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Office of Inspector General

Healthcare Inspection

Evaluation of VHA Community Based Outpatient Clinics Fiscal Year 2012

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Contents

Executive Summary

Introduction

The VA Office of Inspector General, Office of Healthcare Inspections completed an evaluation of Veterans Health Administration (VHA) community based outpatient clinics (CBOCs) for fiscal year 2012. The purpose of the evaluation was to assess if CBOCs provide veterans with consistent, safe, and high-quality health care. Our objectives were to determine whether VHA CBOCs have:

- Implemented processes to manage Diabetes Mellitus-Lower Limb Peripheral Vascular Disease to prevent lower limb amputation.
- Complied with selected VHA requirements regarding the provision of mammography services for women veterans.
- Providers who were credentialed and privileged in accordance with VHA Handbook 1100.19.
- Environments of care and emergency management processes in place as required.
- Provided Primary Care and Mental Health services at contracted CBOCs according to contract provisions and with required contract oversight.

Recommendations

To improve operations, we recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Networks and facility senior managers:

- Ensure that CBOC clinicians document foot care education provided to diabetic patients in the electronic health record (EHR).
- Ensure that CBOC clinicians perform risk assessments and document risk levels for diabetic patients in the EHR.
- Ensure that CBOC clinicians document referrals for preventative foot care, including foot wear, as clinically indicated, for patients with diabetes in the EHR.
- Ensure that CBOC managers establish a process to consistently link breast imaging and mammography results to the appropriate radiology mammogram or breast study order for all fee basis and contract patients.

- Ensure that CBOC managers establish a process to notify patients of normal mammogram results within the allotted timeframe and that notification is documented in the EHR.

- Ensure that service chiefs' documentation in VetPro reflects documents reviewed and the rationale for privileging or re-privileging CBOC providers.

- Ensure that facility Directors grant privileges consistent with the services provided at the CBOCs.

- Ensure that adequate resources and controls are in place to address deficiencies in the invoice validation process and to reduce the risk of overpayments.

- Ensure that the oversight of the contract acquisition process is compliant with VA Directives, including a thorough pre-award review and interim contract authority prior to contract approval.

- Ensure that all new CBOCs undergo the required contract approval processes prior to initiating operations.

Comments

The Under Secretary for Health concurred with our findings and recommendations. See Appendix B (pages 25–34) for the full text of his comments. We accepted VHA's action plans and had subsequent discussions with VHA leadership regarding the need for all CBOC activations to be officially approved prior to the start of clinical operations. We will follow up on the corrective actions until all recommendations have been fully implemented.

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Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a systematic review of the Veterans Health Administration's (VHA's) community based outpatient clinics (CBOCs) to assess whether they are operated in a manner that provides veterans with safe, consistent, and high-quality health care in accordance with VHA policies and procedures.

Our objectives were to determine whether VHA CBOCs have: (1) implemented processes to manage Diabetes Mellitus-Lower Limb Peripheral Vascular Disease to prevent lower limb amputation, (2) complied with selected VHA requirements regarding the provision of mammography services for women veterans, (3) providers who were appropriately credentialed and privileged as required, (4) an environment of care (EOC) and emergency management (EM) processes in place as required, and (5) provided Primary Care and Mental Health services at contracted CBOCs according to contract provisions and with required contract oversight.

Background

Since 1995, VHA has transitioned from a hospital bed-based system of care to a more effective system rooted in ambulatory and primary care. CBOCs are an important component of the VA health care delivery system as they aim to improve access to health care services while providing high-quality care in a cost effective manner.[1] As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year (FY) 2009, the VA OIG has been systematically reviewing VHA CBOCs since April 2009.

A VHA CBOC is a health care site that is geographically distinct and separate from a parent medical facility and may be a site that is VA-operated and/or contracted. The establishment of a VHA CBOC is subject to the: (1) development of business plans, (2) application of national CBOC criteria, (3) appropriate VA Central Office approval, (4) notification of Congress, (5) availability of funds within the Veterans Integrated Service Networks (VISN), and (6) applicable federal statutes and VA regulations.[2] Additionally, CBOCs are required to have a unique 5-digit station identifier for workload reporting purposes.

[1] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.
[2] VHA Handbook 1006.1.

VHA CBOCs can provide primary, specialty, subspecialty, mental health (MH) care, or any combination of health care delivery services that can be appropriately provided in an outpatient setting.[3] This includes health promotion (screening and counseling), disease prevention, and management of acute minor illnesses and chronic conditions.[4] Each CBOC is affiliated with a single VA medical center or parent facility that is administratively responsible for that CBOC. One standard of care must be maintained at the parent facility and CBOCs.

VHA established its Preservation-Amputation Care and Treatment (PACT) Program in 1993 to prevent and treat lower extremity complications that can lead to amputation. Best practices include annual foot screenings, preventive foot care, and patient self-management and education.[5] VHA policy requires the identification of all patients at risk for limb loss from the day of entry to the VA health care system through all levels of care. The provision of therapeutic footwear and orthoses is also required for patients assessed with moderate or greater risk for the development of foot ulcers.[6]

Since 2010, VHA has required that all sites providing primary care services must offer comprehensive primary care to women veterans. VHA has specific requirements that must be met by facilities that perform mammography services for women veterans.[7] This includes timely results notification to ordering providers and patients with processes for appropriate follow-ups as needed. VHA policy requires that test results be communicated to patients no later than 14 calendar days from the date the results are available to the ordering practitioner.[8]

VHA also requires that mammography studies completed by fee or contract providers or VA-certified mammography centers be linked to the provider order in the Computerized Patient Record System (CPRS).[9] Documentation of mammography results must be described using the Breast Imaging-Reporting and Database System (BI-RADS) category code.[10] (See Appendix A.) VHA CBOCs must also designate a Women's Health (WH) clinical liaison to coordinate women's issues with the parent facility.

[3] VHA Directive 2008-048, *Assignment of Station Number Suffix Identifiers for Community-Based Outpatient Clinics (CBOCs)*, August 22, 2008.
[4] VHA Handbook 1006.1.
[5] VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus, Version 4.0, August 2010.
[6] VHA Directive 2006-050, *Preservation-Amputation Care and Treatment (PACT) Program*, September 14, 2006.
[7] VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
[8] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[9] VHA Handbook 1330.01.
[10] The American College of Radiology's Breast Imaging Reporting and Database System is a quality assurance guide designated to standardize breast imaging reporting and facilitate outcomes monitoring.

All VHA CBOC licensed independent providers (LIPs) must be credentialed and privileged by the parent facility. The Credentialing and Privileging program ensures that LIPs have the appropriate professional license(s) and other qualifications to practice in a health care setting and that they practice within the scopes of their licenses and competencies. Clinical privileges must be facility- and practitioner-specific and within available resources at the clinical setting.[11] The list of documents reviewed and the rationale for privileging conclusions reached by the service chief must also be documented in VetPro.[12]

Ongoing reviews conducted by service chiefs must be comprised of activities with defined criteria that emphasize the facility's performance improvement plan, appropriateness of care, patient safety, and desired outcomes. Ongoing Professional Practice Evaluations allow the facility to identify professional practice trends that impact patient safety and the quality of care.

