and resource management decisions contained significant inaccuracies. Moreover, Network and CBOC staff did not ensure the prompt completion of required TBI and MST screenings, and in some cases, allowed the improper billing of veterans for MST related care.

## What We Recommended

We recommended the Under Secretary for Health establish comprehensive CBOC management controls and monitoring mechanisms and strengthen CBOC PCMM data management, TBI and MST screening, and MST billing management controls.

## Agency Comments

The Under Secretary for Health agreed with our findings and recommendations and plans to complete all corrective actions by January 1, 2011. We consider the planned actions acceptable and will follow up on their implementation.

*(original signed by:)*
BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

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# INTRODUCTION

***Objective***

This audit evaluated the effectiveness of VHA's management of CBOCs. Past OIG reviews have identified concerns regarding care provided to Operation Enduring Freedom and Iraqi Freedom (OEF/OIF) veterans and the provision of consistent mental health services at all VHA facilities, particularly CBOCs. This audit evaluated VHA CBOC monitoring and evaluation policies and processes and specifically examined CBOC patient management controls related to PCMM and the completion of required TBI and MST screenings.

***Monitoring and Evaluation of CBOC Operations***

In FY 2009, VHA provided ambulatory care and primary care services to about 2.8 million patients at 783 CBOCs at a cost of about $2.9 billion. During this period, operating costs for VHA's 581 VA-staffed CBOCs totaled about $2.7 billion (16 million encounters representing 2.5 million patients) and costs for its 202 contractor-staffed CBOCs totaled about $228 million (1.2 million encounters representing 358,000 patients).

VHA's CBOC Planning and Activation Handbook 1006.1 (Handbook 1006.1) defines procedures for the planning and activation of new CBOCs and establishes consistent planning criteria and standardized expectations for CBOCs. This policy assigns various responsibilities for monitoring and evaluating CBOC operations to the Under Secretary for Health, the Deputy Under Secretary for Health for Operations and Management (DUSHOM), the Office of Quality and Performance (OQP), and the Veterans Integrated Service Networks (Networks).

***PCMM and VHA Resource Management***

VHA's large primary care system, which includes CBOCs, strives to balance productivity with quality, access, and patient service. Accordingly, VHA uses PCMM to track patients and their assigned Primary Care Providers through the system. Accurate PCMM workload data allows VHA to quantify its primary care capacity (the total number of patients for whom it can provide care), align delivery of services to match the needs of veterans, and make meaningful comparisons between Networks, medical facilities, and their substations, including CBOCs. When properly maintained, PCMM provides VHA managers with the information needed to track, prepare case findings, and compare workload data for primary care activities such as CBOCs.

***TBI and MST Screenings and Evaluations***

CBOCs increase veterans' access to care and provide OEF and OIF veterans more access points to obtain needed care and services, such as MST and TBI screenings and evaluations. VHA has required MST screenings for all veterans since February 2000. As of April 2007, VHA also required TBI screening and evaluations for all OEF and OIF veterans. As part of VHA's efforts to deliver consistent, quality care to veterans across the nation, CBOCs must provide VHA required MST and TBI screenings and evaluations.

# RESULTS AND RECOMMENDATIONS

## Finding 1 VHA Needs to Strengthen CBOC Monitoring and Evaluation Policies and Processes

VHA needs to strengthen CBOC monitoring and evaluation policies and processes to be able to effectively evaluate and manage CBOC performance and promptly identify operational problems at CBOCs. Handbook 1006.1 assigns the Under Secretary and several other VHA offices and Networks various ongoing CBOC monitoring and evaluation responsibilities. However, VHA has not ensured the effectiveness of the monitors it established for CBOCs. In addition, VHA has not issued adequate guidance to ensure the effective ongoing monitoring and evaluation of CBOCs. As a result, VHA lacks an effective management control system to ensure CBOCs provide consistent, quality care nationally in accordance with VA policies, regulations, and procedures. VHA has not implemented specific CBOC monitoring and evaluation processes because it believes CBOCs are like any other clinic at the parent facility and that they do not require separate monitoring and evaluation.

***VHA Lacks Effective CBOC Guidance and Monitors***

Handbook 1006.1 guidance on the planning and activation of CBOCs lacks adequate direction for the establishment of a comprehensive CBOC monitoring and evaluation system and effective ongoing monitors. It requires the DUSHOM's office to establish monitors to evaluate CBOC progress in areas such as costs, number of visits, encounters, unique veterans treated, and waiting times and to post this data on the VHA Support Service Center (VSSC) website. Nevertheless, Handbook 1006.1 does not provide the Networks or facilities specific guidance on how to use the posted data nor does it establish specific requirements for ongoing local CBOC monitoring activities. The DUSHOM's Office has had the authority to enhance the CBOC monitors established in Handbook 1006.1 as additional CBOC data has become available but it has not done so even though 696 (89 percent) of VHA's current 783 CBOCs have been operational for 5 or more years and are well beyond their planning and activation phases.

Moreover, we found that data reliability issues limited the usefulness of the CBOC data posted on the VSSC website. The VSSC website relies on data abstracted from numerous VHA information systems, thus, it is difficult to complete extensive data testing. Nevertheless, a review of the website's FY 2009 CBOC site, cost, and outpatient visit data identified significant discrepancies in the data that limit its usefulness in monitoring and evaluating CBOC operations.

VHA's Planning Systems Support Group (PSSG) in the Office of Policy and Planning reported that VHA operated 783 CBOCS in FY 2009. However, VSSC FY 2009 cost center, workload, and patient encounter monitoring data on the VSSC website showed that the total number of CBOCs reporting data in FY 2009 varied significantly. While the PSSG reported VHA had 783 CBOCs in FY 2009, VSSC CBOC expenditure and staffing data from the Decision Support System (DSS) Account Level Budgeter reported data for only 676 CBOCs and CBOC workload data from the VA Site Tracking Workload report included data for 719 CBOCs.

Similarly, CBOC cost data reported on the VSSC website also varied greatly depending on the data source. For example, encounter data from VA's managerial cost accounting system, DSS, showed that VHA had 715 CBOCs with 26.9 million outpatient visits during FY 2009 while VSSC's VA Site Tracking workload data reported that VHA had 719 CBOCs with 14.2 million outpatient visits. While the number of CBOCs reported in these two systems differed by four, the reported number of outpatient visits in these two systems differed by over 12.7 million visits.

Similarly, the VSSC website's DSS encounter data reported that the CBOCs cost $3.6 billion to operate in FY 2009 while VSSC Cost Center data showed $2.9 billion in costs—a $700 million difference. In response to the disparities in the data, the VSSC Deputy Director stated that she was not aware of one source that VHA could use to provide a definitive number of activated CBOCs, operating costs, and number of outpatient visits for FY 2009.

