Department of Veterans Affairs
Office of Inspector General

Informational Report

Community Based Outpatient Clinic Cyclical Reports FY 2011

Report No. 11-01406-177

May 31, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year (FY) 2009, the VA Office of Inspector General (OIG) began a systematic review of Veterans Health Administration (VHA) community based outpatient clinics (CBOCs). The purpose of this report is to describe the study design of the forthcoming CBOC reviews.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

SUBJECT: Informational Report – Community Based Outpatient Clinic Cyclical Reports

Purpose

As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year (FY) 2009, the VA Office of Inspector General (OIG) began a systematic review of Veterans Health Administration (VHA) community based outpatient clinics (CBOCs) in FY 2009. The purpose of this report is to describe the review design of the CBOC focused topic areas for April through September 2011.

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.

The Office of Healthcare Inspections has conducted reviews at 190 CBOCs, which have resulted in 18 published reports.

Review Purpose and Objectives

The purpose of the cyclical reviews 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 focused reviews for this identified review period are:

1. Determine whether CBOCs comply with selected standards in VHA Handbook 1160.01[1] regarding the management of mental health (MH) emergencies.
    a. Determine whether the CBOCs have a local policy/guideline defining how MH emergencies are handled.
    b. Determine whether the CBOCs are sharing/receiving information if a patient had a MH emergency and was treated at a community emergency department.

2. Assess Short-Term Fee Basis authorization and follow up processes for outpatient radiology consults including computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET) scan, and mammography in an effort to ensure quality and timeliness of patient care in CBOCs.
    a. Determine the parent facility's compliance with established standards, regulations, and policies in regards to the authorization of Short-Term Fee Basis consults for CBOCs.
    b. Determine whether the parent facility has a local policy or guideline defining how Short-Term Fee Basis consults are handled in CBOCs.
    c. Determine if VA providers appropriately ordered and followed up on Short-Term Fee Basis outpatient radiology procedures (CT, MRI, PET scan, and mammography) in a timely manner.

3. Determine whether CBOCs comply with selected VHA requirements regarding the provision of mammography services for women veterans.
    a. Determine whether screening mammograms were offered in a timely manner to women veterans receiving care at CBOCs and whether results were available in Computerized Patient Record System using required Breast Imaging Reporting and Data System [BI-RADS] code categories.
    b. Determine whether ordering providers and patients received notification of mammography results within timeframes established by VHA.
    c. Determine whether non-VA contract mammography facilities providing services for CBOC women veterans maintain required certification.
    d. Determine whether VHA facilities have established effective oversight of mammography services.
    e. Determine whether CBOCs have designated women's health liaisons who collaborate with the parent facility Women Veterans Program Manager to ensure coordinated and comprehensive care for women veterans.

4. Determine whether CBOC providers are appropriately credentialed and privileged in accordance to VHA Handbook 1100.19.[2]

[1] VHA Handbook 1160.1, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

5. Determine if the CBOCs have a skills competency assessment and validation policy and process in place and if individuals performing competency assessment and validation have the education, background, experience, or knowledge related to the skills assessed.
    a. Determine if staff competence is initially assessed and documented as part of orientation.
    b. Determine ongoing competency assessment and validation for skill-specific competencies.

6. Determine whether CBOCs are in compliance with standards of operations according to VHA Handbook 1006.1[3] in the areas of:
    a. Environmental safety.
    b. Emergency plan.

7. Determine whether primary care active panel management and reporting are in compliance with VHA policy[4] in the areas of:
    a. Primary Care Provider (PCP) panel sizes.
    b. Patient assignment to PCP panels, with emphasis on patient assignment to more than PCP.
    c. Timing of patient removal from panels for inactivity.

8. Determine whether primary care and MH services provided at contracted CBOCs are in compliance with the contract provisions and evaluate the effectiveness of contract oversight provided by the VA focusing on:
    a. Contract provisions related to payment for services, invoice format, and performance-based incentives and penalties.
    b. The invoice validation process.
    c. Timely access to care.

