Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Community Based Outpatient Clinics Fiscal Year 2011

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VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections completed an evaluation of Veterans Health Administration (VHA) community based outpatient clinics (CBOCs). The purposes of the evaluation were to determine whether:

- The CBOCs' quality of care measures are comparable to the parent VA medical center (VAMC) clinics.
- CBOCs comply with selected VHA requirements regarding the provision of mammography services for women veterans.
- Short-Term Fee Basis (STFB) authorizations and follow-up processes for selected outpatient radiology consults are assessed in an effort to ensure quality and timeliness of patient care in CBOCs.
- CBOCs comply with selected standards in VHA Handbook 1160.01 regarding the management of mental health (MH) emergencies.
- CBOCs have a skills competency assessment, 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.
- CBOC providers are appropriately credentialed and privileged in accordance with VHA Handbook 1100.19.
- CBOCs are in compliance with standards of operations according to VHA Handbook 1006.1 in the areas of environment of care and emergency management.
- Primary and MH services provided at contracted CBOCs are in compliance with the contract provisions and evaluate the effectiveness of contract oversight provided by VA.
- Primary care active panel management and reporting are in compliance with VHA policy.

Results and Recommendations

Overall, CBOCs appear to be providing a quality of care that is not substantially different from parent VAMCs. CBOCs estimates are either not different from or statistically significantly higher than the set threshold with the exception of seven indicators for VA-staffed (four rural and three urban) and four indicators for contract (two each for rural and urban) CBOCs.

We have found improvements from previous reviews in administration and oversight of contract CBOCs. VHA has developed a CBOC template, which includes standard contract provisions, quality assessment surveillance plans, and improvements in defining the terminology for the requirements for payment. CBOCs generally met VHA directives and guidelines.

We found the following areas that needed improvement. We found that:

- Five (11 percent) of 44 CBOCs did not have a Women's Health Liaison.
- VA compliance rate for mammogram results linked to the breast study order in Computerized Patient Record System [CPRS] was statistically significantly lower than the 90 percent threshold.
- Seven of 21 parent facilities[1] did not have local policies and procedures regarding non-VA care and services that describe the request, approval, and authorization process for such services.
- The compliance rates for the reason STFB consult procedures were outsourced are statistically significantly below the 85 percent threshold for urban VA-staffed and contract CBOCs, while the rural contract CBOC compliance rate is statistically significantly higher than the threshold.
- Compliance rates for patients that received written notification of STFB consult for urban CBOCs, whether VA-staffed or contract, are statistically significantly below the threshold of 85 percent. Compliance rates are not statistically significantly different from 85 percent for rural CBOCs regardless of type.
- Seven (16 percent) of 44 CBOCs did not have a plan identified in their local policy addressing how MH emergencies would be addressed during the hours of operation if the provider determined that the patient requires a higher level of care.
- Sixty-six (38 percent) of 172 patient care staff members had 1 or more identified skills competency that was not currently assessed in accordance with local policies.
- Six (14 percent) of 41 CBOCs[2] did not maintain auditory privacy during the check-in process.
- Eight (20 percent) of 41 CBOCs did not consistently secure patients' personal information.

[1] Two parent facilities did not have patients that met the criteria for this review.
[2] We did not conduct EOC rounds at three CBOCs because the facilities were closed/suspended at the time of the inspection.

- Seven (17 percent) of 41 CBOCs had security vulnerabilities in the allocated information technology network space.
- Seven of 19 contract CBOCs were noncompliant due to overpayment for ineligible patients on the billable roster and inadequate invoice validation.
- Six of 19 CBOC contracts had issues related to compliance with VA Directive 1663.
- Three of 19 CBOC contracts did not contain any provisions addressing how veterans MH needs would be provided.

To improve operations, we recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers:

Recommendation 1. Ensure that each CBOC has a Women's Health Liaison who collaborates with the parent facility's Women Veterans Program Manager on women's health issues.

Recommendation 2. Ensure that all breast imaging and mammography results are linked to the appropriate radiology mammogram or breast study order.

Recommendation 3. Ensure that each medical center has a local policy for STFB consults.

Recommendation 4. Ensure that practitioners document a justification for the use of STFB care in the medical record, specifically at urban CBOCs.

Recommendation 5. Ensure there is documentation in the medical record that the patient received written notification STFB consult approval, specifically at urban CBOCs.

Recommendation 6. Ensure that each CBOC has a plan that defines how MH emergencies that require a higher level of care are addressed.

Recommendation 7. Ensure patient care staff members at CBOCS have ongoing competency assessments validated for identified core competencies.

Recommendation 8. Ensure that auditory privacy is maintained during the check-in process.

Recommendation 9. Ensure that all personal identifiable information is secured and protected.

Recommendation 10. Implement measures to minimize information technology network space vulnerabilities in accordance with VA policy.

Recommendation 11. Review the invoice validation process to consider creating a standardized billable roster report to improve oversight and accuracy of billable patient lists, thereby reducing man hours currently performing those duties and potential overpayments.

Recommendation 12. Strengthen the oversight of the contract acquisition process to ensure that adequate planning occurs and that proper approvals are documented in the contract management system [eCMS] in accordance with VA Directives.

Recommendation 13. Ensure that MH services for contract CBOCs are addressed in a separate contract or within the primary care contract.

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

TO: Under Secretary for Health (10)

SUBJECT: Healthcare Inspection—Evaluation of Community Based Outpatient Clinics, Fiscal Year 2011

Introduction

Purpose

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

Background

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

The CBOC model provided the VA with the option of hiring VA staff or contracting with outside health care providers to deliver care to its veterans. Each CBOC would be affiliated with a single VA medical center (VAMC) that would be administratively responsible for that CBOC.

VA policy outlines specific requirements that must be met at CBOCs. The minimum standards were developed in 2001 to ensure that veterans receive one standard of care at all VHA health care facilities.

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 OIG has been systematically reviewing VHA CBOCs since April 2009.

Scope and Methodology

We performed this review based on the inspections of 38 CBOCs from October 18, 2010, through March 7, 2011 (Period I), and 44 CBOCs from April 11, 2011, through September 26, 2011 (Period II). The 82 CBOCs' findings were issued in 11 CBOC reports.[3] The CBOCs we inspected represented a mix of facility size, geographic location, and Veterans Integrated Service Networks (VISNs). Our review focused on FY 2010 and 2011 activities. We analyzed results and reported deficiencies in each CBOC report.

Because the CBOCs reviewed during Period I were selected utilizing a fixed randomization, a projection over all VHA is not possible and therefore not analyzed in this report. The results of those reviews are discussed in five CBOC reports.

There are 14 standards that must be met for CBOC operations. Nine of the 14 standards were addressed during our reviews and discussed in this report.[4] The standards can be found in VHA Handbook 1006.1.[5]

VA uses two key performance measures to assess the quality of health care delivery, the Chronic Disease Care Index II and the Prevention Index II (PI II). These indices measure the degree to which the VA follows nationally recognized guidelines for the treatment and care of patients. This report evaluated PI II (women's breast cancer screening). Data for the indicators were obtained from the patient medical record and compared to the parent facilities' results. The time period utilized for the PI II review was quarter (Qtr) 1, FY 2011.[6]

Statistical Methodology. The study population consists of all patients who used VHA CBOCs for healthcare during FY 2010. We categorized the VAMCs into one of the following three CBOCs staffing types:

- The "Contract" type where VAMCs staffed all their CBOCs by contracted personnel.
- The "VA" type where VAMCs operated all their CBOCs by VA staff, regardless of leased or VA owned building.
- The "Both" type where VAMCs staffed some of their CBOCs by contracted personnel and other CBOCs by VA staff.

We used a three-stage complex probability sample design to select patients for chart reviews. In the first stage of sampling, we statistically randomly selected 24 VAMCs: 2 with contracted staff alone, 5 with VA staff alone, and 17 with both.

[3] Report Numbers: 11-00839-79, 11-00840-104, 11-00841-122, 11-00843-169, 11-00844-220 (Period I) and 11-01406-228, 11-01406-238, 11-01406-288, 11-01406-13, 11-01406-14, 11-01406-38 (Period II).
[4] Staffing, Timeliness, Station Numbering, Cost Accounting, and Patient Complaints were omitted from this review.
[5] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.
[6] VHA's comparison dates for Qtr 1, FY 2011, are October through December 2010.

In the second stage of sampling, we selected two of its CBOCs from each of the 24 selected VAMCs. For the 17 VAMCs that staffed CBOCs using both contracted and VA personnel, we selected one CBOC from its CBOCs staffed under contract and one from its CBOCs staffed with VA personnel. The design yielded a statistical sample of 48 CBOCs: 27 VA staff and 21 contracted staff. We excluded 4[7] of the 48 sampled CBOCs later because 1 was closed, 1 switched to a new contractor, and 2 were mental health (MH) clinics. Thus, a total of 44 CBOCs (25 VA staff and 19 contracted staff) were included for on-site inspections and for patient chart review.

In the third stage of sampling, we selected patients from the 44 CBOCs for chart review. We randomly selected 30 patients within each of the 44 CBOCs, except for review of radiology short-term fee basis (STFB) consults where we randomly sampled 50 patients within a CBOC. All patients were included for chart review if a CBOC had fewer than 30 (50 for STFB consults) patients.

We conducted a contract review for the 19 contracted CBOCs in the sampled 44 CBOCs.

Statistical Analysis. We estimated the VA compliant percentages for each of performance measures. Breast cancer screening performance measures were computed for patients whose screenings were done on or after June 1, 2010. When a particular performance measure did not apply to a patient, the patient was excluded from analyses for that measure. For example, among other conditions, the Breast Imaging Reporting and Data System (BI-RADS) result must be negative or benign in order to be applicable to the patient for the notifying a patient of normal results within 30 days.