***DUSHOM Network Performance Reviews Do Not Address CBOCs***

The DUSHOM's Network Performance Reviews (NPRs), that are supposed to include discussion of CBOC clinical performance, do not ensure the effective monitoring and evaluation of CBOCs. Handbook 1006.1 requires the DUSHOM's office to review clinical performance monitors with the Networks on a quarterly basis during the NPR. During VHA's review process, the DUSHOM's office relies on External Peer Review Program (EPRP) clinical performance measurement data but focuses exclusively on the performance of the Network and individual parent facilities, instead of CBOCs. In addition, the DUSHOM's reliance on EPRP data often means that it lacks sufficient data, particularly for VA-staffed CBOCs, to evaluate CBOCs.

The OQP staff selects medical records for EPRP review based on social security numbers and diagnostic codes. As a result, the current EPRP review process does not distinguish between the performances of VA-staffed CBOCs and their parent facilities. This is because the sampled medical records may include as few as five patients per diagnostic code from some parent facilities and may not include any CBOC patients. Furthermore, although the EPRP does collect and provide performance measurement data

for contractor-staffed CBOCs, the OQP lacked accurate FY 2008 and 2009 EPRP data for contractor staffed CBOCs because of scoring errors. VHA's Director of Performance Management stated that by the end of FY 2010, the EPRP process would include larger samples of medical records and data for both VA- and contractor-staffed CBOCs.

### Networks Do Not Consistently Monitor CBOCs

Networks do not consistently monitor CBOC performance even though Handbook 1006.1 requires Networks to monitor CBOCs and ensure they consistently deliver quality care in accordance with VA regulations, policies, and procedures. Our nationwide survey of VHA's 21 Network Directors disclosed that only 2 of the 21 Networks had written policies that described their requirements or procedures for monitoring and evaluating CBOCs. In addition, 17 of the 21 Networks delegated complete oversight for CBOCs to their parent facilities. At the four Networks we visited, the Networks only required CBOC-specific performance monitoring when it was necessary to identify the site or sites responsible for a parent facility's substandard score on a performance measure. Furthermore, Network managers did not hold routine meetings with parent facility Directors and managers to discuss performance at the CBOCs.

### Effects of Lack of Monitoring and Evaluation

VHA's delegation of all CBOC monitoring and evaluation functions to the parent facilities has resulted in inconsistent CBOC management and oversight. At the eight parent facilities we reviewed, three provided some form of weekly oversight that involved the discussion of CBOC performance relative to the VSSC website performance measures, four met monthly with CBOC staff to discuss CBOC performance, and one had not established any CBOC oversight and evaluation process.

The amount of oversight a parent facility provides its CBOCs can significantly affect the CBOCs' day to-day operations. For example, one parent facility that discussed CBOC performance on a weekly basis developed a corrective action plan for its CBOCs after it noted that some of them had not met VHA's diabetic care performance standard. In contrast, the parent facility that lacked a formal CBOC monitoring and evaluation plan did not provide a contractor-staffed CBOC guidance and training on VHA clinical performance measures until about 10 months after the CBOC's staff requested assistance. Additional examples of inconsistent local CBOC management and inadequate oversight follow in Findings 2 and 3 on pages 7–17.

### Reasons for Inadequate CBOC Monitoring and Evaluation

The lack of adequate policies and monitors for CBOCs is the result of the widely held belief in VHA that CBOCs are just additional clinics that belong to the parent facility. Management officials in the DUSHOM's office and the Networks stated that they did not actively monitor and evaluate CBOCs because this function resided with the parent facilities. Similarly, VHA managers contended that existing VHA performance monitoring data

measuring the parent facilities' performance provided sufficient CBOC coverage because the performance data included CBOC data.

***Conclusion***

VHA lacks a comprehensive CBOC management control system to monitor and evaluate oversight provided by parent facilities, national and regional CBOC performance, and the performance of individual CBOCs. VHA needs to develop standardized guidelines, processes, and monitors to ensure the consistency and adequacy of CBOC monitoring and evaluation throughout the nation. While we agree with VHA and Network officials that parent facilities must be responsible for monitoring and evaluating the day-to-day operations of CBOCs, CBOCs require specific attention due to their distance from the parent facilities and the growing numbers of veterans seeking care from local CBOCs, and VHA's overall financial investment in this health care delivery model. VHA has established policies, procedures, and requirements to ensure one standard of care at all of its facilities. However, it currently lacks the means to effectively monitor and evaluate whether CBOCs adhere to this one standard of care and deliver consistent, quality care to veterans. Finally, VHA needs an effective CBOC monitoring and evaluation system to identify gaps in health care at VA-and contractor-staffed CBOCs that are not identifiable by monitoring only the parent facility's performance.

***Recommendations***

1. We recommended that the Under Secretary for Health establish national standards and guidance that defines oversight responsibilities at the Network and parent facility level and provides for the ongoing monitoring of CBOC operations.

2. We recommended that the Under Secretary for Health develop a set of comprehensive monitoring mechanisms to evaluate CBOC performance and hold quarterly CBOC reviews with the Networks to discuss CBOC performance results, and as needed, corrective actions.

***Management Comments and OIG Response***

The Under Secretary for Health agreed with the finding and recommendations. The DUSHOM will work with OQP to appoint a multi-disciplinary team comprised of VA Central Office, network, medical facility, and CBOC staff to improve CBOC management oversight. The team will help VHA establish national standards and requirements for parent facilities providing CBOC oversight, such as the frequency of periodic meetings with CBOCs to discuss performance issues and a requirement for Network Directors to address CBOC performance issues during regularly scheduled quarterly reviews with facility directors. In addition, the team will establish new CBOC clinical performance measures for inclusion in the DUSHOM's NPR. The team will also conduct a review to identify gaps in provision of health care and determine how to monitor both contractor and VA-managed CBOC performance.

In addition, the DUSHOM and OQP will create a comprehensive mechanism to evaluate CBOC performance. A multi-disciplinary team will review CBOC data collection and data variations and discrepancies posted by VSSC and DSS. The team will recommend specific guidance for facilities and Networks on the use of posted data, such as costs, number of visits, encounters, unique veterans treated, and waiting times. The data and other factors will be analyzed to determine the best strategy to provide analysis and oversight for CBOCs. In addition, the guidance will require Networks to have written policies that describe requirements or procedures for monitoring and evaluating CBOCs based on the revised national policy. We consider the planned actions acceptable and will follow up on their implementation.

## Finding 2 CBOC PCMM Data Management Controls Need Improvement

Parent medical facility staff did not ensure the accuracy of the CBOC provider panel data in PCMM although this data is critical to the effective management of CBOC funding and resources. Since 1999, VHA has required the use of PCMM. Subsequently, VHA issued Handbook 1101.02 establishing PCMM procedures to ensure that VHA managers have reliable and consistent primary care provider workload data with which to make national and local resource decisions. Nevertheless, we found PCMM overstated the size of CBOCs panels and included patients with unauthorized dual assignments, as well as inactive and deceased patients.

These inaccuracies in the PCMM panel data occurred because local PCMM Coordinators and CBOC staff lacked training on VHA PCMM processes and procedures. Because VHA lacks comprehensive national standards and monitoring processes for CBOCs, it cannot identify systemic CBOC PCMM data problems and does not have accurate and reliable PCMM workload data to evaluate CBOC performance and make budgetary and resource management decisions.