Methodology

CBOC inspections consist of four components: (1) CBOC site-specific information gathering and review; (2) medical record reviews for determining compliance with VHA performance measures, standards, and regulations; (3) on-site inspections; and (4) CBOC contract review and primary care management model review.

The VISN and Facility Directors will be notified 7 weeks prior to the on-site visit of the CBOCs selected for review along with instructions for completing an on-line survey and a list of documents needed to conduct the topic area reviews. Through the survey we will

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

collect descriptive information of each CBOC to include the types of services provided and types of providers and auxiliary staff employed at the respective CBOC.

The requested documents include: (1) CBOC local policies and standard operating procedures; (2) list of patients cared for in the specified CBOC who were referred for emergency MH services; (3) list of patients who were approved for fee basis services to receive imaging studies (CT, MRI, PET Scan and mammography); (4) list of female patients ages 50-69; (5) Primary Care Management Module (PCMM) data; and (6) copies of the CBOC contract and modifications for Primary Care Services, invoices, and payment schedules covering the 1st Quarter, FY 2011 for contracted CBOCs. We request that facility managers create a secured SharePoint or shared drive site and place the documents there for our review.

Focused Topic Areas

MH Continuity of Care

According to VHA policy, healthcare facilities need to have professional oversight of the delivery of MH care in associated CBOCs.[5] Also, there must be methods and procedures for ensuring communication between the leadership of MH services and the associated CBOCs. This requirement for oversight and communication is intended to ensure the ability of the CBOC to respond to patients' MH needs.

The MH services that must be provided in CBOCs vary according to their size. The size of the CBOC is determined by the number of unique veterans annually served. Very large CBOCs, those serving 10,000 or more unique veterans each year, are encouraged to provide MH intensive case management teams, psychosocial rehabilitation and recovery centers intensive outpatient programs for specialty substance abuse treatment services, and grant and per diem programs for homeless veterans. Very large CBOCs must provide MH services during evening hours at least 1 day per week to those who need them. Large CBOCs, those serving 5,000 or more unique veterans annually, must provide a substantial component of the MH services required by their patients, either onsite or by tele-mental health, but may supplement these services by referrals to geographically accessible VA facilities through sharing agreements, contracts, or fee-basis mechanisms. Mid-sized CBOCs, those serving between 1,500 and 5,000 unique veterans annually, must provide general MH services, if needed by their patients, utilizing tele-mental health as necessary. Specialty services must be available to those who require them by using on-site services, sharing agreements, contracts, or referrals, as well as tele-mental health or fee-basis. Smaller CBOCs, those serving less than 1,500 uniques veterans, are to provide access to the full range of general and specialty MH services to those who require them through on-site services, referrals, contracts, or fee-basis, as well as tele-mental health.

[5] VHA Handbook 1160.01.

General MH services include:

- Diagnostic and treatment planning evaluations for the full range of MH problems;
- Treatment services using evidence-based pharmacotherapy or evidence-based psychotherapy;
- Patient and family education;
- Referrals as needed to inpatient and residential care programs; and
- Consultations about special emphasis problems.

Specialty MH services include:

- Consultation and treatment services for the full range of MH conditions;
- Evidence-based psychotherapy;
- MH Intensive Case Management;
- Psychosocial rehabilitation services including:
    - family education,
    - skills training and peer support,
    - compensated work therapy, and
    - supported employment;
- Post traumatic stress disorder teams or specialists;
- Military sexual trauma special clinics;
- Homeless programs; and
- Specialty substance abuse treatment services.

CBOCs must have a predetermined plan for responding to MH emergencies when they occur during the times of operation. Parent facilities must identify at least one accessible VA or community-based emergency department where veterans are directed for emergent care. Contracts, sharing agreements, or other appropriate arrangements with those facilities for sharing information must be identified. Financial arrangements for payment for authorized emergency services and necessary subsequent care must be addressed.