VHA CBOCs must comply with the statutes and regulations applicable to individuals with disabilities, including special patient populations [for example, the Americans with Disabilities Act (ADA)]. Additionally, CBOCs are required to comply with relevant regulatory and accrediting standards with respect to general environmental safety, including the Office of Safety and Health Administration and The Joint Commission.

VHA CBOCs must also maintain appropriate emergency response capability. Parent facilities are responsible for making a determination as to the type of equipment that needs to be located at the CBOC sites. CBOCs that do not have trained Advance Cardiac Life Support providers, appropriate supplies, and/or a Code team, are required to have an automated external defibrillator at their site. Each CBOC must also have a local policy or standard operating procedure defining how health emergencies are handled, including MH emergencies.[13]

The CBOC model provides VHA with the option of hiring VA staff or contracting with outside health care providers to deliver care to veterans. If using the latter option, CBOC contracts must meet requirements as outlined by the VHA Procurement and Logistics Office and the Office of Patient Care Services.[13] The parent facility is responsible for ensuring that appropriate quality assurance standards are in place, data collection is performed, and performance of medical care is monitored. The inclusion of performance-based penalties provides VHA the means to ensure that quality of care measures are met.

The interim contract authority (ICA) is intended to provide health care services on a short-term or emergent basis. VA policies state that the terms and renewals of

[11] VHA Handbook 1100.19, *Credentialing and Privileging,* October 15, 2012.
[12] VetPro is VHA's electronic credentialing system.
[13] VHA Handbook 1006.1.

ICAs are strictly limited.[14] ICAs are only approved for 180 days, but additional authority may be granted on an exception basis, not to exceed 1 year.

Scope and Methodology

We performed this review with inspections of 92 VHA CBOCs during FY 2012. These inspected CBOCs are a statistical sample of all VHA CBOCs with more than 500 patients aligned under selected parent VA facilities. Our review focused on four components: (1) FY 2012 CBOC-specific information gathering and review, (2) EHR reviews of care performed in FY 2011 for determining compliance with VHA policies, (3) on-site EOC and EM inspections during FY 2012, and (4) CBOC contract reviews of quarter 3 of FY 2011.

To determine compliance with VHA policy for each sampled CBOC, we reviewed the EHRs of a random sample of 30 women veterans who were 50 to 69 years of age and 30 patients 18 to 70 years of age at the time of the review with a diagnosis of DM and no previous lower limb amputation(s). During site visits, we inspected the CBOCs' EOC and EM procedures and reviewed credentialing and privileging folders of LIPs and scopes of practice and competency folders of non-LIP staff. We also interviewed CBOC managers and VHA staff and discussed preliminary findings related to compliance with VA policy and other regulatory requirements.

We validated inspection results and reported deficiencies in 24 CBOC reports. There are 14 standards that must be met for VHA CBOC operations.[15] Nine of the 14 VHA standards for CBOC operations were addressed during our reviews and are discussed in this report.[16]

Study Population and Sample Design. The study population consists of all patients who used VHA CBOCs for health care during FY 2011. We used a multiple-stage complex probability sample design to select patients for chart reviews. In the first stage of sampling, we statistically randomly selected 55 VA Medical Centers (VAMCs) stratified by the 12 catchment areas of the Office of Healthcare Inspection regional offices.

In the second stage of sampling, we utilized the list of sampled VAMCs and selected 8 CBOCs within each of the 12 catchment areas. The number of CBOCs selected from each sampled VAMC was proportional to the total number of CBOCs under its supervision. Four of the 96 selected CBOCs were not inspected because 1 was deactivated, 2 were recently established (too soon to

[14] VA Directive 1663, *Healthcare Resources Contracting-Buying Title 38 USC 8153*, August 10, 2006.
[15] VHA Handbook 1006.1.
[16] Staffing, Timeliness, Station Numbering, Cost Accounting, and Patient Complaints were omitted from this review.

inspect), and 1 did not provide primary care. We inspected 92 CBOCs, which included 72 VA-staffed and 20 contracted clinics. We also conducted a contract review for the 20 contracted CBOCs.

In the third stage of sampling, we selected patients from the 92 CBOCs for electronic health record (EHR) review. We randomly selected 30 patients within each of the 92 CBOCs. All patients were included for chart review. If a CBOC had fewer than 30 patients who met the criteria for a focused review, we reviewed all of the patients.

Statistical Analysis. We estimated the VA compliant percentages for each of the quality measures. Breast cancer screening quality measures were computed for patients whose screenings were done on or after June 1, 2010.

To take into account the complexity of our multi-stage sample design, we used Horvitz-Thompson sampling weights (reciprocal of sampling probabilities) to account for unequal probability sampling and the Taylor expansion method to obtain the sampling errors for the estimates. We set the desired levels of at least 90 percent for the breast cancer screening criteria.

We presented 95 percent confidence intervals (95% CI) for the true values (parameters) of the study population. A confidence interval gives an estimated range of values (being calculated from a given set of sample data) that is likely to include an unknown population parameter. The 95% CI indicates that among all possible samples we could have selected of the same size and design, 95 percent of the time the population parameter would have been included in the computed intervals.

Percentages can only take non-negative values from 0 to 100, but their logits can have unrestricted range so that the normal approximation can be used. Thus, we calculated the confidence intervals for percentages on the logit scale and then transformed them back to the original scale to ensure that the calculated confidence intervals contained only the proper range of 0 to 100 percent. All data analyses were performed using SAS statistical software, version 9.3 (TS1M0), SAS Institute, Inc. (Cary, North Carolina).

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

Inspection Results

Issue 1: CBOC Characteristics

We collected CBOC characteristics from web-based questionnaires completed by the respective CBOC Directors/Managers. We aggregated the data from survey responses to report the types of services offered by the CBOCs. We also reported the number of unique patients enrolled in FY 2011 as available in VA data sources. A summary of these results are reported in Table 1.

Table 1. FY 2012 Profile of Sampled CBOCs

CBOC Characteristic	Result
CBOCs Inspected	92
Average Number of Patients Enrolled in FY 2011	4,400 (range 159 to 29,501)
Average Number of MH Patients Enrolled in FY 2011	982 (range 21 to 6,491)
CBOCs Providing Ancillary Services	88
CBOCs Providing MH Services	83
CBOCs Providing Telehealth Services	79
CBOCs Providing Specialty Care Services	50

Of the 92 CBOCs in our study sample, 72 were VA-staffed and 20 were contracted sites.[17,18] The localities consisted of 46 VA-staffed and 8 contracted CBOCs in urban locations, 25 VA-staffed and 12 contracted CBOCs in rural locations, and 1 VA-staffed CBOC in a highly rural location.[19] Eighty-two CBOCs were dedicated VA clinics, which provide care to veterans only; and 10 were combined clinics that provide care to veterans and private patients.