### *Inaccurate PCMM Data*

PCMM provider panels at the 16 reviewed CBOCs included patients with unauthorized dual panel assignments, inactive patients, and deceased patients. When assigning patients to a panel, the PCMM Coordinator or the person enrolling the patient must determine if the patient is receiving care at another VHA facility and if so, whether the patient fits VHA criteria for assignment to two primary care provider panels. The parent facilities' PCMM Coordinators must periodically review the panels to remove inactive patients—patients who are either deceased, did not receive primary care within the past 12 (newly assigned patients) to 24 (established patients) months, or who no longer require care at the currently assigned VHA medical facility.

For the period April 1, 2008–March 31, 2009, reviews of PCMM panel data determined that 128 (8 percent) of the 1,600 randomly-selected patients on the panels at the 16 CBOCs either lacked authorization for dual enrollment or were inactive or deceased. Of the 128 patients who should not have been included on the provider panels, 76 lacked authorizations for their dual enrollments, 51 were inactive, and 14 were deceased (13 patients fit into more than 1 error category). Based on these results, we projected that 65,578 (9 percent) of the total 728,472 patients listed on the 16 CBOCs provider panels should have been excluded. Table 1 shows the results of our panel reviews and the related statistical projections by Network, medical facility, and CBOC.

**Table 1. Projected CBOC PCMM Panel Errors**

| Network | Parent Facility | VA Staffed or Contracted CBOC | Lack of Authorization for Dual Enrollment | Inactive | Deceased | Unique Errors |
|---|---|---|---|---|---|---|
| **A** | Facility A | | | | | |
| | | VA | 0 | 7,755 | 431 | 7,755 |
| | | Contracted | 6,120 | 11,425 | 2,448 | 15,913 |
| | Facility B | | | | | |
| | | VA | 6,925 | 0 | 0 | 6,925 |
| | | Contracted | 1,091 | 0 | 0 | 1,091 |
| **Subtotal** | | | **14,136** | **19,180** | **2,879** | **31,684** |
| **B** | Facility C | | | | | |
| | | VA | 164 | 0 | 164 | 247 |
| | | Contracted | 608 | 0 | 406 | 1,013 |
| | Facility D | | | | | |
| | | VA | 667 | 0 | 500 | 1,000 |
| | | Contracted | 98 | 0 | 0 | 98 |
| **Subtotal** | | | **1,537** | **0** | **1,070** | **2,358** |
| **C** | Facility E | | | | | |
| | | VA | 11,570 | 0 | 0 | 11,570 |
| | | Contracted | 99 | 50 | 0 | 149 |
| | Facility F | | | | | |
| | | VA | 2,014 | 0 | 0 | 2,014 |
| | | Contracted | 144 | 0 | 0 | 144 |
| **Subtotal** | | | **13,827** | **50** | **0** | **13,877** |
| **D** | Facility G | | | | | |
| | | VA | 2,983 | 0 | 0 | 2,983 |
| | | Contracted | 111 | 0 | 0 | 111 |
| | Facility H | | | | | |
| | | VA | 7,138 | 2,676 | 0 | 9,814 |
| | | Contracted | 3,563 | 1,188 | 0 | 4,751 |
| **Subtotal** | | | **13,795** | **3,864** | **0** | **17,659** |
| **Total** | | | **43,295** | **23,094** | **3,949** | **65,578** |

***Reasons for Inaccurate PCMM Data***

The PCMM data overstated the number of veterans on the CBOC providers' panels because PCMM Coordinators and CBOC staff lacked adequate PCMM training or they felt they lacked the time necessary to maintain the data. Many of the data problems occurred due to multiple lapses in PCMM panel management at the national, parent facility, and CBOC level. VHA had not adequately trained parent facility PCMM Coordinators on the management of PCMM panels. Consequently, the PCMM Coordinators did not establish effective local PCMM management policies and procedures and did not properly train facility and CBOC staff on PCMM management. In

addition, VHA lacks effective national and local PCMM management controls to assess and ensure the accuracy of CBOC PCMM panel data.

The most common PCMM data problem we found, unauthorized dual assignments, occurred due to a number of reasons. Staff responsible for assigning new CBOC patients in PCMM did not always use the Veterans Health Information Systems and Technology Architecture (VistA) to identify patients already assigned to a panel. At one parent facility, the PCMM Coordinator did not know that VHA required staff to check the assignment status of new CBOC patients in VistA prior to assigning the patients to panels. In addition, some PCMM Coordinators did not know they could use the "Duplicated PCP Assignment Report" on the VSSC website to identify unauthorized dual assignments. Other PCMM Coordinators who were aware of the VSSC report chose not to review it because of the length of the report and perceived time constraints.

PCMM Coordinators also stated they relied heavily on an automated national PCMM patch to remove inactive patients who had not received primary care within the specified timeframes. VHA required all medical facilities to download and implement this PCMM patch by early January 2007. However, one parent facility did not implement the patch until March 2009. Due to the delayed implementation of the patch, 46 of the 51 inactive patients identified during our panel reviews for the 16 CBOCs occurred at this facility.

Finally, deceased patients also remained on some CBOCs panels because parent facility and CBOC staff did not know they could use the "Active Panel Report" on the VSSC website to identify deceased patients. This report generates lists of all the providers at a location, such as the Network, medical facility, or station; all of their assigned patients; and identifies deceased patients still assigned to panels.

Although VHA required implementation of PCMM in 1999, its Primary Care service line in the Office of Patient Care Services did not begin developing formal national PCMM training program for PCMM Coordinators until 2009. PCMM program officials and Coordinators stated that in lieu of formalized training, they have provided new PCMM Coordinators with on-the-job training using the PCMM User Manual and a PCMM e-mail group. The PCMM e-mail group, comprised of PCMM Coordinators, answers PCMM questions that staff cannot address locally. The Office of Patient Care Services plans to implement the national PCMM training program sometime in FY 2010.

### *Conclusion*

The inaccuracies in CBOC PCMM data means that VHA, Networks, and parent facilities do not have accurate and reliable workload data to evaluate CBOC performance and make budgetary and resource management

decisions. Furthermore, although it was not a problem at the contract CBOCs we reviewed, inaccurate PCMM data could result in improper payments if facilities rely on inaccurate PCMM panel data to pay contractor-staffed CBOCs. Although inaccuracies in CBOC PCMM data have national ramifications for VHA management decision processes and operations, VHA lacks an effective management control system with which to monitor local management of PCMM data.

***Recommendations***

3. We recommended that the Under Secretary for Health monitor and ensure the implementation of the proposed PCMM Coordinators' training program.

4. We recommended that the Under Secretary for Health implement national and local management controls and monitors to ensure the accuracy of CBOC PCMM data.