We will review the respective facility policy as well as sharing agreements and/or contracts to determine if there is a plan to respond to MH emergencies. We will also review the medical records of 10 patients, unless fewer patients are available, who were referred for emergency non-VA MH services, to ensure that documentation related to the care received was documented in the medical record. The review of the medical records is to determine if local policy documentation requirements were met.

Short-Term Fee Basis

VHA's Chief Business Office, which is aligned under the Deputy Under Secretary for Health for Operations and Management, has primary responsibility for the Fee Program. Total annual payments for the Fee Program have grown from approximately $1.6 billion in FY 2005 to approximately $3.8 billion in FY 2009.

The purpose of the Fee Program is to assist veterans who cannot easily receive care at a VA medical center (VAMC). The Program pays the medical care costs of eligible veterans who receive care from non-VA providers when the VAMCs are unable to provide specific treatments or provide treatment economically because of their geographical inaccessibility. This type of care is known as "Fee Basis" and it may include dental services, outpatient care, inpatient care, emergency care, and medical transportation. All VAMCs can use this program when needed. It is governed by federal laws containing eligibility criteria and other policies specifying when and why it can be used. With the exception of some emergencies, Fee Basis care must be authorized prior to veterans receiving the services from non-VA providers. Fee Basis care is not an entitlement program or a permanent treatment option.

Short-Term Fee Basis consults are initiated for examinations or for complete episodes of treatment within a designated, concise period of time, usually 60 days. VA providers request Short-Term Fee Basis care for veterans by initiating a Fee Basis Consult using VA Form10-7079 in the Computerized Patient Record System. Veterans who are authorized for Short-Term Fee Basis care may select a qualified physician of their choice to render the services required. In the absence of this selection, facility staff will arrange for treatment by a qualified physician located within a reasonable distance of the veteran's residence.

We will evaluate if VA providers appropriately ordered and followed up on outpatient radiology procedures (CT, MRI, PET scan, and mammography). We will request the facility's local policies for Short-Term Fee Basis Care. We will also review the medical records of 50 patients, unless fewer patients are available, to evaluate if the facility followed applicable VHA policies.[6]

Women's Health

Breast cancer is the second most common type of cancer among American women, with approximately 207,000 new cases reported each year.[7] Timely screening, diagnosis,

[6] Manual M-1, Part I, Chapter 18, *Outpatient Care – Fee*, July 20, 1995.
VHA Directive 2008-056, VHA *Consult Policy*, September 16, 2008.
VHA Handbook 1907.01, *Health Information Management and Health Records,* August 25, 2006.
VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
VHA CBO Procedure Guide 1601.F, *Fee Service.*
[7] American Cancer Society, Cancer Facts & Figures 2009.

notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. Screening by mammography (an x-ray of the breast) has been shown to reduce mortality by 20–30 percent among women age 40 and older. VHA has established gender specific performance measures in the facility and CBOCs. Breast cancer screening for women ages 50–69 is an ongoing CBOC preventive care performance measure. The breast cancer screening performance measure assesses the percentage of patients screened according to prescribed timeframes. The performance management system uses the best scientific evidence in clinical practice to reliably and efficiently achieve the highest quality health outcomes and sets national benchmarks for the quality of preventive and therapeutic healthcare services that exceed private sector performance.

We will review the medical records of 30 randomly selected female patients between 52 and 69 years of age who had mammograms, unless fewer patients are available determine compliance with VHA performance measures and selected VHA policies.

VHA policy outlines specific requirements that must be met by facilities that perform mammography services for women veterans.[8] When mammography services are obtained through contracts or sharing agreements, the VHA facility must ensure the provider is certified by the U.S. Food and Drug Administration (FDA) or a State that has been approved by FDA under 21 C.F.R. 900.21 to certify mammography facilities. VHA policy[9] also requires:

> All VA medical facilities referring patients, under any circumstances, to outside (non-VA) mammography facilities must verify that the site(s) has a current and valid mammography MSQA [Mammography Quality Standards Act] certificate, issued by either FDA or an FDA-approved State. The retention of an FDA certificate is assurance the facility is appropriately accredited and certified to perform mammography. No patients can be referred to a mammography facility that is not FDA or VA-certified.

