Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03851-117

Community Based Outpatient Clinic Reviews at Marion VA Medical Center Marion, IL

February 26, 2013

Washington, DC 20420

Why We Did This Review

The VA OIG is undertaking a systematic review of the VHA's CBOCs to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care.

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

Veterans are required to receive one standard of care at all VHA health care facilities. Care at CBOCs needs to be consistent, safe, and of high quality, regardless of model (VA-staffed or contract). CBOCs are expected to comply with all relevant VA policies and procedures, including those related to quality, patient safety, and performance.

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/hotline/default.asp)

Glossary

C&P	credentialing and privileging
CBOC	community based outpatient clinic
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
MH	mental health
NCP	National Center for Health Promotion and Disease Prevention
NC	noncompliant
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PSB	Professional Standards Board
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH	women's health

Table of Contents

Executive Summary

Purpose: We evaluated select activities to assess whether the CBOCs operated in a manner that provides veterans with consistent, safe, high-quality health care.

For the EHR review component of the WH and vaccinations topic areas, patients were randomly selected from all CBOCs assigned to the respective parent facilities.

We conducted an onsite inspection of the CBOCs during the week of November 5, 2012. The C&P, EOC, and emergency management onsite inspections were only conducted at the randomly selected CBOCs (see Table 1).

VISN	Facility	CBOC Name	Location
15	Marion VAMC	Mayfield	Mayfield, KY
		Vincennes	Vincennes, IN

Table 1. Sites Inspected

Review Results: The review covered the following topic areas:

- WH
- Vaccinations
- C&P
- EOC
- Emergency Management

We made recommendations in three review areas.

Recommendations: The VISN and Facility Directors, in conjunction with the respective CBOC managers, should take appropriate actions to:

- Ensure that the ordering provider or surrogate is notified of normal cervical cancer screening results within the allotted timeframe and that notification is documented in the EHR.
- Ensure that patients with cervical cancer screening results are notified of results within the defined timeframe and that notification is documented in the EHR.
- Ensure that clinicians document all required tetanus and pneumococcal vaccination administration elements and that compliance is monitored.
- Ensure that the PSB grants setting-specific privileges for all LIPs at the Mayfield and Vincennes CBOCs.

Comments

The VISN and Facility Directors agreed with the CBOC review findings and recommendations and provided acceptable improvement plans. (See Appendixes A–B, pages 11–14, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

- Evaluate whether CBOCs comply with selected VHA requirements regarding the provision of cervical cancer screening, results reporting, and WH liaisons.
- Evaluate whether CBOCs properly provided selected vaccinations to veterans according to Centers for Disease Control and Prevention guidelines and VHA recommendations.
- Determine whether CBOC providers are appropriately credentialed and privileged in accordance with VHA Handbook 1100.19.[1]
- Determine whether CBOCs are in compliance with standards of operations according to VHA policy in the areas of environmental safety and emergency planning.[2]

Scope and Methodology

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the environment of care. In performing the reviews, we assessed clinical and administrative records as well as completed onsite inspections at randomly selected sites. Additionally, we interviewed managers and employees. The review covered the following five activities:

- WH
- Vaccinations
- C&P
- EOC
- Emergency Management

Methodology

To evaluate the quality of care provided to veterans at CBOCs, we conducted EHR reviews for the WH and vaccinations topic areas. For WH, the EHR reviews consisted of a random sample of 50 women veterans (23–64 years of age). For vaccinations, the EHR reviews consisted of random samples of 75 veterans (65 and older) and 75 additional veterans (all ages), unless fewer patients were available, for tetanus and

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.

pneumococcal, respectively. The study populations consisted of patients from all CBOCs assigned to the parent facility.[3]

The C&P, EOC, and emergency management onsite inspections were only conducted at the randomly selected CBOCs. Two CBOCs were randomly selected from the 56 sampled parent facilities, with sampling probabilities proportional to the numbers of CBOCs eligible to be inspected within each of the parent facilities.[4]

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

This report is available at http://www.va.gov/oig/publications/default.asp

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

[3] Includes all CBOCs in operation before October 1, 2011.
[4] Includes 96 CBOCs in operation before October 1, 2011, that had 500 or more unique enrollees.

CBOC Profiles

To evaluate the quality of care provided to veterans at CBOCs, we designed reviews with an EHR component to capture data for patients enrolled at all of the CBOCs under the parent facility's oversight.[5] The table below provides information relative to each of the CBOCs under the oversight of the respective parent facility.

