Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Community Based Outpatient Clinics Fiscal Year 2009

Report No. 10-03103-12

October 21, 2010

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
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Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections completed an evaluation of Veterans Health Administration (VHA) community based outpatient clinics (CBOCs). The purposes of the evaluation were to determine: (1) if the CBOCs' quality of care measures are comparable to the parent VA medical center (VAMC) clinics, (2) whether CBOCs maintain the same standard of care as their parent facility to address the Mental Health (MH) needs of the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) era veterans, (3) whether CBOC providers are appropriately credentialed and privileged in accordance with VHA Handbook 1100.19, (4) whether CBOCs are in compliance with standards of operations according to VHA Handbook 1006.1 in the areas of environmental safety and emergency management, and (5) whether the CBOC contracts were administrated in accordance with contract terms and conditions.

Results and Recommendations

The CBOCs generally met VHA directives and guidelines. CBOCs overall appear to be providing a quality of care that is not substantially different from parent VAMCs. No statistically significant differences were found between VA-staffed and contract CBOC estimates overall. When controlling for geographic location, some differences were found. Rural VA-staffed CBOCs had higher mean compliance rate than contract CBOCs, and three of seven indictors were statistically significant. Urban CBOCs average compliance rates were higher for contract, but not statistically significant.

We found the following areas that need improvement. We found that 6 (19 percent) of 31 VA-staffed and 7 (28 percent) of 25 contract CBOCs granted clinical privileges for procedures that exceeded the services provided at the CBOC setting. We found that 9 (29 percent) of 31 VA-staffed and 3 (11 percent) of 27 contract CBOCs either did not collect performance improvement (PI) data, did not compare PI data, or did not use PI data during the appointment or reappraisal process.

Eight (14 percent) of the 58 CBOCs we inspected did not provide or partially provide handicap accessibility for disabled veterans. Thirteen (22 percent) CBOCs that provided mental health services for patients did not have a panic alarm system or was not operational at the time of our inspection. At 9 (15.5 percent) of the CBOCs we found auditory privacy was compromised because there was no zone of audible privacy during the check-in process.

We found that VHA has been overpaying for contracted primary care due to the following factors: (1) VHA relied on contractor data for payment for veterans receiving primary care, (2) the invoice approval process had inadequate checks and balances, (3) contracts were non-standard with differing provisions and conflicting language, and (4) there was no standard Veterans Health Information Systems and Technology Architecture

report to assist the Contracting Officer's Technical Representative to identify billable primary care veterans. These factors attributed to an estimated financial loss of $853,160.

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

Recommendation 1: Grants privileges that are consistent with providers' practices at the CBOCs.

Recommendation 2: Collects and appropriately uses PI data in the medical staff reprivileging process.

Recommendation 3: Ensures that all CBOCs are handicap accessible.

Recommendation 4: Ensures that a vulnerability assessment is conducted at all CBOCs to determine if a panic alarm system is required and ensures a system is implemented if one is deemed necessary.

Recommendation 5: Ensures that all CBOCs maintain auditory privacy during the check-in process.

Recommendation 6: Reviews the oversight of the invoice approval process and implements steps to strengthen the oversight process and identify additional administrative support when needed.

Recommendation 7: Reviews the contract process for primary care to improve oversight, simplifies the invoice process to rely on VHA data, and standardizes essential provisions such as billable enrollee.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Acting Under Secretary for Health (10)

SUBJECT: Healthcare Inspection – Evaluation of Community Based Outpatient Clinics Fiscal Year 2009

Introduction

Purpose

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

Background

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. The creation of CBOCs increased veterans' access to primary care while decreasing the travel time necessary to be seen by a primary care provider. The type of care veterans receive at these clinics is comparable to that available during visits to a private physician's general practice office. It also created the opportunity for community providers to operate a CBOC on a contract basis.

The CBOC model provided the VA with the option of hiring VA staff or contracting with outside health care providers to deliver care to its veterans. Each CBOC would be affiliated with a single VA medical center (VAMC) that would be administratively responsible for that CBOC.

CBOCs fall into five categories:[1]

- VA-Owned – a CBOC that is owned and staffed by VA.
- Leased – a CBOC where the space is leased (contracted, to include donated space) but is staffed by VA.
- Contracted – a CBOC where the space and the staff are not VA. This is typically a Healthcare Management Organization [HMO] type provider where multiple sites can be associated with a single station identifier.
- Shared – a CBOC where there is one geographic location (address) which is used by two or more stations and/or parent facilities.
- Not Operational – a CBOC which has been approved by Congress but has not yet begun operating.

VA policy outlines specific requirements that must be met at CBOCs. The minimum standards were developed in 2001 to ensure that veterans receive one standard of care at all VHA health care facilities. Care at CBOCs must be consistent, safe, and of high quality, regardless of whether it is VA-staffed or contract. CBOCs must comply with VA policy and procedures related to quality, patient safety, and performance. There are 14 standards that must be met for CBOC operations. Only 9 of the 14 standards were addressed during our reviews and discussed in this report.[2] The standards can be found in VHA Handbook 1006.1.[3]

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 Office of Inspector General began a systematic review of VHA CBOCs on April 2009. Figure 1 displays the locations of 610 VA CBOCs subject to review and inspection with the 58 CBOCs sampled.

[1] Although not used here, CBOCs may also be suspended or closed.
[2] Staffing, Timeliness, Station Numbering, Cost Accounting, and Patient Complaints were omitted from this review.
[3] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004