The size of a CBOC is determined by the number of veterans served each year and is categorized as very large (>10,000 uniques), large (5,000-10,000), mid-size (1,500-5,000), and small (<1,500). Our CBOC sample consisted of 9 very large, 18 large, 50 mid-size, and 15 small CBOCs.[20]

Ancillary Services. We estimated that the most commonly provided ancillary services were laboratory and electrocardiogram (EKG) testing: 91.4 percent (95% CI: 82.25–96.09) and 88.5 percent (95% CI: 79.86–93.76), respectively.[21]

[17] There were initially 95 CBOCs in the sample; however, 3 inspections were canceled (1 CBOC was deactivated, 1 was recently established, and 1 did not provide Primary Care). Therefore, the three CBOCs were not included in the data analysis for CBOC characteristics or clinical care quality.
[18] http://vaww.pssg.med.va.gov/
[19] http://vaww.pssg.med.va.gov/
[20] 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).
[21] An EKG is a test that records the electrical activity of the heart.

Many CBOCs also provide radiology, pharmacy, and physical medicine services. A summary of the results is displayed in Table 2.

Table 2. FY 2012 CBOC Ancillary Services

Ancillary Services		Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
Laboratory	86	91.4	82.25	96.09
EKG	81	88.5	79.86	93.76
Radiology	20	21.8	15.46	29.93
Pharmacy	18	19.2	12.32	28.61
Physical Medicine	15	14.2	8.62	22.56
Pulmonary Function Test	5	5.0	1.84	13.01
Vascular Studies	2	1.3	0.43	3.98
Bladder Scanning	2	2.1	0.45	9.48

Specialty Care Services and Procedures. We estimated that 49.4 percent (95% CI: 38.61–60.32) of the CBOCs provided WH services during FY 2012. We estimated the percentage of VHA CBOCs in the provision of other specialty services: optometry, 17.5 percent (95% CI: 11.04–26.48); podiatry, 16 percent (95% CI: 9.02–26.89); and audiology, 12.8 percent (95% CI: 8.14–19.60). For specialty services not provided on site, facilities reported that veterans received needed specialty care and procedures at other geographically accessible VA facilities through a sharing agreement with the Department of Defense (DoD), non-VA fee-basis, or contracted facilities. Table 3 details results for the specialty services provided on site by VHA CBOCs.

Table 3. FY 2012 CBOC Specialty Care Services

Specialty Care Service	Number of CBOCs Reporting this Service (92 CBOCs Reviewed)	Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
WH	47	49.4	38.61	60.32
Optometry	17	17.5	11.04	26.48
Podiatry	14	16.0	9.02	26.89
Audiology	13	12.8	8.14	19.60
Dermatology	8	8.4	4.88	14.07
Dental	6	6.1	3.05	11.86
Cardiology	5	6.0	1.69	18.93
Orthopedics	5	6.1	2.42	14.68
Urology	5	5.9	3.03	11.11

We also collected information on the types of providers assigned to the CBOCs and found varied categories of primary care, MH, and specialty care clinicians. Table 4 provides a summary of our results.

Table 4. Types of Providers Reported by CBOCs during FY 2012 Reviews

Provider	Number of CBOCs Reporting These Types of Providers (92 CBOCs Reviewed)	Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
Primary Care Physicians	86	94.3	88.42	97.26
Licensed Clinical Social Workers	68	75.4	65.05	83.44
Nurse Practitioner	64	71.1	61.51	79.05
Psychiatrist	53	60.4	50.73	69.37
Psychologist	51	54.0	44.64	63.04
Physician Assistant	28	24.6	18.02	32.62
Pharmacist	17	20.2	12.81	30.34
Audiologist	5	4.8	1.69	12.97
Optometrist	5	4.6	2.14	9.48
Dentist	3	2.9	1.09	7.54
Podiatrist	3	3.2	1.19	8.47
Radiologist	1	1.3	0.28	6.11

MH Services. We estimated that 90.2 percent (95% CI: 84.80–93.81) of the VHA CBOCs provided MH services on site. Table 5 summarizes the MH services provided by the CBOCs. Diagnostic and treatment planning evaluations, psychotherapy, and medication management were provided by 82.3 (95% CI: 73.92–88.44), 82.4 (95% CI: 75.04–87.93), and 77.9 (95% CI: 67.80–85.51) percent of the CBOCs, respectively.

Table 5. FY 2012 CBOC MH Services

MH Services Provided	Number of CBOCs Reporting These MH Services (92 CBOCs Reviewed)	Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
Diagnostic and Treatment Planning Evaluations	77	82.3	73.92	88.44
Psychotherapy	75	82.4	75.04	87.93
Medication Management	71	77.9	67.80	85.51
Consultation to Include Post-Traumatic Stress Disorder (PTSD)	67	73.1	63.11	81.13
Consultation to Include Military Sexual Trauma	58	64.1	53.93	73.07

The CBOCs also provided MH services by referring veterans to other geographically accessible VA and non-VA providers. Table 6 details the percentage of VHA CBOCs that initiated MH referrals during FY 2012.

Table 6. FY 2012 CBOC MH Referrals

Referral Site	Number of CBOCs Reporting MH Referrals (92 CBOCs Reviewed)	Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
Another VAMC	89	96.5	91.06	98.70
Another CBOC	24	27.8	19.34	38.15
Contracted Services	9	9.5	4.14	20.49
Sharing Agreement with DoD	2	3.5	0.74	15.18
Fee Basis Services	25	25.6	18.26	34.70

Some CBOCs provided specialty MH services. We estimated that 42.3 percent (95% CI: 32.07–53.18) of the CBOCs provided PTSD and 34.7 (95% CI: 24.50–46.64) percent provided substance abuse treatment. Table 7 details the specialty MH services provided by the CBOCs surveyed during FY 2012.

Table 7. FY 2012 CBOC Specialty MH

Specialty Service	Number of CBOCs Providing Specialty MH Services	Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
PTSD	36	42.3	32.07	53.18
Substance Use Treatment	33	34.7	24.50	46.64
Homeless Programs	28	29.8	21.22	40.08
MH Intensive Case Management	18	18.8	11.93	28.29
Peer Support	17	18.6	11.86	27.86
Social Skills Training Services	16	17.7	11.24	26.82
Military Sexual Trauma Treatment	14	16.6	10.18	25.93
Compensated Work Therapy	7	8.8	4.62	16.25
Psychosocial Rehabilitation	6	6.9	2.99	15.02

Telemental Health Services. We estimated that telehealth services were provided by 86 percent (95% CI: 79.41–90.78) of the CBOCs. This modality was most frequently used for telemental health services. We estimated that 66.3 percent (95% CI: 56.34–74.94) of the CBOCs provided care with MH clinical video technology to remotely assess, treat, and provide care; 52.6 percent (95% CI: 43.72–61.28) provided individual therapy for MH care through the use of telehealth technology; and 43.6 percent (95% CI: 33.73–54.08) provided telemental health for medication management. Table 8 summarizes the percent of VA CBOCs provided telemental health services during FY 2012.

Table 8. FY 2012 CBOC Telemental Health Services

Telemental Health Services Provided	Number of CBOCs Reporting Telemental Health Services (92 CBOCs Reviewed)	Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
MH Clinical Video	60	66.3	56.34	74.94
Individual Therapy	48	52.6	43.72	61.28
Medication Management	42	43.6	33.73	54.08
Group Therapy	22	24.9	16.75	35.38
Case Management	16	18.6	11.98	27.82
Consultation with other providers	11	11.8	6.01	21.86
Supervision/Guidance for Prescriptions	7	8.6	3.56	19.28
Addiction and PTSD Treatment	2	2.8	0.93	8.26
MH	2	2.2	0.72	6.68
ER follow-up visits	1	0.8	0.16	3.57

Issue 2: Management of Diabetes Mellitus – Lower Limb Peripheral Vascular Disease

Our sample consisted of 2,675 VHA CBOC patients at least 18 years of age and less than 71 who were seen in the CBOC for primary care appointments during the study months of April, May, and June 2011. We excluded the patients if they had lower limb amputations, were newly diagnosed with DM, or refused the foot examination. Our resulting sample then consisted of 2,426 patients.