VISN	Parent Facility	CBOC Name	Locality[6]	Uniques, FY 2012[7]	Visits, FY 2012[8]	CBOC Size[9]
15	Marion VAMC	Effingham	Rural	3,031	12,528	Mid-Size
		Evansville	Urban	13,445	103,281	Very Large
		Hanson	Rural	1,067	3,930	Small
		Mayfield	Rural	2,341	10,514	Mid-Size
		Mt. Vernon	Rural	2,512	12,067	Mid-Size
		Owensboro	Urban	2,722	12,773	Mid-Size
		Paducah	Rural	4,863	20,961	Mid-Size
		Vincennes	Rural	1,939	6,277	Mid-Size

Table 2. CBOC Profiles

[5] Includes all CBOCs in operation before October 1, 2011.
[6] http://vaww.pssg.med.va.gov/
[7] http://vssc.med.va.gov
[8] http://vssc.med.va.gov
[9] Based on the number of unique patients seen as defined by VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, the size of the CBOC facility is categorized as very large (> 10,000), large (5,000-10,000), mid-size (1,500-5,000), or small (< 1,500).

WH and Vaccination EHR Reviews Results and Recommendations

WH

Cervical cancer is the second most common cancer in women worldwide.[10] Each year, approximately 12,000 women in the United States are diagnosed with cervical cancer.[11] The first step of care is screening women for cervical cancer with the Papanicolaou test or "Pap" test. With timely screening, diagnosis, notification, and treatment, the cancer is highly preventable and associated with long survival and good quality of life.

VHA policy outlines specific requirements that must be met by facilities that provide services for women veterans.[12] We reviewed EHRs, meeting minutes and other relevant documents, and interviewed key WH employees. Table 3 shows the areas reviewed for this topic. The review elements marked as noncompliant needed improvement.

NC	Areas Reviewed
	Cervical cancer screening results were entered into the patient's EHR.
X	The ordering VHA provider or surrogate was notified of results within the defined timeframe.
X	Patients were notified of results within the defined timeframe.
	Each CBOC has an appointed WH Liaison.
	There is evidence that the CBOC has processes in place to ensure that WH care needs are addressed.

Table 3. WH

There were 26 patients who received a cervical cancer screening at the Marion VAMC's CBOCs.

Provider Notification. VHA requires that normal cervical cancer screening results must be reported to the ordering provider or surrogate within 30 calendar days of the report being issued and the notification is documented in the EHR.[13] We reviewed the EHRs of 26 patients who had normal cervical cancer screening results and did not find documentation in 8 records that the ordering provider or surrogate was notified within 30 calendar days.

[10] World Health Organization. Cancer of the cervix. Retrieved from: http://www.who.int/reproductivehealth/topics/cancer
[11] U.S. Cancer Statistics Working Group, United States Cancer Statistics: 1999-2008 Incidence and Mortality Web-based report.
[12] VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
[13] VHA Handbook 1330.01, *Healthcare Services for Women Veterans*, May 21, 2010.

Patient Notification of Normal Cervical Cancer Screening Results. We reviewed 26 EHRs of patients who had normal cervical cancer screening results and determined that 7 patients were not notified of results within the required 14 days from the date the pathology report became available.

Recommendations

1. We recommended that a process is established to ensure that the ordering provider or surrogate is notified of normal cervical cancer screening results within the allotted timeframe and that notification is documented in the EHR.

2. We recommended that managers ensure that patients with cervical cancer screening results are notified of results within the defined timeframe and that notification is documented in the EHR.

Vaccinations

The VHA NCP was established in 1995. The NCP establishes and monitors the clinical preventive services offered to veterans, which includes the administration of vaccinations.[14] The NCP provides best practices guidance on the administration of vaccinations for veterans. The Centers for Disease Control and Prevention states that although vaccine-preventable disease levels are at or near record lows, many adults are under-immunized, missing opportunities to protect themselves against diseases such as tetanus and pneumococcal.

Adults should receive a tetanus vaccine every 10 years. At the age of 65, individuals that have never had a pneumococcal vaccination should receive one. For individuals 65 and older who have received a prior pneumococcal vaccination, one-time revaccination is recommended if they were vaccinated 5 or more years previously and were less than 65 years of age at the time of the first vaccination.

We reviewed documentation of selected vaccine administrations and interviewed key personnel. Table 4 shows the areas reviewed for this topic. The review element marked as noncompliant needed improvement.

NC	Areas Reviewed
	Staff screened patients for the tetanus vaccination.
	Staff screened patients for the pneumococcal vaccination.
X	Staff properly documented vaccine administration.
	Managers developed a prioritization plan for the potential occurrence of vaccine shortages.