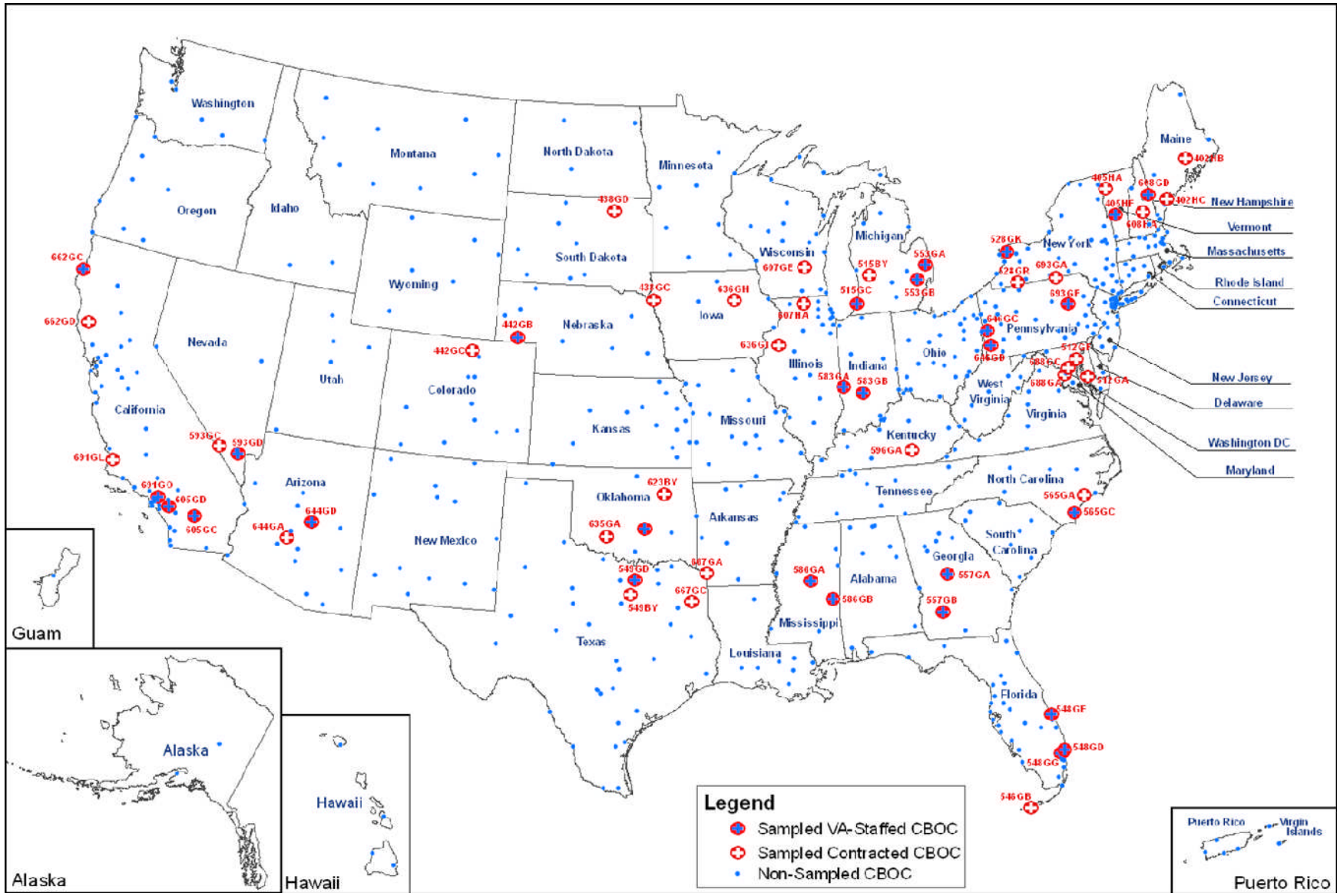

Figure 1. CBOC Map

Scope and Methodology

We performed this review in conjunction with the inspections of 58 CBOCs from April 13, 2009, through February 11, 2010 (31 VA-owned or leased CBOCs and 27 contract CBOCs). The statistical sampling methodology used to select the 58 CBOCs is explained in Appendix D. The CBOCs we visited represented a mix of facility size, geographic location, and Veterans Integrated Service Networks (VISNs). Our review focused on FYs 2008 and 2009 activities. We analyzed results and reported deficiencies in each CBOC report.

Our review focused on compliance with selected requirements from VHA Handbook 1006.1 and other VHA policies. CBOC inspection consists of four components: (1) CBOC site-specific information gathering and review, (2) medical record reviews for determining compliance with VHA performance measures, (3) onsite inspections, and (4) CBOC contract review.

1. CBOC Characteristics

We formulated a list of CBOC characteristics and developed a questionnaire for data collection. We requested that the CBOC Director/Manager complete the web SurveyPro questionnaire. Responses to the questionnaire provided characteristics that include identifiers and descriptive information for the CBOC evaluation.

2. Medical Record Review

For each CBOC, a random sample of 50 patients with a diagnosis of diabetes, 50 patients with a diagnosis of ischemic vascular disease (hyperlipidemia), and 30 patients with a service release date after September 11, 2001, without a diagnosis of post traumatic stress disorder (PTSD) were selected, unless fewer patients were available. (See Appendix D for the statistical sample methodology.) We reviewed the medical records of these selected patients to determine compliance with VHA performance measures.

3. Onsite Inspections

As part of the onsite visit, we inspected the CBOC for environment of care (EOC) issues and emergency management procedures, reviewed CBOC providers' credentialing and privileging (C&P) files and supporting documentation, and discussed their compliance with VHA performance measures. We interviewed CBOC managers and staff, VHA and contractor personnel.

4. Contract Review

We reviewed how the contract parameters affect the quality of care veterans receive at the contract CBOC. We verified that the number of enrollees or visits that are reported are consistent with what was actually supported with collaborating documentation. We

conducted an analysis of VHA and contractor patient data and documents. We reviewed each contract including amendments, modifications and addendums, as well as invoices and payments. We examined key contract provisions regarding patient enrollment, disenrollment, performance measures, and capitated payments in order to evaluate VHA's oversight and contractor compliance.

Analytical tests were performed on VHA and contractor data to identify inactive (enrollees who have not received services within the contractually defined time frames) or duplicate enrollees included on contractor invoices. Data sets of patient care encounters for each contracted CBOC were compared to contractor records of invoiced enrollees. We queried the data sets to identify inactive or duplicate enrollees to verify the number of patients and the number of visits. We verified the data provided by cross referencing with VHA administrative and financial systems including the Primary Care Management Module (PCMM) System, the Financial Management System, and the Document Management System.

We conducted the review in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: CBOC Characteristics

We formulated a list of CBOC characteristics and developed a questionnaire for data collection. The characteristics included identifiers and descriptive information for the CBOC evaluation. The aggregated results of the CBOC characteristics data from an online questionnaire are reported below.

A. Rurality

The study population[4] constitutes all patients who were enrolled in these CBOCs for their health care. VA-staffed CBOCs had a greater number of urban locations (63 percent) where as contract CBOCs had a greater number of rural locations (59 percent). (See Figure 2).

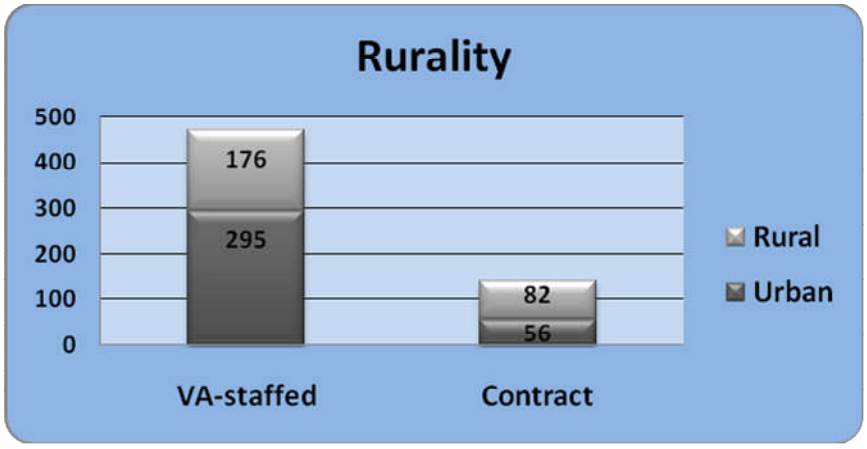

Figure 2. Urban and Rural by CBOC Type (Source: VHA Site Tracking (VAST) System)

Of the 58 CBOCs in our sample, there were 20 VA-staffed CBOCs and 15 contract CBOCs in rural locations, and 11 VA-staffed CBOCs and 12 contract CBOCs in urban locations.

B. Unique Veterans

The average number of uniques (study population) seen at 471 VA-staffed CBOCs was 4,669 (range 28 to 45,481) and at the 138 contract CBOCs was 2,346 (range 111 to 9,351). Figure 3 displays uniques by CBOC type and location. Of the sampled CBOCs, the average number of unique patients seen at the 31 VA-staffed CBOCs was 5,267 (range 610 to 24,927) and 4,380 (range 169 to 6,937) at the 27 contract CBOCs.

[4] Of the 618 CBOCs initially in the study population, 9 were excluded. Four CBOCs were determined to be free standing ambulatory clinics, one had only one unique patient enrolled, two were shared CBOCs, and two were suspended or not in operation prior to our initiation of the CBOC reviews.