To take into account the complexity of our multi-stage sample design, we used Horvitz-Thompson sampling weights--which are the reciprocal of sampling probabilities--to account for unequal probability sampling, and the Taylor expansion method to obtain the sampling errors for the estimates. We set the desired levels of at least 90 percent and 85 percent for the breast cancer screening performance measures and the STFB criteria, respectively. We first estimated CBOC performance measures/criterion separately based on their staffing type and rural/urban location. We then pooled CBOCs across for staffing type and rural/urban location according to whether or not their performance measure/criteria met or exceeded the desired level at the statistical significance level of 0.05, to estimate a performance measure/criterion for those CBOCS whose performance measure/criterion met or exceeded the desired level, and another for those CBOCS whose measures did not meet the desired level.

We presented 95 percent confidence intervals (95% CI) for the true values (parameters) of the study population. A confidence interval gives an estimated range of values (being calculated from a given set of sample data) that is likely to include an unknown population parameter. The 95% CI indicates that among all possible samples we could

[7] Two CBOCs were assigned to 1 parent facility; therefore, total number of parent facilities changed to 23 from 24.

have selected of the same size and design, 95 percent of the time the population parameter would have been included in the computed intervals.

Percentages can take only non-negative values from 0 to 100, but their logits can have unrestricted range so that the normal approximation can be used. Thus, we calculated the confidence intervals for percentages on the logit scale and then transformed them back to the original scale to ensure that the calculated confidence intervals contained only the proper range of 0 to 100 percent.

All data analyses were performed using SAS statistical software (SAS Institute, Inc., Cary, NC), version 9.3 (TS1M0).

Our review focused on compliance with selected requirements from VHA Handbook 1006.1 and other VHA policies. CBOC inspections consisted of four components: (1) CBOC site-specific information gathering and review, (2) medical record reviews for determining compliance with VHA performance measures or directives, (3) on-site inspections, and (4) CBOC contract review.

1. CBOC Characteristics

We collected CBOC characteristics from an online questionnaire completed by the CBOC Director/Manager. We validated and aggregated the data to determine if any trends and statistical significant difference were found between VA-staffed and contract CBOCs.

2. Medical Record Review

For each CBOC, we reviewed the Computerized Patient Record System (CPRS) of a random sample of 30 female patients who were 50 to 69 years of age and 50 patients that had selected radiology STFB consults, unless fewer patients were available. We reviewed the medical records for a probability-based statistical sample of patients within each sampled CBOC to determine compliance with VHA performance measures and compliance with VA policy.

We also reviewed 10 patients, unless fewer were available, who were referred for emergency non-VHA MH services. No statistical analysis was conducted for this patient category.

3. On-site Inspections

As part of the on-site visit, we inspected the CBOC for environment of care (EOC) issues and emergency management procedures, reviewed CBOC providers' credentialing and privileging or scope of practices folders, reviewed auxiliary staff's competency folders, and discussed their compliance with VA policy, as applicable. We interviewed CBOC managers and VHA staff.

4. Contracted CBOC Review

We conducted reviews of primary care and MH services at 19 contract CBOCs during the review period April through September 2011 to evaluate: (1) effectiveness of VHA oversight and administration for selected contract provisions relating to quality of care and payment of services, (2) invoice validation process, and (3) proper execution of contracts and related documents. Of the 19 contract CBOCs reviewed, 15 offered both primary care and MH services and 4 referred MH services to other facilities.

Reviews were based on the requirements of VA Directive 1663.[8] This directive details the requirements and responsibilities for contracting and buying health care resources.

Each CBOC engagement included: (1) a review of the contract, (2) analysis of patient care encounter data, (3) corroboration of information with VHA data sources, (4) site visits, and (5) interviews with VHA and contractor staff.

Primary Care. We assessed each primary care contract for consistency with VHA directives, and inclusion of specific payment and performance provisions such as: (1) effective dates of agreements, (2) assignments of responsibility between VHA and the contractor, (3) contractor's reporting requirements, (4) criteria used to define a qualifying visit for billing purposes, (5) billing rates and invoice formats, (6) performance measures, and (7) incentive/penalty provisions. We assessed VHA's oversight of the contractor while enforcing the provisions of the contract and conducted a technical review of the contract documents to determine compliance with VA Directive 1663.

MH. VHA has established minimum clinical requirements for MH services to ensure that all veterans receiving primary care at a VHA facility have access to MH services when needed, per VHA Directives.[9] These requirements are based on the principle that MH is an essential component of health care. The services that must be provided in CBOCs differ according to the number of patients served at the clinics. MH services may be provided at the clinic by a provider or through tele-MH services, where the use of technology allows a provider at another location to provide services to the veteran via a monitor. Services may also be provided at another geographically accessible VA clinic or at a non-VA clinic using fee basis care to the extent the veteran is eligible.

We conducted our review of contract MH services using the same methodology as described above for primary care. However, we performed additional inquiries to determine who provided care (VHA or contractor), where services were being provided, and contract provisions relating to MH care.

5. Primary Care Management Module

We conducted reviews of Primary Care Management Module (PCMM) administration for all CBOCs reviewed during the period to assess VHA's management and accuracy of the primary care panels. PCMM is a Veterans Health Information Systems and Technology Architecture application used to manage Primary Care Provider (PCP)

[8] VA Directive 1663, Health *Care Resources Contracting – Buying,* August 10, 2006.
[9] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers And Clinics*, September 11, 2008.

workload to balance productivity with quality, access, and patient service. A patient may have more than one PCP assigned in certain circumstances; however, this dual assignment requires specific approval. 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 aligning the supply of services with demand.

We reviewed reports to determine the number of patients assigned to each PCP panel, the number of enrollees assigned to more than one PCP, and if deceased patients were still assigned to a panel.

We conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: CBOC Characteristics

We formulated a list of CBOC characteristics and developed a questionnaire for data collection. The characteristics included identifiers and descriptive information for the CBOC evaluation. The aggregated results of the CBOC characteristics data from an online questionnaire are reported below.

The study population constitutes all patient enrolled in the CBOCs for their health care. There were 557 VA CBOCs subject to review. VA-staffed CBOCs had a greater number of urban locations (56 percent) where contract CBOCs had a greater number of rural locations (75 percent). (See Table 1.)

	Urban	Rural/Highly Rural
VA-staffed	261	205
Contract	23	68

Table 1. Urban and Rural by CBOC Type (Source: VHA Site Tracking (VAST) System)

Of the 44 CBOCs[10] in our sample, there were 14 VA-staffed and 13 contract CBOCs in rural locations and 11 VA-staffed and 6 contract CBOCs in urban locations.

The average number of uniques (study population) seen at 466 VA-staffed CBOCs was 4,604 (range 31 to 52,019) and at the 91 contract CBOCs was 2,047 (range 166 to 7,793). Table 2 displays uniques by CBOC type and location. Of the sampled CBOCs, the average number of unique patients seen at the 25 VA-staffed CBOCs was 5,993 (range 97 to 30,390) and at the 19 contract CBOCs was 2,346 (range 166 to 5,219).

	Total Unique	Urban	Rural/Highly Rural
VA-staffed	2,145,295	1,604,440	537,855
Contract	186,282	93,904	92,378

Table 2. Enrollees by CBOC Type and Location (Source: VAST System)

Table 3 and 4 shows the sample counts and VA estimate of VA-staffed and contract CBOCs with each type of service listed that were statistically significant.

[10] There were initially 48 CBOCs in the sample; however, 1 CBOC was closed, 1 had a new contractor, and 2 were primarily MH clinics. Therefore, the four CBOCs were not included in the data analysis for CBOC characteristics or performance measures.

Characteristic	VA-staffed CBOCs (Total Sampled CBOCs=25)				Contract CBOCs (Total Sampled CBOCs=19)			
			95% CI				95% CI	
Name	Number	Percent (Weighted)	Lower	Upper	Number	Percent (Weighted)	Lower	Upper
Specialty Care at VAMC	23	90.4	55.77	98.59	19	100.0		
Specialty Care at other CBOC	1	1.0	0.23	4.22	4	14.9	6.91	29.06
Ancillary Staff RN	25	100.0			16	76.2	53.17	90.07
Ancillary Staff Social Worker	20	94.7	88.66	97.59	9	43.6	27.54	61.05
Ancillary Service Lab	24	92.4	52.78	99.24	19	100.0		
Ancillary Service EKG	24	98.3	93.11	99.62	15	63.1	40.96	80.85

Table 3. FY 2011 Specialty and Ancillary CBOC Characteristics Estimates by Contract/VA-staffed for Characteristics That Are Statistically Different for VA-staffed and Contract CBOCs

Characteristic	VA-staffed CBOCs (Total Sampled CBOCs=25)				Contract CBOCs (Total Sampled CBOCs=19)			
			95% CI				95% CI	
Name	Number	Percent (Weighted)	Lower	Upper	Number	Percent (Weighted)	Lower	Upper
MH Services On site	25	100.0			14	61.4	40.87	78.52
General Diagnosis	25	100.0			11	49.5	32.07	67.06
General Medical Management	24	98.3	93.11	99.62	12	52.5	34.29	70.03
General Psychotherapy	23	98.0	93.21	99.44	10	49.5	32.06	67.07
General PTSD	23	97.7	92.88	99.27	14	61.4	40.87	78.52
General Consult MST	21	96.7	91.98	98.66	12	52.5	34.29	70.03
Special Consul and Treatment	23	97.0	91.57	98.98	7	35.1	17.24	58.51
Special Psychotherapy	18	92.0	84.91	95.95	6	32.2	15.01	56.04
Special MHICM	10	59.7	39.77	76.85	1	5.9	1.44	21.47
Special Peer Support	7	54.5	16.81	87.62	1	3.0	0.70	11.69
Referrals to VAMC	24	92.4	52.78	99.24	19	100.0		
MH Emergency Written Plan	23	97.7	92.88	99.27	16	79.2	58.19	91.25

Table 4. FY 2011 MH CBOC Characteristics Estimates by Contract/VA-staffed for Characteristics That Are Statistically Different for VA-staffed and Contract CBOCs

Conclusion

We found that most of the VA-staffed and contract CBOCs had comparable characteristics. However, VA-staffed CBOCs served a higher percentage of patients in urban areas, while contract CBOCs provided care fairly equally in rural and urban locations. VA-staffed CBOCs generally had higher estimates when the differences between estimates for VA-staffed and contract CBOCs were statistically significant.