Additionally, the CBOC and/or parent facility and contract mammography provider must have procedures to identify patients with breast implants and to ensure proper care for these patients prior to mammography.

The CBOC must have assurance of timely result notification to ordering providers, as well as processes to ensure patients receive results with appropriate follow-up as needed. VHA requires oversight of the tracking and timeliness of follow-up of findings from breast cancer screening as a responsibility of the quality management team, in collaboration with the Women Veterans Program Manager, diagnostic services, and

[8] VHA Handbook 1330.01, *Healthcare Services for Women Veterans*, May 21, 2010.
[9] VHA Handbook 1104.1, *Mammography Standards*, August 6, 2003.

Primary Care Service. CBOCs and independent clinics also must designate a Women's Health clinical liaison to coordinate women's issues with the parent facility.

We will evaluate whether: (1) women veterans receiving care at CBOCs had a screening mammogram done at least every 2 years, (2) results were available in the patient's medical record, (3) ordering providers and patients received notification of the results, (4) non-VA mammography facilities maintained required certification, (5) parent facilities established effective oversight of mammography services, and (6) the CBOCs designated a women's health liaison.

Credentialing and Privileging

All VHA health care professionals who are permitted by law and the facility to provide patient care services independently must be credentialed and privileged. The credentialing and privileging (C&P) process is used by medical centers to ensure that clinical providers have the appropriate professional licenses and other qualifications to practice in a health care setting and that they practice within the scopes of their licenses and competencies.

We will conduct an overall review to assess whether the medical center's C&P process complies with VHA policy.[10] We will review providers' (maximum of five) C&P folders (electronic and paper). We will review the privileges granted and Scopes of Practice approved by the parent facility to ensure they were appropriate for services rendered at the assigned CBOC. During our review of providers' folders, we will review service-specific criteria to ensure that ongoing professional practitioner evaluations have been developed and approved that outline the minimum competency criteria for privileges with documented evidence of sufficient performance data to meet current requirements.

Skills Competency

VHA has a High Performance Development Model, which "provides a framework for the VHA to develop a highly skilled, customer-centered workforce for the 21st century." By focusing on eight core competencies, the High Performance Development Model contributes to the development of a continuous supply of excellent leaders committed to VHA's mission.[11] The program objectives and competency behaviors are broad and not inclusive of specific skills required to perform duties.

Some CBOCs are located in communities far away from the clinical resources of their parent facilities, and CBOC staff members are performing a variety of skills. To ensure patient safety, it is important that staff are trained and maintain competence to perform the skills they are assigned.

[10] VHA Handbook 1100.19.
[11] http://vaww4.va.gov/hpdm/

We will evaluate the training records of patient care staff members to ensure that skill-specific competency was validated and documented. Additionally, we will evaluate facility policies to ensure that skill-specific competencies are assessed during orientation and that the policy addresses the education, background, experience, or knowledge related to those who assess the skills.

Environment and Emergency Management

Environment of care is crucial to achieving a safe patient care environment, reducing infection control risks and improving patient care outcomes. CBOCs must be maintained in a state of cleanliness that fully meets all VHA, Occupational Safety and Health Administration, and Joint Commission standards. We will conduct environment of care rounds at each CBOC to ensure that they adhere to Americans with Disabilities Act, National Fire Protection Association regulations, patient safety, and infection control guidelines.

We will review each CBOC's local emergency management policy and interview employees to ensure there is a plan in place to address patients who experience a medical or psychological emergency such as heart attack, hypoglycemic events, suicidal, or homicidal ideations. We will also ensure that staff are aware and can articulate the steps of handling a medical or psychological emergency.

