Department of Veterans Affairs
Office of Inspector General

Informational Report

Community Based Outpatient Clinic Cyclical Reports Fiscal Year 2012

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VA Office of Inspector General
Washington, DC 20420

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Contents

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) in FY 2009. The purpose of this report is to describe the review design of the CBOC focused topic areas for FY 2012.

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

SUBJECT: Informational Report – Community Based Outpatient Clinic Cyclical Reports Fiscal Year 2012

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 FY 2012.

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 187 CBOCs, which have resulted in 22 published reports as of August 15, 2011.

Purpose and Topic Area Review 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. Assess Short-Term Fee Basis authorization and follow-up processes for outpatient radiology consults including computerized tomography (CT), magnetic resonance imaging (MRI), and positron emission tomography (PET) scan 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 guidelines defining how Short-Term Fee Basis consults are handled.
    c. Determine if VA providers appropriately ordered and followed up on Short-Term Fee Basis outpatient radiology procedures (CT, MRI, and PET scan) in a timely manner.
    d. Determine if Fee Basis payments to primary care providers are in accordance with VA reimbursement policies.

2. Evaluate 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 the 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.

3. Evaluate the extent CBOCs have implemented the management of Diabetes Mellitus-Lower Limb Peripheral Vascular Disease (DM-LLPVD) in order to prevent lower limb amputation**.**
    a. Determine whether facilities have developed a system to identify and track patients at risk for lower limb amputations as outlined in VHA Directive 2006-050.[1]
    b. Determine whether at-risk veterans are screened, identified by risk category, and referred for follow-up according to VHA Directive 2006-050.
    c. Determine whether facilities document education to DM-LLPVD veterans about preventive foot care and footwear as outlined in *VA/DoD [Department*

[1] VHA Directive 2006-050, *Preservation-Amputation Care and Treatment (PACT) Program*, September 14, 2006.

of Defense] Clinical Practice Guideline: Management of Diabetes Mellitus (DM) and VHA Handbook 1122.01.[2]

d. Determine whether employees providing diabetic foot care education meet the requirements specified in VHA Handbook 1122.01.

4. Evaluate the continuity of care for enrolled CBOC patients discharged from the parent facility in FY 2011 with a primary discharge diagnosis of congestive heart failure (HF).
    a. Determine if discharge plans were addressed in the primary care setting.
    b. Determine if providers communicated the "hand off" of patient care to optimize continuity.
    c. Determine if primary care clinicians include medication, diet, and daily management [symptom and /or trigger] interventions in the treatment plans of patients diagnosed with HF.
    d. Determine if patients receive timely access to primary care and/or cardiology visits.

5. Determine whether CBOC providers are appropriately credentialed and privileged in accordance to VHA Handbook 1100.19.[3]

6. Determine whether CBOCs are in compliance with standards of operations according to VHA Handbook 1006.1[4] in the areas of:
    a. Environmental safety.
    b. Emergency plan.

7. Determine whether primary care and mental health (MH) services provided at contracted CBOCs are in compliance with the contract provisions and VA directives.
    a. Review specific contract provisions related to payment for services, invoice format, contractor monitoring procedures, traveling veterans, and performance-based incentives and penalties.
    b. Review the contract to ensure compliance with VA directives.
    c. Evaluate the effectiveness of contract oversight provided by the Contracting Officer's Technical Representative (COTR) to ensure compliance with the contract.
    d. Determine whether the contract, modifications, and extensions have been appropriately prepared and processed.
    e. Review documentation that supports proper designation of the COTR.

8. Determine if CBOC procedures regarding traveling veterans are performed in accordance with VHA Directive 2007-016.[5]

[2] VHA Handbook 1122.01, *Podiatric Medical and Surgical Services for Veterans Health Administration Medical Facilities*, November 25, 2009.
[3] VHA Handbook 1100.19, *Credentialing and Privileging,* November 14, 2008.
[4] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics,* May 19, 2004.
[5] VHA Handbook 2007-016, *Coordinated Care Policy for Traveling Veterans,* May 7, 2007.

a. The facility uses Veterans Health Information Systems and Technology Architecture's [VistA's] Register Once functionality to register patients who are enrolled at other facilities.
b. The facility has a Referral Case Manager to assist the veteran and staff in providing care to the traveling veteran at the non-preferred VA medical center.