We collected this data for informational purposes only. Therefore, we made no recommendations.

Issue 2: Quality of Care Measures Based on Medical Record Review

VHA's breast cancer screening performance measure assesses the percentage of patients screened according to prescribed timeframes. 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. We reviewed 789 women veteran medical records that met the criteria. We found 45 patients who refused mammography. Patients who refused to have a procedure performed were considered compliant for the respective performance measure.

Mammogram Compliance Estimates by Urban/Rural and VA-staffed/Contract. The compliance rates for breast cancer screening are not statistically different from the 90 percent threshold for VA-staffed CBOCs, whether urban or rural. However, estimates for contract CBOCs (both urban and rural) are statistically higher than 90 percent. The results are displayed in Table 5.

Performance Measure	VA-staffed					Contract					Estimates Are 90% or Higher*
	Number of Patients		Percent Compliant	95% CI for Percent Compliant		Number of Patients		Percent Compliant	95% CI for Percent Compliant		
	Total	Compliant		Lower	Upper	Total	Compliant		Lower	Upper	
Rural Breast Cancer Screening	278	254	83.0	71.10	90.65	133	125	93.0	90.69	94.77	1
Urban Breast Cancer Screening	271	250	95.0	89.66	97.65	107	101	94.8	92.00	96.63	1

Table 5. Compliance Estimates by Urban/Rural and VA-staffed/Contract

Mammogram CBOC 2011 Rollup Compliance Estimates by Rural and Urban. The compliance rate of CBOCs, regardless of type is not statistically significantly different from 90 percent for rural CBOCs. Urban CBOCs rate is statistically significantly higher than 90 percent. (See Table 6.)

Performance Measure	Rural					Urban					Estimates Are 90% or Higher*
	Number of Patients		Percent Compliant	95% CI for Percent Compliant		Number of Patients		Percent Compliant	95% CI for Percent Compliant		
	Total	Compliant		Lower	Upper	Total	Compliant		Lower	Upper	
Breast Cancer Screening	411	379	83.2	71.13	90.82	378	351	95.0	89.78	97.61	1

Table 6. Compliance Estimates by Urban and Rural

* This column is coded 1 if both estimates are either not different from or statistically significantly higher than the threshold.

Mammogram Compliance Estimates for VA. The VA compliance rate is not statistically significantly different from the threshold. See results displayed in Table 7 below.

	Number of Patients			95% CI for Percent Compliant	
Performance Measure	Total	Compliant	Percent Compliant	Lower	Upper
Breast Cancer Screening	789	730	87.3	71.59	94.96

Table 7. Performance Measure Statistical Significance

Conclusion

All VA-staffed CBOCs rates are not statistically significant from the 90 percent threshold. Contract CBOCs in rural locations had better performance measure scores than VA-staffed CBOCs. There is no statistical difference when comparing VA-staffed and contract CBOC in urban locations. All contract CBOCs compliance rates, whether located in rural or urban, are statistically significantly higher than the 90 percent threshold. We made no recommendations.

Issue 3: Mammography Compliance

VHA Handbook 1330.01[11] outlines specific requirements that must be met by facilities that perform mammography services for women veterans.

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. Documentation of mammography results must be described using the BI-RADS category code.[12] (See Appendix A.) CBOCs must also designate a Women's Health clinical liaison to coordinate women's issues with the parent facility.

Women's Health Liaisons. We found that 5 (11 percent) of 44 CBOCs did not have a Women's Health Liaison. Therefore, the facility could not ensure that women patient-related issues were addressed.

[11] VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
[12] The American College of Radiology's Breast Imaging Reporting and Database System is a quality assurance guide designated to standardize breast imaging reporting and facilitate outcomes monitoring.

We reviewed 227 medical records of female patients who had a mammogram during the period of June 1, 2010, through December 31, 2010, to determine compliance with VHA policy. There were exceptions for certain indicators; therefore, denominators may vary in the reported results. We used 90 percent as the general level of expectation for performance. A summary of our findings are listed in Tables 8–10.

	VA-staffed					Contract					
	Number of Patients			95% CI for Percent Compliant		Number of Patients			95% CI for Percent Compliant		Estimates Are 90% or Higher*
Compliance Criteria	Total	Compliant	Percent Compliant	Lower	Upper	Total	Compliant	Percent Compliant	Lower	Upper	
BI-RADS Code Category	157	153	99.7	99.07	99.93	70	65	90.8	73.24	97.25	1
Mammogram Results Linked in CPRS	102	48	10.8	2.03	41.26	31	20	53.8	28.82	76.99	0

Table 8. Compliance Estimates by VA-Staffed/Contract

	VA-staffed					Contract					
	Number of Patients			95% CI for Percent Compliant		Number of Patients			95% CI for Percent Compliant		Estimates Are 90% or Higher*
Compliance Criteria	Total	Compliant	Percent Compliant	Lower	Upper	Total	Compliant	Percent Compliant	Lower	Upper	
Rural											
BI-RADS Code Category	71	68	99.7	98.10	99.94	36	31	84.4	59.86	95.17	1
Mammogram Results Linked in CPRS	54	25	7.8	0.67	51.64	24	14	48.0	22.58	74.46	0
Patient Notified of Normal Result Within 30 Days	61	47	67.4	42.67	85.22	30	25	86.5	68.74	94.91	2
Urban											
BI-RADS Code Category	86	85	99.9	99.44	99.98	34	34	100.0			1
Mammogram Results Linked in CPRS	48	23	18.4	2.99	62.09	7	6	80.9	33.69	97.25	2
Patient Notified of Normal Result Within 30 Days	76	36	80.6	54.32	93.55	33	27	82.4	58.99	93.81	1

Table 9. Compliance Estimates by Urban/Rural and VA-staffed/Contract

*This column is coded 0 if both VA-staffed CBOCs and contract CBOCs compliance estimates for the given criteria are statistically significantly below the 90 percent threshold, 1 if both estimates are either not different from or statistically significantly higher than the threshold, or 2 if one estimate is statistically significantly below and the other is not below the threshold of 90 percent.

Performance Measure	Number of Patients		Percent Compliant	95% CIs for Percent Compliant	
	Total	Compliant		Lower	Upper
BI-RADS Code Category	227	218	**99.6**	98.40	99.89
Results Linked to CPRS	133	68	**11.2**	2.21	41.28
Patient Abnormal Result Notification	18	13	**96.5**	89.41	98.91

Table 10. Compliance Estimates for VA

Results Linked to CPRS. Mammography studies that are completed by a fee provider, contract, or VA-certified mammography centers must be linked to the provider order in CPRS to ensure that the study is complete and the patient receives the required notification. The mammogram results were not linked to the breast study order in CPRS in 65 of 133 exams. The VA compliance rate for results linked to CPRS is statistically significantly lower than the 90 percent threshold.

Patient Normal Result Notifications. It is required that VHA mammography programs and off-site non-VHA mammography providers establish a system to provide a lay summary of the written mammography report to the patient within 30 days from the date of the procedure. The written communication has to comply with VA or Mammography Quality Standards Act [MQSA] standards and guidelines.[13] The evidence that the requirements are satisfied is entered in the patient's medical record. We did not find documentation that 65 of 200 patients were notified. The compliance rate of VA-staffed CBOCs located in rural areas is statistically significantly lower than the 90 percent compliance threshold. Rural contract and urban (both VA-staffed and contract) CBOCs' compliance rate is not statistically significantly different from the threshold. Therefore, we made no recommendations. Specific recommendations were made in individual CBOC reports for the 18 facilities.

Patient Abnormal Result Notifications. The notification for abnormal results needs to occur in the timeframe that minimizes the risk to the patient. It is the ordering practitioner that must communicate the results of BI-RADS code, categories 0 and 3, findings to the patient. This communication must occur within 14 calendar days from the date on which the results are available to the provider. We found that 5 of 18 patients with abnormal results (categories 4 and 5) were not notified within the require timeframes; however, the VA compliance level is not statistically significantly different from 90 percent. Therefore, we made no recommendations. Specific recommendations were made in individual CBOC reports for the four facilities.

BI-RADS Category Codes. There was prevalent use of the BI-RADS categories codes to report the assessment of the mammography exam in 218 of 227 cases. These included fee basis providers, contracts, and VA mammography centers. We found that all VA-staffed CBOCs compliance rate is statistically significantly higher than the

[13] VHA Handbook 1330.01.

90 percent threshold. The compliance rate of contract urban CBOCs is 100 percent. We made no recommendations.

Conclusion

We found that several CBOCs that did not have a designated Women's Health Liaison as required by VHA policy. Also, we did not find consistent documentation of patient notification of mammography results at rural VA-staffed CBOCs or that the results were linked to the breast study order in CPRS regardless of type or location of CBOC. We found the VA compliance rate for results linked to CPRS is statistically significantly lower than the 90 percent threshold.

