Department of Veterans Affairs

Office of Inspector General

Healthcare Inspection

Community Based Outpatient Clinic Reviews Farmington and Espanola, NM Show Low and Buckeye, AZ Maui and Kona, HI Sonora and Modesto, CA

Report No. 10-00627-17 **November 2, 2010**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

Introduction

The VA OIG, Office of Healthcare Inspections conducted a review of eight community-based outpatient clinics (CBOCs) during the week of August 23−27, 2010. The CBOCs reviewed in Veterans Integrated Service Network (VISN) 18 were Farmington and Espanola, NM; and Show Low and Buckeye, AZ; and, in VISN 21, Maui and Kona, HI; and Sonora and Modesto, CA. The parent facilities of these CBOCs are New Mexico VA Health Care System (HCS), Phoenix VA HCS, VA Pacific Islands HCS, and VA Palo Alto HCS. The purpose of the review was to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care.

Results and Recommendations

We would like to acknowledge the following areas of accomplishments:

New Mexico VA HCS

- We acknowledge there have been substantive improvements in the invoice validation process used to identify enrollees ineligible for billing since June 2009. The HCS discovered there were billing discrepancies in prior years and instituted a process to identify and remove enrollees ineligible for billing. As a result of this new process, 172 enrollees were removed from the July 2009 invoice.

Phoenix VA HCS

- We commend the Phoenix VA HCS for a contract that clearly defined the responsibilities and requirements for payment and disenrollment of patients, particularly the provision that required an annual Level 3[1] office visit for payment.

We also noted several opportunities for improvement and made recommendations to address all of these issues. The Directors, VISN 18 and 21, in conjunction with the respective facility managers, should take appropriate actions on the following recommendations:

New Mexico VA HCS

- Ensure all designated CBOC staff at the Farmington and the Espanola CBOCs maintain current basic life support certification.

[1] Level 3 office visits require patient history, examination, and medical consultation for new patients (30 minutes) and two out of three aforementioned criteria for established patients (15 minutes).

- Locate all Espanola CBOC printers in secure areas to ensure personally identifiable information (PII) is protected.
- Require the Espanola CBOC to collect, analyze, and report hand hygiene data as required by the Center for Disease Control and Prevention.
- Develop safety plans at the Farmington CBOC for all patients identified as high risk for suicide.
- Provide contract oversight in accordance with terms and conditions in the Espanola CBOC contract, to include enforcing penalties as necessary and requiring the contractor to reformat the invoice to comply with contract requirements.
- Review the invoice validation process for all contract CBOCs to ensure there are adequate controls and proper validation before payment.
- Have a process to provide improved oversight and coordination of contracted primary care.

Phoenix VA HCS

- Implement the recommendation to upgrade the panic alarm system at the Show Low CBOC.
- Require that modifications to the entrance doors be made to improve access for disabled veterans at the Buckeye CBOC.
- Conduct a review of the invoice validation process to improve efficiency and accuracy. Specifically, provide the list of billable patients to the contractor to eliminate the need to manually verify each patient.
- Conduct a review of the procedures for identifying and invoicing traveling veterans.
- Ensure the Primary Care Management Module Coordinator performs in accordance with Veterans Health Administration (VHA) Handbook 1101.02 to reduce the number of veterans assigned to more than one primary care provider.

VA Pacific Islands HCS

- Require that service chiefs comply with VHA Handbook 1100.19 and establish threshold/criteria for Ongoing Professional Practice Evaluations at both CBOCs.
- Require that supplies and equipment are stored in the appropriate areas at the Kona CBOC.
- Ensure all PII is secured and protected at the Maui CBOC.
- Improve access for disabled veterans at the Kona CBOC.
- Develop safety plans for patients at high risk for suicide at the Kona CBOC.

VA Palo Alto HCS

- Require that the Professional Standard Board grant privileges appropriate for the services provided at the Sonora and Modesto CBOCs.
- Ensure all designated staff at the Sonora and Modesto CBOCs maintain current cardiopulmonary resuscitation training as required by VHA policy.
- Conduct fire drills at the Modesto CBOC as required by National Fire Protection Association policy.
- Conduct an environmental safety risk analysis to determine if there are safety hazards at the Modesto CBOC.
- Monitor staff compliance to local policy and VHA suicide safety plan requirements at the Sonora and Modesto CBOCs.