Methodology

CBOC inspections consist of four components: (1) CBOC site-specific information gathering and review; (2) medical record reviews for determining compliance with VHA and The Joint Commission standards and regulations; (3) on-site inspections; and (4) CBOC contract review.

The VISN and Facility Directors will be notified 10–12 weeks prior to the on-site visit of the CBOCs selected for review and provided instructions for completing an on-line survey and a list of documents needed to conduct the topic area reviews. Through the survey we will collect descriptive information of each CBOC, to include the types of services provided and types of providers employed at the respective CBOC.

The requested documents include: (1) parent facility and CBOC local policies and standard operating procedures; (2) a list of Primary Care and MH providers; (3) list of patients who were approved for fee basis services to receive imaging studies (CT, MRI, and PET scan); (4) list of female patients ages 52–69; (5) list of patients cared for in the specified CBOC who are 18–70 years of age and have a diagnosis of DM and no previous lower limb amputation(s); (6) a list of patients who were discharged from the parent medical center with a primary diagnosis of HF; and (7) copies of the CBOC contract and modifications for Primary Care Services, invoices, and payment schedules covering the 3rd Quarter, FY 2011 for the 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

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 $3 billion in FY 2008 to approximately $4.4 billion in FY 2010.

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 Short-Term Fee Basis consults for outpatient radiology procedures (CT, MRI, and PET scan). We will request the facility's local policies for Short-Term Fee Basis care. We will also review the medical records of 50 randomly selected patients, unless fewer patients are available, to evaluate if the facility followed applicable VHA policies.[6] We will evaluate the Fee Basis payments for timeliness and correct amount.

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, 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.

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, to determine compliance with 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. Furthermore, when the services are outsourced, VHA requires that the site performing the mammogram communicate the results directly to the veteran when follow up treatment or care is not recommended.[9]

[6] Manual M-1, Part I, Chapter 18, *Outpatient Care – Fee*, July 20, 1995.
[7] American Cancer Society, Cancer Facts & Figures 2009.
[8] VHA Handbook 1330.01, *Healthcare Services for Women Veterans*, May 21, 2010.
[9] VHA Handbook 1105.03, *Mammography Program Policies and Guidance*, April 28, 2011

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 Primary Care Service. CBOCs and independent clinics must also 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 which included the BI-RADS code category, (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.

DM-LLPVD

The Center for Disease Control and Prevention (CDC) estimates that 25.8 million people in the United States, or 8.3 percent of the population, suffer from DM. The CDC further estimates that approximately 15 percent of individuals with diabetes will develop foot ulcers and that 15 to 20 percent of these ulcers will result in lower extremity amputations.

Diabetes is the leading cause of non-traumatic lower-limb amputations, resulting in 60 percent of all non-traumatic lower-limb amputations. It has been estimated, however, that 85 percent of diabetic foot amputations could be prevented through education of health professionals and patients regarding proper foot care and prevention of diabetic foot ulcers.

The VHA established its Preservation-Amputation Care and Treatment (PACT) Program in 1993 to prevent and treat lower extremity complications that can lead to amputation. An important component of this program is the screening of at-risk populations, including veterans with diabetes.

The VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus represents a compendium of best practices for medical providers in the treatment of DM. It includes the provisions that clinicians should perform and document patient education for preventive foot care and address patient self-management and education.

It is vital that veterans diagnosed with such conditions as DM-LLPVD receive annual screenings and foot care education in accordance with VHA Directives and Clinical Practice Guidelines. A clear goal is early intervention with younger veterans so that they do not join the estimated 90 percent of veterans over the age of 65 who suffer from

some type of painful foot condition, severe enough to limit ambulation. The ability to walk has a profound influence on the veteran's physical and psychological condition and quality of life.