We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers:

Recommendation 1. Ensure that each CBOC has a Women's Health Liaison who collaborates with the parent facility's Women Veterans Program Manager on women's health issues.

Recommendation 2. Ensure that all breast imaging and mammography results are linked to the appropriate radiology mammogram or breast study order.

Issue 4: Short-Term Fee Basis Care

The purpose of the Fee Program is to assist veterans who cannot easily receive care at a 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. 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.

Policy. VA health care facilities must have local policies and procedures regarding non-VA care and services that describe the request, approval, and authorization process for such services. We found that 7 (30 percent) of 21 parent facilities[14] did not have a policy for STFB care.

We reviewed the medical records of 454 patients that had STFB care. There were exceptions for certain indicators; therefore, denominators may vary in the reported results. We used 85 percent as the general level of expectation for performance. A summary of our findings is listed in Table 11.

[14] Two parent facilities did not have patients that met the criteria for review.

	VA-staffed					Contract					
	Number of Patients			95% CI for Percent Compliant		Number of Patients			95% CI for Percent Compliant		Estimates Are 85% or Higher*
Performance Measure	Total	Compliant	Percent Compliant	Lower	Upper	Total	Compliant	Percent Compliant	Lower	Upper	
Rural											
Fee Basis Justification	190	106	85.5	54.48	96.69	72	70	96.5	87.18	99.10	1
Consult Approval Date	190	174	97.5	80.61	99.73	72	61	85.4	59.08	95.97	1
Consult Approval Process	190	131	87.8	35.75	98.94	72	41	56.9	47.38	65.92	2
Patient Consult Notification	190	67	66.4	35.07	87.85	72	53	71.9	35.78	92.18	1
Copy of Report in CPRS	190	183	99.6	96.10	99.95	72	72	100			1
Provider Reviewed Report	190	165	63	43.01	79.36	72	64	88.2	62.30	97.11	2
Provider Informed Patient of Results within 14 days	172	121	47.1	26.51	68.65	72	63	85.8	59.62	96.12	2
Urban											
Fee Basis Justification	145	84	45.3	14.51	80.13	47	16	39.6	9.02	81.24	0
Consult Approval Date	145	116	80.4	60.48	91.64	47	43	89.1	62.28	97.59	1
Consult Approval Process	145	102	72.6	47.94	88.38	47	47	100			1
Patient Consult Notification	145	36	23.6	4.29	68.08	47	6	11.5	3.82	29.98	0
Copy of Report in CPRS	145	144	99.98	99.886	99.998	47	45	96.2	86.56	98.98	1
Provider Reviewed Report	145	105	90.5	40.00	99.27	47	44	91.8	70.41	98.15	1
Provider Informed Patient of Results within 14 days	144	68	73.4	19.18	96.99	47	38	79.5	68.49	87.35	1

Table 11. STFB Compliance Estimates by Urban/Rural and VA-staffed/Contract

*This column is coded 0 if both VA-staffed CBOCs and contract CBOCs compliance estimates for the given criterion are statistically significantly below the 85 percent threshold, 1 if both estimates are either not different from or statistically significantly higher than the threshold, or 2 if one estimate is statistically significantly below and the other is not below the threshold of 85 percent.

Fee Basis Justification. The requesting physician must document in the health record a justification for using fee status in lieu of providing VA staff treatment. Justification for extending STFB services must also be documented in the health record. We found that 178 of 454 STFB consults did not specify the reason the procedure was outsourced. The compliance rate for rural VA-staffed CBOCs was not statistically significantly different from the 85 percent threshold, while the rural contract CBOCs compliance rate is statistically significantly higher than the threshold. However, the compliance rate of urban CBOCs, whether VA-staffed or contract, is statistically significantly below the 85 percent threshold.

Patient Consult Notification. The veteran must be notified in writing of the approval of outpatient Fee Basis care. We did not find evidence that 292 of 454 patients received written notification of approval of STFB consults. The compliance rate of urban CBOCs, whether VA-staffed or contract, is statistically significantly below the threshold of 85 percent. Compliance rate is not statistically significantly different from 85 percent for rural CBOCs, whether VA-staffed or contract.

Consult Approval Date. STFB consults are required to be approved within 10 days from the date the consult was initiated. We found that 60 of 454 consults exceeded the 10-day timeframe. Each of the CBOCs' compliance rate, by rural/urban and VA-staffed/contract, is not statistically significantly different from 85 percent for days from initiation to approval of consult. Therefore, we made no recommendations.

Consult Approval Process. STFB consults must be approved by the Chief of Staff, Clinic Chief, Chief of Medical Administrative Services, or an approved designee. We found that 133 of 454 STFB consults were not authorized as required by VHA and local policy. The compliance rate of the rural contract CBOCs is statistically significantly below the 85 percent threshold, while urban contract CBOCs have a sample compliance rate of 100 percent. VA-staffed CBOCs' (both rural and urban) compliance rates are not statistically significantly different from the threshold. Therefore, we made no recommendations. Specific recommendations were made in individual CBOC reports for the 14 facilities.

Report Review. It is VHA policy that test results must be communicated to the ordering practitioner, or surrogate practitioner, within a timeframe allowing prompt attention and appropriate clinical action to be taken, and that the ordering practitioner further communicates such test results to patients so that they may participate in health care decisions. We did not find evidence that 76 of 454 procedure results were reviewed by the provider. The compliance rate of rural VA-staffed CBOCs is statistically significantly below the threshold; however, the compliance rates of rural contract and urban (both VA-staffed and contract) CBOCs are not statistically significantly different from the threshold. Therefore, we made no recommendations. Specific recommendations were made in individual CBOC reports for the 12 facilities.

Communication of Results. The notification of results needs to occur in the timeframe that minimizes the risk to the patient. This communication must occur within 14 calendar days from the date on which the results are available to the provider. We

found that 145 of 435 patients were not notified within the required timeframe.[15] The compliance rates of rural VA-staffed CBOCs are statistically significantly below the threshold. The compliance rate of rural contract and urban (both VA-staffed and contract) CBOCs is not statistically significantly different from the threshold. Therefore, we made no recommendations. Specific recommendations were made in individual CBOC reports for the 18 facilities.

Conclusion

We found several VA facilities that did not have a STFB local policy. We also found that urban CBOCs did not properly document justification for reason to outsource services or had evidence that patients were provided written notification of the authorized STFB consults as required by VHA policy. Justification and authorization provide assurance that VA health care facilities are making sound clinical and business decisions allocating health care resources.

We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers:

Recommendation 3. Ensure that each medical center has a local policy for STFB consults.

Recommendation 4. Ensure that practitioners document a justification for the use of STFB care in the medical record, specifically at urban CBOCs.

Recommendation 5. Ensure there is documentation in the medical record that the patient received written notification STFB consult approval, specifically at urban CBOCs.

Issue 5: MH Continuity of Care

Facilities must comply with VHA policy,[16] which outlines specific requirements for MH care at CBOCs. All CBOCs and facilities without an Emergency Department (ED) or 24/7 urgent care must have predetermined plans for responding to MH emergencies during times of operation. We found that 7 (16 percent) of 44 CBOCs did not have a plan identified in their local policy addressing how MH emergencies would be addressed during the hours of operations if the provider determined that the patient requires a higher level of care. We also found three CBOCs that had a plan did not identify a VA or community-based ED where veterans would be directed to seek care. Four CBOCs that had identified a community-based ED did not develop contracts, sharing agreements, or appropriate arrangements with the external organization for sharing information.

[15] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009, requires notification of abnormal results sooner than the 14-day timeframe. Nineteen patients fell into this category.
[16] VHA Handbook 1160.01.

We reviewed medical records of 118 patients that were referred to the ED for emergent MH care and did not find documentation of the referral in 13 (11 percent) records. Of the 105 patient records that had documentation of the MH referral, 4 (4 percent) did not document the results of the ED visit. The lack of documentation in the 13 records represented 2 CBOCs belonging to 1 parent facility.

Conclusion

All CBOCs did not have predetermined plans for responding to MH emergencies when they occur during times of operation. In addition, those CBOCs that did have predetermined plans, a few did not identify at least one accessible VA or community-based ED or develop appropriate arrangements with non-VA facilities for sharing information. We found that one parent facility's CBOCs were not consistently documenting that the patient was referred to an ED for emergent MH care. Therefore, no trends were identified in this area. Specific recommendations were made in the individual CBOC report for these two facilities.

We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers:

Recommendation 6. Ensure that each CBOC has a plan that defines how MH emergencies that require a higher level of care are addressed.

Issue 6: Skills Competency

VHA has a High Performance Development Model,[17] 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. 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.

Skills Competency Assessment. We found that 66 (38 percent) of 172 patient care staff members had 1 or more identified skills competency that was not currently assessed in accordance with local polices.

Skills Competency Policy. We found that all but one CBOC had skills competency assessment and validation policy/process in place. We were able to determine that the individuals performing competency assessment and validation had the appropriate education, background, experience, or knowledge related to the skills assessed. We

[17] http://vaww4.va.gov/hpdm

found that most CBOCS had elements in their local policies that defined responsibilities of those who validate competency and a selection process for qualified personnel.

Conclusion

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. We found that some staff did not have current competency assessments. To ensure patient safety, it is important that staff are trained and maintain competency to perform the skills they are assigned.

We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers:

Recommendation 7. Ensure patient care staff members at CBOCs have ongoing competency assessments validated for identified core competencies.