Comments

The VISN and VAMC Directors agreed with the CBOC review findings and recommendations and provided acceptable improvement plans. (See Appendixes A–F, pages 25–42 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Part I. Introduction

Purpose

The VA Office of Inspector General (OIG) is undertaking 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.

Veterans are required to receive one standard of care at all VHA health care facilities. Care at CBOCs needs to be consistent, safe, and of high quality, regardless of model (VA-staffed or contract). CBOCs are expected to comply with all relevant VA policies and procedures, including those related to quality, patient safety, and performance. For additional background information, see the *Informational Report for the Community Based Outpatient Clinic Cyclical Reports*, 10−00627−124, issued April 6, 2010.

Scope and Methodology

Objectives. The purpose of this review is to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. The objectives of the review are to:

- Determine whether CBOC performance measure scores are comparable to the parent VA medical center (VAMC) outpatient clinics.
- Determine whether CBOC providers are appropriately credentialed and privileged in accordance to VHA Handbook 1100.19.[2]
- Determine whether CBOCs maintain the same standard of care as their parent facility to address the Mental Health (MH) needs of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) era veterans.
- Determine whether patients who are assessed to be high risk for suicide have safety plans that provide strategies that help mitigate or avert suicidal crises.

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

- Determine whether CBOCs are in compliance with VHA Handbook 1006.1[3] in the areas of environmental safety and emergency planning.
- Determine whether the CBOC primary care and MH contracts were administered in accordance with contract terms and conditions.
- Determine whether primary care active panel management and reporting are in compliance with VHA Handbook 1101.02.[4]

Scope. We reviewed CBOC policies, performance documents, provider credentialing and privileging (C&P) files, and nurses' personnel records. For each CBOC, random samples of 50 patients with a diagnosis of diabetes mellitus (DM); 75 patients who were 50 years of age or older; and 30 patients with a service separation date after September 11, 2001, without a diagnosis of post-traumatic stress disorder (PTSD); were selected, unless fewer patients were available. We reviewed the medical records of these selected patients to determine compliance with VHA performance measures.

We conducted environment of care (EOC) inspections to determine the CBOCs' cleanliness and condition of the patient care areas, condition of equipment, adherence to clinical standards for infection control (IC) and patient safety, and compliance with patient data security requirements.

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

In this report, we make recommendations for improvement.

[3] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics,* May 19, 2004.
[4] VHA Handbook 1101.02, *Primary Care Management Module (PCMM),* April 21, 2009.

Part II. CBOC Characteristics

Veterans Integrated Service Network (VISN) 18 has 6 VHA hospitals and 54 CBOCs, and VISN 21 has 7 VHA hospitals and 32 CBOCs. As part of our review, we inspected 8 CBOCs. The CBOCs reviewed in VISN 18 were Farmington and Espanola, NM; and Show Low and Buckeye, AZ; and, in VISN 21, Maui and Kona, HI; and Sonora and Modesto, CA. The parent facilities of these CBOCs are New Mexico VA Health Care System (HCS), Phoenix VA HCS, VA Pacific Islands HCS, and VA Palo Alto HCS.

We formulated a list of CBOC characteristics and developed an information request for data collection. The characteristics included identifiers and descriptive information for the CBOC evaluation.

In FY 2009, the average number of unique patients seen at the 6 VA-staffed CBOCs was 2,668 (range 1,091 to 6,415) and at the 2 contract CBOCs was 944 (range 611 to 1,277). Table 1 shows characteristics of the 8 CBOCs we reviewed to include size[5] and type of CBOC, rurality, number of full-time equivalent employees (FTEs), primary care providers (PCPs), number of unique veterans enrolled at the CBOC, and number of veteran visits.

