Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00026-198

Community Based Outpatient Clinic Reviews at Sioux Falls VA Health Care System Sioux Falls, SD

May 17, 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
CCHT	Care Coordination Home Telehealth
CDC	Centers for Disease Control and Prevention
EKG	electrocardiogram
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HCS	Health Care System
LCSW	Licensed Clinical Social Worker
MH	mental health
NCP	National Center for Health Promotion and Disease Prevention
NC	noncompliant
OIG	Office of Inspector General
PCP	primary care provider
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.

We conducted onsite inspections of the CBOCs during the week of April 1, 2013.

The review covered the following topic areas:

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

For the WH and vaccinations topics, EHR reviews were performed for patients who were randomly selected from all CBOCs assigned to the respective parent facilities. 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
23	Sioux Falls VA HCS	Aberdeen (Brown County)	Aberdeen, SD
		Spirit Lake	Spirit Lake, IA
		Watertown	Watertown, SD

Table 1. Sites Inspected

Review Results: 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 patients with normal cervical cancer screening results are notified of results within the defined timeframe and that notification is documented in the EHR.
- Ensure that clinicians administer pneumococcal vaccinations when indicated.
- Ensure that clinicians document all required pneumococcal vaccination administration elements and that compliance is monitored.
- Ensure that access is improved for disabled veterans at the Spirit Lake CBOC.

- Ensure that signage for fire extinguishers is correctly displayed at the Aberdeen (Brown County) and Watertown 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 12–15, 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 EOC. 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 (all ages) and 75 additional veterans (65 and older), unless fewer patients were available, for the 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 reviews, 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. Three 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.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the 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[7]	CBOC Size[8]
23	Sioux Falls VA HCS	Aberdeen (Brown County) (Aberdeen, SD)	Rural	2,219	12,388	Mid-Size
		Sioux City (Sioux City, IA)	Urban	4,301	22,409	Mid-Size
		Spirit Lake (Spirit Lake, IA)	Rural	2,588	15,846	Mid-Size
		Wagner (Wagner, SD)	Rural	532	2,945	Small
		Watertown (Watertown, SD)	Rural	1,834	8,743	Mid-Size

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. The review element marked as noncompliant needed improvement. Details regarding the findings follow the table.

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.
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 25 patients who received a cervical cancer screening at the Sioux Falls VA HCS and its CBOCs.

Patient Notification of Normal Cervical Cancer Screening Results. VHA requires that normal cervical cancer screening results must be communicated to the patient in terms easily understood by a layperson within 14 days from the date of the pathology report becoming available. We reviewed 24 EHRs of patients who had normal cervical cancer screening results and determined that 4 patients were not notified within the required 14 days from the date the pathology report became available.

[9] World Health Organization. *Cancer of the cervix*. Retrieved from: http://www.who.int/reproductivehealth/topics/cancers/en/index.html.
[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.

Recommendation

1. We recommended that managers ensure that patients with normal 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.[12] The NCP provides best practices guidance on the administration of vaccinations for veterans. The CDC 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 elements marked as noncompliant needed improvement. Details regarding the findings follow the table.

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

Table 4. Vaccinations

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.[13] 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 the EHRs of two patients with pre-existing conditions who received their first vaccine prior to the age of 65. We did not find

[12] VHA Handbook 1120.05, *Coordination and Development of Clinical Preventive Services*, October 13, 2009.
[13] Centers for Disease Control and Prevention, http://www.cdc.gov/vaccines/vpd-vac/.

documentation in either of the patient EHRs indicating that their second vaccination had been administered.

Documentation of Pneumococcal Vaccination. Federal Law requires that documentation for administered vaccinations include specific elements, such as the vaccine manufacturer and lot number of the vaccine used.[14] We reviewed the EHRs of 41 patients 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 25 of the EHRs.

Recommendations

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 vaccination administration elements and that compliance is monitored.

[14] Childhood Vaccine Injury Act of 1986 (PL 99 660) sub part C, November 16, 2010.

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).

	Aberdeen (Brown County)	Spirit Lake	Watertown
VISN	23	23	23
Parent Facility	Sioux Falls VA HCS	Sioux Falls VA HCS	Sioux Falls VA HCS
Types of Providers	LCSW Nurse Practitioner Physician Assistant PCP	LCSW Physician Assistant PCP Psychiatrist	LCSW Nurse Practitioner PCP
Number of MH Uniques, FY 2012	238	414	201
Number of MH Visits, FY 2012	2,009	1,507	907
MH Services Onsite	Yes	Yes	Yes
Specialty Care Services Onsite	WH	WH	WH
Ancillary Services Provided Onsite	EKG Laboratory	EKG Laboratory Pharmacy	EKG Laboratory Pharmacy
Tele-Health Services	Endocrinology Infectious Disease MH MOVE[15] Nephrology Neurology Nutrition Oncology Orthopedic Pain Management Pulmonary CCHT	Endocrinology Infectious Disease MH MOVE Nephrology Neurology Nutrition Oncology Orthopedic Pain Management Pulmonary Retinal Imaging CCHT	Endocrinology Infectious Disease MH MOVE Nephrology Neurology Nutrition Oncology Orthopedic Pain Management Pulmonary CCHT

Table 5. Characteristics

[15] 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 facilities had consistent processes to ensure that providers complied with applicable requirements as defined by VHA policy.[16] 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 was based in part on results of Ongoing Professional Practice Evaluation activities.

Table 6. C&P

[16] VHA Handbook 1100.19.