Table 4. Vaccinations

Documentation of Vaccinations. Federal Law requires that documentation for administered vaccinations include specific elements such as the vaccine manufacturer

[14] VHA Handbook 1120.05, *Coordination and Development of Clinical Preventive Services*, October 13, 2009.

and lot number of the vaccine used.[15] We reviewed eight patients' EHRs and did not find documentation of all the required information related to tetanus vaccine administration. We reviewed 47 patients' EHRs and did not find documentation of all the required information related to pneumococcal vaccine administration.

Recommendation

3. We recommended that managers ensure that clinicians document all required tetanus and pneumococcal vaccination administration elements and that compliance is monitored.

[15] Childhood Vaccine Injury Act of 1986 (PL 99 660) sub part C.

Onsite Inspections
Results and Recommendations

CBOC Characteristics

We formulated a list of CBOC characteristics that includes identifiers and descriptive information for the randomly selected CBOCs (see Table 5).

	Mayfield	Vincennes
VISN	15	15
Parent Facility	Marion VAMC	Marion VAMC
Types of Providers	licensed clinical social worker nurse practitioner physician assistant primary care provider	licensed clinical social worker physician assistant primary care provider psychiatrist
Number of MH Uniques,[16] FY 2012	423	532
Number of MH Visits, FY 2012	2,372	2,167
MH Services Onsite	Yes	Yes
Specialty Care Services Onsite	WH	WH
Ancillary Services Provided Onsite	Electrocardiogram Laboratory	Electrocardiogram Laboratory
Tele-Health Services	MH MOVE Retinal Imaging	MH MOVE Retinal Imaging

Table 5. Characteristics

[16] http://vssc.med.va.gov

C&P

We reviewed C&P folders, scopes of practice, meeting minutes, and VetPro information and interviewed senior managers to determine whether facilities had consistent processes to ensure that providers complied with applicable requirements as defined by VHA policy.[17] Table 6 shows the areas reviewed for this topic. The CBOCs identified as noncompliant needed improvement. Details regarding the findings follow the table.

NC	Areas Reviewed
	Each provider's license was unrestricted.
New Provider	
	Efforts were made to obtain verification of clinical privileges currently or most recently held at other institutions.
	FPPE was initiated.
	Timeframe for the FPPE was clearly documented.
	The FPPE outlined the criteria monitored.
	The FPPE was implemented on first clinical start day.
	The FPPE results were reported to the medical staff's Executive Committee.
Additional New Privilege	
	Prior to the start of a new privilege, criteria for the FPPE were developed.
	There was evidence that the provider was educated about FPPE prior to its initiation.
	FPPE results were reported to the medical staff's Executive Committee.
FPPE for Performance	
	The FPPE included criteria developed for evaluation of the practitioners when issues affecting the provision of safe, high-quality care were identified.
	A timeframe for the FPPE was clearly documented.
	There was evidence that the provider was educated about FPPE prior to its initiation.
	FPPE results were reported to the medical staff's Executive Committee.
Privileges and Scopes of Practice	
	The Service Chief, Credentialing Board, and/or medical staff's Executive Committee list documents reviewed and the rationale for conclusions reached for granting licensed independent practitioner privileges.
Mayfield Vincennes	Privileges granted to providers were setting, service, and provider specific.
	The determination to continue current privileges were based in part on results of OPPE activities.

[17] VHA Handbook 1100.19.

NC	Areas Reviewed (continued)
	The OPPE and reappraisal process included consideration of such factors as clinical pertinence reviews and/or performance measure compliance.

Table 6. C&P

Clinical Privileges. VHA requires that privileges must be setting specific and only granted within the scope of the setting mission.[18] The PSB granted clinical privileges for two LIPs at the Mayfield CBOC and two LIPs at the Vincennes CBOC that were not setting specific.

Recommendations

4. We recommended that the PSB grants setting-specific privileges for all LIPs at the Mayfield and Vincennes CBOCs.

EOC and Emergency Management

EOC

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, infection control, and general maintenance. We reviewed relevant documents and interviewed key employees and managers. Table 7 shows the areas reviewed for this topic.

NC	Areas Reviewed
	The CBOC was Americans with Disabilities Act compliant, including: parking, ramps, door widths, door hardware, restrooms, and counters.
	The CBOC was well maintained (e.g., ceiling tiles clean and in good repair, walls without holes, etc.).
	The CBOC was clean (walls, floors, and equipment are clean).
	Material safety data sheets were readily available to staff.
	The patient care area was safe.
	Access to fire alarms and fire extinguishers was unobstructed.
	Fire extinguishers were visually inspected monthly.
	Exit signs were visible from any direction.
	There was evidence of fire drills occurring at least annually.
	Fire extinguishers were easily identifiable.
	There was evidence of an annual fire and safety inspection.
	There was an alarm system or panic button installed in high-risk areas as identified by the vulnerability risk assessment.
	The CBOC had a process to identify expired medications.
	Medications were secured from unauthorized access.
	Privacy was maintained.