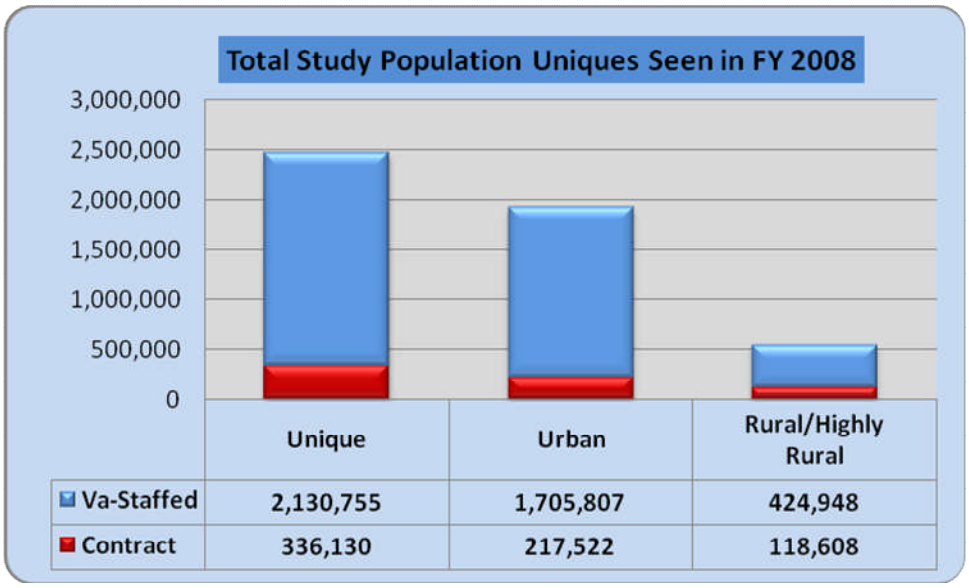

Figure 3. Unique Enrollees by CBOC Type and Location (Source VAST System)

C. Services

Table 1 shows the sample count and weighted percent of VA-staffed CBOCs and of contract CBOCs with each type of service listed. For VA-staffed CBOCs, the estimated laboratory, pharmacy, nutritional, and social services percents are higher; radiology and electrocardiogram (EKG) services estimated percents are lower. Of those services, only radiology has a statistically significant association (p-value=.0096) with VA-staffed/contract. About 15.7 percent of VA-staffed CBOCs had radiology services compared to 51.2 percent of contract CBOCs.

	VA-staffed (N=31)		Contract (N=27)	
Service	**N**	**Percent**	**N**	**Percent**
Laboratory	29	**92**	21	**89**
Pharmacy	12	**33**	3	**13**
Radiology	5	**16**	14	**51**
EKG	30	**93**	26	**95**
Nutritional Counseling	19	**62**	9	**31**
Social Services	23	**73**	13	**62**

Table 1. Services at VA-staffed and Contract CBOCs

D. Statistically Significant Findings

We found a statistically significant association exists between VA-staffed/contract CBOCs in each of the following:

- Registered Nurse — Approximately 99.2 percent of VA-staffed CBOCs had registered nurses compared to about 79.9 percent of contract CBOCs.
- CBOC specialty care onsite — Approximately 64.1 percent of VA-staffed CBOCs had some type of specialty care onsite; compared to approximately 10.4 percent of contract CBOCs.
- Telemedicine — Approximately 50.4 percent (1 of 2) VA-staffed CBOCs had telemedicine compared to 1 in 20 (4.8 percent) contract CBOCs.
- Voluntary public transport — Approximately 61.3 percent of VA-staffed CBOCs had voluntary public transportation compared to 18.6 percent of contract CBOCs.

Conclusion

VA-staffed and contract CBOC have comparable characteristics with the following exceptions. Contract CBOCs had a higher percentage of radiological services and provided care to more patients in rural locations. VA-staffed CBOCs served a higher percentage of patients in urban locations and provided specialty care and telemedicine. We collected this data for informational purposes only; therefore, we made no recommendations.

Issue 2: Quality of Care Measures Based on Medical Record Review

VA uses two key performance measures to assess the quality of health care delivery, the Chronic Disease Care Index II (CDCI II) and the Prevention Index II (PI II). These indices measure the degree to which the VA follows nationally recognized guidelines for the treatment and care of patients. The CDCI II focuses on the care of patients with ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus (DM), major depressive disorder, and schizophrenia. The PI II focuses on primary prevention and early detection recommendations for nine diseases or health factors that significantly determine health outcomes. This review evaluated PI II (hyperlipidemia screening) and CDCI II (DM and PTSD screening). Data for the indicators were obtained from the patient medical record and compared to the parent

facilities' results. We used the same time period, Quarter 1 (Qtr 1), FY 2009,[5] for comparison.

For the CBOC performance evaluation presented in this report, a subset of 7 of the 9 PI II and 9 of the 14 CDCI II indicators were assessed (see Appendix B and C). We reviewed 2,330 DM, 1,811 hyperlipidemia, and 641 PTSD medical records. There were exceptions for certain indicators; therefore, denominators may vary in the reported results. In addition, of the 641 PTSD reviews, 27 patients (screened positive for PTSD on or after October 1, 2001) required further review of suicidal ideation/behavior. Due to the small number of available patients that screened positive for PTSD, we did not perform any analysis of these patients.

Statistical analyses were conducted using the SAS System software version 9.2. Patient compliance rates and their 95 percent confidence intervals (95% CI) were estimated for the different performance measures.

A. CBOCs Compared to VA and VA-staffed Compared to Contract CBOCs

Based on the PI II and CDCI II indicators, CBOCs overall appear to be providing a quality of care that is not substantially different from parent VAMCs, although some individual CBOCs are not providing the same quality as affiliated parents on all indicators. When individual CBOCs were compared to their affiliated parent VAMCs, performance was more variable.

Table 2 shows VAMCs performance measures (data source) for outpatients and our estimated performance measures and their associated confidence intervals for VA CBOCs. VA CBOCs performance score for foot sensory exam is statistically significantly higher than VA, while VA CBOCs performance score for retinal exam is significantly lower. No differences are statistically evident for the other measures.

[5] VHA's comparison dates for Qtr 1, FY 2009, are October 1-November 30, 2008.

	VA		VA CBOCs			
					95% CI Limits	
Performance Measure	Number Sampled Patients	Performance Scores Percent (PS%)	Number Sampled Patients	PS%	Lower	Upper
Diabetes (Outpatient)						
Foot Inspection	5,971	92.5	2,328	94.3	90.32	96.75
Foot Pedal Pulse	5,971	90.4	2,328	92.1	87.13	95.21
Foot Sensory Exam	5,951	88.5	2,325	92.6	89.22	94.97
Renal Testing	5,263	94.5	2,330	94.7	91.21	96.82
LDL-C[6] Measured	5,209	95.8	2,330	96.6	94.92	97.71
Retinal Eye Exam	5,258	87.5	2,330	82.8	78.10	86.70
Hyperlipidemia						
Hyperlipidemia Screen - Overall	13,587	96.8	1,726	91.0	76.48	96.88
Behavioral Health Screening						
PTSD - Screening	4,987	95.3	598	93.5	89.05	96.28

Table 2. VA Performance Scores and Estimated VA CBOCs Performance Scores

Table 3 displays VA CBOCs performance estimates for VA-staffed CBOCs and for contract CBOCs separately. Retinal eye exam is the sole measure with an estimated performance score below 90 percent for VA-staffed CBOCs. For contract CBOCs, estimates for retinal exam and foot pedal pulse are below 90 percent. Differences between estimates for VA-staffed CBOCs and contract CBOCs are not statistically significant.