We conducted medical record reviews for 2,426 sampled patients. From this sample population, we identified 139 patients who were at a moderate or greater risk for limb loss. We used 90 percent as the OIG benchmark for performance. Table 9 displays the VA estimates for the selected aspects of care.

Table 9. FY 2012 CBOC Care for Diabetes Mellitus-Lower Limb Peripheral Vascular Disease

Aspect of Care	Number of Patients		Estimated VA CBOC Compliance		
	Sampled	Compliant	Percent	95 Percent Confidence Interval Limits	
				Lower	Upper
Foot Screening	2,426	2,253	93.3	90.74	95.12
Foot Care Education	2,426	1,356	**63.1***	51.64	73.28
Risk Assessment	2,426	747	**25.1***	15.45	38.17
Orthotic Intervention for At-Risk Patients	139+	85	**72.7***	46.26	89.17

* The compliance rate was statistically significantly lower than the 90 percent OIG benchmark.
+139 patients were identified at a higher risk for limb loss through risk assessments.

Foot Care Education. We estimated that 63.1 percent of VHA CBOC patients' EHRs contained documentation indicating that foot care education was provided, and we are 95 percent confident that the true compliance is somewhere between 51.64 and 73.28 percent.

Risk Assessments. We estimated that 25.1 percent (95% CI: 15.45–38.17) of VHA CBOC patients whose EHRs included a completed risk assessment.

Orthotic Interventions. We estimated that 72.7 percent (95% CI: 46.26–89.17) of VHA CBOC patients' EHRs that had a risk classification of moderate or greater contained documentation indicating that clinicians implemented interventions for therapeutic footwear.

Issue 3: Mammography Compliance

Our sample consisted of 1,617 women veterans, between the ages of 52–69, who were treated at the CBOC during May and June 2011 and had a primary care visit during the 13-24 months prior to May 1 – June 30, 2011. Our final patient sample consisted of 772 women veterans who had a VA-covered mammogram performed on or after June 1, 2010, after excluding patients with mammograms performed prior to June 1, 2010; ordered by private sector provider; diagnosed with a history of bilateral mastectomy or terminal illness (diagnosis of cancer of the esophagus, liver, or pancreas); enrolled in hospice care; or had a life expectancy of less than 6 months.

We conducted medical record reviews to determine CBOC compliance with VHA policy. Of the 772 sampled patients, 555 had mammograms performed by VA fee-basis or contract providers. The requirement for mammogram results to be linked to the provider order in CPRS is only applicable to these 555 women veterans**.** We used 90 percent as the OIG benchmark for performance. A summary of our findings are listed in Table 10.

Table 10. FY 2012 CBOC Compliance with VHA Mammography Requirements

Aspect of Care	Number of Patients		Estimated VA CBOC Compliance		
	Total	Compliant	Percent	95 Percent Confidence Interval Limits	
				Lower	Upper
Mammogram Results in Radiology Package	772	662	92.8	88.35	95.62
Mammogram Results from Fee-Basis/Contract Care Patients Linked in CPRS	555+	217	**55.1***	37.89	71.13
Patient Notified of Normal Result Within 14 Days	772	515	**40.2***	27.34	54.67

* The compliance rate was statistically significantly lower than the 90 percent OIG benchmark.
+555 patients received mammograms through fee-basis or contract providers.

Mammography Results. We estimated that mammogram results were available in the Radiology software package for 92.8 percent (95% CI: 88.35–95.62) of the CBOC patients.

Results Linked to CPRS. We estimated that 55.1 percent (95% CI: 37.89–71.13) of the results of mammograms performed by a fee-basis or contract provider were linked to the provider order in CPRS.

Patient Normal Result Notifications. We estimated that 40.2 percent (95% CI: 27.34–54.67) of the CBOC patients' EHRs contained documentation that patients were notified of their mammogram results within 14 days.

Issue 4: Credentialing and Privileging

We reviewed the credentialing folders for providers at 92 VHA CBOCs. Credentialing information was validated utilizing VetPro. Provider privileges or scopes of practice and LIP profiles were examined on site. A CBOC is considered compliant if we published no findings or related recommendations in a facility report. We used 90 percent as the OIG benchmark for performance. A summary of our cumulative findings are listed in Table 11.

Table 11. FY 2012 CBOC Credentialing and Privileging Compliance

Element Reviewed	Number of CBOCs		Estimated VA CBOC Compliance		
	Total	Compliant	Percent	95 Percent Confidence Interval Limits	
				Lower	Upper
Evidence of documents reviewed and rational for conclusion of privileges	92	72	**80.4***	74.03	85.49
Privileges granted were facility, service, and provider specific	92	74	**83.6***	77.81	88.12

* The compliance rate was statistically significantly lower than the 90 percent OIG benchmark.

Documentation of Privileging Decisions. Based on the review of the credentialing and privileging folders of LIPs, we estimated that the clinical privileges granted at 80.4 percent (95% CI: 74.03–85.49) of CBOCs included the required documentation by the service chief.

Clinical Privileges. We estimated that the clinical privileges granted at 83.6 percent (95% CI: 77.81–88.12) of the CBOCs were consistent with the services provided at the CBOC settings.

Issue 5: Environment and Emergency Management

EOC. We conducted EOC inspections at 92 VHA CBOCs, evaluating each of the following: (1) cleanliness, (2) adherence to clinical standards for infection control and patient safety, (3) compliance with patient data security requirements, and (4) hand hygiene monitoring. A CBOC is considered compliant if we published no findings or related recommendations in a facility report. We used 90 percent as the OIG benchmark for performance. We estimated that the CBOCs met standards at the 90 percent benchmark. A summary of the compliance results is found in Table 12.

Table 12. FY 2012 CBOC Compliance with EOC Requirements

EOC Requirements	Number of CBOCs Compliant (92 CBOCs Reviewed)	Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
ADA parking spaces	89	96.2	90.28	98.54
ADA entrance ramps	91	99.1	95.69	99.80
ADA entrance doors	86	92.1	85.53	95.82
ADA restrooms	83	88.7	82.12	93.04
Clean Environment	92	100	–	–
Safe environment	87	95.3	91.07	97.54
Environment in good repair	91	98.7	94.04	99.75
Process for expired medications	92	100		
Secured Medications	90	97.4	92.28	99.16
Panic alarms in high-risk areas	88	96.4	92.59	98.32
Privacy maintained	83	88.9	81.55	93.49
Compliance with information technology rules	81	88.9	82.33	93.20
Protection of personally identifiable information	83	88.9	81.70	93.43
Availability of alcohol hand wash or soap	92	100	–	–
Maintenance of sharps containers	92	100	–	–
Annual fire drills	91	99.0	95.23	99.79
Annual fire and safety inspections	88	95.2	89.59	97.84
Identifiable fire extinguishers	86	93.3	87.66	96.47
Monitoring and analysis of hand hygiene data	85	93.7	88.85	96.48
Proper patient identification for blood collection	91	99.1	96.18	99.82
CBOC inclusion in facility-wide EOC activities	89	97.4	94.69	98.79
Available eyewash station	90	97.3	91.49	99.16
Unobstructed means of egress	91	98.1	91.53	99.58

EM. We conducted EM inspections at 92 VHA CBOCs, evaluating each for compliance with requirements for medical and MH emergencies. A CBOC is considered compliant if we published no findings or related recommendations in a facility report. We used 90 percent as the OIG benchmark for performance. We estimated that the CBOCs met standards at the 90 percent benchmark. A summary of the compliance results is found in Table 13.

