Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03854-115

Community Based Outpatient Clinic Reviews at William S. Middleton Memorial Veterans Hospital Madison, WI

February 28, 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.

Glossary

C&P	credentialing and privileging
CBOC	community based outpatient clinic
CDC	Centers for Disease Control and Prevention
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
NC	noncompliant
NCP	National Center for Health Promotion and Disease Prevention
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH	women's health

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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 parent facility.

We conducted an onsite inspection of the CBOCs during the week of December 3, 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
12	William S. Middleton Memorial Veterans Hospital	Freeport	Freeport, IL
		Janesville	Janesville, WI

Table 1. Sites Inspected

Review Results: The review covered the following topic areas:

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

We made recommendations in one review area**.**

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

- Ensure that clinicians screen patients for tetanus vaccinations.
- Ensure that clinicians administer pneumococcal vaccinations when indicated.
- Ensure that clinicians document all required pneumococcal and tetanus vaccination administration elements and that compliance is monitored.

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 CDC 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 parent facility.[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 parent facility.

VISN	Parent Facility	CBOC Name	Locality[6]	Uniques, FY 2012 [7]	Visits, FY 2012 [7]	CBOC Size[8]
12	William S. Middleton Memorial Veterans Hospital	Baraboo	Rural	1,509	5,516	Mid-Size
		Beaver Dam	Rural	2,052	6,883	Mid-Size
		Freeport	Rural	1,853	5,665	Mid-Size
		Janesville	Urban	2,953	10,941	Mid-Size
		Rockford	Urban	8,291	47,077	Large

Table 2. 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] 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.[9] Each year, approximately 12,000 women in the United States are diagnosed with cervical cancer.[10] 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.[11] We reviewed EHRs, meeting minutes and other relevant documents, and interviewed key WH employees. Table 3 shows the areas reviewed for this topic.

NC	Areas Reviewed
	Cervical cancer screening results were entered into the patient's EHR.
	The ordering VHA provider or surrogate was notified of results within the defined timeframe.
	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 William S. Middleton Memorial Veterans Hospital's CBOCs.

Generally the CBOCs assigned to the parent facility were compliant with the review areas; therefore, we made no recommendations.

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.[12] The NCP provides best practices guidance on the administration of vaccinations for veterans. The CDC states that although vaccine-preventable disease

[9] World Health Organization. Cancer of the cervix. Retrieved from: http://www.who.int/reproductivehealth/topics/cancer
[10] U.S. Cancer Statistics Working Group, United States Cancer Statistics: 1999-2008 Incidence and Mortality Web-based report.
[11] VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
[12] VHA Handbook 1120.05, *Coordination and Development of Clinical Preventive Services*, October 13, 2009.

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 elements marked as noncompliant needed improvement.

NC	Areas Reviewed
X	Staff screened patients for the tetanus vaccination.
X	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

Tetanus Vaccination Screening. Through clinical reminders, VHA requires that CBOC clinicians screen patients for tetanus vaccinations.[13] We reviewed 75 patients' EHRs and did not find documentation of tetanus vaccination screening in 33 patient records.

Pneumococcal Vaccination Administration for Patients with Pre-Existing Conditions. The CDC recommends that at the age of 65, individuals that have never had a pneumococcal vaccination should receive one.[14] For individuals 65 and older who have received a prior pneumococcal vaccination, a 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 seven EHRs for patients with pre-existing conditions who received their first vaccine prior to the age of 65. In seven patient's EHRs we did not find documentation indicating that both vaccinations had been administered.

Documentation of Vaccinations. Federal Law requires that documentation for administered vaccinations include specific elements, such as the vaccine manufacturer and lot number of the vaccine used.[15] We reviewed 33 patients' EHRs who received a pneumococcal vaccine administration at the parent facility or its associated CBOCs and did not find documentation of all the required information related to pneumococcal vaccine administration in 29 patient EHRs. We reviewed seven patients' EHRs who received a tetanus vaccine administration at the parent facility or its associated CBOCs

[13] VHA Handbook 1120.05, *Coordination and Development of Clinical Preventive Services*, October 13, 2009.
[14] Centers for Disease Control and Prevention, http://www.cdc.gov/vaccines/vpd-vac/.
[15] Childhood Vaccine Injury Act of 1986 (PL 99 660) sub part C.

and did not find documentation of all the required information related to tetanus vaccine administration in five of the patient EHRs.