[6] Low-density lipoprotein-cholesterol

Performance Measure	VA-staffed Number Sampled Patients	VA-staffed PS%	VA-staffed 95% CI Limits Lower	VA-staffed 95% CI Limits Upper	Contract Number Sampled Patients	Contract PS%	Contract 95% CI Limits Lower	Contract 95% CI Limits Upper
Diabetes Mellitus								
Foot Inspection	1,241	94.6	90.01	97.19	1,087	92.4	77.46	97.74
Foot Pedal Pulse	1,241	93.1	87.75	96.26	1,087	85.2	57.91	96.02
Foot Sensory Exam	1,241	93.0	90.10	95.06	1,084	90.1	72.89	96.88
Renal Testing	1,243	94.6	90.95	96.79	1,087	95.3	89.80	97.94
LDL-C Measured	1,243	96.9	94.98	98.07	1,087	94.7	88.16	97.72
Retinal Eye Exam	1,243	82.5	76.63	87.10	923	85.1	73.55	92.10
Hyperlipidemia								
Hyperlipidemia Overall	888	90.1	73.34	96.79	886	96.3	93.05	98.02
Behavioral Health Screening								
PTSD Screening	374	94.0	88.44	97.00	267	91.9	80.59	96.91

Table 3. VA-staffed and Contract CBOCs Estimated Performance Scores[7]

B. Rural Compared to Urban CBOCs

When stratifying by geographic location, VA-staffed CBOCs in rural areas tended to perform better than their contract counterparts, while the opposite was observed for CBOCs located in urban; although, the differences might not be statistically significant. Performance estimates of foot pedal pulse, foot sensory, and LDL-C performance scores for VA-staffed CBOCs in rural areas are statistically higher than the corresponding estimates for contract CBOCs. In urban locations, the VA-staffed CBOCs estimate for retinal exam was statistically lower than the contract CBOCs estimate. See Table 4.

[7] The diabetes measures are based on sample patient totals of 1,243 and 1,087 for VA-staffed CBOCs and contract CBOCs, respectively. Two VA-staffed CBOCs patients were excluded for foot inspection and for foot pedal pulse. Five patients were excluded for Foot Sensory: two from VA-staffed CBOCs and three from contract CBOCs. Hyperlipidemia Screen estimates were computed from patient totals of 888 and 923 for VA-staffed CBOCs and contract CBOCs, respectively. The total sample patients for PTSD Screen are 374 for VA-staffed CBOCs and 267 for contract CBOCs.

	VA-staffed				Contract			
	Number Sampled Patients	PS%	Lower 95% CL	Upper 95% CL	Number Sampled Patients	PS%	Lower 95% CL	Upper 95% CL
Rural								
Foot Inspection	468	98.6	94.80	99.64	428	85.3	50.09	97.09
Foot Pedal Pulse	**468**	**97.0**	**91.89**	**98.92**	**428**	**64.1**	**30.16**	**88.06**
Foot Sensory Exam	**468**	**96.1**	**92.89**	**97.93**	**427**	**75.8**	**51.32**	**90.27**
Renal Testing	469	92.2	78.66	97.43	428	94.7	87.95	97.74
LDL-C Measured	**469**	**97.0**	**94.38**	**98.45**	**428**	**87.9**	**80.73**	**92.64**
Retinal Exam	469	88.9	81.09	93.71	428	73.3	55.67	85.71
Hyperlipidemia	307	96.6	90.86	98.78	338	93.7	89.45	96.30
PC-PTSD Screen	111	93.3	82.28	97.67	95	87.5	43.33	98.45
Urban								
Foot Inspection	773	93.5	88.74	96.28	669	95.5	81.81	99.00
Foot Pedal Pulse	773	92.0	85.76	95.64	659	94.2	72.76	99.01
Foot Sensory Exam	773	92.0	88.75	94.43	657	96.3	90.43	98.60
Renal Testing	774	95.3	91.15	97.53	659	95.6	85.18	98.81
LDL-C Measured	774	96.8	94.06	98.33	659	97.6	95.73	98.67
Retinal Exam	**774**	**80.6**	**75.49**	**84.80**	**659**	**90.1**	**85.03**	**93.58**
Hyperlipidemia	581	88.4	68.58	96.39	585	98.1	93.35	99.49
PC-PTSD Screen	263	94.2	86.25	97.67	172	93.8	85.73	97.41

Table 4. VA-staffed and Contract CBOCs Estimates by Rural/Urban

Conclusion

Estimated compliance rates are slightly higher, on average, in VA-staffed CBOCs than in contract CBOCs; however, the differences are not statistically significant. However, rural VA-staffed CBOCs had higher mean compliance rate than contract CBOCs, and three of seven indictors were statistically significant. Urban CBOCs average compliance rates were higher for contract, but not statistically significant. We made no recommendations.

Issue 3: Credentialing and Privileging

All VHA health care professionals who are permitted by law and the facility to provide patient care services independently must be credentialed and privileged. The C&P program is used by medical centers to ensure that clinical providers have the appropriate professional license and other qualifications to practice in a health care setting and that they practice within the scopes of their licenses and competencies. The credentialing, but not privileging, requirements apply to all Advanced Practice Registered Nurses and Physician Assistants (PAs) even though these practitioners may not practice as licensed independent practitioners in most states.

We reviewed the C&P files of 260 providers, utilizing VetPro[8] to conduct our initial review to include verifying education and training, licensure, and type of appointment. Provider privileges or scope of practice and physician quality profiles were examined onsite.

A. Scope of Privileges

We found that 6 (19 percent) of 31 VA-staffed and 7 (26 percent) of 27 contract CBOCs granted clinical privileges for procedures that exceeded the services provided at the CBOC setting. Although VHA clinical privileges must be facility and provider specific, it is the setting in which care is delivered that dictates the type(s) of care, treatment, and procedure that a practitioner will be authorized to perform. We recommended that VHA ensure compliance with privileging requirements.

B. Performance Improvement Activities

We found that 9 (29 percent) of 31 VA-staffed and 3 (11 percent) of 27 contract CBOCs did not collect PI data, did not compare PI data, or did not use PI data during the appointment or reappraisal process. According to VHA Handbook 1100.19,[9] the appointment and reappraisal process needs to include consideration of such factors as: (1) the number of procedures performed or major diagnoses treated, (2) rates of complications compared with those of others doing similar procedures, and (3) adverse results indicating patterns or trends in a practitioner's clinical practice. In addition, relevant practitioner-specific data needs to be compared to the aggregate data of those privileged practitioners that hold the same or comparable privileges. We recommended that VHA collect PI data and use PI data during the appointment or reappraisal process.

[8] VetPro is VHA's electronic credentialing system.
[9] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

C. Inadequate Nurse Practitioners/Physician Assistant Oversight

We found inconsistencies in the monitoring of Advance Practice Nurses' prescriptive authority and the monitoring of PAs in 2 (6 percent) of 31 VA-staffed and 3 (11 percent) of 27 contract CBOCs. We found that the identified collaborating physician on the Scope of Practice was not always the monitoring physician. In addition, the requirements of clinical pertinence review were completed at irregular intervals and their clinical outcomes were not documented in the discussion of the Professional Standards Board prior to the renewal of their Scope of Practice. No trends were identified. Specific recommendations were made in individual CBOC reports for these five facilities.

D. Length of Privileges

Since 2007, VHA has required that for any providers with less than a 2-year association with the facility (for example, contract, fee basis, and temporary), the length of privileges granted must match the length of the association. Of the 27 contract CBOCs where some providers had less than a 2-year association, 5 (18.5 percent) were granted privileges greater than the length of the contract. We found that the chiefs of staff and medical staff coordinators, who are responsible for processing privileges, were generally unaware of this requirement. Also, we often found that staff responsible for processing contracts did not communicate the length of contracts to the medical staff coordinators. On April 13, 2010, the Deputy Under Secretary for Health for Operations and Management issued a memorandum[10] stating that contract provider privileges can be granted to exceed the contract period, but cannot exceed a 2-year period, if the extension periods are clearly defined in the contract. Since the five contracts had extension options, we made no recommendations.