Table 13. FY 2012 CBOC Compliance with EM Requirements

Criteria Reviewed	Number of CBOCs Compliant (92 CBOCs Reviewed)	Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
Automated External Defibrillator	92	100	–	–
Local medical EM plan	86	93.98	89.062	96.76
Staff articulated medical EM plan	90	98.30	95.45	99.37
Local medical MH plan	83	91.23	86.11	94.58
Staff articulated MH EM plan	88	96.33	92.85	98.15

Issue 6: CBOC Contract Review

We conducted reviews of primary care and MH services at 20 contract CBOCs to evaluate: (1) effectiveness of VHA oversight and administration for selected contract provisions relating to quality of care and payment of services, (2) invoice validation processes, and (3) proper execution of contracts and related documents. These reviews focused on documents and records for 3rd quarter, FY 2011.

Each CBOC engagement included: (1) a review of the contract and related documents, (2) analysis of patient care encounter data, (3) corroboration of information with VHA data sources, (4) site visits, and (5) interviews with VHA and contract staff. Reviews were based on the requirements of the contract and VA Directives 1663 and 1160.01 which detail the requirements and responsibilities for providing care and buying health care resources. We assessed 10 compliance categories:

1) Invoice Validation – Invoice validation process is designed to reasonably detect invoice errors and lessen the opportunity for improper payments.

2) Technical Review – Contract documents are complete, properly authorized, and include support for pricing justification and use of ICA, where applicable.[22]

3) Requirement for Payment – Contract clearly defines terms and conditions that qualify the contractor to receive payment for services.

4) Performance Measure – Contract clearly defines service expectations, performance benchmarks, and deficiency penalties.

5) Invoice Format – Invoice is formatted as required by the contract and includes description of the services rendered, date of service, and patient identifier.

6) Rate/Frequency of Payments – Payments are made according to the terms of the contract.

7) Oversight – Facility provides an adequate level of oversight to ensure overall contract compliance.

8) Access to Care – Access to care follows contract guidelines and VHA directives that require CBOCs to provide primary care and MH services, depending upon the number and needs of veterans in the designated service area.[23]

9) Third Party Billing – Contract includes a provision that prohibits the contractor from billing the patient or other third parties.

10) Contracting Officer Technical Representative (COTR) Designation and Training – COTR is properly designated and has received the required training.

In 2008, VHA mandated the provision of varying levels of MH care in the primary care settings, including CBOCs.[24] Onsite MH services were provided at 18 of the 20 contract CBOCs. The two sites that did not offer onsite MH care reported that patients were referred to the parent VAMC. Contract MH services were reviewed for appropriate billing and adherence to the contract when payment was made separate from the primary care payment. Contract CBOCs were also reviewed

[22] Per VA Directive 1663, an ICA is established to provide required health care resources on an emergency basis for short-term needs, or as an interim measure to complete the contracting cycle for long-term needs.
[23] VHA Handbook 1006.1.
[24] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

to determine general responsibilities of the MH providers, which included the types of services provided, who provides care, where services are provided, how care is provided, and if services are provided through fee-basis agreements.

We assessed VHA's oversight of contracted primary care and MH services. We found discrepancies in 8 of 10 compliance categories reviewed; however, only 7 of these did not meet the 90 percent OIG benchmark used for performance. The two categories without discrepancies were Third Party Billing and COTR Designation and Training. Table 14 displays the compliance categories followed by a summary of our findings.

Table 14. VHA CBOC Contract Compliance in Third Quarter, FY 2011

Categories Reviewed	Num	Estimated VA CBOC Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
Invoice Validation	9	**46.4***	26.03	68.02
Technical Review	13	**64.9***	39.87	83.75
Requirements for Payment	14	**75.0***	54.05	88.43
Invoice Format	16	83.3	67.10	92.39
Performance Measures	16	84.3	67.79	93.23
Rate/Frequency of Payments	17	89.6	72.13	96.64
Oversight	18	85.5	52.15	96.95
Access to Care (including traveling veterans)	19	94.6	75.85	98.98
Third Party Billing	20	100.0	–	–
COTR Designation and Training	20	100.0	–	–

* The compliance rate was statistically significantly lower than the 90 percent OIG benchmark.

Invoice Validation Process**.** We estimated that 46.4 percent (95% CI: 26.03–68.02) of contract CBOCs reviewed had an invoice validation process that was designed to reasonably detect invoice errors and lessen the opportunity for improper payments.

Technical Review**.** We estimated that 64.9 percent (95% CI: 39.87–83.75) of contract CBOCs reviewed had contract documents that were complete, properly authorized, and/or included pricing justification or support for use of ICA, where applicable.

For contracting process oversight, we found that contracting officers (COs) awarded contracts and made contract modifications that were not in VA's interests and not compliant with VA policy.[25] There is currently no mechanism or process to ensure that VA directives are followed and proper approvals are

[25]VA Directive 1663.

attained prior to signing a contract. We found abuse of the ICA for periods much longer than allowed, effectively bypassing competitive bidding.

In one case, the ICA was renewed for 3 consecutive years. One CO proceeded with an ICA despite denial by the approving authority. Two CBOC contracts were inappropriately changed by the CO to increase pricing less than 1 year after contract award. There was no justification, and these resulted in an additional cost of $209,000 over their respective 5-year contract periods.

For clinics lacking proper approval, we found that four contract CBOCs had not gone through the required VHA approval process prior to the start of clinical operations. These CBOCs increased access and provided quality care for veterans. However, because these CBOCs were not officially approved, they did not have assigned 5-digit station identifiers to report workload. The reported EHR location for the medical care provided was under the identifier of another clinic.

In one instance, a contractor operated two clinics (one approved and one unapproved) less than 30 miles apart. The capitated rate charged to the VA was double at the unapproved clinic with no justification for the difference. Due to the close proximity of the clinics, 40 out of an estimated 2,000 patients were invoiced by both clinics resulting in overcharges to the VA. Facility staff was unable to identify which clinic location the patients received their care.

Requirements for Payment**.** We estimated that 75 percent (95% CI: 54.05–83.75) of CBOC contracts contained clearly defined terms and conditions that qualified the contractor to receive payment for services.

There were six noncompliant CBOC contracts that had undefined or missing terms, or provisions that lead to inefficient use of VHA resources. Three contracts had either undefined or conflicting terms regarding visits that qualified for contractor payment. These terms are critical to documenting the understanding for payment requirements between VHA and the contractor. An example would be defining a vested or qualified visit by identifying the specific current procedure terminology codes that meet the billable roster criteria. Undefined or conflicting payment provisions may result in higher costs for the VA.