VISN Number	CBOC Name	Size of CBOC	CBOC Type	Urban/ Rural	Number of Clinical Providers (FTE)	Uniques	Visits
18	Farmington, NM	Mid-size	VA-staffed	Urban	2.0	1,831	13,094
18	Espanola, NM	Small	Contract	Rural	1.0	1,277	7,241
18	Show Low, AZ	Mid-size	VA-staffed	Rural	1.9	2,107	9,834
18	Buckeye, AZ	Small	Contract	Rural	1.0	611	1,204
21	Maui, HI	Mid-size	VA-staffed	Rural	3.3	1,749	9,976
21	Kona, HI	Small	VA-staffed	Rural	1.4	1,091	6,769
21	Sonora, CA	Mid-size	VA-staffed	Rural	3.5	2,815	10,004
21	Modesto, CA	Large	VA-staffed	Urban	6.5	6,415	25,045

Table 1 - CBOC Characteristics, FY 2009

Five of the eight CBOCs (Farmington, Espanola, Show Low, Maui, and Kona) provide specialty care services, while the other three CBOCs refer patients to another geographically accessible VA facility. Show Low provides podiatry services; and Farmington, Espanola, Maui, and Kona offer women's health services. Maui and Kona provide services for cardiology, gastrointestinal, optometry, orthopedics, and rheumatology; and Kona also offers dermatology services. Veterans have access to tele-retinal services at Farmington, Maui, and Sonora CBOCs. Tele-medicine is available at Maui and Kona CBOCs.

[5] Based on the number of unique patients seen as defined by the VHA Handbook 1160.01, 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).

Seven CBOCs provide MH services onsite (see Table 2).

CBOC Station Number	CBOC Name	CBOC Type	Substance Use Disorder	PTSD	MST	Homelessness	Psychosocial rehab
501GB	Farmington, NM	VA-staffed	Yes	Yes	Yes	Yes	No
501GE	Espanola, NM	Contract	Yes	Yes	Yes	Yes	No
644GB	Show Low, AZ	VA-staffed	No	No	No	No	No
644GC	Buckeye, AZ	Contract	No	No	No	No	No
459GA	Maui, HI	VA-staffed	Yes	Yes	Yes	Yes	Yes
459GC	Kona, HI	VA-staffed	Yes	Yes	Yes	Yes	Yes
640GB	Sonora, CA	VA-staffed	Yes	Yes	Yes	Yes	Yes
640HB	Modesto, CA	VA-staffed	Yes	Yes	Yes	Yes	Yes

Table 2. Mental Health Services

The Buckeye CBOC refers patients to another geographically accessible VA facility for MH services, and the Show Low CBOC offers general MH services.

The type of clinicians that provide MH services varied among the CBOCs to include PCPs, psychologists, psychiatrists, nurse practitioners (NPs), licensed clinical social workers (LCSWs), and addiction counselors.

The Maui CBOC provides MH services during evening hours (after normal business hours) at least one day per week, and weekend MH services are available at the Sonora CBOC. Three CBOCs (Maui, Sonora, and Modesto) have plans for responding to MH emergencies outside hours of operation. The plans identify at least one accessible VA or community-based emergency department where veterans are directed to seek emergent care.

Tele-mental health is available at five CBOCs (Farmington, Show Low, Maui, Kona, and Sonora). Tele-mental health is utilized for medication management at Farmington, Show Low, and Sonora CBOCs. Farmington, Maui, and Kona CBOCs use tele-mental health for individual therapy; and Kona also provides group therapy through the use of tele-mental health. In addition, the Show Low CBOC uses tele-mental health to provide consultations.

Part III. Overview of Review Topics

The review topics discussed in this report include:

- Quality of Care Measures.
- C&P.
- EOC and Emergency Management.
- Suicide Safety Plans.
- CBOC Contracts.

We reviewed the medical records of selected patients to determine compliance with first (1st) quarter (Qtr), FY 2010 VHA performance measures.

We conducted an overall review to assess whether the medical center's C&P process complied with VHA Handbook 1100.19. We reviewed CBOC providers' C&P files and nursing staff personnel folders. We conducted EOC inspections at each CBOC, evaluating cleanliness, adherence to clinical standards for IC and patient safety, and compliance with patient data security requirements. We evaluated whether the CBOCs had a local policy/guideline defining how health emergencies, including MH emergencies, are handled.

A previous OIG review of suicide prevention programs in VHA facilities[6] found a 74 percent compliance rate with safety plan development. The safety plan issues identified in the review were that plans were not comprehensive, not developed timely, or not developed at all. At the request of VHA, the OIG agreed to follow up on the prior findings. Therefore, we reviewed the records of 10 patients (unless fewer are available) assessed to be at high risk for suicide to determine if clinicians developed safety plans that included all required elements.

We evaluated whether the two CBOC contracts (Espanola and Buckeye) had quality of care matrices. We also verified that the number of enrollees or visits reported was supported by collaborating documentation.