Conclusion

The CBOCs generally met VHA directives and guidelines. However, we concluded the following areas required improvement: grant privileges to providers that are actually performed at the VA-specific location and compare practitioner data either to those practitioners doing similar procedures or to aggregate data of those privileged practitioners with the same or comparable privileges.

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

Recommendation 1: Grants privileges that are consistent with providers' practices at the CBOCs.

[10] Deputy Under Secretary for Health for Operations and Management, *Privileges On-station Contracted Care* Memorandum, April 13, 2010.

Recommendation 2: Collects and appropriately uses PI data in the medical staff reprivileging process.

Issue 4. Environment and Emergency Management

A. Environment of Care

We conducted EOC inspections at each CBOC, evaluating cleanliness, adherence to clinical standards for infection control and patient safety, and compliance with patient data security requirements. We used 90 percent as the general level of expectation for performance. We found the following (See Figure 5):

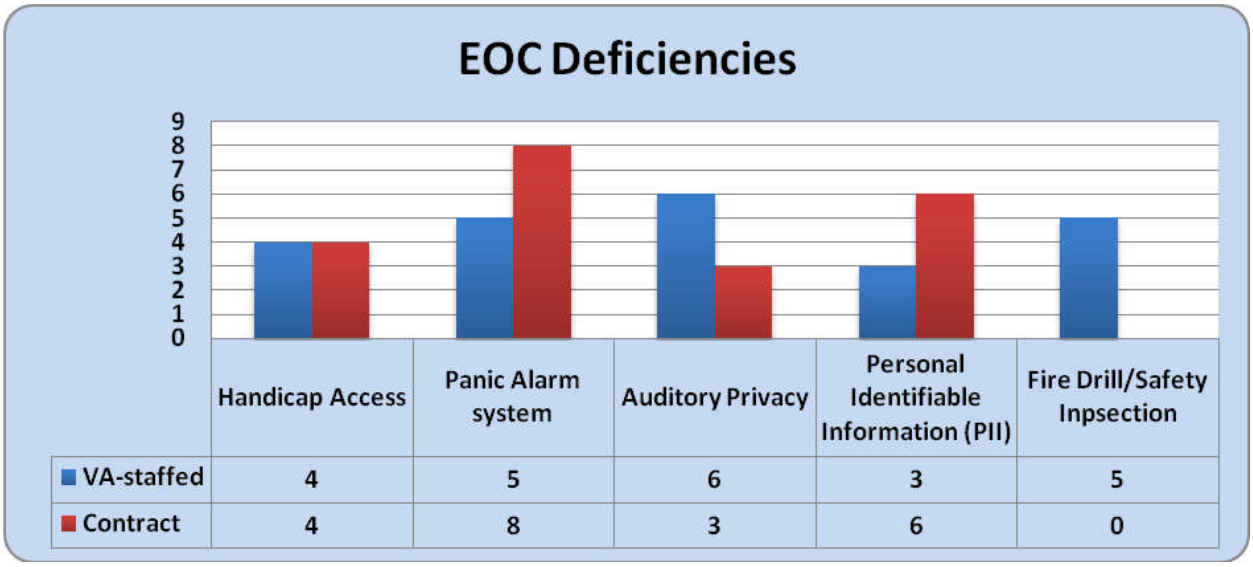

Figure 5. EOC Deficiencies

Handicap Accessibility. Eight (14 percent) of the 58 CBOCs we inspected did not provide or partially provide handicap accessibility for disabled veterans. The Americans with Disabilities Act[11] and the Joint Commission require that buildings and grounds are suitable to service disabled individuals. We recommended that VHA ensure that all CBOCs are handicap accessible.

Panic Alarms. Thirteen (22 percent) CBOCs that provided mental health (MH) services for patients did not have a panic alarm system or it was not operational at the time of our inspection. We recommended that VHA require all CBOCs conduct a vulnerability risk assessment and have a panic alarm system in place, if indicated.

Auditory Privacy. Most of the 58 CBOCs we inspected had very small patient waiting areas. At 9 (15.5 percent) of the CBOCs we found the waiting room seats were located

[11] Americans with Disabilities Act of 1990 is a wide-ranging civil rights law that prohibits, under certain circumstances, discrimination based on disability.

next to or in close proximity to the check-in windows. Patients communicated with staff and provided personally identifiable information (PII) through open-glass or sliding-glass windows where auditory privacy was compromised. There were no instructions to incoming patients to allow patients a zone of audible privacy during the check-in process. We recommended that VHA ensure that all CBOCs maintain auditory privacy during the check-in process.

Personally Identifiable Information. We found nine (15.5 percent) CBOCs did not consistently secure patient's PII. We found no consistent trend in how the PII was inappropriately secured. Specific recommendations were made in individual CBOC reports for these nine facilities.

Fire Drills and Safety Inspections. We found no documentation for annual fire drills at three VA-staffed CBOCs and no documentation of annual safety inspections at two VA-staffed CBOCs. In addition, we found one VA-staffed and one contract CBOC did not provide signage on or near fire extinguishers. No trends were identified. Specific recommendations were made in our individual CBOC reports for these five facilities.

B. Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or standard operating procedure (SOP) defining how medical and MH emergencies are handled. Only 10 percent of the CBOCs we inspected (5 VA-staffed and 1 contract) did not have a local policy or SOP to address medical and MH emergencies. One VA-staffed CBOC utilized the parent facility's plan, which indicated staff would dial 911 in the event of an emergency. However, during our visit, we found a 911 emergency system did not exist in the CBOC's catchment area. In addition, the telephone system in this CBOC was not programmed to dial out to a 911 system. Specific recommendations were made in our individual CBOC reports for these six facilities.

Conclusion

All CBOCs, with the exception of one, were clean and well maintained. However, we identified three areas with significant trends. The following areas required improvement: (1) ensure handicap accessibility, (2) install a panic alarm system when applicable, and (3) improve auditory privacy.

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

Recommendation 3: Ensures that all CBOCs are handicap accessible.

Recommendation 4: Ensures that a vulnerability assessment is conducted at all CBOCs to determine if a panic alarm system is required and ensures a system is implemented if one is deemed necessary.

Recommendation 5: Ensures that all CBOCs maintain auditory privacy during the check-in process.

Issue 5: CBOC Contract Review

We found that VHA has been overpaying for contracted primary care due to the following factors: (1) VHA relied on contractor data for payment for veterans receiving primary care, (2) the invoice approval process had inadequate checks and balances, (3) contracts were non-standard with differing provisions and conflicting language, and (4) there was no standard Veterans Health Information Systems and Technology Architecture (VistA) report to assist the Contracting Officer's Technical Representative (COTR) to identify billable primary care veterans.

A. Reliance on Contractor Data

The COTR would receive an invoice with thousands of patient names that required confirmation that all met the requirements for payment under the provisions of the contract. This is the most common process prescribed in the payment provision of the contract and the reason for most of the overpayments. We have found large numbers of inactive or deceased patients that remain on invoices due to inadequate validation processes. Some COTRs have administrative and Information Technology (IT) support to assist with the validation process, but it is still a difficult and timely task to validate the entire list of contractor's data. In some instances the list would be a hard copy, which made the validation more difficult. The COTRs of some CBOCs manually check the contractor list by individually looking up each patient in the computerized patient record system to verify the most recent visit date. This manual review, even for a smaller CBOC, could take weeks to validate the list of billed patients.

The requirements for payment should be clearly defined and not coupled with the provisions for enrollment. In most contracts the invoicing procedures state that payment is based on the number of enrollees and not based on an annual vesting office visit. The requirements for enrollment and disenrollment are different than requirements for payment. We frequently see a provision stating that it is "VA's sole responsibility for disenrollment" of a patient and a requirement for VHA to notify the contractor. This notification was not being done in many cases, which has lead to significant overpayments and made reimbursement difficult at best.