***Management Comments and OIG Response***

The Under Secretary for Health agreed with the finding and recommendations. The DUSHOM, in conjunction with the Employee Education System Information Technology National Training and Education Office, and the Office of the Associate Deputy Chief Medical Director provided PCMM training on May 11, 13, and 17, 2010. The training targeted PCMM Coordinators and provided instruction on basic PCMM software functionality. In addition, the DUSHOM and the VSSC created a national registry that allows each person listed on the registry to correct errors in their respective PCMM report. Finally, a national e-mail group created for PCMM Coordinators addresses questions on topics such as the tracking and accuracy of data on the VSSC website. We consider the planned actions acceptable.

## Finding 3 CBOC TBI and MST Screening Controls Need To Be Strengthened

VA and contract CBOC staff did not always complete required TBI and MST screenings and comprehensive TBI evaluations. Our review of MST screenings also found that some CBOCs had improperly billed patients for MST-related care. These deficiencies generally occurred because medical facility and CBOC staff had not received training and were unaware of required VHA processes and procedures related to the performance of required TBI and MST screenings. Subsequently, VHA lacks adequate assurance that CBOCs are consistently providing veterans prompt TBI and MST evaluations and related care. Moreover, VHA lacks the means to identify systemic problems in areas such as these at CBOCs because it does not have comprehensive national CBOC standards and monitors and relies heavily on parent facilities to implement and monitor CBOC compliance with VHA requirements.

***TBI Screenings and Evaluations***

As of April 2007, VHA required medical facilities to screen all OEF/OIF veterans receiving medical care for possible TBI regardless of the clinic or the reason for their visit. If a veteran screens positive for possible TBI, an appropriate clinical staff member must discuss the positive results with the patient and schedule the patient for a TBI evaluation within 30 days.

For the period April 1, 2008–March 31, 2009, at the 16 reviewed CBOCs, we found that clinic staff had not screened 71 (12 percent) of the 578 selected patients during their initial visit. The elapsed days from the patients' initial visits to the completion of the TBI screening averaged 123 days (range = 1 to 739 days). Of these 578 patients, 52 (9 percent) had not been screened as of the date of our review or an average of 397 days (range = 70 to 877 days) from their initial visit. Based on these results, we projected that as many as 361 (15 percent) of the 2,465 patients at the 16 CBOCs had missing or delayed screenings. Table 2 shows the results of our screening reviews and the related statistical projections by Network, medical facility, and CBOC.

**Table 2. Projected TBI Screening Errors**

| Network | Parent Facility | VA Staffed or Contracted CBOC | Missing TBI Screening | Late TBI Screening |
|---|---|---|---|---|
| **A** | Facility A | | | |
| | | VA | 6 | 34 |
| | | Contracted | 0 | 5 |
| | Facility B | | | |
| | | VA | 29 | 121 |
| | | Contracted | 0 | 6 |
| **Subtotal** | | | **35** | **166** |
| **B** | Facility C | | | |
| | | VA | 3 | 4 |
| | | Contracted | 0 | 6 |
| | Facility D | | | |
| | | VA | 0 | 9 |
| | | Contracted | 0 | 0 |
| **Subtotal** | | | **3** | **19** |
| **C** | Facility E | | | |
| | | VA | 10 | 69 |
| | | Contracted | 0 | 0 |
| | Facility F | | | |
| | | VA | 3 | 16 |
| | | Contracted | 0 | 6 |
| **Subtotal** | | | **13** | **91** |
| **D** | Facility G | | | |
| | | VA | 0 | 0 |
| | | Contracted | 1 | 0 |
| | Facility H | | | |
| | | VA | 7 | 2 |
| | | Contracted | 6 | 18 |
| **Subtotal** | | | **14** | **20** |
| **Total** | | | **65** | **296** |

Of the 507 reviewed OEF/OIF patients who had TBI screenings, 85 screened positive for TBI and required comprehensive evaluations. Of these 85, 9 patients (11 percent) did not have evaluations completed within the required 30-day timeframe. The elapsed days between the initial screening and the comprehensive TBI evaluation averaged 47 days (range = 32 to 92 days). These delays occurred due to a shortage of appointment slots at the parent facilities' Polytrauma units but these scheduling problems had been resolved by the time of our site visits in July and October 2009.

***Reasons for Missing or Delayed TBI Screenings***

Delays occurred in the completion of TBI screenings because the CBOC staff was not always aware of TBI screening procedures or due to oversights. For example, at one of the contracted clinics, the Patient Services Assistant did not know what TBI was prior to our visit, and some staff lacked awareness of the VHA TBI screening requirement. Consequently, 6 of 12 reviewed patients who received care at this clinic did not receive the TBI screening during their initial visit. VHA established a national performance measure for the completion of TBI screenings in FY 2008. However, the performance measure monitors the performance of TBI screenings at the Network and parent facility level and does not focus on the completion of screenings at individual CBOCs.

***Missing or Delayed MST Screenings***

In February 2000, VHA mandated the completion of MST screenings at all VHA medical facilities, established education and training requirements for staff, and required an MST Coordinator to monitor the completion of required screenings, education, and training. Nevertheless, our audit found that MST coordinators and CBOC staff did not ensure the completion of required MST screenings during patients' primary care intake and initial assessments at the CBOCs as required by VHA policy.

In 2006, the Office of Mental Health Services (OMHS) established an MST Support Team to monitor national MST screening and treatment and expand MST-related education, training, and outreach resources in VHA. Subsequently, the Chief Medical Officer at each Network appointed a MST point of contact (Network POC) to oversee MST Coordinators at the parent facilities. Of the 958 randomly selected patients at the 16 CBOCs we visited, 152 (16 percent) did not receive MST screenings until an average of 604 days (range = 1 to 3,366 days) after their intake and initial assessment at the CBOC. Also, 89 (9 percent) of 958 patients had not received an MST screening and had waited an average of at least 1,386 days (range = 29 to 3,390 days) for an MST screening as of the date of the site visits completed between July and October 2009.

Based on these results, we projected that as many as 2,078 (20 percent) of 10,684 patients who received care at the 16 CBOCs had missing or delayed MST screenings. Table 3 shows the results of our screening reviews and the related statistical projections by Network, medical facility, and CBOC.

**Table 3. Projected MST Screening Errors**

| Network | Parent Facility | VA Staffed or Contracted CBOC | Missing MST Screening | Delayed MST Screening |
|---|---|---|---|---|
| **A** | Facility A | | | |
| | | VA | 7 | 302 |
| | | Contracted | 9 | 60 |
| | Facility B | | | |
| | | VA | 186 | 322 |
| | | Contracted | 6 | 96 |
| **Subtotal** | | | **208** | **780** |
| **B** | Facility C | | | |
| | | VA | 0 | 5 |
| | | Contracted | 0 | 5 |
| | Facility D | | | |
| | | VA | 3 | 71 |
| | | Contracted | 4 | 77 |
| **Subtotal** | | | **7** | **158** |
| **C** | Facility E | | | |
| | | VA | 131 | 44 |
| | | Contracted | 4 | 11 |
| | Facility F | | | |
| | | VA | 23 | 45 |
| | | Contracted | 333 | 30 |
| **Subtotal** | | | **491** | **130** |
| **D** | Facility G | | | |
| | | VA | 0 | 65 |
| | | Contracted | 5 | 27 |
| | Facility H | | | |
| | | VA | 17 | 17 |
| | | Contracted | 0 | 173 |
| **Subtotal** | | | **22** | **282** |
| **Total** | | | **728** | **1,350** |

***Reasons for Missing or Delayed MST Screenings***

Problems in the timely completion of MST screenings at CBOCs occurred because VHA lacks a coordinated MST screening program that adequately defines national and local duties and responsibilities for ensuring the completion of MST screenings. Although the MST Support Team provided guidance to MST Coordinators through monthly conference calls and e-mails, significant lapses in communication and coordination still occurred.