We will evaluate the extent VHA CBOCs have implemented the management of DM-LLPVD in order to prevent lower limb amputation. We will request the facility's local policies related to the PACT Program and the screening, education, and program monitoring of DM-LLPVD. We will also review the medical records of 30 randomly selected patients, unless fewer are available, to evaluate if the facility followed applicable VHA/DoD Guidelines[10] and VHA policies.[11]

HF Follow-up

About 5.7 million people in the United States have HF, and it results in about 300,000 deaths each year. HF is more common in people who are 65 years old or older, African Americans, and people who are overweight. Additionally, men have a higher rate of HF than women. The most common signs and symptoms of HF include shortness of breath or trouble breathing; fatigue; and swelling in the ankles, feet, legs, abdomen, and veins in the neck. Fluid buildup from HF also causes weight gain, frequent urination, and a cough that is worse at night and when lying down.

About 550,000 new HF cases are diagnosed each year. The prevalence of HF increases with age, with nearly 5 percent of patients seen at VAMCs having a primary diagnosis of HF. According to a recent report from the American Heart Association, 80 percent of men and 70 percent of women with a diagnosis of HF, who are less than 65 years of age, will die within 8 years. In addition, the 1-year mortality rate was reported as 20 percent. Hospitalizations for HF have increased, accounting for 6.5 million hospital days annually. HF was also reported to be the main reason for 12 to 15 million clinic visits each year. The VA provides care for over 212,000 veterans with HF, with nearly 24,500 of these patients being hospitalized during a 12-month period during FYs 2010 and 2011 with a primary diagnosis of HF.[12] The leading causes of HF are diseases that damage the heart, to include coronary artery disease, high blood pressure, and diabetes.[13]

Treatment for HF depends on the type and stage (or severity) of the condition. Treatments usually include lifestyle changes, medicines, and ongoing care. Management of HF includes recommendations to follow a heart healthy diet, proper fluid intake, weight loss (if indicated), physical activity (as indicated), smoking cessation, and getting adequate rest. Successful management is also dependent on following a prescribed medication regimen. Additionally, patients must be educated to recognize signs and symptoms and to initiate contact with their practitioner when necessary.

[10] VA/DoD Clinical Practice Guideline, *Management of Diabetes Mellitus (DM),* August 2010.
[11] VHA Directive 2006-050, *Preservation-Amputation Care and Treatment (PACT) Program*, September 14, 2006
[12] Statistics from VHA Support Services Center, accessed July 11, 2011.
[13] National Heart Lung and Blood Institute, Diseases and Conditions Index, U.S. Department of Health and Human Services, National Institute of Health.

Lastly, patients should be encouraged to keep all medical appointments, including visits to their practitioner and appointments for tests.[14]

We will evaluate the continuity of care for enrolled CBOC patients discharged from the parent facility with a primary discharge diagnosis of HF. We will review the medical records of 30 randomly selected patients, unless fewer patients are available, to determine if patients receive timely access to primary care after hospitalization discharge.

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.[15] 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. We will also review all providers placed on focused professional practitioner evaluations for initial and new privileges or for performance issues.

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 The 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.

[14] National Heart Lung and Blood Institute.
[15] VHA Handbook 1100.19.

Contract Review

Approximately 18 percent of all CBOCs are contract. CBOC contracts are administered and monitored by the parent facility. A COTR is delegated to provide oversight of the contractor providing care at the CBOC.

We will review invoices and supporting documentation to determine accuracy of calculations, rates charged, and the number of enrollees or visits. We will interview VA and contractor personnel to gain an understanding of the invoice validation process and learn about any contractual and/or performance related matters. We will also perform inquiries of the CBOC MH providers, VA MH Chief, and/or COTRs to determine if MH services are provided by the contractor or VA and the types of MH services being provided.

VHA has established guidelines to assist veterans that require health care while traveling away from home. We will review continuum of care for these traveling veterans to ensure compliance with VHA Directive 2007-016, *Coordination of Care for Traveling Veterans* at contract sites. A traveling veteran should not be assigned to a provider panel at the visiting facility. Assignment to a provider panel could inflate the panel size and could lead to increased costs for contracted facilities.

Report Timeline

A report will be issued approximately 90 days after the on-site inspection of the CBOC. The report will cover the inspection of three to eight CBOCs, which are usually two CBOCs per parent facility. Each report will cover our findings of the objectives described in this report. The first report will be issued in December 2011 (CBOCs visited in October 2011).

At the end of the fiscal year, we will aggregate the data and issue a report. The FY 2012 report is projected to address 95 inspections conducted during the months of October 2011 through September 2012.

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