[6] *Healthcare Inspection – Evaluation of Suicide Prevention Program Implementation in Veterans Health Administration Facilities January–June, 2009,* Report No. 09-00326-223, September 22, 2009.

Part IV. Results and Recommendations

A. VISN 18, New Mexico VA HCS – Farmington and Espanola

Quality of Care Measures

The Farmington and Espanola CBOCs equaled or exceeded their parent facility's quality measure scores with the following exceptions. The Farmington CBOC scored lower in the influenza vaccination, ages 65 or older. Espanola CBOC scores were lower than the parent facility for the influenza vaccination, for ages 65 or older, and the DM foot inspection, foot pedal pulses, foot sensory with monofilament, and renal testing. (See Appendix H.)

Credentialing and Privileging

We reviewed the C&P files of four providers and the personnel folders of four nurses at the Farmington CBOC and six providers and two nurses at the Espanola CBOC. We reviewed eight providers and three nurses from five satellite clinics affiliated with the Espanola CBOC. All providers possess a full, active, current, and unrestricted license; and privileges were appropriate for services rendered. All nurses' licenses and education requirements were verified and documented.

We also reviewed the providers and nurses' basic life support (BLS) certifications and found that two providers from the Farmington CBOC and one provider from an Espanola satellite had expired BLS certifications. The facility did not have a process in place to ensure timely renewal of BLS certification as required by VHA policy.[7]

Recommendation 1. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director requires that all designated CBOC staff at the Farmington and the Espanola CBOCs maintain current BLS certification.

The VISN and VAMC Directors concurred with our finding and recommendation. The New Mexico VA HCS is in the process of implementing a process to achieve 100 percent BLS compliance for all designated CBOC staff. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment and Emergency Management

Environment of Care

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, IC, and general maintenance. Both CBOCs met most standards, and the environments were

[7] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

generally clean and safe. We also reviewed EOC General Safety Requirement Checklists and Life Safety Inspection Reports for the current and past year of the five Espanola satellite clinics. We found evidence that the deficiencies were corrected or an appropriate corrective action plan was developed. However, we identified the following areas that needed improvement at the Espanola CBOC.

Personally Identifiable Information

We found at the Espanola CBOC that personally identifiable information (PII) was compromised on two unsecured printers. One printer was located in a hallway and the other in a room without a door. Staff were not in the immediate area to ensure PII was secure from unauthorized access. We found PII documents on one of the printers. According to the Health Insurance Portability and Accountability Act (HIPAA) regulations,[8] control of the environment includes control of confidential patient information.

Infection Control

We found that hand hygiene data for the Espanola CBOC was not collected; therefore, the facility could not identify any trends or conduct the appropriate data analysis. The Center for Disease Control and Prevention (CDC)[9] recommends that healthcare facilities develop a comprehensive IC program with a hand hygiene component, which includes monitors, data analysis, and provider feedback. The intent is to foster a culture of hand hygiene compliance that ensures the control of infectious diseases.

Recommendation 2. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director requires all printers at the Espanola CBOC be located in secure areas to ensure PII is protected.

The VISN and VAMC Directors concurred with our finding and recommendation. The Information Security Officers will incorporate this issue into their review and audit process for all CBOCs. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 3. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director requires that the Espanola CBOC collect, analyze, and report hand hygiene data as required by the CDC.

The VISN and VAMC Directors concurred with our finding and recommendation. Beginning FY 2011, the Espanola CBOC will collect hand hygiene data, and Infection

[8] The Health Insurance Portability and Accountability Act of 1996 (HIPAA), privacy rule's protection of the privacy of individually identifiable health information.

[9] CDC is one of the components of the Department of Health and Human Services that is responsible for health promotion; prevention of disease, injury and disability; and preparedness for new health threats.

Control will analyze and report the data. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical and MH emergencies are handled. Both CBOCs had a policy for emergency management that detailed the handling of medical and MH emergencies. Our interviews revealed staff at each facility articulated responses that accurately reflected the local emergency response guidelines.

Suicide Safety Plans

Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. Safety plans should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Additionally, safety plans must include information about how patients can access professional help 24 hours a day, 7 days a week.