We found that MST Network POCs and parent facility MST Coordinators relied on erroneous data contained in a quarterly national MST report generated by VA's Health Eligibility Center to determine if patients still

required MST screenings. The MST Support Team knew this report contained inaccurate information; however, they did not share this information with Network and parent facility MST Coordinators because they were not aware that the Coordinators used the quarterly report. The report showed that the CBOCs we visited had no patients who required MST screenings, but we found that 12 CBOCs still had 89 patients who required screenings.

In addition, due to communication lapses and a lack of national monitoring, most of the MST Coordinators we interviewed did not know VistA contained the "Reminders Due" report, which listed patients who still needed MST screenings. After we informed the facility MST Coordinators of this report, one obtained it from the facility's program specialist, but others could not, because the facility staff did not know how to generate it.

VHA's current national MST policy does not define OMHS, Network, parent facility, and CBOC MST oversight responsibilities nor has it established monitors to ensure the completion of required evaluations. As a result, facility MST Coordinators did not monitor the completion of MST screenings at the CBOCs. Similarly, they did not train CBOC staff on VHA MST policy because they stated they were not aware of the requirement to monitor MST education and training at CBOCs.

After the completion of our site visits in November 2009, MST Support Team managers stated that they provided an FY 2008 CBOC MST screening report measuring the effectiveness of MST screenings at the CBOC level to all MST Network and facility coordinators. In addition, OMHS managers stated they were drafting a new national policy to replace the current MST policy.

***Erroneous MST-Related Billings***

Medical facilities sometimes erroneously billed CBOC patients for free MST-related care. Veterans do not need to be service-connected and may be able to receive this benefit even if they are not eligible for other VA care. Subsequently, when VHA healthcare providers provide MST-related care or services to a patient, they must check a box in CPRS that notifies the billing staff that the services are MST-related and are not billable. However, improper MST-related care billings occurred at 6 of the 14 CBOCs (patients at 2 of the reviewed CBOCs did not have any MST-related encounters). The improper billings occurred because 16 CBOC providers in 3 different Networks did not check the appropriate MST box in CPRS.

In total, 14 (9 percent) of 162 reviewed patients were improperly billed $2,552 for MST-related care and medications. Although the amount of the improper billings was small, the billing errors violated VHA policy and

could have caused veterans undue financial hardship. Table 4 shows the results of our billing review by Network, parent facility, and CBOC.

**Table 4. Improper MST Care and Medication Billings**

| Network | Parent Facility | VA Staffed or Contracted CBOC | Bills Generated in Error | Billed Amount Generated in Error |
|---|---|---|---|---|
| **A** | Facility A | | | |
| | | VA | 1 | $ 15.00 |
| | | Contracted | 0 | 0.00 |
| | Facility B | | | |
| | | VA | 5 | 143.80 |
| | | Contracted | 0 | 0.00 |
| **Subtotal** | | | **6** | **158.80** |
| **B** | Facility C | | | |
| | | VA | 0 | 0.00 |
| | | Contracted | 0 | 0.00 |
| | Facility D | | | |
| | | VA | 0 | 0.00 |
| | | Contracted | 0 | 0.00 |
| **Subtotal** | | | **0** | **0.00** |
| **C** | Facility E | | | |
| | | VA | 5 | 982.37 |
| | | Contracted | 0 | 0.00 |
| | Facility F | | | |
| | | VA | 2 | 356.81 |
| | | Contracted | 0 | 0.00 |
| **Subtotal** | | | **7** | **1,339.18** |
| **D** | Facility G | | | |
| | | VA | 4 | 91.17 |
| | | Contracted | 0 | 0.00 |
| | Facility H | | | |
| | | VA | 0 | 0.00 |
| | | Contracted | 11 | 963.16 |
| **Subtotal** | | | **15** | **1,054.33** |
| **Total** | | | **28** | **$ 2,552.31** |

***Reasons for Erroneous MST Billings***

CBOC staff we interviewed did not always know the purpose of the MST box on the CPRS encounter and medication forms. For example, a provider who did not know what the MST box was for on the encounter form properly checked the box when she diagnosed a patient's post-traumatic stress disorder as being MST-related. However, she did not check the MST box during subsequent related visits, thus creating improper billings. Another provider thought the MST box served only reporting and statistical purposes.

***Conclusion***

Problems in the implementation of TBI and MST screening requirements demonstrate the many difficulties VHA faces in its efforts to implement national requirements across a large geographically dispersed network of VA and contractor staffed clinics. To ensure veterans receive one standard of care, VHA needs to strengthen CBOC oversight to ensure the timely completion of TBI and MST screenings and evaluations. In addition, VHA generally needs to focus more attention on CBOC operations and to develop a CBOC management control system that can identify, evaluate, and resolve problems similar to those identified during our audit.

***Recommendations***

5. We recommended that the Under Secretary for Health provide staff training and establish specific national monitoring mechanisms to ensure that TBI and MST screenings are promptly completed and patients are not billed for MST-related care.

6. We recommended that the Under Secretary for Health cancel outstanding bills and reimburse improperly billed patients for MST-related care and medications.

***Management Comments and OIG Response***

The Under Secretary for Health agreed with the finding and recommendations. VHA has already established and will update, as needed, national guidance for TBI screening and evaluation and monitoring mechanisms. VHA is also conducting national level staff training related to the TBI screening and evaluation process.

The OMHS established a national mechanism for monitoring MST screening and treatment and implemented MST-related training for staff. The training instructs staff that MST-related care is not billable and shows staff the appropriate documentation needed to prevent MST-billings. In addition, facilities have either canceled all MST-related bills identified by this audit or processed refunds. The total amount processed was $2,552.31. We consider the planned actions acceptable and will follow up on their implementation.

# Appendix A Background

### *Legislation Establishing CBOCs*

In 1995, VHA announced plans to transition from hospital-based care to a system rooted in primary and ambulatory care, namely CBOCs. The following year, Congress passed the Veterans' Health Care Eligibility Reform Act (Public Law 104-262), which expanded eligibility requirements and allowed all veterans to receive hospital and medical care. To address the increased demand for health care services and expand the access points for care, VHA began establishing CBOCs.