B. Invoice Approval Process with Inadequate Checks and Balance

We found that the invoice approval process used by many VHA facilities did not have adequate checks and balances to ensure that overpayments were not being made. We found problems with over 70 percent of the contracted CBOCs due to failures of VHA oversight. These discrepancies were attributable to contractor invoices containing errors in capitated rates, mathematical errors, duplicate enrollees, and payments for services

previously covered. Most of the COTRs had clinical backgrounds and did not have the administrative skills to adequately confirm the accuracy of the patient list in a timely manner without other administrative or IT support.

For example, when an invoice was received, there was limited time for the COTR to approve the invoice before payment due to the Prompt Payment Act.[12] In order to meet time constraints many of the COTRs would only verify new enrollees and not verify the entire patient list. In some instances, we found that 10−15 percent of the patient list should have been inactivated due to no visits within the last year. In many cases there was no oversight to ensure the COTR had an adequate process to verify the invoices.

We found that many COTRs were not familiar with the provisions in the contract that they were responsible for enforcing. Many contracts had performance measures with incentives and penalties. The COTR would be responsible for monitoring these measures and to initiate action in accordance with the contract. In some cases the COTR never informed the Contracting Officer when penalties should have been applied.

C. Non-standard Primary Care Contracts

There was no standard VHA contract for primary care services in CBOCs. We found significant differences between contracts at the same VHA facility and the same contractor. There is no standard within VHA identifying who are billable enrollees for contracted primary care. Veterans eligible for billing (billable enrollees) are defined by certain factors that include whether the enrollee has had a vesting visit at that clinic within the contractually specified timeframe (generally 12 months). Of the 27 contracts we reviewed, 17 contracts had 12 months, 1 contract had 13 months, 3 contracts had 24-month provisions, and 6 contracts did not have a limit. At one clinic, VHA was paying for patients that had not been seen in 5 years but could not be reimbursed because VHA had not notified the contractor to remove these patients from the contractor's invoices.

The requirements for invoicing were very different and attempted to put the responsibility of patient tracking on the contractor by requiring lists of new enrollees, disenrollees, and existing enrollees with the invoice. However, VHA was still ultimately responsible for the accuracy of these lists.

Standard provisions in primary care contracts would help eliminate conflicting language and clarify VHA responsibilities under the contract.

[12] The Prompt Payment Final Rule (formerly OMB Circular A-125, "Prompt Payment") requires Executive departments and agencies to pay commercial obligations within certain time periods and to pay interest penalties when payments are late.

D. No Standard VistA Report for Contracted Primary Care

The VHA has patient encounter data readily available in VistA. There were four (15 percent) medical centers in our review that used a VistA report that generated the list of all active patients enrolled at a contract CBOC. The report was provided to the contractor, who in turn would use this list to generate the invoice. This report was designed to ensure that the patient had a qualifying visit within the contract timeframe. The process was accurate and protected VHA from overpayments by identifying and removing large numbers of inactive patients on the contractor's invoice.

COTRs that had administrative support to help prepare or validate enrollees eligible for billing that used VHA data and reports had the least amount of discrepancies. COTRs who tried to manually validate invoices with potentially thousands of enrollees by sampling techniques or verifying only new enrollees had the most discrepancies and were the greatest source of VHA overpayments. Having a standard report would be made easier if VHA had a standard contract or standard provisions for enrollment, disenrollment, and a standard definition of a billable enrollee.

We found that without support, most COTRs were not able to perform the functions required to validate thousands of names on an invoice within the time required. Some of the processes that the COTRs used would never find the errors that resulted in overpayments. Generally, the COTRs did not have the administrative skills to perform what was required of them; and, subsequently, there were inadequate checks in place to discover these discrepancies. A standard report will help make invoice validation more efficient and help VHA ensure that primary care resources are spent effectively.

E. Estimated Financial Loss

A summary of findings by category for the 27 contract CBOCs reviewed is reported in Table 5.

Category	CBOCs with findings (reported in percentages)	Findings Dollar Amount
Overpayments due to inactive enrollees	44	**$517,200**
Invoice payments made in excess of contracted capitated rates	15	**$182,350**
Overpayments made on invoices with duplicate enrollees	22	**$85,880**
Performance measures not enforced in accordance with contract terms	30	**$16,980**
Overpayments for services included in the contract	11	**$50,750**
Total Identified 1st Qtr, FY 2009[13]		**$853,160**

Table 5. Summary of Findings by Category

Overpayments Due to Inactive Enrollees. We found that 12 (44 percent) of the 27 contracted CBOCs did not have processes in place to identify inactive patients on the contractor's invoice, which resulted in overpayments in excess of $517,000. An inactive patient is one that should have been disenrolled due to timeframe since last visit, a move to a new location, or death. Most contracts reviewed relied on VHA to notify the contractor of a disenrollment. The timeframe since the last patient visit requirement in the contract varied from 12 to 24 months. Contractors were to be paid only for patients seen within that timeframe. We found that overpayments for inactive patients represented on average 10−15 percent of the monthly capitated rate for the 12 CBOCs in our findings.

Invoice Payments in Excess of Contracted Rate. We found that 4 (15 percent) of the 27 contracted CBOCs were paying more than the contracted capitated rate for the services, which totaled $182,350. In three of the cases it appeared to be an oversight where the COTR did not verify the amount in the contract. In one case the program managers agreed to a higher rate, but did not document the agreement or inform the contracting officer. In this case, the higher rate was paid shortly after award of the contract and continued for several years.

[13] This amount does not include the extent of the overpayments that preceded the 1st Qtr, FY 2009, period of our review.

Overpayments Due to Duplicate Enrollees on Invoices. We found that 6 (22 percent) of the 27 contracted CBOCs paid a total of $85,880 due to patients listed more than once on the same invoice. In each case, the invoice was received in paper form or as an electronic image that could not be sorted to find duplicates. The COTRs generally had a time-consuming manual process to validate the invoice.

Performance Measures Not Enforced in Accordance with Contract Terms. We found that 8 (30 percent) of the 27 contracted CBOCs were not monitoring or enforcing the contract terms if the contractor was not meeting performance requirements. In most of these cases, the COTR was not aware that there were performance measure requirements in the contract. In general, if the contractor was not meeting a performance measure, the contracting officer would be informed, which could result in a reduction of 5−15 percent of the monthly invoice amount.

Overpayments for Services Included in the Contract. We found that 3 (11 percent) of the 27 CBOCs were paying for services, such as laboratory tests, pharmacy, or courier services that were already provided for in the contract. In these cases, VHA was not aware of these inclusive services in the contract. These overpayments totaled $50,750.

Conclusion

The VHA needs to implement more effective contract oversight to ensure that VA resources are expended for services provided in accordance with the terms and conditions of the contract. The availability of standard VA-generated reports to identify inactive enrollees could have reduced payments to contractors by $500,000 for services never rendered. Standardization of contracts with clear requirements for payment as well as proper training and support, applied consistently throughout the agency, is necessary to improve contract oversight and contribute to the VHA utilizing its financial resources more efficiently.

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

Recommendation 6: Reviews the oversight of the invoice approval process and implements steps to strengthen the oversight process and identify additional administrative support when needed.

Recommendation 7: Reviews the contract process for primary care to improve oversight, simplifies the invoice process to rely on VHA data, and standardizes essential provisions such as billable enrollee.