We reviewed the medical records of two Farmington CBOC patients assessed to be at high risk for suicide and found in both cases that clinicians did not develop safety plans. We found evidence that one patient made telephone contact with the National Suicide Hotline. The parent facility was aware of this call, the patient was placed on the high-risk list, and medical record was flagged. Following the telephone call to the National Suicide Hotline, the patient had two documented visits and two telephone calls with a MH provider but did not have a safety plan developed. The patient was then arrested and incarcerated, and the Suicide Prevention Coordinator notified the prison staff of the patient's suicide attempt history.

The second patient was admitted after an apparent suicide attempt. The veteran later denied being suicidal and did not wish to complete a safety plan. A sole act of providing a safety plan does not guarantee that the patient will not engage in self-injurious acts; however, a safety plan provides a pre-determined list of potential coping strategies to help a patient lower his imminent risk of suicidal behavior.

Recommendation 4. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director requires safety plans are developed at the Farmington CBOC for all patients identified as high risk for suicide.

The VISN and VAMC Directors concurred with our finding and recommendation. Education will be provided to the Farmington CBOC Behavioral Health staff concerning the timely completion of the suicide prevention plan. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

CBOC Contract

Espanola CBOC

The contract for the Espanola CBOC is administered through the New Mexico VA HCS for delivery and management of primary and preventative medical care for all eligible veterans in VISN 18. This contract includes the Las Vegas CBOC, also located in New Mexico. Services were also provided at 11 satellite clinics located around, but not in, Las Vegas and Espanola, NM. The Espanola CBOC included six[10] of these satellite clinics. Contracted services with El Centro Family Health (ECFH) began on January 1, 2005, with a base year and four option years extending the contract through December 31, 2009. A 6-month extension was issued for the period January 1, 2010, through June 30, 2010. They are currently operating under a 6-month sole source contract until December 2010. The contract terms state that PCPs are to be licensed in the state of New Mexico and Board Certified/Board Eligible in their subspecialty. The Espanola CBOC also serves private practice patients. The VA patients cared for at the clinic make up approximately 18 percent of the patient workload. There was 1.0 FTE PCP composed of six physicians, two NPs, and one physician assistant for the 1st Qtr, FY 2010. The contractor was compensated by the number of enrollees at a monthly capitated rate per enrollee. The Espanola CBOC had 1,277 unique primary medical care enrollees with 7,241 visits as reported on the FY 2009 CBOC Characteristics report (see Table 1).

MH services were included in the primary care contract and provided by the LCSW. VA MH practitioners provided support with prescriptions, consults, total assessments, and therapy. There were 237 MH encounters at the CBOC during the 1st Qtr, FY 2010.

We reviewed the contract to determine the contract type, the services provided, the invoices submitted, and supporting information. We also performed inquiries of key personnel at New Mexico VA HCS and ECFH. Our review focused on documents and records for the 1st Qtr, FY 2010. We reviewed the methodology for tracking and reporting the number of enrollees in compliance with the terms of the contract. We reviewed paid capitation rates for compliance with the contract; form and substance of the contract invoices for ease of data analysis by the Contracting Officer's Technical Representative (COTR); and duplicate, missing, or incomplete social security numbers (SSNs) on the invoices.

The Primary Care Management Module (PCMM) Coordinator is responsible for maintaining currency of information in the PCMM database. As of August 2010, the New Mexico VA HCS has approximately 39,000 active patients with approximately 1,200 assigned to the Espanola CBOC. We reviewed PCMM data reported by VHA Services Support Center (VSSC) and the New Mexico VA HCS for compliance with

[10] One satellite was in a suspended status at the time of our review.

VHA policies. We made inquiries about the number of patients who were unassigned, assigned to more than one PCP, or potentially deceased.

We acknowledge there have been substantive improvements in the invoice validation process used to identify enrollees ineligible for billing since June 2009. The HCS discovered there were billing discrepancies in prior years and instituted a process to identify and remove enrollees ineligible for billing. As a result of this new process, 172 enrollees were removed from the July 2009 invoice.

We noted the following regarding contract administration and oversight:

1. The New Mexico VA HCS did not apply contractual penalty provisions against ECFH for failure to meet their External Peer Review Program (EPRP) performance measure requirements in the 1st Qtr, FY 2010 for the Espanola CBOC. Espanola CBOC's performance measures averaged 69 percent during the 1st Qtr, FY 2010 compared to a minimum contractual benchmark of 80 percent. If this provision had been enforced, approximately $24,000 in penalties would have been assessed. The contract states, "Ten percent (10 percent) of capitation rate shall be deducted if EPRP guidelines are not met 80 percent of the time." We noted that the Espanola CBOC failed to meet their performance benchmarks from January through March 2010, which would have resulted in additional penalties of approximately $26,000.