Two of the six noncompliant CBOC contracts required only one qualified visit every 24 months. This allowed the contractor to receive the monthly capitated rate as long as the patient was seen at least once during the prior 24-month period. We found that VHA could have saved an estimated $500,000 annually on two contracts that required one qualifying visit every 24 months instead of

every 12 months.[26] VHA has adopted an annual visit requirement in the standard CBOC contract template that should be used for future contracts. This savings is based on actual utilization and not on medical considerations.

For the remaining one noncompliant CBOC contract, VHA paid an estimated $320,000 more on a contract that required the prepayment of 12 months of healthcare services and did not have a reimbursement provision for early termination of services.[27] Most VA contracts call for payment for medical services after the services are provided. We suggest the contract have a provision for a pro-rata reimbursement of the annual capitated payment for early termination of services due to death, disenrollment, or transfers to other facilities.

Conclusions

We estimated that the 91.4 percent (95% CI: 82.25–96.09) and 88.5 percent (95% CI: 79.86–93.76) of the CBOCS provided laboratory and EKG studies, respectively. Women's health care is provided at 49.4 percent (95% CI: 38.61–60.32) of the CBOCs while MH care services are provided by 90.2 percent (95% CI: 84.80–93.81) of the CBOCs, and telehealth services, by 86 percent (95% CI: 79.41–90.78) of the CBOCs.

For the evaluation of the care of diabetic patients and adherence to the PACT Program policy, we estimated that 63.1 percent (95% CI: 51.64–73.28) of the EHRs reviewed contained documentation indicating that foot care education was provided. We also estimated that 25.1 percent (95% CI: 15.45–38.17) of the CBOC patients had a completed risk assessment. Of those who had risk classifications of "moderate or greater," 72.7 percent (95% CI: 46.26–89.17) had implementation of interventions for therapeutic footwear.

In our EHR reviews to determine CBOCs' compliance with VHA requirements for select components relating to mammography and reporting results, we estimated that 55.1 percent (95% CI: 37.89–71.13) of the mammogram studies completed by a fee or contract provider were linked to the provider order in CPRS. We also estimated that 40.2 percent (95% CI: 27.34–54.67) of the patients were notified of their mammogram results within 14 days.

In assessing for VHA compliance to credentialing and privileging requirements, we estimated that the clinical privileges granted at 80.4 percent (95% CI: 74.03–85.49) of the CBOCs included the required documentation by the service chief.

[26] We estimated the savings by calculating the difference between patients with a qualifying visit 12 and 24 months for 3rd QTR FY2011 ($125,000), then projecting the savings over the year ($500,000).

[27] We estimated the savings by identifying the portion of the full year payments made for new patients with less than a year remaining on the contract. The $320,000 was the sum of the remaining portion of the annual capitation for new patients who would not receive a full year's service due to termination of the contract.

We also estimated that the clinical privileges granted at 83.6 percent (95% CI: 77.81–88.12) CBOCs were consistent with the services provided at the CBOC setting.

We estimated that the CBOCs met standards at the 90 percent OIG benchmark for both EOC standards and requirements as well as for EM processes

In the review of the oversight and administration of the CBOC contracts, we concluded that overall, most facilities were compliant with selected VA rules. However, the compliance rates for 3 out of the 10 compliance categories were statistically significantly lower from the 90 percent benchmark. VA estimates for invoice validation, contract technical review, and requirements for payment were 46.4 (95% CI: 26.03–68.02), 64.9 (95% CI: 39.87–83.75), and 75.0 (95% CI: 54.05–83.75) percent, respectively.

Recommendations

We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers:

Recommendation 1. Ensure that CBOC clinicians document foot care education provided to diabetic patients in the electronic health record.

Recommendation 2. Ensure that CBOC clinicians perform risk assessments and document risk levels for diabetic patients in the electronic health record.

Recommendation 3. Ensure that CBOC clinicians document referrals for preventative foot care, including foot wear, as clinically indicated, for patients with diabetes in the electronic health record.

Recommendation 4. Ensure that CBOC managers establish a process to consistently link breast imaging and mammography results to the appropriate radiology mammogram or breast study order for all fee basis and contract patients.

Recommendation 5. Ensure that CBOC managers establish a process to notify patients of normal mammogram results within the allotted timeframe and that notification is documented in the electronic health record.

Recommendation 6. Ensure that service chiefs' documentation in VetPro reflects documents reviewed and the rationale for privileging or re-privileging CBOC providers.

Recommendation 7. Ensure that facility Directors grant privileges consistent with the services provided at the CBOCs.

Recommendation 8. Ensure that adequate resources and controls are in place to address deficiencies in the invoice validation process and to reduce the risk of overpayments.

Recommendation 9. Ensure that the oversight of the contract acquisition process is compliant with VA Directives, including a thorough pre-award review and interim contract authority prior to contract approval.

Recommendation 10. Ensure that all new CBOCs undergo the required contract approval processes prior to initiating operations.

BIRADS Scores

Category	Diagnosis	Number of Criteria
0	Incomplete	Need additional imaging evaluation or prior mammograms for comparison
1	Negative	There is nothing to comment on.
2	Benign	A definite benign finding
3	Probably Benign	Probably benign findings (less than 2 percent malignant). Initial short-interval follow-up suggested.
4	Suspicious Abnormality	Malignancy 2 to 95 percent probability. Biopsy should be considered.
5	Highly Suspicious of Malignancy	Greater than or 95 percent probability. Appropriate action should be taken.
6	Known Biopsy Proven Malignancy	Lesions known to be malignant that are being imaged prior to definitive treatment; assure that treatment is completed.

CBOC Site Visits

501GC Silver City, NM
501GJ Durango, CO*
501HB Raton, NM
502GB Lafayette, LA
506GA Toledo, OH
506GB Flint, MI
516GH Sebring, FL
519GA Odessa, TX
520BZ Pensacola (Joint Ambulatory Care Center), FL
523GA Framingham, MA
526GD Sunnyside (Queens), NY
528GT Glens Falls, NY*
528GW Schenectady, NY*
528GY Clifton Park, NY
528G4 Elmira, NY
528G7 Catskill, NY
534BY Savannah, GA
534GD Goose Creek, SC
539GA Bellevue, KY
539GE Hamilton, OH
544GB Florence, SC
544GC Rock Hill, SC*
544GF Sumter (Sumter County), SC
546GB Key West, FL
546GC Homestead, FL
548GA Ft. Pierce, FL*
549GA Tyler, TX
549GD Denton, TX*
550GD Springfield, IL
550GF Charleston (Mattoon), IL
553GA Yale, MI*
562GD Franklin (Venango), PA
564GB Ft. Smith, AR
565GC Wilmington, NC
568GA Rapid City, SD
568GB Pierre, SD*
568HJ Mission, SD*
575GA Montrose, CO
589GI St. Joseph, MO
589GN Emporia, KS
589GU Lawrence, KS
589G2 Dodge City, KS
589G7 Hutchinson, KS
590GB Virginia Beach (Norfolk-Virginia Beach), VA
600GC Long Beach (Cabrillo), CA
600GE Laguna Hills, CA*
612BY Oakland, CA
612GG Chico, CA
612GH McClellan, CA
613GC Stephens City, VA
613GD Franklin, WV*
614GA Smithville, MS*
614GI Dyersburg, TN*
618GA St. James (South Central), MN*
618GE Chippewa Valley, WI
618GH Hayward, WI
619GA Columbus, GA
620GE Port Jervis, NY
620GH Pine Plains (E. Dutchess), NY
626GJ Hopkinsville (Christian Co.), KY*
626GK McMinnville, TN*
630GC Brooklyn (Chapel Street), NY
631BY Springfield, MA
636GA Norfolk, NE
636GL Bellevue, NE
636A5 Lincoln, NE
644GB Show Low, AZ
644GD Payson, AZ*
650GA New Bedford, MA
653GA North Bend, OR
654GA Auburn (Sierra Foothills), CA
654GB Minden (Carson Valley), NV
656GB Montevideo, MN
657GD O'Fallon (St. Charles), MO
663GA Bellevue (King County), WA*
663GC Mount Vernon, WA
664GC Chula Vista, CA
664GD Escondido, CA*
671GB Victoria, TX
671GL New Braunfels, TX*
671GO San Antonio (North Central Federal Clinic), TX
676GA Wausau, WI
676GC La Crosse, WI
676GD Wisconsin Rapids, WI
687GC La Grande, OR