Comments

The Under Secretary for Health agreed with the findings and conclusions and provided acceptable improvement plans. See Appendix E for the complete text of the Under Secretary's comments. We will continue to follow up until all actions are complete.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

List of CBOCs Visited

402HB Bangor, ME
402HC Portland, ME
405HF Rutland, VT
405HA Colchester, VT
608GD Conway, NH
608HA Tilton, NH
515GC Benton Harbor, MI
515BY Grand Rapids, MI
553GA Yale, MI
553GB Pontiac, MI
583GA Terre Haute, IN
593GB Bloomington, IN
593GB Henderson, NV
593GC Pahrump, NV
605GC Palm Desert, CA
605GD Corona, CA
691GO Pasadena, CA
691GL Santa Maria, CA
528GK Lockport, NY
528GR Olean, NY
646GC Monaca, PA
646GD Washington, PA
693GF Berwick, PA
693GA Sayre, PA
596GA Somerset, KY
512GA Cambridge, MD
512GF Fort Howard, MD
688GA Alexandria, VA
688GC Greenbelt, MD
565GC Wilmington, NC
565GA Jacksonville, NC
557GA Macon, GA
557GB Albany, GA
607GE Beaver Dam, WI
607HA Rockford, IL
438GC Sioux City, IA
438GD Aberdeen, SD
636GH Waterloo, IA
636GI Galesburg, IL
586GA Kosciusko, MS
586GB Meridian, MS
623BY Tulsa, OK
635GD Konawa, OK
635GA Lawton, OK
667GA Texarkana, AR
667GC Longview, TX
546GG Coral Springs, FL
546GB Key West, FL
548GD Boca Raton, FL
548GE Vero Beach, FL
549GD Denton, TX
549BY Fort Worth, TX
644GD Payson, AZ
644GA Sun City, AZ
442GB Sidney, NE
442GC Fort Collins, CO
662GC Eureka, CA
662GD Ukiah, CA

Appendix B

Category/Indicator	Definition
Dyslipidemia Screening-Group 1 Patients being treated for or had a new diagnosis of one of the following: Coronary artery disease Stable angina Lower extremity/peripheral artery disease Ischemia Stroke Atheroembolism Abdominal aortic aneurysm Renal artery atherosclerosis	The proportion of patients who are not terminally ill; cases that do not have DM or a past Acute Myocardial Infarction[14] (AMI), who have documentation that within the past 2 years they had a total cholesterol and either an high density lipoprotein (HDL) or low density lipoprotein (LDL).
Dyslipidemia Screening-Group 2 Patient is a male age < 35 OR Patient is a female age < 45 Patient has no ischemic vascular disease diagnosis Patient has a family history of coronary events occurring prior to age 45.	The proportion of patients who are not terminally ill; cases that do not have DM or a past AMI, who have documentation that within the past 5 years they had a total cholesterol and either an HDL or LDL.
Dyslipidemia Screening-Group 3 One of the following: Patient has diagnosis of DM Patient has diagnosis of a past AMI Patient. had a Percutaneous coronary intervention[15] (PCI) in the past 2 years Patient had a Coronary artery bypass graft[16] (CABG) in the past 2 years	Those with a complete lipid profile performed in the past 2 years, a complete lipid profile was or was not performed.

Figure 7. PI II Indicators in the Analysis

[14] Heart attack
[15] PCI is a therapeutic procedure to treat the narrowed coronary arteries of the heart found in coronary heart disease.
[16] Surgery to re-route blood flow through a new artery or vein that is grafted around diseased section of the coronary arteries.

Appendix C

***Category*/Indicator**	**Definition**
DM	
Foot inspection	The proportion of diabetics, excluding bilateral amputees, with chart documentation of visual inspection of feet in the past year.
Foot pulse checked	The proportion of diabetics, other than bilateral amputees, with chart documentation of examination of pedal pulses in the past year.
Foot Sensation	The proportion of diabetics, other than bilateral amputees, with documentation of foot sensory with monofilament in the past year.
Retinal eye exam	The proportion of diabetics with chart documentation of a retinal examination by an eye specialist in the past year.
LDL-C measured	The proportion of diabetics with chart documentation of a full lipid panel in the past year.
Nephropathy screening	The proportion of diabetic patients having a nephropathy screening test during the past year or documented evidence of nephropathy.
PTSD	
Screened for PTSD at required intervals with Primary Care-PTSD (PC-PTSD)	The proportion of patients not moderately or severely cognitively impaired and did not have a clinical encounter within the past year with PTSD identified as a reason for the visit whose screening was done using the PC-PTSD screen.
Positive PC-PTSD screen with timely suicide ideation/ behavior evaluation	The proportion of patients not moderately or severely cognitively impaired and did not have a clinical encounter within the past year with PTSD identified as a reason for the visit whose screening using the PC-PTSD screen was positive and had a suicide ideation/behavior evaluation by a provider within one day of the positive PTSD screen.

Figure 8. CDCI II Indicators in the Analysis

Appendix D

Statistical Methodology

Population and Sample Design

The study design was described in detail in the CBOC information report.[17] Briefly, the population comprised all patients who were enrolled in VHA CBOCs for their healthcare. A three-stage complex probability sample design was used to select patients for chart review.

CBOCs within a same parent facility share the same administrative leadership. In the first stage of sampling, we statistically randomly selected 30 VHA parent facilities from the universe of 135 parent facilities, stratified by staffing types. We categorized each of the 135 parent facilities into one of the following three strata of staffing type:

- The "Contract" stratum of parent facilities with all its CBOC facilities operated by contracted staff.
- The "VA" stratum of parent facilities with all its CBOC facilities operated by VA staff, regardless of leased or VA owned building.
- The "Both" stratum of parent facilities with some of its CBOC facilities operated by contracted staff and some by VA staff.

In the second stage, two CBOCs were randomly sampled from CBOCs within each of the 30 parent facilities. For the facilities that operated CBOCs both by contracted staff and by VA staff, one CBOC was randomly sampled from the CBOCs staffed under contract and one from the CBOCs staffed by VA. A total of 59 CBOCs were sampled from the 30 facilities as one of the selected facilities operated just one CBOC. One of the sampled CBOCs was found inactive after it was sampled and thus excluded. Therefore, 58 CBOCs were included in our onsite inspection.

The third stage sampling was used for selecting patients from the 58 CBOCs for the patient medical chart review. From each CBOC, we randomly selected 50 patients diagnosed with diabetes, 50 patients diagnosed with ischemic vascular disease, and 30 patients who were not diagnosed with post-traumatic stress disorder, independently.

Statistical Data Analysis

We estimated the compliant percentages for each of performance measures. Four patients who refused foot sensation testing and eight who refused the lipid test were counted compliant for the corresponding performance measures. If a particular performance measure did not apply to a patient, the patient was excluded from analyses for that measure. For example, foot sensation testing would not apply to a patient whose legs were amputated.

[17] VA Office of Inspector General Report No. 08-00623-169 issued on July 16, 2009.

Horvitz-Thompson sampling weights, which are the reciprocal of sampling probabilities, were used to account for our unequal probability sampling. To take into account the complexity of our multistage sample design, the jackknife replicate-based method was employed to obtain the sampling errors for the estimates.

We also presented a 95% CI for the true performance value (parameter) 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 take only non-negative values from zero to 100, but their logits can have unrestricted range; hence, the normal approximation can be used to estimate the parameters. 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 zero to 100 percent.

Similarly, the estimated percent of CBOCs with each characteristic and 95% CI were computed. Rao-Scott Chi-Square tests of association between VA-staffed/contract and the various characteristics of CBOCs were performed.

All data analyses were performed using SAS statistical software (SAS Institute, Inc., Cary, NC), version 9.2 (TS1M0). Maps were produced using ArcGIS software (Environmental Systems Research Institute, Redlands, CA), version 9.2.