2. The contractor provided services to VA patients at 11 satellite clinics. Contract requirements limited services to those provided at facilities located in Espanola and Las Vegas. The services provided at the 11 satellite clinics were outside the scope of the contract. VA personnel were aware that the services were being provided at the 11 satellite clinics and even inspected the clinics. Since a new contract will be awarded in November 2010 and the parent facility is rectifying this issue in the new contract, we made no recommendation.

3. The ECFH invoice did not meet the required format described in the contract. The contract specifies that the invoice format includes: (1) patient's name and SSN, (2) date of the service, (3) applicable Current Procedural Terminology (CPT)[11] or Disease Related Group (DRG)[12] code, and (4) medical documentation that services were performed. The invoices submitted did not include the dates of service, the applicable CPT or DRG code, or medical documentation that services were performed.

[11] Current Procedural Terminology (CPT) – unique five-digit number created by American Medical Association for medical billing purposes.
[12] Disease Related Group (DRG) – diagnosis code set.

4. The New Mexico VA HCS manually validated only 10 percent of Espanola's approximately 1,100 invoiced enrollees on a monthly basis. A verification of only 10 percent of all invoiced enrollees does not ensure that overpayment will be detected.

5. The COTR does not receive information from the PCMM Coordinator about deaths or transfers of enrolled veterans that would allow timely removal of invoiced enrollees.

Recommendation 5. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director provides contract oversight in accordance with terms and conditions in the Espanola CBOC contract, to include enforcing penalties as necessary and requiring the contractor to reformat the invoice to comply with contract requirements.

The VISN and VAMC Directors concurred with our finding and recommendation. The Rural Health COTR and Business Manager are implementing a process to provide contract oversight, the Business Manager is determining performance and penalty calculations, and the COTR met with the Espanola Contract staff to provide education on the correct invoice format. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 6. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director reviews the invoice validation process for all contract CBOCs to ensure there are adequate controls and proper validation before payment.

The VISN and VAMC Directors concurred with our finding and recommendation. To enhance the current validation process, the sample size will be expanded to satisfy the accuracy of the invoice. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 7. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director has a process to provide improved oversight and coordination of contracted primary care.

The VISN and VAMC Directors concurred with our finding and recommendation. The New Mexico VA HCS Leadership and Contracting implemented a Contracting Council in July 2010 to improve oversight and coordination of all contracting activities, including contracted primary care. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

B. VISN 18, Phoenix VA HCS – Show Low and Buckeye

Quality of Care Measures

Both CBOCs equaled or exceeded their parent facility's quality measure scores with the following exceptions. Show Low CBOC scored lower in the influenza vaccination, ages 65 and older; and the Buckeye CBOC scored lower in both age groups for influenza. (See Appendix I.)

Credentialing and Privileging

We reviewed the C&P files of three providers at the Show Low CBOC and one provider at the Buckeye. We reviewed six nursing personnel folders at the Show Low CBOC (Buckeye CBOC was staffed with medical technicians). All providers possess a full, active, current, and unrestricted license; and privileges were appropriate for services rendered. All nurses' license and education requirements were verified and documented. Facility managers implemented Focused Professional Practice Evaluations (FPPE) for new providers and developed service-specific criteria for Ongoing Professional Practice Evaluations (OPPEs).

Environment and Emergency Management

Environment of Care

We inspected patient care areas for cleanliness, safety, infection control, and general maintenance. The clinics met standards for cleanliness and infection control. However, we identified the following areas that needed improvement.

Panic Alarms

The Show Low CBOC did not have panic alarms for either the administrative or the clinical staff in the MH section of the clinic. The staff indicated that if they felt threatened and needed assistance, they would call out for help and try to leave the room. The parent facility conducted a vulnerability risk assessment in May 2010 and recommended upgrading the panic alarm system; however, no action had been implemented at the time of our inspection.

Handicap Access

Ramps to the front doors at the Buckeye CBOC allowed patients in wheelchairs or with other assistive devices to independently maneuver to the CBOC doors. However, the Buckeye CBOC was not equipped with an automatic door opener or doorbell to assist patients to access the building. In addition, the door had a turn knob. The Americans

with Disabilities Act (ADA)[13] requires that accessible doors are equipped with handles that are easy to grasp with one hand and do not require tight grasping, pinching, or twisting of the wrist to operate.