[18] VHA Handbook 1100.19.

NC	Areas Reviewed (continued)
	Patients' personally identifiable information was secured and protected.
	Laboratory specimens were transported securely to prevent unauthorized access.
	Staff used two patient identifiers for blood drawing procedures.
	Information Technology security rules were adhered to.
	There was alcohol hand wash or a soap dispenser and sink available in each examination room.
	Sharps containers were less than 3/4 full.
	Safety needle devices were available for staff use (e.g., lancets, injection needles, phlebotomy needles)
	The CBOC was included in facility-wide EOC activities.
Table 7. EOC	

All CBOCs were compliant with the review areas; therefore, we made no recommendations.

Emergency Management

VHA policy requires each CBOC to have a local policy or standard operating procedure defining how medical and MH emergencies are handled.[19] Table 8 shows the areas reviewed for this topic.

NC	Areas Reviewed
	There was a local medical emergency management plan for this CBOC.
	The staff articulated the procedural steps of the medical emergency plan.
	The CBOC had an automated external defibrillator onsite for cardiac emergencies.
	There was a local MH emergency management plan for this CBOC.
	The staff articulated the procedural steps of the MH emergency plan.
Table 8. Emergency Management	

All CBOCs were compliant with the review areas; therefore, we made no recommendations.

[19] VHA Handbook 1006.1.

VISN 15 Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 22, 2013

From: Director, VISN 15 (10N15)

Subject: **CBOC Reviews at Marion VAMC**

To: Director, 54KC Healthcare Inspections Division (54KC)

Director, Management Review (VHA 10AR MRS OIG CAP CBOC)

I have reviewed the draft report of the Marion, IL VAMC Mayfield, KY and Vincennes, IN CBOCs and I concur with the recommendations and Medical Center Director's response. Thank you for this opportunity of review to ensure that we continue to provide exceptional care to our Veterans.

For additional questions please feel free to contact Jimmie Bates, VISN 15 Quality Management Officer at 816-701-3000.

William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Marion VAMC Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 18, 2013

From: Director, Marion VAMC (657A5/00)

Subject: **CBOC Reviews at Marion VAMC**

To: Director, VISN 15 (10N15)

I concur with the recommendations of the OIG Report.

Paul Bockelman

Paul Bockelman, FACHE
Director, Marion VA Medical Center, (657A5/00)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

1. We recommended that a process is established to ensure that the ordering provider or surrogate is notified of normal cervical cancer screening results within the allotted timeframe and that notification is documented in the EHR.

Concur

Target date for completion: April 15, 2013

The facility will enhance our current process of notification of normal cervical cancer screening results with the requirement of an electronic acknowledgement. This will document that results were received by the ordering provider or surrogate within the allotted timeframe. A Standard Operating Procedure (SOP) will be developed outlining this process.

2. We recommended that managers ensure that patients with cervical cancer screening results are notified of results within the defined timeframe and that notification is documented in the EHR.

Concur

Target date for completion: April 15, 2013

The facility will enhance our current process of notification of cervical cancer screening results with the requirement of electronic documentation that results were communicated to the patient within the allotted timeframe. A SOP will be developed outlining this process.

3. We recommended that managers ensure that clinicians document all required tetanus and pneumococcal vaccination administration elements and that compliance is monitored.

Concur

Target date for completion: April 15, 2013

The Immunization Clinical Reminders were updated to include the current edition of the Vaccine Information Sheet (VIS). A monitor will be developed with second quarter FY13 reviews to be completed.

4. We recommended that the PSB grants setting-specific privileges for all LIPs at the Mayfield and Vincennes CBOCs.

Concur

Target date for completion: Completed

The PSB approved the addition of setting-specific site privileges to the LIP Primary Care Core privileges for the Mayfield and Vincennes CBOCs on January 17, 2013.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	James Seitz, RN, MBA, Team Leader Dorothy Duncan, RN, MHA Cindy Niemack-Brown, CMSW, LMHP Larry Selzler, MSPT Laura Snow, LMSW, MHCL Jennifer Whitehead, Program Support Assistant

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VISN 15 (10N15)
Director, Marion VAMC (657A5/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Dan Coats, Joe Donnelly, Dick Durbin, Mark Kirk, Mitch McConnell, Rand Paul
U.S. House of Representatives: Larry Bucshon, William Enyart, Brett Guthrie, John Shimkus, Ed Whitfield

This report is available at www.va.gov/oig.