Appendix E

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: October 4, 2010

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, Healthcare Inspection – Evaluation of Community Based Outpatient Clinics Fiscal Year 2009 (WebCIMS 422813)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and am including an action plan to address the report's recommendations.

2. I concur with the report's recommendations that the Veterans Health Administration's (VHA) senior managers will:

- **Grant privileges that are consistent with providers' practices at the community-based outpatient clinics (CBOC).**
  The Principal Deputy Under Secretary for Health made an announcement during the Chief of Staff conference call on appropriate privileges. A plan to monitor privileging at CBOCs will be developed.

- **Collect and appropriately use Prevention Index data in the medical staff reprivileging process.**
  The Chief Quality and Performance Office (OQP) will publish service specific competencies for VHA facilities to use in their evaluation processes.

Page 2.

OIG Draft Report, Healthcare Inspection—Evaluation of Community Based Outpatient Clinics Fiscal Year 2009 (WebCIMS 422813)

- **Ensure that all CBOCs are handicap accessible.**
  VHA's Capital Asset Management and Planning Service (CAMPS) will work with the Department of Veterans Affairs (VA) Office of Construction and Facilities Management (CFM) and local Contracting Officers to bring any non-compliant CBOCs into compliance.

- **Ensure that a vulnerability assessment is conducted at all CBOCs to determine if a panic alarm system is required, and ensure a system is implemented if one is deemed necessary.**
  The Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will work with VA's Office of Operations, Security and Preparedness (OSP) to determine if a panic alarm system is required. If systems are necessary, VHA will take necessary actions to install and implement the use of panic alarms.

- **Ensure that all CBOCs maintain auditory privacy during the check-in process.**
  The DUSHOM will work in conjunction with VHA's Chief Health Information Officer to issue a memorandum to facilities emphasizing compliance with VHA auditory privacy policies.

- **Review the oversight of the invoice approval process, implement steps to strengthen the oversight process, and identify additional administrative support when needed.**
  VHA's Procurement and Logistics Office (P&LO) will initiate a workgroup of subject matter experts in both the procurement, and patient care disciplines to develop new processes. The DUSHOM will work with P&LO to implement and monitor the workgroup's recommendations.

Page 3.

OIG Draft Report, Healthcare Inspection—Evaluation of Community Based Outpatient Clinics Fiscal Year 2009 (WebCIMS 422813)

- **Review the contract process for primary care to improve oversight, simplify the invoice process to rely on VHA data, and standardize essential provisions such as billable enrollee.**
  VHA P&LO will initiate a workgroup of subject matter experts in both the procurement and patient care disciplines to develop new processes. The DUSHOM will work with P&LO to implement and monitor the workgroup's recommendations.

3. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

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

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Healthcare Inspection—Evaluation of Community Based Outpatient Clinics Fiscal Year 2009 (WebCIMS 422813)

Date of Draft Report: August 23, 2010

Recommendations/ Actions	Status	Completion Date

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network (VISN) and facility senior managers, grants privileges that are consistent with providers' practices at the Community Based Outpatient Community (CBOCs).

VHA Comments

Concur

The Principal Deputy Under Secretary for Health (PDUSH) made an announcement during the Chief of Staff conference call on September 9, 2010, regarding appropriate privileging requirements. A plan to monitor privileging requirements will be developed.

In Process October 31, 2010

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, collects and appropriately uses PI data in the medical staff reprivileging process.

VHA Comments

Concur

The Chief Quality and Performance Office (OQP) will publish service specific competencies that VHA facilities can use in their professional practice evaluation processes. A plan to ensure that Performance Improvement (PI) information is properly collected and used will be developed.

In process October 31, 2010

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that all CBOCs are handicap accessible.

VHA Comments

Concur

VHA's Capital Asset Management and Planning Service (CAMPS) will work with the Department of Veterans Affairs (VA) Office of Construction and Facilities Management (CFM) and local Contracting Officers to bring any non-compliant CBOC into compliance.

In Process September 1, 2011

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that a vulnerability assessment is conducted at all CBOCs to determine if a panic alarm system is required and ensures a system is implemented if one is deemed necessary.

VHA Comments

Concur

The Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will work with VA's Office of Operations, Security and Preparedness (OSP) in identifying recommendations and if there are any survey risk gaps, VHA will request facilities to do on-site reviews to assess panic alarm needs. If a system is deemed necessary, VHA will take necessary actions to install and implement the use of panic alarms.

In process December 31, 2010

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that all CBOCs maintain auditory privacy during the check-in process.

VHA Comments

Concur

The DUSHOM will work in conjunction with VHA's Chief Health Information Officer (OHI) to issue a memorandum to facilities emphasizing compliance with VHA Handbook 1605.1, Privacy and Release of Information, section 3(d)(1), which states that facilities must ensure that there are appropriate safeguards to ensure that security and confidentiality of individually-identifiable information and records.

The memorandum will also provide examples of how to maintain auditory privacy. A plan to monitor facilities compliance with VHA Handbook 1605.1 will be developed.

In process October 31, 2010

Recommendation 6. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers review the oversight of the invoice approval process and implements steps to strengthen the oversight process and identify additional administrative support when needed.

VHA Comments

Concur

VHA's Procurement and Logistics Office (P&LO) will initiate a workgroup of subject matter experts in both the procurement and patient care disciplines. This workgroup will review a sampling of VHA's current contractor staffed, capitated rate CBOC contracts to seek out best practices, and develop a template that utilizes those best practices in combination with new process improvements. The workgroup will share their findings with VISN and facility managers and provide guidance on how the oversight of the invoice approval process needs to be enacted, and how to identify when additional administrative support is needed.

The DUSHOM will work in conjunction with P&LO to develop, implement, and monitor the above actions.

In process March 31, 2011

Recommendation 7. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, reviews the contract process for primary care to improve oversight, simplifies the invoice process to rely on VHA data, and standardizes essential provisions such as billable enrollee.

VHA Comments

Concur

VHA's P&LO will initiate a workgroup of subject matter experts in both the procurement and patient care disciplines. This workgroup will review a sampling of VHA's current contractor staffed, capitated rate CBOC contracts to seek out best practices, and develop a template that utilizes those best practices in combination with new process improvements. The workgroup will ensure that they offer process improvements to simplify the invoice process to rely on VHA data and standardize essential provisions such as billable enrollees.

Once the workgroup has completed this initial task, they will provide training sessions to all VHA contracting officers and contracting officer technical representatives who award and administer CBOC contracts to share the findings and educate the staff on these practices. The DUSHOM will work in conjunction with P&LO to develop a plan to implement and monitor the above actions.

In process March 31, 2011

Veterans Health Administration
September 2010

Appendix F

OIG Contact and Staff Acknowledgments

OIG Contact	Marisa Casado, Director CBOC Program Review (727) 395-2416
Acknowledgments	Wachita Haywood, Associate Director Annette Acosta, MN, RN Nancy Albaladejo, RN, MSA Shirley Carlile, BA Lin Clegg, Ph.D. Jennifer Christensen, DPM Marnette Dhooghe, MS Kathy Gudgell, RN, JD Stephanie Hensel, RN, JD Zhana Johnson, CPA Cathleen King, BS, MHA, RN BC, CRRN Jennifer Kubiak, RN, BSN, MPH, CPHQ Anthony M. Leigh, CPA, CFE Jennifer Reed, RN Annette Robinson, MSN, MBA, HCM Tom Seluzicki, CPA, CFE Patrick Smith, MSA, Mathematical Statistician Marilyn Stones, BS, Lead Program Specialist Roberta J. Thompson, MSW Ann R. Ver Linden, RN, BSN Marilyn Walls, RN, MS, CPHQ

Appendix G

Report Distribution

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