Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00026-306

Community Based Outpatient Clinic Reviews at VA Maryland Health Care System Baltimore, Maryland

September 11, 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
HCS	Health Care System
LCSW	licensed clinical social worker
MH	mental health
MSEC	Medical Staff Executive Committee
NC	noncompliant
NCP	National Center for Health Promotion and Disease Prevention
OIG	Office of Inspector General
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 CBOC during the week of July 15, 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 CBOC (see Table 1).

VISN	Facility	CBOC Name	Location
5	VA Maryland HCS	Loch Raven	Baltimore, MD

Table 1. Site Inspected

Review Results: 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 administer pneumococcal vaccines when indicated.
- 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 and B, pages 10–13, 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. One 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 facilities' 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]
5	VA Maryland HCS	Cambridge (Cambridge, MD)	Rural	5,350	40,068	Large
		Fort Howard (Fort Howard, MD)	Urban	6,369	24,612	Large
		Glen Burnie (Glen Burnie, MD)	Urban	6,204	36,824	Large
		Loch Raven (Baltimore, MD)	Urban	11,341	53,153	Very Large
		Pocomoke City (Pocomoke City, MD)	Rural	1,873	7,966	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.

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 20 patients who received a cervical cancer screening at the VA Maryland HCS's CBOCs.

Generally the CBOCs assigned to the parent facility name 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 vaccines.[12] The NCP provides best practices guidance on the administration of vaccines for veterans. The CDC states that although vaccine-preventable disease levels are at or

[9] 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.
[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.

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 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 NC needed improvement. Details regarding the findings 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.
X	Staff administered the pneumococcal vaccine when indicated.
X	Staff properly documented vaccine administration.

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 three patients with pre-existing conditions who received their first vaccine prior to the age of 65. We did not find documentation in any of the EHRs indicating that their second vaccinations had been administered.

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 nine 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.

Recommendations

1. We recommended that managers ensure that clinicians administer pneumococcal vaccines when indicated.

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

[13] Centers for Disease Control and Prevention, http://www.cdc.gov/vaccines/vpd-vac/.
[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).

	Loch Raven
VISN	5
Parent Facility	VA Maryland HCS
Types of Providers	LCSW Licensed Professional Counselor Nurse Practitioner Primary Care Physician Psychiatrist Psychologist Pharmacist
Number of Mental Health Uniques, FY 2012	2,303
Number of Mental Health Visits, FY 2012	7,634
Mental Health Services Onsite	Yes
Specialty Care Services Onsite	Audiology Dermatology MOVE![15] Neurology Optometry Podiatry Polytrauma/Traumatic Brain Injury Rheumatology WH
Ancillary Services Provided Onsite	Laboratory Nutrition Radiology
Tele-Health Services	Dermatology MH MOVE! Care Coordination Home Telehealth

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 MSEC.
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 MSEC.
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 MSEC.
Privileges and Scopes of Practice	
	The Service Chief, Credentialing Board, and/or MSEC 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

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

[16] VHA Handbook 1100.19.

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 5 Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2013

From: Director, VISN 5 (10N5)

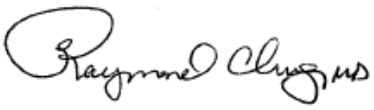
Subject: **CBOC Reviews at VA Maryland HCS**

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

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

1. VISN 5 Leadership has reviewed the comments provided by the Medical Center Director, VA Maryland Health Care System and concur with the responses and action plan for the recommendations outlined in the report.

2. Should you require any additional information, please contact Mr Jeffrey Lee, Quality Management Officer, VA Capitol Health Care Network, VISN 5 at 410-691-7816.



FOR Fernando O. Rivera, FACHE

VA Maryland HCS Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 13, 2013

From: Director, VA Maryland HCS (512/00)

Subject: **CBOC Reviews at VA Maryland HCS**

To: Director, VISN 5 (10N5)

1. The VAMHCS concurs with the results of the review of the Loch Raven CBOC and the combined VAMHCS CBOC documentation. We have developed an action plan and have begun implementation. We are pleased with the results and will use them as motivation across the VAMHCS CBOCs.

2. The professionalism and cooperative manner demonstrated by the team was appreciated by all involved.

3. The experience not only reinforced positive work practices but encouraged staff to continue to improve the quality of care to our veterans.

4. If you have any additional questions, please contact my office at 410-605-7016.

Dennis H. Smith

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 administer pneumococcal vaccines when indicated.

Concur

Target date for completion: December 2013

Facility Response:

- The Clinical Center Director, Managed Care will send an email to all primary care providers and other Clinical Center Directors reiterating the necessity of re-vaccination for pneumococcal vaccine, if patients received one prior to age 65 years. (September 2013).

- The current Clinical Reminder will be reassessed to determine the best method for assuring veterans at high risk are identified at any age and revaccinated after age 65. The Reminder will continue to identify all veterans over age 65 eligible for vaccination and be designed to identify veterans requiring revaccination after age 65. Contact is being made with other VAMCs to determine the programming for their pneumococcal clinical reminder and possible use at the VAMHCS. (November 2013)

- Once changes in the Clinical Reminder are completed, the Clinical Center Director, Managed Care will send an email to all primary care providers, nurses, and other Clinical Center Directors explaining the revised features. (November 2013)

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

Concur

Target date for completion: January 2014

Facility Response:

- Clinical Informatics will add the date the Vaccine Information Statement (VIS) provided to patient and the edition of the VIS provided to the existing Clinical Reminders. (September 2013)

- The Clinical Center Director, Managed Care will send an email to all primary care providers and other Clinical Center Directors regarding the addition to the Clinical Reminder. (September 2013)

- Use of the updated Clinical Reminder will be monitored for 3 months starting October 2013 and reported monthly to the Clinical Center Director, Managed Care.

OIG Contact and Staff Acknowledgments

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