PCMM Review

The application that runs on the Veterans Health Information Systems and Technology Architecture (VistA) is the primary means for VHA to track and manage patients in primary care panels. The PCMM Coordinator is responsible for ensuring that the information in the PCMM database is accurate and current. We will be reviewing compliance with VHA policy regarding patient assignment to and removal from a PCP panel.[12]

We will accomplish this by:

- Inquiring with the PCMM Coordinator about the process used to maintain timely and accurate data in the PCMM.
- Reviewing the PCMM panel assignment process to determine if the facility checks to see if a patient is already assigned to a PCP panel at another facility prior to assigning a new patient to a PCP panel.
- Verifying that inactivation is performed if the patient expires, transfers, or has not been seen by his or her assigned PCP within PCMM established timeframes.[13]

[12] VHA Handbook 1101.02.

[13] Timeframes cannot exceed 12 months for newly assigned patients and 24 months for established patients.

- Using the VHA Support Service Center (VSSC) web site to run reports to analyze data reported by the parent facility.

The accuracy of the data in the PCMM database is critical to ensuring that resources supporting primary care are appropriately allocated. PCMM is used to identify the PCP assigned to care for each patient. A patient should not have more than one PCP assigned; however, in certain approved cases it is appropriate. This application is an important tool in determining the total number of veterans that can be cared for in the VA health care system and align the supply of services with demand.

We will perform inquiries of PCMM Coordinators to review the processes used to update PCMM patient panels for transfers to other facilities, deaths, and duplicate enrollments and software service patches are current. We will review reports from the VSSC for active and unique enrollees to compare against the number of invoiced enrollees. Additionally, we will review VSSC reports on duplicated PCP assignments to assess if the PCMM Coordinators were monitoring duplicate enrollees.

Contract Review

Approximately 23 percent of all CBOCs are contract. CBOC contracts are administered and monitored by the parent facility. A Contracting Officer's Technical Representative (COTR) is delegated to provide oversight of the contractor providing care at the CBOC. We will conduct our reviews of primary care and MH CBOC contracts to evaluate the effectiveness of oversight provided by the COTR and the compliance with selected contract provisions relating to payment of services.

We will verify that the number of enrollees or visits that are reported is consistent with what is actually supported with collaborating documentation. We will accomplish this by:

- Interviewing the COTR to gain an understanding of the invoice validation process.
- Reviewing invoices and supporting documentation focusing on accuracy of calculations, rates charged, and the number of enrollees or visits.
- Analyzing VistA, data to assess the reasonableness of invoice amounts.
- Comparing invoice amounts with what the VA actually paid by cross-checking with payments made and recorded in the Data Management System.
- Interviewing the Contracting Officer about contractual and performance matters.

We will review the methodology for tracking and reporting the number of enrollees in compliance with the terms of the contract. Additionally, we will review paid 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 social security numbers on the invoices.

We will perform inquiries of COTRs to determine the scope of MH services provided, compliance with contract terms and conditions, contracted care pricing models, and processes used to validate MH billings. We will analyze VistA data for MH encounters to test accuracy of billings and determine the providers of care. Additionally, we will review the pricing models employed.

Report Timeline

A report will be issued approximately 60 days after the on-site inspection of the CBOC. The report will cover the inspection of three to five VAMCs' CBOCs, which are usually two per medical center. Each report will cover our findings of the objectives described earlier in this report. The first report will be issued in June 2011 (CBOCs visited in April 2011).

At the end of the fiscal year, we will aggregate the data and issue a report. The FY 2011 report will address 85 inspections conducted during the months of October 2010 through September 2011. However, this informational report addresses inspection activities planned for April through September 2011.

(original signed by Patricia Christ,
Deputy Assistant Inspector General for
Healthcare Inspections for:)

JOHN D. DAIGH, JR., M.D.
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