### *CBOCs in VHA's Healthcare System*

VHA is one of the nation's largest and most comprehensive health care systems. It provides a full range of health care services at sites that are located in the United States, Puerto Rico, Guam, U.S. Virgin Islands, and the Philippines. In FY 2008, the VA health care system included 153 medical facilities and 919 outpatient clinics (VHA outpatient clinics are comprised of hospital-based; independent; mobile outpatient; and CBOCs) operating at a cost of about $39.4 billion. As of September 30, 2009, VHA's Site Tracking System reported 783 CBOCs with 581 either VA-owned or leased and 202 contractor-staffed clinics.

VHA plans to activate an additional 68 CBOCs within the next 12 months. The scope of services that CBOCs provide vary based on the type of clinic and population served. At a minimum, CBOCs must provide primary care and mental health services, based on the needs of veterans in the designated service area. All VHA facilities, including CBOCs regardless of whether they are VA- or contractor-staffed, must provide veterans one standard of care. Care provided by CBOCs must be consistent, safe, and of high quality; and all CBOCs must comply with all relevant VA policies and procedures, including those related to quality, patient safety, and performance.

### *Prior OIG Reports*

Prior OIG reports have raised concerns related to VHA care provided to OEF and OIF veterans and difficulties in ensuring veterans receive consistent mental health services at all VHA facilities, particularly CBOCs. In 2008, a healthcare inspection report concluded that 3 years after veterans' initial inpatient rehabilitation for TBI, many patients continued to have significant disabilities. The report concluded that even though case management had improved, staff did not uniformly provide long-term case management for this group of patients.

Furthermore, a 2009 healthcare inspection report on the implementation of VHA's Uniform Mental Health Service Handbook expected medical facilities to be more successful than CBOCs in implementing mental health recommendations, and smaller, rural CBOCs to face more obstacles in implementation due to geographic distance and difficulties recruiting mental health providers.

In addition, the OIG's Office of Healthcare Inspections (OHI) issued eight CBOC Review Reports during our review period:

- Healthcare Inspection CBOC Reviews-Kosciusko and Meridian, MS; Tulsa, OK Konawa and Lawton, OK; Texarkana, AR; and Longview, TX, Report No. 09-01446-105, March 17, 2010

- Healthcare Inspection CBOC Reviews-Macon and Albany, GA; Beaver Dam, WI; and Rockford, IL; Sioux City, IA; and Aberdeen, SD; Waterloo, IA; and Galesburg, IL, Report No. 09-01446-37, December 2, 2009

- Healthcare Inspection CBOC Reviews-Cambridge and Fort Howard, MD; Alexandria, VA; and Greenbelt, MD; Wilmington and Jacksonville, NC, Report No. 09-01446-233, September 30, 2009

- Healthcare Inspection CBOC Reviews-Lockport and Olean, NY; Monaca and Washington, PA; Berwick and Sayre, PA; Somerset, KY, Report No. 09-01446-226, September 23, 2009

- Healthcare Inspection CBOC Reviews-Henderson and Pahrump, NV; Palm Desert and Corona, CA; Pasadena and Santa Maria, CA, Report No. 09-01446-203, August 26, 2009

- Healthcare Inspection CBOC Reviews-Benton Harbor and Grand Rapids, MI; Terre Haute and Bloomington, IN; Yale and Pontiac, MI, Report No. 09-01446-199, August 20, 2009

- Healthcare Inspection CBOC Reviews-Bangor and Portland, ME; Conway and Tilton, NH; Rutland and Colchester, VT, Report No. 09-01466-167, July 16, 2009

- Informational Report-Community Based Outpatient Clinic Cyclical Reports, Report No. 08-00623-169, July 16, 2009

The OHI CBOC review process consisted of four components: (1) CBOC site-specific information gathering and review; (2) medical record reviews for determining compliance with VHA performance measures; (3) onsite inspections; and (4) CBOC contract reviews.

# Appendix B Scope and Methodology

***Scope and Methodology***

To assess our audit objectives, we identified and reviewed applicable Federal regulations and VHA policies related to the management of CBOCs and the administration of selected patient care management areas at VA- and contractor-staffed CBOCs. We conducted interviews with VHA officials to assess national management controls related to the oversight and management of CBOCs and conducted a web-based survey at all 21 Networks.

Using June 2009 data from VHA's Site Tracking System, we identified all VA- and contractor-staffed CBOCs activated as of January 2009 and their corresponding Networks and parent facilities for inclusion in our audit universe. Using criteria such as the size of the patient population, budget, and geographical distribution, we judgmentally selected four Networks for site visits. After we identified all of the parent facilities within the Networks that had both VA- and contractor staffed-CBOCs, we judgmentally selected two parent facilities and two related CBOCs to evaluate the effectiveness of local oversight for the CBOCs. In total, we visited or contacted 16 CBOCs consisting of 8 VA- and 8 contractor-staffed clinics, the CBOCs' 8 parent facilities, and the parent facilities' 4 Network offices.

We interviewed Network, parent facility, and CBOC level managers and staff and reviewed local CBOC policies and procedures to assess national and local CBOC management controls. In addition, we reviewed local information and data and conducted interviews as needed to assess whether parent facility and CBOC staff used PCMM properly, performed required TBI and MST screenings for CBOC patients, and suppressed billings for MST-related care in accordance with VHA policy.

We also obtained for review detailed patient information for the 16 judgmentally selected CBOCs from VistA and statistically selected samples of patients from each CBOC for the 12-month period of April 1, 2008–March 31, 2009. We reviewed pertinent information in CPRS, the Compensation and Pension Records Interchange (CAPRI), VSSC website, and the OIG's Data Analysis Division Death Match Database for each patient to assess compliance in these areas. We projected our results to the 16 CBOCS reviewed for all areas except MST billing (we did not project as we reviewed all MST billings at the CBOCs, not a sample).

Consequently, we reviewed data for 1,600 patients included on CBOC panels during our audit period by randomly selecting 100 patients from each CBOC. Likewise, to assess the completion of TBI screenings and evaluations and MST screenings, we reviewed information for 578 OEF/OIF patients and 958 patients, respectively for each area, by randomly selecting 50 patients

from each CBOC population. For those CBOCs that had less than the set sample size of 50, we reviewed all of the patients in the CBOC's patient population. Appendix C contains detailed discussion of our sampling methodology.

***Reliability of Computer-Processed Data***

For the PCMM (patient panel data analysis), TBI (patient screenings), and MST-related (patient screenings and billings) audit review areas, we assessed the reliability of the 12-months of VistA patient data by comparing the data with information available in the CPRS patient medical records. In addition, we conducted tests to determine whether the data reported in VistA, CPRS, CAPRI, and in the VSSC website data repositories was accurate. We tested the data for accuracy of reported patient information, missing data from key fields, duplication of patient records, and determined whether the data was within our audit timeframe.

Finally, where applicable, we also compared data from the OIG's Data Analysis Division's Death Match Database with data from the Social Security Death Index (generated from the Social Security Administration's Death Master File) and VistA patient records. Based on these reviews and assessments, we concluded that the patient data extracted from VistA and the Death Match Database was sufficiently reliable to support our audit findings, conclusions, and recommendations.