Recommendations

1. We recommended that managers ensure that clinicians screen patients for tetanus vaccinations.

2. We recommended that managers ensure that clinicians administer pneumococcal vaccinations when indicated.

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

Onsite Reviews
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).

	Freeport	Janesville
VISN	12	12
Parent Facility	William S. Middleton Memorial Veterans Hospital	William S. Middleton Memorial Veterans Hospital
Types of Providers	clinical pharmacist licensed clinical social worker nurse practitioner primary care provider	clinical pharmacist nurse practitioner primacy care provider
Number of Mental Health Uniques, FY 2012	151	318
Number of Mental Health Visits, FY 2012	580	1,988
Mental Health Services Onsite	No	No
Specialty Care Services Onsite	None	None
Ancillary Services Provided Onsite	Electrocardiogram Laboratory	Electrocardiogram Laboratory
Tele-Health Services	Mental Health MOVE[16] Retinal Imaging Care Coordination Home Telehealth	Audiology Mental Health MOVE Retinal Imaging Care Coordination Home Telehealth

Table 5. Characteristics

[16] VHA Handbook 1120.01, *MOVE! Weight Management Program For Veterans*, March 31, 2011

C&P

We reviewed C&P folders, scopes of practice, meeting minutes, and VetPro information and interviewed senior managers to determine whether the facility 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.

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.
	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.
	Scopes of practice were setting specific.
Table 6. C&P	

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

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.
	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.

NC	Areas Reviewed (continued))
	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.[18] 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.

[18] VHA Handbook 1006.1.

Appendix A

VISN 12 Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 1, 2013

From: Director, VISN 12 (10N12)

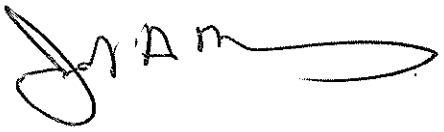
Subject: **CBOC Reviews at William S. Middleton Memorial Veterans Hospital**

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

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

I have reviewed the document and concur with the response as submitted.

If additional information is needed please contact Jean Farrell-Holtan Organizational Improvement Manager at (608) 256-1901, x17718



Jeffrey A. Murawsky, M.D.
Network Director

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 29, 2013

From: Director, William S. Middleton Memorial Veterans Hospital (607/00)

Subject: **CBOC Reviews at William S. Middleton Memorial Veterans Hospital**

To: Director, VISN 12 (10N12)

1. Thank you for the opportunity to review the draft report on the Community Based Outpatient Clinic Reviews at Wm. S. Middleton Memorial Veterans Hospital, Madison WI (Freeport & Janesville).

2. I have reviewed the document and concur with the recommendations. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(original signed by:)
JUDY K. MCKEE

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 managers ensure that clinicians screen patients for tetanus vaccinations.

Concur

Target date for completion: March 31, 2013

The Tdap clinical reminder logic was re-written and will be due on all patients that do not have a recorded Tdap vaccination. This is a "one-time" reminder that will be satisfied for the life time of the Veteran once a Tdap vaccination administration is recorded. A separate clinical reminder addressing the Tetanus vaccination will become due 10 years after the recorded date of the Tdap administration. Changes to the clinical reminders were communicated to all providers. Clinical reminder reports for Tdap will be run monthly with the goal of 90% completion rate for three consecutive months. Once this goal has been achieved, monitoring will occur quarterly.

2. We recommended that managers ensure that clinicians administer pneumococcal vaccinations when indicated.

Concur

Target date for completion: April 30, 2013

Pneumococcal clinical reminder logic will be re-written for the booster to include if the patient is older than 65, they received Pneumovax before age 65 AND it has been more than 5 years since the immunization, the clinical reminder will be due for the patient. In addition, the reminder identifies if the Herpes Zoster vaccine in the last 30 days and if the patient had the vaccine in that time frame, it will NOT be due for the patient. Clinical reminder reports for Pneumococcal vaccination will be run monthly with goal of 90% completion rate for three consecutive months. Once this goal has been achieved, monitoring will occur quarterly.

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

Concur

Target date for completion: March 31, 2013

All vaccination templates were re-written to include all required pneumococcal and tetanus vaccination administration elements. Monthly chart reviews will be conducted with the goal of 90% of charts will contain all required vaccination elements for three consecutive months.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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