CBOC Site Visits

688GB Southeast Washington, DC
688GC Greenbelt, MD
692GA Klamath Falls, OR
693GC Tobyhanna, PA
693B4 Allentown, PA
695BY Appleton, WI
695GA Union Grove, WI

* Contract CBOC

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: September 23, 2013

From: Under Secretary for Health (10)

Subject: **Healthcare Inspection – Evaluation of Community Based Outpatient Clinics, Fiscal Year 2012**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations. Attached are corrective action plans.

2. Should you have additional questions, please contact Karen Rasmussen, M.D., Acting Director, Management Review Service, at (202) 461-6643, or by e-mail at karen.rasmussen@va.gov.

(original signed by:)
Robert A. Petzel, M.D.

Attachment

Under Secretary for Health Comments to Office of Inspector General's Report

The following Under Secretary for Health's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. Ensure that CBOC clinicians document foot care education provided to diabetic patients in the electronic health record.

VHA Comments

Concur

Monitoring of compliance with provision of foot care education by clinicians will be based on VHA Directive 2012-020, Prevention of Amputation in Veterans Everywhere (PAVE) Program, which establishes requirements and outlines specific expectations for program implementation and monitoring for VHA facilities. The following actions will take place:

a. Monthly communications with PAVE program leads will continue to be conducted to support field implementation efforts.

b. Continue to monitor compliance with Directive 2012-020 via annual report submissions from VHA facilities. The Annual PAVE report provides documentation of compliance status on the mandated items in VHA Directive 2012-020.

Target date for completion: January 31, 2014

This action plan is complete when VHA provides documentation of:

- Evidence of educational forums for Veterans Integrated Service Networks (VISNs) and facility clinical leadership (e.g., PowerPoint presentations, call minutes, or other similar documentation).

- Results of the Annual PAVE report on provision of patient education.

Recommendation 2. Ensure that CBOC clinicians perform risk assessments and document risk levels for diabetic patients in the electronic health record.

VHA Comments

Concur

Monitoring of compliance with risk assessments and documentation will be based on VHA Directive 2012-020, Prevention of Amputation in Veterans Everywhere (PAVE) Program, which establishes requirements and outlines specific expectations for program implementation and monitoring for VHA facilities. The following actions will take place:

a. Monthly communications with PAVE program leads will continue to be conducted to support field implementation efforts.

b. Continue to monitor compliance with the directive via annual report submissions from VHA facilities.

Target date for completion: January 31, 2014

This action plan is complete when VHA provides documentation of:

- Evidence of educational forums for VISN and facility clinical leadership (e.g., PowerPoint presentations, call minutes, or other similar documentation).

- Results of the Annual PAVE report on provision of patient education.

Recommendation 3. Ensure that CBOC clinicians document referrals for preventative foot care, including foot wear, as clinically indicated, for patients with diabetes in the electronic health record.

VHA Comments

Concur

a. Monthly communications with PAVE program leads will continue to be conducted to support field implementation efforts.

b. Continue to monitor compliance with the directive via annual report submissions from VHA facilities. The Annual PAVE report provides

documentation of compliance status on the mandated items in VHA Directive 2012-020.

Target date for completion: January 31, 2014

This action plan is complete when VHA provides documentation of:

- Results of the Annual PAVE report on tracking of the referral process for foot risk score 2 and 3 patients.

Recommendation 4. Ensure that CBOC managers establish a process to consistently link breast imaging and mammography results to the appropriate radiology mammogram or breast study order for all fee basis and contract patients.

VHA Comments

Concur

In 2012-2013, VHA responded to a 2011 OIG review of VHA Community Based Outpatient Clinics (CBOCs) which found that reports of mammography studies performed through Fee Basis were often not documented in the electronic health record (EHR) and linked to appropriate radiology orders. The following actions were taken in response to the 2011 report but may not have had time to result in improvements before the 2012 review was completed:

a. In November 2011, a memo was released to Network Directors clarifying that VA ordering providers are required to notify patients of mammogram results and communicate plans for follow-up and additional testing, as necessary, no later than 14 days after receiving the results of the mammogram.

b. In June 2012, a work group was established to examine best practices and advise the field of optimal pathways and standardized processes to ensure that mammography reports performed through Non-VA Care were documented in the EHR and linked to the appropriate radiology order. This work group, made up of representatives from Radiology, Women's Health Services, Health Information Management, and Non-VA Care, developed a process flow map and technical guide to standardize reporting and documentation procedures for non-VA Care mammography results VHA-wide. This process was communicated to Network Directors in January 2013 and presented on national calls to VISN Chief Medical Officers/Quality Management Officers, Primary Care, Radiology Health Information Management, and Women's Health programs.

Actions:

a. In fiscal year 2014, VHA Women's Health Services will repeat communications of the process flow map and technical guide to CBOC managers and Women's Health CBOC Liaisons to ensure that CBOC providers consistently use the radiology order to request fee basis and contract mammograms.

b. The Radiology Program Office will repeat communication of the process flow map and technical guide on their monthly national conference call.

c. The Clinical Business Systems Office will repeat communication of the process flow map and technical guide on the Clinical Applications Coordinators, National Non-VA Medical Care Program Office, Non-VA Medical Care Coordination Post Deployment, and Health Information Management conference calls to ensure technical processes are in place to ensure the linkage of Breast Imaging-Reporting and Data System (BI-RADS) results to mammogram radiology orders in CPRS.

d. The Clinical Business Systems Office will write an article addressing this issue in the Clinical Business Office Purchased Care Bulletin.

Target date for completion: January 31, 2014

This action plan is complete when VHA provides documentation of:

- Communication to CBOC Managers, CBOC Women's Health Liaisons, Radiology Program, National Non-VA Medical Care Program Office, Non-VA Medical Care Coordination Post Deployment, Health Information Management, and Clinical Application Coordinators.

- Article included in the Clinical Business Office Purchased Care Bulletin.