Issue 7: 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 Program is used by medical centers to ensure that clinical providers have the appropriate professional license(s) and other qualifications to practice in a health care setting and that they practice within the scopes of their licenses and competencies.

We reviewed the credentialing folders of 203 providers, utilizing VetPro[18] to conduct our initial review. Provider privileges or scopes of practice and licensed independent practitioner (LIP) quality profiles were examined on site.

Privileges and Scopes of Practice. We found 16 (16 percent) of 102 LIPs' clinical privileges and 8 (11 percent) of 75 non-LIPs' scopes of practice exceeded the services provided at the CBOC setting. The setting in which care is delivered dictates the type(s) of care, treatment, and procedure that a practitioner will be authorized to perform. Granting of privileges improved from our FY 2010 report; therefore, we made no recommendations. Specific recommendations were made in individual CBOC reports for the 15 facilities.

Practitioner Evaluations. We found evidence that all CBOCs developed Ongoing Professional Practice Evaluations (OPPEs). However, we found that the OPPE data results were not used to reappraise 5 (5 percent) of 102 practitioner's privileges. We also found that 2 of 27 Focused Professional Practice Evaluations (FPPEs), which should have been developed for new providers or new privileges, were not initiated. Of the 25 LIPs that had FPPEs initiated: (a) 4 of the FPPEs did not have designated timeframes, (b) 2 were initiated after the practitioner started his first clinical work day, (c) 3 FPPE results were not documented in the practitioner's quality profile, (d) 5 FPPEs

[18] VetPro is VHA's electronic credentialing system.

were not reported to the medical staff's Executive Committee, (e) there was no evidence in the medical staff's Executive Committee minutes of the results of 7 FPPEs, and (f) 2 of the providers were not educated on the criteria to successfully complete the FPPE.

OPPEs and FPPEs allow the facility to identify professional practice trends that impact the quality of care and patient safety. We did not identify any trends; therefore, we made no recommendations. Specific recommendations were made in individual CBOC reports for the 10 CBOCs.

Conclusion

The CBOC generally met VHA directives and guidelines and followed the Joint Commission standards. We found no trends in privileges granted to providers, OPPEs, or FPPEs; therefore, we made no recommendations.

Issue 8: Environment and Emergency Management

A. Environment of Care

We conducted EOC inspections at each CBOC,[19] evaluating cleanliness, adherence to clinical standards for infection control and patient safety, compliance with patient data security requirements, and hand hygiene monitoring. We used 90 percent as the general level of expectation for performance. We found the following (see Table 12):

	Numerator	Denominator	FY 2011 Percentage	FY 2010 Results (Percent)
Physical Access	4	41	10	**11**
Panic alarms	4	36	11	**8**
Fire Drills	4	41	10	**11**
Personally Identifiable Information (PII)	8	41	20	**19**
Auditory Privacy	6	41	14	**13**
Hand Hygiene Data	4	41	10	**26**
Information Technology (IT) Security	7	41	17	**NA**

Table 12. EOC Deficiencies

[19] We did not conduct EOC rounds at three CBOCs because the facilities were closed/suspended at the time of the inspection.

These results represent an improvement compared to those in our FY 2010 report, with the exception of auditory privacy, PII, and panic alarms.

Auditory Privacy. Six (14 percent) of 41 CBOCs were not maintaining auditory privacy. Although we found that several CBOCs had instructions to incoming patients to allow patients a zone of audible privacy during the check-in process, CBOC staff were not ensuring the instructions were followed.

PII. Eight (20 percent) of 41 CBOCs did not consistently secure patients' personal information. This represents a slight increase from our FY 2010 report.

IT Security. We found security vulnerabilities in the allocated IT network space at 7 (17 percent) of 41 CBOCs. We found IT network equipment was located with water sources (sinks and water heaters), doors were unlocked, and access was not controlled.

Panic Alarms. Four (11 percent) of the 36 CBOCs identified at high risk did not have a panic alarm system or did not perform a vulnerability risk assessment to determine if a panic alarm system was needed. We did not identify a specific trend; therefore, we made no recommendations.

B. Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or standard operating procedure defining how medical and MH emergencies are handled. All but 3 of the 41 CBOCs we inspected had a local policy or SOP. Therefore, we made no recommendations.

Conclusion

CBOCs met most standards, and the environments were generally clean and safe. Safety guidelines were generally met, and risk assessments were in compliance with VHA standards. VHA has made improvements in many of the EOC areas identified as needing improvement. VHA needs to ensure that auditory privacy is improved, patients' PII is protected, and IT network equipment is secured.

We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers:

Recommendation 8. Ensure that auditory privacy is maintained during the check-in process.

Recommendation 9. Ensure that all PII is secured and protected.

Recommendation 10. Implement measures to minimize IT network space vulnerabilities in accordance with VA policy.

Issue 9: CBOC Contract Review

We assessed VHA's oversight of contracted primary care and had findings in 8 of 9 compliance categories reviewed, as shown in Table 13 below. The one category with no findings was Contracting Officer Technical Representative (COTR) designation and training. Overall, we found many of the contracted CBOCs in our sample were effectively managed and monitored quality performance measures with proper oversight. Table 13 displays our findings by category for the 19 contract CBOCs.

Number of CBOCs = 19			95% CI	
	CBOCs Compliant	Percent (Weighted)	Lower	Upper
Invoice Validation Process	12	76.2	61.03	86.79
Technical Review	13	55.4	36.47	72.95
Requirements For Payment	13	79.7	58.2	91.7
Performance Measures	16	82.2	61.17	93.10
Third Party Billing Provisions	16	91.1	80.49	96.20
Rate and Frequency Of Payment	16	88.6	64.81	97.05
Invoice Format	17	94.1	84.42	97.88
Contractor Oversight	17	85.1	62.69	95.14
COTR Designation and Training	19	100.0		

Table 13. Contract Findings

A. Invoice Validation Process

Seven of 19 contract CBOCs were noncompliant due to overpayment for ineligible patients on the billable roster and inadequate invoice validation.

Overpayments for Ineligible Patients. Three CBOCs had $92,600 in overpayments because the validation process did not include verification that all billed patients met minimum qualifications for payment. One facility paid the invoice without performing any validation and did not require supporting documentation from the contractor, which accounted for $72,000 of these overpayments.

Inadequate Invoice Validation. Three facilities used a manual validation process, which did not verify eligibility for all invoiced enrollees, thereby increasing the risk for payment errors. Verification of payment eligibility using a manual validation process would require a review of each patient's medical record to ensure eligibility criteria have been met. This process is very tedious and time consuming, particularly when the billable

roster has hundreds or thousands of patients. Many VAMCs validate the billable roster by using existing Veterans Health Information Systems and Technology Architecture reports, which allows for a 100 percent validation and saves time, since it eliminates the need to look up each patient record manually.

One CBOC used a PCMM report to validate the invoice for contract CBOCs, contrary to the PCMM Handbook. The requirements to stay on a PCMM panel differ from the requirements that qualify a patient as billable under the contract terms. The PCMM data requires manual adjustments to account for these differences. While we did not find discrepancies, PCMM data should not be utilized to validate the billable roster due to the increased risk of errors associated with manual adjustments.

B. Technical Review

Six of 19 CBOC contracts had issues related to compliance with VA Directive 1663.[20] These issues included improper contract extensions, lack of required approval, missing required VHA provisions, and insufficient time allowed in the acquisition process. Some of the facilities had issues in more than one of these areas. Frequently high turnover in the Contracting Officer (CO) position and the lack of documentation impeded our ability to determine the root cause of these issues.

Improper Contract Extensions/Missing Approvals. Two CBOC contracts were improperly extended up to 2 years beyond the authorized timeframe by issuing a series of interim contracts and not obtaining VHA Sharing Office approval. Interim contract authorities are approved for 180 days, with additional interim contract authorities granted on an exception basis, not to exceed 1 year. Interim contracts are only allowed to provide required health care resources on an emergency basis for short-term needs or as an interim measure to complete the contracting cycle for long-term needs.

Missing Federal Acquisition Regulation and VA Acquisition Regulations Clauses. Three CBOC contracts were missing substantive clauses required by Federal Acquisition Regulation and VA Acquisition Regulations. The Federal Acquisition Regulation and VA Acquisition Regulations established uniform policies and procedures to follow in the acquisition of supplies and services for all federal agencies and VA, respectively.[21]

Missing Statement of Work. One CBOC contract was missing the statement of work, which describes the clinical, administrative, and financial requirements to be procured. The contract consisted of the contractor's proposal and contract amendments but did not include or refer to a significant portion of the original request for proposal. We were provided a draft of a more complete contract that the contractor possessed; however, this contract was not signed by either party.

Insufficient Time Allowed in the Acquisition Process. The solicitation process for one CBOC contract allowed only 2 months between the date of the request for proposal (RFP) and the contract start date. VA Directive 1663 states that contracting officials

[20] VHA Directive 1663, *Health Care Resources Contracting – Buying Title 38 U.S.C.*, August 10. 2006.
[21] Federal Acquisition Regulation, issued March 2005, https://www.acquisition.gov/far/current/pdf/FAR.pdf.

should allow approximately 7 months from solicitation development to the award date. Two months is insufficient time to ensure a fair and objective contract award. This resulted in VHA accepting a contractor that did not meet the requirements of the contract.

C. Requirements for Payment

Undefined requirements for payment in the contract have made it very difficult for VHA to satisfactorily resolve discrepancies when overpayments are identified. The terms and conditions that describe such things as eligibility for payment between qualifying visits need to be clearly defined. Six of 19 CBOC contracts had undefined or conflicting requirements for payment.

