Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00026-259

Community Based Outpatient Clinic Review at Jack C. Montgomery VA Medical Center Muskogee, OK

July 24, 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
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
MH	mental health
NC	noncompliant
NCP	National Center for Health Promotion and Disease Prevention
OIG	Office of Inspector General
VAMC	VA Medical Center
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.

We conducted an onsite inspection of the Vinita CBOC during the week of May 20, 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 parent facility. The C&P, EOC, and emergency management onsite inspections were only conducted at the randomly selected CBOC (see Table 1).

VISN	Facility	CBOC Name	Location
16	Jack C. Montgomery VAMC	Vinita	Vinita, OK

Table 1. Site Inspected

Review Results: We made recommendations in two review areas.

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

- Establish a process to ensure that the ordering provider or surrogate is notified of abnormal cervical cancer screening results within the required timeframe and that notification is document in the EHR.
- Ensure that patients with normal cervical cancer screening results are notified within the required timeframe and that notification is documented in the EHR.
- Ensure that clinicians document all required tetanus vaccine 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 the 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 EOC. In performing the reviews, we assessed clinical and administrative records as well as completed an onsite inspection at one randomly selected site. 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 CBOC. This CBOC was 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[8]	CBOC Size[9]
16	Jack C. Montgomery VAMC	Hartshorne (Hartshorne, OK)	Rural	1,973	8,664	Mid-Size
		Tulsa (Tulsa, OK)	Urban	20,711	189,614	Very Large
		Vinita (Vinita, OK)	Rural	2,393	15,954	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 NC needed improvement. Details regarding the findings follow the table.

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 required timeframe.
X	Patients were notified of results within the required 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 19 patients who received a cervical cancer screening at the Jack C. Montgomery VAMC's CBOCs.

Provider Notification of Abnormal Cervical Cancer Screening Results. VHA requires that abnormal cervical cancer screening results must be reported to the provider or surrogate within 5 business days of the report being issued and that the notification is documented in the EHR. We reviewed the EHRs of three patients and did not find documentation in two of the records that the interpreting physician notified the ordering provider or surrogate of the abnormal cervical cancer screening results within 5 business days.

[10] World Health Organization, *Comprehensive Cervical Cancer Prevention and Control: A Healthier Future for Girls and Women*, Retrieved (4/25/2013): http://www.who.int/reproductivehealth/topics/cancers/en/index.html.
[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.

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 16 EHRs of patients who had normal cervical cancer screening results and determined that 3 patients were not notified 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 abnormal cervical cancer screening results within the required timeframe and that notification is documented in the EHR.

2. We recommended that managers ensure that patients with normal cervical cancer screening results are notified of the results within the required 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 vaccines.[13] The NCP provides best practices guidance on the administration of vaccines 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 tetanus and pneumococcal diseases.

Adults should receive a tetanus vaccine every 10 years. At the age of 65, individuals who have never had a pneumococcal vaccine 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 NC needed improvement. Details regarding the finding follow the table.

NC	Areas Reviewed
	Staff screened patients for the tetanus vaccination.
	Staff administered the tetanus vaccine when indicated.
	Staff screened patients for the pneumococcal vaccination.
	Staff administered the pneumococcal vaccine when indicated.
X	Staff properly documented vaccine administration.

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

NC	Areas Reviewed (continued)
	Managers developed a prioritization plan for the potential occurrence of vaccine shortages.

Table 4. Vaccinations

Documentation of Tetanus Vaccination. Federal Law requires that documentation for administered vaccines include specific elements, such as the vaccine manufacturer and lot number of the vaccine used.[14] We reviewed the EHRs of 10 patients who received a tetanus vaccine administration at the parent facility or its associated CBOCs and did not find documentation of all the required information related to tetanus vaccine administration in any of the EHRs.

Recommendation

3. We recommended that managers ensure that clinicians document all required tetanus vaccine 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 CBOC (see Table 5).

	Vinita
VISN	16
Parent Facility	Jack C. Montgomery VAMC
Types of Providers	Licensed Clinical Social Worker Nurse Practitioner Primary Care Physician Psychiatrist Pharmacist
Number of MH Uniques, FY 2012	670
Number of MH Visits, FY 2012	3,707
MH Services Onsite	Yes
Specialty Care Services Onsite	WH
Ancillary Services Provided Onsite	Electrocardiogram Laboratory
Tele-Health Services	MH MOVE[15] Rehabilitation Retinal Imaging Surgery Care Coordination Home Teleheath

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.

The CBOC was 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.
	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

The CBOC was 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.[17] 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

The CBOC was compliant with the review areas; therefore, we made no recommendations.

[17] VHA Handbook 1006.1.

VISN 16 Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 2, 2013

From: Director, VISN 16 (10N16)

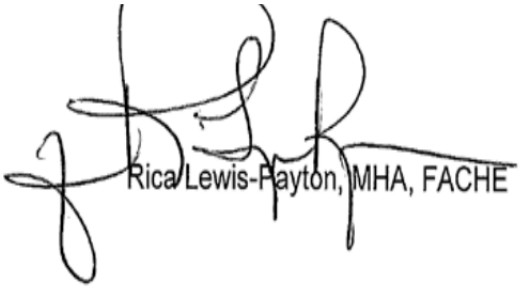
Subject: **CBOC Review at Jack C. Montgomery VAMC**

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

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the draft report submitted by the Jack C. Montgomery VA Medical Center, Muskogee, OK.

2. If you have questions regarding the information submitted, please contact Reba T. Moore, VISN 16 Accreditation Specialist at 601-208-7022.



Jack C. Montgomery VAMC Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 1, 2013

From: Director, Jack C. Montgomery VAMC (623/00)

Subject: **CBOC Review at Jack C. Montgomery VAMC**

To: Director, VISN 16 (10N16)

1. We have reviewed and concur with the preliminary report of the Vinita, OK CBOC review. We have developed an action plan and have begun implementing our plan.

2. If there are any questions or concerns please contact Martha Hardesty RN, Performance Improvement Specialist at 918-577-3473.

James R. Floyd, FACHE
Acting Medical Center Director

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 abnormal cervical cancer screening results within the required timeframe and that notification is documented in the EHR.

Concur

Target date for completion: January 31, 2014

A Standard Operating Procedure (SOP) was created from VHA Handbook 1330.01 to clarify results reporting timeframes and documentation requirements to staff. This SOP was shared with all Primary Care staff at the parent facility and all CBOC's on June 27, 2013. The Women's Veterans Program Manager (WVPM) will monitor the reporting timeframes and documented dates the ordering provider or surrogate is notified of abnormal cervical cancer screening results for 6 months. WVPM will keep the Chief of Staff, Acting Chief of Primary Care, and Chief of Pathology and Laboratory Medicine informed of the monitoring results.

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

Concur

Target date for completion: January 31, 2014

An SOP was created from VHA Handbook 1330.01 to clarify results reporting timeframes and documentation requirements to staff. This SOP was shared with all Primary Care staff at the parent facility and all CBOC's on June 27, 2013. The WVPM will monitor the reporting timeframes and documented dates that patients with normal cervical cancer screening are notified of their results for 6 months. WVPM will keep the Chief of Staff, Acting Chief of Primary Care, and Chief of Pathology and Laboratory Medicine informed of the monitoring results.

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

Concur

Target date for completion: June 27, 2013

Clinical Applications Coordinators have developed and implemented a template to include all elements required for proper documentation of vaccinations. This template was incorporated into vaccination documentation after the time period of Electronic Health Record review performed by OIG.

OIG Contact and Staff Acknowledgments

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