***Compliance with Government Audit Standards***

We conducted our audit work from June 2009 through March 2010. Our assessment of internal controls focused on those controls relating to our audit objectives. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

# Appendix C Statistical Sampling Methodology

We judgmentally selected CBOCs then randomly selected patients within the selected CBOCs to test the accuracy of PCMM panels and to determine if CBOC patients received required TBI and MST screenings.

***Population***

As of January 2009, VA had activated 764 VA- and contractor-staffed CBOCs. Using selection criteria such as the size of the patient population, budget, and geographical distribution, we judgmentally selected 4 Networks, 8 parent facilities, and 16 CBOCs to visit and assess management controls for our areas of review. We then obtained from VistA 12-months (April 1, 2008–March 31, 2009) of detailed patient data for each judgmentally selected CBOC. The population (audit universe) of the 16 CBOCs consisted of 728,472 patients assigned to a panel within our timeframe for PCMM, 2,465 patients for TBI screening, and 10,684 patients for MST screening.

***Sampling Design***

We selected a simple random sample of patients from each of the judgmentally selected CBOCs. For each CBOC, we selected 100 patients to review for PCMM, 50 unique OEF/OIF patients for TBI screening, and 50 unique patients for MST screening and billing. For CBOCs that had fewer than 50 patients in the sampled population, we reviewed data for all of the patients. In total, we reviewed data belonging to 1,600 patients for PCMM, 578 patients for TBI screening, and 958 patients for MST screening. Sampling errors fell into the following categories:

- For the PCMM sample, we counted a case as an error if the patient was dead, inactive, or assigned to more than one patient panel without proper approval.
- For the TBI and MST screenings, we considered a case an error if staff had not screened the patient during their initial visit or as of the dates of our site visits from July–October, 2009. OEF/OIF patients who tested positive during the initial TBI screening but who did not receive a comprehensive evaluation within 30 days were also errors.
- Finally, we considered any patient billed for MST-related care or a prescription to be an error.

***Weights***

We computed sampling weights for the random samples within each CBOC to project results for each CBOC. We projected the sample results for each CBOC by summing the weights for each projection. Weights were computed as the inverse of the probability of selection. Since each CBOC had a different number of patients served and the samples sizes were the same across selected CBOCs, the sampling weights varied in size. This

accounts for the percentages calculated from the raw sample numbers being different from the percentages calculated from the weighted projections.

***Projections***

Based on the results of our review, we project the following results for the 16 CBOCs during our 12-month review period:

- The PCMM panels containing 728,472 patients improperly included an estimated 65,578 patients—43,295 lacked authorization for dual assignments, 23,094 were inactive, and 3,949 were deceased.

- As many as 361 of the 2,465 OEF/OIF patients lacked an initial TBI screening during their initial visit—65 did not have a TBI screening and 296 had delayed screenings.

- As many as 2,078 of 10,684 patients did not receive an MST screening during their primary care intake and initial assessment—728 had missing MST screenings and 1,350 had delayed screenings.

## Appendix D Agency Comments

**Department of Veterans Affairs**

# Memorandum

Date: July 15, 2010

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Audit of Community-Based Outpatient Clinic Management Oversight (WebCIMS 434358)

To: Assistant Inspector General for Audits and Evaluations (52)

1. I have reviewed the draft report and concur with the recommendations. I ask that the OIG consider Veterans Health Administration's (VHA) comments about recommendation five. Attached is VHA's corrective action plan for the report's recommendations.

2. VHA concurs with the report's recommendations to:

**Recommendation 1. Establish national standards and guidance that defines oversight responsibilities at the Network and parent facility level and provides for the ongoing monitoring of CBOC operations.** The Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will ensure that Networks provide ongoing monitoring of CBOCs by ensuring that Networks evaluate whether CBOCs are meeting their business purposes and overall goals and objectives.

**Recommendation 2. Develop a set of comprehensive monitoring mechanisms to evaluate Community-based Out Patient Clinic (CBOC) performance and hold quarterly CBOC reviews with the Networks to discuss CBOC performance results, and as needed, corrective actions.** VHA's Office of Quality and Performance is adjusting the external Peer Review Program to provide quarterly performance updates.

**Recommendation 3. Monitor and ensure the implementation of the proposed Primary Care Management Module (PCMM) Coordinators' training program.** The DUSHOM in conjunction with the Employee Education System (EES) Information Technology (IT) National Training and Education Office, and the Office of the Associate Deputy Chief Medical Director provided PCMM training on May 11, 13, and 17, 2010.

**Recommendation 4. Implement national and local management controls and monitors to ensure the accuracy of CBOC PCMM data.** The DUSHOM in collaboration with VHA Support Service Center (VSSC) created a national registry that allows each person listed on the registry to correct errors in their respective PCMM report.

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OIG Draft Report, Audit of Community-Based Outpatient Clinic Management Oversight (WebCIMS 434358)

> **Recommendation 6. Cancel outstanding bills and reimburse improperly billed patients for military sexual trauma (MST)-related care and medications.** VHA's Chief Business Office has ensured that all payments for improperly billed MST-related care and medications have been refunded to affected patients.

3. **Recommendation 5 provides staff training and establish specific national monitoring mechanisms to ensure that traumatic brain injury (TBI) and MST screenings are promptly completed and patients are not billed for MST-related care.** VHA has already established a performance measure for TBI screening and evaluations, and provides ongoing training regarding the management of patients who may have suffered TBI. In addition, VHA's Office of Mental Health Service (OMHS) has already established a national mechanism for monitoring MST screening and treatment and has implemented MST-related training for staff. VHA believes that these efforts address the intent and content of the recommendation.

4. Thank you for the opportunity to review the draft report. A complete action plan to address the report's recommendation is attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

*(original signed by:)*

Robert A. Petzel, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)**
**Action Plan**

**Office of Inspector General (OIG) Draft Report, Audit of Community–Based Outpatient Clinic Management Oversight, (WebCIMS 434358)**

**Date of Draft Report: June 2010**

| Recommendations/ Actions | Status | Completion Date |
|---|---|---|

**Recommendation 1. We recommend that the Under Secretary for Health establish national standards and guidance that defines oversight responsibilities at the Network and parent facility level and provides for the ongoing monitoring of CBOC operations.**

**VHA Comments**

Concur

Veterans Health Administration's (VHA) Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) in collaboration with the VHA's Office of Quality and Performance (OQP) will appoint a multi-disciplinary team comprised of Veterans Affairs (VA) Central Office, network, facility and community-based outpatient clinic (CBOC) staff. The team is charged with gathering applicable information to establish national standards that define specific oversight requirements for parent facilities; frequency of periodic meetings with CBOCs to discuss performance issues; requirement for network directors to address CBOC performance issues during the regularly scheduled quarterly reviews with facility directors; and, inclusion of newly formulated CBOC clinical performance measures in the DUSHOM's Network Performance Reviews. In addition, the appointed team will conduct a review to identify gaps in provision of health care and determine how to monitor both contract and VA-managed CBOC performance.

| | | |
|---|---|---|
| | In process | December 30, 2010 |

**Recommendation 2. We recommend that the Under Secretary for Health develop a set of comprehensive monitoring mechanisms to evaluate CBOC performance and hold quarterly CBOC reviews with the Networks to discuss CBOC performance results, and as needed, corrective actions.**

**VHA Comments**

Concur

VHA's DUSHOM in collaboration with VHA's OQP will create a comprehensive mechanism to evaluate CBOC performance. In addition, a multi-disciplinary team will be appointed to review collection, variation, and discrepancies reported in the data posted in VHA Support Service Center (VSSC) and Decision Support Systems (DSS). The team will be tasked with recommending specific guidance for facilities and networks to use posted data, such as costs, number of visits, encounters, unique veterans treated, and waiting times. These and other factors will be analyzed to determine the best strategy for extending analysis and oversight of the CBOCs. These actions will require networks to have written policies describing requirements or procedures for monitoring and evaluating CBOCs based on the revised national policy.