Undefined Requirements. Four CBOC contracts included language regarding vesting or qualifying visits but failed to define those terms and the payment criteria for those visits.

Conflicting Requirements. One CBOC contract contained a provision which compensated the contractor a pro-rated monthly capitated rate for veterans who were treated at the clinic in the month of disenrollment. However, a conflicting provision stated that the contractor would be paid for the full monthly capitated rate in the month the veteran was disenrolled.

One facility relaxed the requirements for payment for a qualifying visit, without obtaining CO approval or modifying the contract. This caused confusion in how many patients met the criteria for payment.

We made no recommendation regarding this issue since VHA is currently in the process of creating a standard CBOC agreement for contracted healthcare.

D. Performance Measures Not Included in Contract

According to VA Directive 1663, contracts should include monitoring procedures to ensure compliance with the contract. VA is responsible for monitoring contractor performance to ensure that contracted care meets VA standards.

Three of 19 CBOC contracts were missing detailed performance measures. VHA Directive 1663 states that each solicitation must contain a detailed description of the monitoring procedures used by the VA to ensure contract compliance. These performance measures typically include, for example: (1) access to care, (2) timely entry of medical data into the electronic medical record, (3) patient satisfaction, and (4) quality of care. One contract stated that the contractor needed to exceed VHA performance measures without defining the goals or targets to be met.

Performance-Based Penalties. Fourteen of 19 CBOC contracts did not contain penalties for sub-standard performance or noncompliance with contract provisions. Performance-based penalties provide a means for enforcing contractor compliance short of contract termination and disruption of patient care. The most frequently used penalty is a deduction based on a percentage of the monthly invoiced amount.

We made no recommendation regarding this issue since VHA is currently in the process of creating a standard CBOC agreement for contracted healthcare.

E. Third Party Billing

Three of 19 CBOC contracts did not have provisions prohibiting the contractor from billing a third party insurer for medical services provided. All contracts need to contain a provision that clearly states it is fraudulent to bill the patient or third party insurance sources (e.g., Medicare). This provision is of particular importance for contracted providers that also have a private practice. We made no recommendation regarding this issue since VHA is currently in the process of creating a standard CBOC agreement for contracted healthcare.

F. Rate and Frequency of Payment

Three of 19 CBOC contracts either did not have published rates or the contractor was reimbursed at the incorrect rate. One contract contained a provision to provide medical services to visiting veterans as an ancillary charge but did include a schedule of the charges. Two contractors were paid less than the contracted capitation rate, resulting in underpayments totaling $23,000. We found no identified trends; therefore, we made no recommendations.

G. Invoice Format

Two of 19 CBOC contractors were not providing the invoice in the prescribed format. The invoices require, at a minimum, description of the services rendered, date of service, patient name and unit costs, to help expedite invoice validation and payment processing. The contract may require this information electronically along with specific supporting information that assists in validating the invoice. In these two cases there were also problems with invoice validation. We found no identified trends; therefore, we made no recommendations.

H. Oversight

Two of 19 facilities did not have a complete copy of the contract. The COTR is responsible for monitoring contract compliance; however, in these cases, the COTRs were not familiar with many of the provisions they were responsible to monitor. There was a lack of oversight by the facility to ensure the COTRs were performing their responsibilities. We found no identified trends; therefore, we made no recommendations.

Conclusion

Overall, we have found improvements from previous reviews in administration and oversight of contract CBOCs. VHA has developed a CBOC template which includes standard contract provisions, quality assessment surveillance plans, and improvements in defining the terminology for the requirements for payment, which we feel will address many of the issues noted above. This template will take time to fully implement and we

should see continued improvements; however, identified deficiencies should not be delayed as they impact the quality and cost of medical care.

Although improved at many facilities, we still find that there needs to be better verification that the COTR's responsibilities are adequately performed. It is imperative that they have a complete copy of the contract and are familiar with the provisions for monitoring performance as well as the requirements for payment. We feel that reliance on a manual invoice validation process is difficult to verify and provides little assurance that errors will not be made. A standard report that produces the billable roster is needed to reduce the time to validate the invoice and provide better assurance to management that the appropriate amount is being paid.

In our technical reviews we continue to find contracts that are missing important provisions and have contract extensions without proper approvals and insufficient acquisition planning. VHA needs to make improvements in the contract acquisition process to ensure that procurement of health care resources is adequately planned and contract awards are a result of fair and open competition. Improved oversight of the contract acquisition process in accordance with VA directives will contribute to VHA utilizing its resources more efficiently.

We recommended that the Under Secretary for Health, in conjunction with the VISN and facility senior managers:

Recommendation 11. Review the invoice validation process to consider creating a standardized billable roster report to improve oversight and accuracy of billable patient lists, thereby reducing man hours currently performing those duties and potential overpayments.

Recommendation 12. Strengthen the oversight of the contract acquisition process to ensure that adequate planning occurs and that proper approvals are documented in the contract management system [eCMS] in accordance with VHA Directives.

Issue 10: Contract CBOC Review – MH

VHA Handbook 1160.01 requirements vary based upon the size of the facility's veteran population. Clinics with less than 1,500 unique primary care patients are strongly encouraged to provide evaluation and treatment-planning services as well as general MH services on site or by tele-MH.

We did not find any significant discrepancies regarding compliance with payment provisions; however, we noted variances in the contract provisions related to MH and access to care were not always reasonably accessible.

MH Contract Provisions. Thirteen of 19 contracts contained primary care and MH services in a combined rate. The level of MH services provided by each clinic varied from PCPs providing MH screening and general counseling to having contracted MH staff that provided more substantive MH services. Some clinics provided space only for

VA staff to provide MH services, either on site or via tele-MH. For clinics that offered telemedicine, prescriptions for MH needs are prescribed by VHA psychiatrists.

Three of 19 contracts contained a separate payment for MH services. One contractor was paid an hourly rate while the other two contractors were paid a monthly capitated rate. All three contracts had minimum staffing requirements and provided comprehensive MH services on site.

Three of the 19 contracts did not contain any provisions addressing how needs of veterans would be provided for emergent or non-emergent MH care.

Access to MH Care. Four of 19 contract CBOCs did not offer MH services on site. For example, two of the sites are over 70 miles (more than a 1-hour drive) to the nearest VA facility; however, one of the two facilities offers fee basis care.

Conclusion

Contractor responsibilities should be clearly defined in the contract for addressing the MH needs of the veteran population for emergent and non-emergent care. Without such clarity, coordination of care for the patient could be negatively impacted. At a minimum, contractors should be aware of VA standards for coordination of care for MH services.

VA's goal is to ensure that all veterans have access to needed MH services regardless of where they obtain care in VHA. For facilities that do not provide on-site MH services, access to care is potentially an issue. VHA uses the term "geographically accessible" to describe the distance for care when referring a patient to another site. However, this term is not defined in regards to time or distance. Traveling over an hour for MH care could deter some patients from getting the care they need. Some level of on-site MH services, whether face to face or via tele-health, would allow VA to meet the MH needs of veterans and minimize the distance they would have to travel to get that care.

We recommended that the Under Secretary for Health, in conjunction with the VISN and facility senior managers:

Recommendation 13. Ensure that MH services for contract CBOCs are addressed in a separate contract or within the primary care contract.

Issue 11: PCMM

We reviewed PCMM for all 44 CBOCs and performed inquiries of PCMM Coordinators to review the processes used to update PCMM patient panels for panel assignments, transfers to other facilities, deaths, and instances where patients are assigned to more than one PCP. Our findings are summarized in the Table 14.

	VA-Staffed					Contract					
	Number of CBOCs			95% CI for Percent Compliant		Number of CBOCs			95% CI for Percent Compliant		
	Total	Compliant	Percent Compliant	Lower	Upper	Total	Compliant	Percent Compliant	Lower	Upper	Significantly Different*
Assigned to PCP Panel Before First Appointment	25	24	99.3	97.16	99.85	19	16	76.2	53.17	90.07	1
Assigned To More Than One PCP Panel	25	19	74.7	29.75	95.37	19	12	58.9	35.69	78.74	0
Inappropriate Panel Maintenance	25	25	100			19	18	97.0	88.31	99.30	
Panel Size Within Handbook Limit	25	25	100			19	19	100			
Billed Enrollees Within Panel Size	25	25	100			19	19	100			

Table 14. FY 2011 PCMM Compliance Rate by Contract or VA-Staffed CBOCs

*This column indicates whether the contract PCMM compliance rate is statistically significantly different from the VA-Staffed compliance rate for a given criterion. The 1 indicates that they are whereas 0 indicates they are not different.

More Than One PCP. Thirteen of 44 CBOCs had more than 5 percent of their patients assigned to more than one PCP. The VHA standard[22] is for each patient to be assigned to one PCP. There are some exceptions, but they must receive specific approval. We determined that if a clinic had 5 percent or more of its patient load assigned to more than one PCP without approval, that would materially affect workload planning and costs. The compliance rates of VA-Staffed CBOCs and Contract-staffed CBOCs are not statistically significantly different. No trends were identified; therefore, we made no recommendations.

[22] VHA Handbook 1101.2, *Primary Care Management Module*, April 21, 2009.

First Appointment. Four of 44 CBOCs had assigned patients to a PCP panel prior to their first appointment. VA directives state that a patient must have a first appointment with a PCP before being assigned to a panel. The compliance rate for VA-staffed CBOCs is statistically significantly higher than that for Contract-staffed CBOCs. We made no recommendations.

Conclusion

VHA needs to more effectively ensure that PCMM Coordinators manage the PCMM in accordance with VHA Handbook 1101.02.[23] Similar issues were noted in our FY 2010 report.[24] VHA concurred with the findings and has established a workgroup and developed training materials for PCMM Coordinators. Therefore, we made no additional recommendations.