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. The CBOC identified as noncompliant needed improvement. Details regarding the findings follow the table.

NC	Areas Reviewed
Spirit Lake	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.
Aberdeen (Brown County) Watertown	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.
	Sharps containers were less than 3/4 full.

NC	Areas Reviewed (continued)
	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

Physical Access. The Americans with Disabilities Act requires that facility doors are equipped with handles that are easy to grasp with one hand and do not require tight grasping, pinching, or twisting of the wrist to operate. One of the two Spirit Lake entrance door handles was not easy to grasp with one hand and was not equipped with an automatic door opener.

Fire Extinguishers. The National Fire Protection Association Life Safety Code requires identification of fire extinguisher locations when they are obscured from view.[17] The Aberdeen (Brown County) and Watertown CBOCs had no signage identifying the location of fire extinguishers. All fire extinguishers were recessed in the wall and obscured from view.

Recommendations

4. We recommended that access is improved for disabled veterans at the Spirit Lake CBOC.

5. We recommended that signage is installed at the Aberdeen (Brown County) and Watertown CBOCs to clearly identify the location of fire extinguishers.

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

[17] National Fire Protection Association, Standard for Portable Fire Extinguishers, 10 6.1.3.3.1.
[18] VHA Handbook 1006.1.

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

VISN 23 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 22, 2013

From: Director, VA Midwest Health Care Network (10N23)

Subject: **CBOC Reviews at Sioux Falls VA HCS**

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

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

The purpose of this memorandum is to submit the Director's comments to Office of Inspector General's Draft Report of Community Based Outpatient Clinic Reviews at the Sioux Falls VA Health Care System, Sioux Falls, SD.

(original signed by:)

Janet P. Murphy, MBA
Network Director, VISN 23

Enclosure

Sioux Falls VA HCS Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 22, 2013

From: Director, Sioux Falls VA HCS (438/00)

Subject: **CBOC Reviews at Sioux Falls VA HCS**

To: Director, VA Midwest Health Care Network (10N23)

1. The purpose of this memorandum is to submit the Director's comments to Office of Inspector General's Draft Report of Community Based Outpatient Clinic Reviews at the Sioux Falls VA Health Care System, Sioux Falls, SD.

2. If you have any questions or would like to discuss this response, please contact me at 605-333-6842.

Patrick J. Kelly, FACHE
Director, Sioux Falls VA HCS

Enclosure

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 patients with normal 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: August 30, 2013

On 4/10/2013, the CBOC Medical Director re-educated the CBOC providers on the results reporting mandate for normal cervical cancer screening results. The CBOC providers were educated on the electronic medical records documentation requirements for this notification. The CBOC Medical Director will conduct monthly chart audits, beginning May 2013, to monitor compliance for 3 months and then add this component to the quarterly audits for the CBOC women's health providers. The CBOC Medical Director will report monthly to the Quality, Safety and Value Council for 3 months on the status of the initial audit and then quarterly until compliance is greater than 90% for 3 months.

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

Concur

Target date for completion: August 30, 2013

The Clinical Application Coordinator instituted a new VISN 23 pneumovax reminder on April 8, 2013, which prompts the clinician to offer a one-time revaccination after the patient reaches the age 65 and has not received a previous revaccination. Clinicians were educated on the new reminder on April 8, 2013. The Nurse Managers at the CBOCs will monitor compliance of the new VISN 23 pneumovax clinical reminder monthly until 90% compliance is achieved for 3 consecutive months. The Nurse Managers will report monthly on the status of the reminder compliance to the Quality, Safety and Value Council**.**

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

Concur

Target date for completion: Completed

All immunization and vaccination reminders were reviewed March 27, 2013 to ensure all administration elements were included. In particular, to ensure the edition date of CDC educational handout given to patient is included in the immunization documentation. This is now being documented automatically when an immunization is entered by a clinician in the computerized electronic medical record. On April 8, 2013, clinicians were re-educated on the reminder. The Nurse Managers at the CBOCs will monitor documentation compliance for the required pneumococcal and tetanus vaccination administration elements monthly until 90% compliance is achieved for 3 consecutive months. The Nurse Managers at the CBOCs will report monthly on the status of the required documentation compliance to the Quality, Safety, and Value Council**.**

4. We recommended that access is improved for disabled veterans at the Spirit Lake CBOC.

Concur

Target date for completion: June 1, 2013

The CBOC Coordinator will ensure access for disabled veterans at the Spirit Lake CBOC is improved by installing a handicap access door opening device by June 1, 2013.

5. We recommended that signage is installed at the Aberdeen (Brown County) and Watertown CBOCs to clearly identify the location of fire extinguishers.

Concur

Target date for completion: May 1, 2013

The CBOC Coordinator will ensure installation of the signage identifying the location of fire extinguishers at the Aberdeen (Brown County) and Watertown CBOC by May 1, 2013.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Onsite Contributors	Stephanie Hensel, RN, JD Team Leader
Other Contributors	Michael Bishop, MSW Shirley Carlile, BA Lin Clegg, PhD Marnette Dhooghe, MS Laura Dulcie, BSEE Matt Frazier, MPH Jennifer Reed, RN, MSHI Victor Rhee, MHS Patrick Smith, M. Stat Marilyn Stones, BS Mary Toy, RN, MSN Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Midwest Health Care Network (10N23)
Director, Sioux Falls VA HCS (438/00)

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: Chuck Grassley, Tom Harkin, Tim Johnson, John Thune
U.S. House of Representatives: Steve King, Kristi Noem

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