In process October 1, 2010

**Recommendation 3. We recommend that the Under Secretary for Health monitor and ensure the implementation of the proposed PCMM Coordinators' training program.**

**VHA Comments**

Concur

The DUSHOM in conjunction with the Employee Education System (EES) Information Technology (IT) National Training and Education Office, and the Office of the Associate Deputy Chief Medical Director provided Primary Care Management Module (PCMM) training on May 11, 13, and 17, 2010. The target audience for the training included PCMM Coordinators. The training provided instruction in basic PCMM software functionality.

Completed

**Recommendation 4. We recommend that the Under Secretary for Health implement national and local management controls and monitors to ensure the accuracy of CBOC PCMM data.**

**VHA Comments**

Concur

The DUSHOM in collaboration with VSSC created a national registry that allows each person listed on the registry to correct errors in their respective PCMM report. In addition, the DUSHOM created a national email group for PCMM Coordinators that members use to address questions on topics such as tracking and accuracy of data on VSSC.

Completed

**Recommendation 5. We recommend that the Under Secretary for Health provide staff training and establish specific national monitoring mechanisms to ensure that TBI and MST screenings are promptly completed and patients are not billed for MST-related care.**

**VHA Comments**

Concur

Because VHA has already established or plans to implement performance measures and training for traumatic brain injury (TBI) screenings and evaluations as well as military sexual trauma (MST) screenings and treatment, the intent of the recommendation to ensure that staff are trained and monitors are in place has been addressed.

Military Sexual Trauma. VHA's Office of Patient Care Services (PCS), Office of Mental Health Services (OMHS), has established a national mechanism for monitoring MST screening and treatment and has implemented MST-related training for staff. The training includes instructions that MST-related care is not billable as well as how to provide appropriate documentation to ensure that billing will not occur. Examples of specific efforts include:

- A training teleconference was held on July 1, 2010, to highlight the reports about MST Support Teams MST Screening and MST-related care in CBOCs to the staff providing MST services in the field.

Completed July 1, 2010

- In response to the requirements of Public Law 111-163, The Caregiver and Veterans Omnibus Health Services Act of 2010, VHA is implementing training about the legislation which will include MST-related information. VHA will require all mental health staff to complete specific MST-related training beginning in FY 2011 and will also require primary care providers to completed related training.

  In process January 1, 2011

VHA will also continue to:

- Produce MST screening and treatment reports aggregated at the facility and CBOC level on an annual basis, distributed each spring.

  Ongoing activity

- Provide technical assistance to the field regarding MST screening and Veterans Health Information Systems and Technology Architecture (VISTA) reports in conjunction with Health Information Systems.

  Ongoing activity

- Engage in training efforts related to dissemination updating directives and ensuring continuing awareness of MST-related policies.

  Ongoing activity

- Provide educational efforts related to MST screening and monitoring by including these topics in monthly training calls and annual training conference as well as developing materials to facilitate local training efforts.

  Ongoing activity

Traumatic Brain Injury. VHA has already established and plans to continue to update as needed the national mechanisms for TBI screening and evaluation; training for staff; as well as monitoring. For example, VHA has issued VHA Directive 2010-012, Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans, addressing the TBI screening and evaluation process. VHA also conducts ongoing national level staff training related to the TBI screening and evaluation process. Reference materials are available on the Physical Medicine and Rehabilitation Web site (vaww.rehab.va.gov/PMR/TBI_Clinical_Reminder.asp).

Examples of other specific efforts include:

- A TBI Comorbidities Conference will be held from July 21-24, 2010, in Orlando, Florida, to address the management of patients with TBI and other related co-morbid conditions through the continuum of VA services.

  In process July 31, 2010

- A satellite broadcast on Post-Traumatic Stress Disorder (PTSD)-Mild TBI management was filmed on July 8, 2010, and will be presented to staff at the end of August 2010.

  In process September 30, 2010

- VA will require its primary care providers to complete a 1 hour on-line Veterans Health Initiative (VHI) TBI Training Module mandatory beginning in FY 2011.

  In process December 30, 2010

VHA will continue to:

- Produce TBI Screening Reports which are distributed to individual sites through the DUSHOM on a monthly basis and encourage sites to monitor their CBOC level activity through available web-based reports.

  Ongoing activity

- Provide technical assistance to the field regarding TBI screening and VISTA reports, in conjunction with Health Information Systems.

  Ongoing activity

- Expand training efforts related to the VHA Directive 2010-012 and ensure continuing awareness of TBI-related policies.

  Ongoing activity

- Provide training related to TBI screening and evaluation process through conference calls with the field and training conferences.

  Ongoing activity

**Recommendation 6. We recommend that the Under Secretary for Health cancel outstanding bills and reimburse improperly billed patients for MST-related care and medications.**

**VHA Comments**

Concur

VHA Chief Business Office (CBO) contacted the three Veterans Integrated Service Networks (VISNs) impacted and requested that they cancel the 28 bills issued in error and refund any payments made. The bills were generated because the providers did not mark the encounters as Military Sexual Trauma (MST) related. As of June 13, 2010, all bills identified by the Office of Inspector General have been cancelled and refunds processed. Since some bills were not paid yet, they were cancelled which resulted in a cancellation total of $1,046.94. Bills that were previously paid resulted in refunds in the amount of $1,505.37. The total amount processed was $2552.31.

Completed June 13, 2010

Veterans Health Administration
July 2010

# Appendix E OIG Contact and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Janet Mah, (310) 268-4335 |
| Acknowledgments | Gregory Gladhill<br>Corina Riba<br>Andrea Lui<br>Timothy Parker<br>Theodore Smith<br>Andrew Hamilton<br>Daniel Rico<br>Milan Gokaldas<br>Herlin Guerra-Sagastume<br><br>Lee Giesbrecht, OIG Statistician |

# Appendix F Report Distribution

## VA Distribution

Office of the Secretary
Veterans Health Administration
Veterans Benefits Administration
National Cemetery Administration
Assistant Secretaries
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## Non-VA Distribution

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House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
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National Veterans Service Organizations
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