Comments

The Under Secretary for Health concurred with the findings and recommendations. The implementation plan is acceptable, and we will follow up until all actions are complete.

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

[23] VHA Handbook 1101.02, *Primary Care Management Module*, April 21, 2009.
[24] VA Office of Inspector General Report No. 11-00794-185, *Evaluation of Community Based Outpatient Clinics Fiscal Year 2010*, June 7, 2011.

BIRADS Scores

Category	Diagnosis	Number of Criteria
0	Incomplete	Need additional imaging evaluation or prior mammograms for comparison
1	Negative	There is nothing to comment on.
2	Benign	A definite benign finding
3	Probably Benign	Probably benign findings (less than 2 percent malignant). Initial short-interval follow-up suggested.
4	Suspicious Abnormality	Malignancy 2 to 95 percent probability. Biopsy should be considered.
5	Highly Suspicious of Malignancy	Greater than or 95 percent probability. Appropriate action should be taken.
6	Known Biopsy Proven Malignancy	Lesions known to be malignant that are being imaged prior to definitive treatment; assure that treatment is completed.

List of CBOCs Reviewed

Period I CBOCs	Period II CBOCs
523GA Framingham, MA	564GC Branson, MO
652GE Charlottesville, VA	564GA Harrison, AR
502GA Jennings, LA	580GD Conroe, TX
502GB Lafayette, LA	580BZ Lufkin, TX
549GE Bridgeport (Decatur), TX	629GB Hammond, LA
549GJ Sherman, TX	629GA Houma, LA
531GG Caldwell, ID	562GC Bradford (McKean County), PA
531GE Twin Falls, ID	562GD Franklin (Venango County), PA
542GE Spring City, PA	595GA Camp Hill, PA
542GA Springfield, PA	595GF Pottsville/Frackville, PA
516GA Sarasota, FL	568HJ Mission, SD
516GH Sebring, FL	568HA Newcastle, WY
657GG Paragould, AR	618GB Hibbing, MN
657GN Salem, MO	618GG Rochester, MN
649GE Cottonwood, AZ	671GO San Antonio, TX
649GC Lake Havasu City, AZ	671GJ Uvalde, TX
689GB Stamford, CT	549GA Tyler, TX
689GA Waterbury, CT	501GI Alamogordo, NM
534GD N. Charleston (Goose Creek), SC	501GA Artesia, NM
534BY Savannah, GA	649GB Bellemont, AZ
660GI Nephi, UT	649GA Kingman, AZ
660GA Pocatello, ID	666GE Gillette, WY
460GA Georgetown, DE	666GD Powell, WY
460HE Ventnor, NJ	554GD Pueblo, CO
672GE Guayama, PR	600GA Anaheim, CA
672BO Ponce, PR	600GE Laguna Hills, CA
610GC Goshen, IN	664GD Escondido, CA
589GB Belton, MO	664GB Oceanside, CA
589GD Nevada, MO	691GG Lancaster, CA
640GA Capitola, CA	691A4 Sepulveda, CA
640HA French Camp (Stockton), CA	405GA Bennington, VT
631BY Springfield, MA	405HC Littleton, NH
558GC Morehead City, NC	528GB Jamestown, NY
558GB Raleigh, NC	528GQ Lackawanna, NY
626GE Clarksville, TN	613GB Hagerstown, MD
626GH Cookeville, TN	613GE Petersburg, WV
635GB Wichita Falls, TX	548GA Ft. Pierce, FL
692GA Klamath Falls, OR	548GF Okeechobee, FL
	581GB Charleston, WV
	581GD Williamson, WV
	541GJ New Philadelphia, OH
	541GD Mansfield, OH
	459GE Agana Heights, GU
	459GB Hilo, HI

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: July 23, 2012

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, Healthcare Inspection Evaluation of Community Based Outpatient Clinics, Fiscal Year 2011**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations.

2. Thank you for the opportunity to review the draft report. Attached is the complete corrective action plan for the report's recommendations. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Healthcare Inspection Evaluation of Community Based Outpatient Clinics Fiscal Year 2011 (*VA IQ* 7249578)

Date of Draft Report: May 31, 2012

Recommendations/ Actions	Status	Completion Date

Recommendation 1. Ensure that each CBOC has a Women's Health Liaison who collaborates with the parent facility's Women Veterans Program Manager on women's health issues.

VHA Response

Concur

The Assistant Deputy Under Secretary for Health (ADUSH)/Clinical Operations on behalf of the Deputy Under Secretary for Health and Operations Management (DUSHOM) and in coordination with the DUSH for Policy and Services will issue a memorandum reinforcing the requirements for each Community Based Outpatient Clinic (CBOC) to have a designated Women's Health Liaison who collaborates with the parent facility's Women Veterans Program Manager.

In process	Memorandum to be issued no later than (NLT) August 31, 2012

Once the memorandum has been released, the DUSHOM will request the Director at each parent facility to provide the name of a designated Women's Health Liaison at each CBOC associated with the parent facility. Each Veterans Integrated Service Network (VISN) Director will be held responsible to ensure all CBOCs in each VISN have an identified Women's Health Liaison.

In Process	Completed by October 30, 2012

Recommendation 2. Ensure that all breast imaging and mammography results are linked to the appropriate radiology mammogram or breast study order.

VHA Response

Concur

The ADUSH/Clinical Operations on behalf of the DUSHOM and in coordination with the DUSH for Policy and Services (P&S) will issue a memorandum reinforcing the requirements for all screening and diagnostic mammograms to be initiated via an order

placed into the Veterans Health Information Systems and Technology Architecture (VistA) radiology package and that all breast imaging and mammography results regardless of where the mammography is performed must be entered into VistA.

In process	Memorandum to be issued NLT August 31, 2012

A work group, comprised of DUSHOM field representatives, DUSHP&S (radiology/mammography and women's health), and Assistant DUSH for Administrative Operations/Chief Business Office/Fee Care, has been established to examine best practices and to advise the field of pathways and systems that work best.

Efforts are being developed to implement these changes in advance of the release of information technology (IT) enhancements in the Computerized Patient Record System (CPRS) to track mammograms from point of order.

In process	Interim Guidance to be issued NLT December 31, 2012

Recommendation 3. Ensure that each medical center has a local policy for STFB consults.

VHA Response

Concur

The Veterans Health Administration (VHA) Directive 2008-056, VHA Consult Policy, defines policy for management of the clinical consultation process and describes processes of care related to those consults associated with clinical consultation including the Short Term Fee Basis (STFB) clinical consultation process. In addition, the procedure guide for documenting the justification for non-Department of Veterans Affairs (VA) care in the patient computerized patient record system indicates that requests for non-VA care from a VA provider must be submitted utilizing a locally developed template consult containing the mandatory justification fields. The VHA Chief Business Office (CBO) for Purchased Care is also in the process of a national roll out of a project called Non-VA Care Coordination (NVCC) which is a nationwide effort to improve and standardize non-VA care (Fee Basis) Coordination processes across VHA.

The NVCC initiative is primarily focused on standardizing front-end non-VA care (Fee Basis) referral processes by:

1. Deploying standardized non-VA consult/referral templates across all VHA medical centers (VAMC), and

2. Implementing new tools and standard operating procedures (SOP) to improve the way non-VA healthcare services are coordinated for Veterans.

The scope of this initiative encompasses the processes between the time when a VA provider generates a consult/referral for a Veteran for non-VA care until the time the Veteran receives the authorized services and non-VA (Fee) program staff receives all required clinical documentation.

The National Non-VA Program Office (NNPO) will remind the field of this national guidance on the next NNPO call scheduled for August 9, 2012. This announcement will also be in the minutes of the national call. In addition NNPO will ensure follow-up action is taken to verify the field is following the national policy. A follow-up action plan will be submitted to ensure national policy is met within 90 days after issuance of the final report. The action plan will include a timeline for implementation.

In process	Policy and process to be reviewed on the NNPO call August 9, 2012 and action plan with timeline to be provided 90 days after issuance of this report.

Recommendation 4. Ensure that practitioners document a justification for the use of STFB care in the medical record, specifically at urban CBOCs.

VHA Response

Concur

The NVCC non-VA care referral review process and NVCC appointment management process for STFB explains that prior to selecting non-VA care as the source for care, internal VA and inter-facility VA sources should be utilized first. When government facilities or capability are not available only then should non-VA care be used. Guidelines for the mandatory justification requirements for the use of non-VA care may be found in the related procedure guide. Also, as part of the NVCC process, the VA provider completes the Non-VA Care Referral Template within the Computerized Patient Record System (CPRS), which contains the mandatory requirements. The provider then signs the referral order and submits it for processing.

The NNPO will remind the field of this national guidance which is outlined in the referenced procedure guide, as well as the NVCC SOPs on the next NNPO call scheduled for August 9, 2012. This announcement will also be in the minutes of the national call. In addition NNPO will ensure follow-up action is taken to verify the field is following the national policy.

A follow-up action plan will be submitted to ensure national policy is met within 90 days after issuance of the final report. The action plan will include a timeline for implementation.

	In process	Policy and process to be reviewed on the NPPO call on August 9, 2012, and action plan with timeline to be provided 90 days after issuance of this report.

Recommendation 5. Ensure there is documentation in the medical record that the patient received written notification STFB consult approval, specifically at urban CBOCs.

VHA Response

Concur

While the VHA cannot ensure that the patient receives the notification, VHA can ensure there is documentation in the electronic health record (EHR) that the patient was notified via mailed correspondence of the STFB consult approval, specifically at urban CBOCs.