Recommendation 5. Ensure that CBOC managers establish a process to notify patients of normal mammogram results within the allotted timeframe and that notification is documented in the electronic health record.

VHA Comments

Concur

In fiscal year 2014 VHA (Women's Health Services and Radiology) will communicate with CBOC managers and Women's Health CBOC Liaisons to

ensure that CBOC providers consistently communicate mammogram test results within 14 days of receiving the result.

Target date for completion: January 31, 2014

This action plan is complete when VHA provides documentation of:

- An educational PowerPoint outlining Directive 2012-020, Test Results, and expectations that are provided to the field.

- Minutes from national calls documenting targeted discussions regarding implementation of Directive 2012-020, Test Results, are conducted including calls to Network Directors and quadrads, Chief Medical Officers, Chiefs of Staff, Primary Care VISN leaders, and Primary Care facility leaders.

Recommendation 6. Ensure that service chiefs' documentation in VetPro reflects documents reviewed and the rationale for privileging or re-privileging CBOC providers.

VHA Comments

Concur

Relevant to this report is the period of review of providers who were credentialed and privileged at CBOCs. VHA has made a concerted effort to increase this awareness over the last several years that may not be recognized in a review of files prior to FY 2011. In FY 2011 the Office of Quality and Performance did an extensive outreach to VISN and facility leadership through conference calls and face-to-face meetings to discuss the roles and responsibilities of clinical leadership which included documentation of provider competency.

The Director of Credentialing and Privileging is in frequent communication through national- and VISN-level conference calls with the VISN Chief Medical Officers (CMOs) and Quality Management Officers (QMOs) reminding them of the importance of good documentation. Review of the credentialing and privileging program was incorporated into the VISN reviews of facilities in FY 2011 and the assessment tool required review of the credentials file (VetPro), including the Service Chief documentation.

The Assessment Tool for Credentialing and Privileging is in the final stages of modification for posting on the Office of Quality, Safety and Value (QSV) website. The review tool is designed to guide VA staff through VHA and Joint Commission (TJC) requirements, citing specific requirements where applicable. This review

tool is designed to identify opportunities for improvement of the credentialing and privileging and medical staff processes.

Target date for completion: September 30, 2013

This action plan is complete when VHA provides documentation of:

- Posting of the Assessment Tool for Credentialing and Privileging on the QSV website.

- Minutes from CMO and QMO conference calls demonstrating communication of VetPro documentation practices and discussion on the use of the Assessment Tool.

Recommendation 7. Ensure that facility Directors grant privileges consistent with the services provided at the CBOCs.

VHA Comments

Concur

VHA has made a concerted effort to increase this awareness over the last several years that may not be recognized in reviews of files prior to FY 2012. The Director of Credentialing and Privileging is in frequent communication through national- and VISN-level conference calls with the VISN CMOs and QMOs reminding them of the requirement for privileges to be granted in accordance with the resources available for the setting in which the care is provided. Review of the credentialing and privileging program was incorporated into the VISN reviews of facilities in FY 2011 and the assessment tool required a review of the process for development, granting, and monitoring of clinical privileges.

The Assessment Tool for Credentialing and Privileging is in the final stages of modification for posting on the QSV website. The review tool is designed to guide VA staff through the VHA and TJC requirements, citing specific requirements where applicable. This review tool is designed to identify opportunities for improvement of the credentialing and privileging and medical staff processes. There are specific questions which address how Service Chiefs evaluate the required resources and support for the defined privileges specific to the settings where care is provided, including CBOCs. Questions directed to the Chief of Staff are related to how the Chief of Staff assures that this process is appropriately addressed.

Target date for completion: September 30, 2013

This action plan is complete when VHA provides documentation of:

- Posting of the Assessment Tool for Credentialing and Privileging on the QSV website.

- Minutes from CMO and QMO conference calls demonstrating communication of the requirements of privileges and discussion on the use of the Assessment Tool.

Recommendation 8. Ensure that adequate resources and controls are in place to address deficiencies in the invoice validation process and to reduce the risk of overpayments.

VHA Comments

Concur

VHA developed and provided a CBOC template for use by the field which addresses the invoice validation issues. The Performance Work Statement (PWS) includes specific instructions and requirements for billing validation. The template was provided as a resource in 2011, revised in 2012 to update for Mental Health requirements, and again updated in July 2013. The PWS is currently pending Office of General Counsel (OGC) and OIG final review and comment and any required changes will be made. In addition, the Medical Sharing/Affiliate Office (MSO) will issue a memorandum through the office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to make the use of the PWS and Quality Assurance Surveillance Plan (QASP) mandatory by all medical centers.

The CBOC Contracting Officer Healthcare training course is being tailored into a customer training format to facilitate Contracting Officer's Representative information. This CBOC Customer Training will include the oversight roles and responsibilities with the medical center.

Target date for completion: January 31, 2014

This action plan is complete when VHA provides documentation of:

- PWS excerpts with specific instructions and requirements for billing validation.

- Memorandum from the DUSHOM making the use of the PWS and QASP mandatory.

Recommendation 9. Ensure that the oversight of the contract acquisition process is compliant with VA Directives, including a thorough pre-award review and interim contract authority prior to contract approval.

VHA Comments

Concur

The Medical Sharing/Affiliate Office (MSO) has tracking tools for all phases of the review and approval requirements for procurements that are processed through MSO. MSO reviews all CBOC procurements in accordance with VA Directive 1663, Health Care Resources Contracting – Buying, and the VHA Procurement Manual. MSO will commence generating a monthly award Electronic Contract Management System (eCMS) report to validate whether CBOC procurements have followed the mandatory review/approval process and develop a monitoring plan to ensure validation and reporting is conducted promptly. If the procurement is found to be not in compliance, it will be reported to the VHA Head of Contracting for action.

Target date for completion: January 31, 2014

This action plan is complete when VHA provides documentation of:

- The MSO procurement tracking tool.
- A monthly eCMS report showing validation of CBOC procurements.

Recommendation 10. Ensure that all new CBOCs undergo the required contract approval processes prior to initiating operations.

VHA Comments

Concur

MSO will use the established tracking tools to monitor the review and approval requirements for all procurements to be processed through MSO. MSO reviews all CBOC procurements in accordance with VA Directive 1663, Health Care Resources Contracting – Buying, and the VHA Procurement Manual. MSO provides workload management reports to Network contracting offices as a tool to facilitate the optimization of timeliness and cost effectiveness through long-term contracts. MSO utilizes the eCMS system to create a monthly report to monitor and review awards to validate that procurements have followed the mandatory review/approval processes. If any non-compliance issues are discovered, an action plan report is provided to the Service Area Office Directors,

VHA Deputy Chief Procurement Officer and VHA Head of Contracting for disposition and action.

The purpose of the eCMS reports is to enhance awareness and assist in promoting acquisition planning requirements for contracts nearing expiration. Since proper acquisition planning is necessary for timely contract award, this report will assist in completing the new long-term contract by the current contract expiration and ensure continuity of services while utilizing the most efficient contracting resources.

Target date for completion: January 31, 2014

This action plan is complete when VHA provides documentation of:

- The MSO procurement tracking tool.
- A monthly eCMS report showing validation of CBOC procurements.

OIG Contact and Staff Acknowledgments

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