The CBO for Purchased Care has provided the requirements in the NVCC guidance. The VA clinician enters a consult/referral in CPRS, which triggers a notification that goes electronically to the NVCC Coordinator. A determination is made as to whether care can be provided by the VA or if the care will need to be outsourced. If the care needs to be provided by a non-VA provider, the NVCC Coordinator contacts the provider and schedules the appointment for the Veteran. At that time, a comment is added to the consult and a letter is generated informing the Veteran of his/her appointment, and then mailed to the Veteran. Currently, the letter is entered via a progress note into CPRS and then deleted. However, it has been recommended that the letter be created as an Administrative Document Class and that the NVCC Coordinator be allowed to electronically sign the letter.[25] This would allow the correspondence to be maintained as part of the EHR and provide supporting documentation of the scheduled fee appointment. The NVCC process was discussed on the National Health Information Management (HIM) Conference Call in November 2011 and on the NNPO conference call in October 2011. A reminder will be announced on a future HIM conference call.

The Health Information Management Field Leadership Council (HIMFLC) is currently working on a Practice Brief to be completed by August 2012 regarding the use and placement of administrative documentation in the EHR. The Practice Brief also addresses guidance regarding individuals in administrative roles being allowed to electronically sign documents that would be considered administrative. The Practice

[25] VHA Handbook 1907.01, Health Information Management and Health Records, defines administrative record as the official record pertaining to the administrative aspects involved in the care of a patient, including demographics, eligibility, billing, correspondence, and other business-related aspects. The administrative folder or tab must contain the applications for care, documents pertaining to eligibility, file copies of pertinent correspondence, and other administrative documents in conjunction with medical care. The administrative folder or tab may contain the advance directive and other administrative documents as defined by local policy. Until there is an administrative tab in CPRS, sites that wish to file administrative documents electronically should create a document class for administrative documents.

Brief will be announced on the September 2012 HIM Conference Call and will be contained in the conference call minutes.

As part of the education effort regarding NVCC, NNPO has developed a web page that contains multiple avenues of training. The NVCC training and references may be found at http://vhahacnonva.vha.med.va.gov/nvcc/.

The NNPO will remind the field of this national guidance on the next NNPO call scheduled for August 9, 2012. This announcement will also be in the minutes of the national call. In addition NNPO will ensure follow-up action is taken to verify the field is following the national policy.

A follow-up action plan will be submitted to ensure national policy is met within 90 days after issuance of the final report. The action plan will include a timeline for implementation.

In process	Practice Brief to be completed by August 2012 and action plan with timeline to be provided 90 days after issuance of this report.

Recommendation 6. Ensure that each CBOC has a plan that defines how MH emergencies that require a higher level of care are addressed.

VHA Response

Concur

Each Veterans Integrated Service Network (VISN) will be required to submit a report NLT September 30, 2012, verifying that each CBOC has established an emergency plan.

The Office of Mental Health Operations (OMHO) Site Visit teams will monitor the ongoing presence of these plans at upcoming visits beginning NLT September 30, 2012, and to be completed NLT October 2013.

In process	October 31, 2012

Recommendation 7. Ensure patient care staff members at CBOCs have ongoing competency assessments validated for identified core competencies.

VHA Response

Concur

The Offices of the DUSHOM, the DUSHP&S, and the ADUSH for Quality, Safety, and Value (QSV) will work with the VISN Quality Management (QM) officials to develop a process to ensure appropriate competency assessments for CBOC staff. It is expected

that each Facility Director will have oversight and accountability to ensure that competencies for staff at all facility CBOCs are maintained, current, and complete including a certification of compliance to the appropriate VISN Director.

In process	Process to be developed and implemented NLT March 1, 2013.

Recommendation 8. Ensure that auditory privacy is maintained during the check-in process.

VHA Response

Concur

The VHA Privacy Office has already taken several steps to address the issues reported in the report as follows:

1. In July 2011, the DUSH issued a memorandum to all facilities alerting them of guidance and required actions necessary related to maintaining auditory privacy.

2. Immediately following the release of the memo, the VHA Privacy Office sent a copy of the memo to all VHA Privacy Officers with a reminder of actions required to be taken by facilities.

3. The privacy policy template, which facilities can utilize to formulate local policies, was updated to include a section about auditory privacy and this was also communicated to all field privacy officers in July 2011.

4. The National Privacy Compliance Assurance team is including the review of adherence with auditory privacy guidance in on-site facility assessments.

Completed

Recommendation 9. Ensure all PII is secured and protected.

VHA Response

Concur

VHA Privacy Compliance Assurance (PCA) Office began evaluating CBOC performance separately from parent VA medical centers (VAMC) in January 2012. PCA has assessed 37 CBOCs. In Fiscal Year (FY) 2012 Quarter 3, the PCA Office began requiring VAMC Privacy Officers to evaluate at least one CBOC per quarter and report their findings on the Quarterly Facility Self Assessment due to PCA at the end of each quarter.

These assessments indicate that CBOCs are reducing their auditory risks by implementing wait lines and clearly posted signs requesting that Veterans adhere to these established space boundaries. Facilities have shown improved auditory privacy where they have reconfigured waiting areas. The PCA performance score for the CBOCs assessed to date for auditory privacy is an average score of 4.6. This is based on a five-point scale of 1 being non-compliance, 2 being minimal evidence of compliance, 3 being moderate evidence, 4 being significant evidence, and 5 being full compliance.

CBOCs are also more likely to be reduced-paper or paper-less environments than VAMCs because some paper-based operations such as Release of Information are typically conducted at the VAMC and not in CBOCs. This significantly reduces the risk of data loss due to paper documents. CBOC performance scores are typically higher than VAMC scores for reasonable physical safeguards and the average PCA performance score for CBOCs for reasonable physical safeguards to date is a score of 4.5.

CBOCs do show lower scores for privacy functions such as employee awareness of their privacy officer or access to their privacy policies with this area trending at a score of 3.8. The VHA Privacy Office and PCA are both providing facility privacy officers with training on topics that impact CBOC performance such as monitoring activities for CBOCs. Overall, CBOCs are scoring a cumulative privacy score of 4.3.

The VHA Privacy Office and PCA are continuing to work with privacy officers to evaluate and expand their facility privacy programs to the CBOCs under their facilities' control.

Completed

Recommendation 10. Implement measures to minimize IT network space vulnerabilities in accordance with VA policy.

VHA Response

Concur

Actions to remediate access vulnerabilities involving information technology (IT) networks at CBOCs have been completed or are almost complete. VISN and facility senior managers will work with their VA Office of Information and Technology (OI&T) counterparts to ensure that access to these networks is consistent with VA Handbook 6500, Information Security.

The Deputy Under Secretary for Health Operations and Management (DUSHOM) will survey the parent facilities to determine the status of implementing IT space vulnerability recommendations.

In process March 1, 2013

Recommendation 11. Review the invoice validation process to consider creating a standardized billable roster report to improve oversight and accuracy of billable patient lists, thereby reducing man hours currently performing those duties and potential.

VHA Response

Concur

The ADUSH/ Administrative Operations/ VHA Medical Sharing/Affiliate Office is collaborating with DUSHOM for Policy and Services/Patient Care Services (PCS) to incorporate specific instructions and requirements for billing validation in the standardized Performance Work Statement (PWA). These changes will be vetted through Office of Inspector General and Office of General Counsel prior to implementation.

In process NLT October 1, 2012

Recommendation 12. Strengthen the oversight of the contract acquisition process to ensure that adequate planning occurs and that proper approvals are documented in the contract management system [eCMS] in accordance with VA Directives.

VHA Response

Concur

The VHA Procurement and Logistics Office (P&LO) quality processes have been implemented to provide adequate oversight for processing, executing, and administrating CBOC contracts. A standardized CBOC Performance Work Statement (PWS) has been implemented for all CBOC procurements. This template ensures appropriate patient care standards and payment procedures are included. All solicitations are processed through the local and P&LO Service Area Office (SAO) Quality Assurance (QA) groups under the requirements of Federal regulations and agency policies. A procurement that falls under the VA Directive 1663 guidelines is processed through the VHA Medical Sharing/Affiliate Office (MSO), Patient Care Services, and Regional Counsel to ensure the standardized CBOC PWC is utilized. This type of procurement has pre-solicitation and pre-award reviews prior to award. These are tracked in the P&LO MSO Share Point. The VHA Acquisition Quality Office also performs internal contract audits to ensure compliance with contract acquisition processes.

Completed

Recommendation 13. Ensure that MH services for contract CBOCs are addressed in a separate contract or within the primary care contract.

VHA Response

Concur

The intent of contracted CBOCs is specifically to provide primary care services. If mental health services were previously required in a CBOC contract, they were included with additional pricing instructions. The pricing instructions separate the primary care services and the mental health services. As a collaborative effort, the DUSH for Policy and Service/PCS and ADUSH for Administrative Operations/MSO have established a workgroup to address this recommendation and related issues**.**

The plan includes the following steps:

- A revised template is currently being created which will require the presence of mental health in every CBOC template. Completed
- VISN Mental Health leads have ensured provisions for mental health services are included in all present CBOC contracts or a plan is in place to add such provisions to contracts. To be completed by July 31, 2012
- Office of Mental Health Services will review all pending CBOC contracts to ensure a mental health plan is included. Ongoing

Ongoing	To be completed NLT July 31, 2012

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Marisa Casado, Director, CBOC Program Review Nancy Albaladejo, MSN Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Zhana Johnson, CPA Anthony Leigh, Jr., CPA Jennifer Reed, MSHI Patrick Smith, MS Marilyn Stones, BS Jarvis Yu, MS

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