Recommendation 8. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director implements the recommendation to upgrade the panic alarm system at the Show Low CBOC.

The VISN and VAMC Directors concurred with our finding and recommendation. The leasor of the Show Low CBOC has informally granted permission to upgrade the panic alarm system. Quality Management will collaborate quarterly with the CBOC to monitor the completion of the panic alarm installation. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 9. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director requires that modifications to the entrance doors be made to improve access for disabled veterans at the Buckeye CBOC.

The VISN and VAMC Directors concurred with our finding and recommendation. A letter will be issued to HealthNet to address the needed modifications to the entrance doors at the Buckeye CBOC. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical and MH emergencies are handled. Both CBOCs had policies that outlined management of medical and MH emergencies. Our interviews revealed staff at each facility articulated responses that accurately reflected the local emergency response guidelines.

Suicide Safety Plans

Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. Safety plans should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Additionally, safety plans must include information about how patients can access professional help 24 hours a day, 7 days a week.

We reviewed the medical records of two Show Low patients assessed to be at high risk for suicide and found that clinicians had developed timely safety plans that included all

[13] ADA Accessibility Guidelines for Buildings and Facilities (ADAAG), 4.27.4. September 2002.

required elements. We also found evidence to support the patients and/or their families participated in the development of the plans.

CBOC Contract

Buckeye CBOC

The contract for the Buckeye CBOC is administered through the Phoenix VA HCS for delivery and management of primary and preventative medical care for all eligible veterans in VISN 18. This contract also includes the Payson CBOC. Contracted services with Health Net Federal Services, LLC (Health Net) began on May 1, 2007, with a base year and four option years through March 31, 2012. The contract terms state that a physician licensed in Arizona will serve as the medical director to oversee and be responsible for the proper supervision of covered services to assigned patients. For the 1st Qtr, FY 2010, the PCPs equaled 1.0 FTE. The contractor was compensated by the number of enrollees at a monthly capitated rate per enrollee. The CBOC had 611 unique primary medical care enrollees with 1,204 visits as reported on the FY 2009 CBOC Characteristics report (see Table 1). MH services were not provided at the Buckeye clinic but were referred to Phoenix VA HCS.

We reviewed the contract to determine the contract type, the services provided, the invoices submitted, and supporting information. We also performed inquiries of key Phoenix VA HCS personnel. Our review focused on documents and records for the 1st Qtr, FY 2010. We reviewed the methodology for tracking and reporting the number of enrollees in compliance with the terms of the contract. We reviewed paid capitation rates for compliance with the contract; form and substance of the contract invoices for ease of data analysis by the COTR; and duplicate, missing, or incomplete SSNs on the invoices.

The VA PCMM Coordinator is responsible for maintaining currency of information in the PCMM database. Phoenix VA HCS has approximately 29,000 active patients with approximately 450 assigned to the Buckeye CBOC. We reviewed PCMM data reported by VSSC and the Phoenix VA HCS for compliance with VHA policies. We made inquiries about the number of patients who were unassigned, assigned to more than one PCP, or potentially deceased.

We commend the Phoenix VA HCS for a contract that clearly defined the responsibilities and requirements for payment and disenrollment of patients, particularly the provision that required an annual Level 3[14] office visit for payment. We also thought the provisions that had the invoicing process start with VA's data of patients seen, helped ensure inactive patients were not invoiced.

[14] Level 3 office visits require patient history, examination, and medical consultation for new patients (30 minutes) and two out of three aforementioned criteria for established patients (15 minutes).

We noted the following regarding contract administration and oversight:

1. The invoice validation process initiated in October 2009 more accurately determined the billable enrollees and costs to the VA. However, the process remained very time intensive by requiring a manual verification to ensure that each patient seen met contract requirements. The contract called for the VA to send the list of billable patients to the contractor. However, this was not done. The contractor obtained the list from Veterans Health Information System and Technological Architecture (VistA), but the Phoenix VA HCS was still performing manual verification.

2. The Phoenix VA HCS had not implemented a process to identify traveling veterans for invoicing. The contract was modified on January 2, 2008, to add a provision to provide compensation for traveling veterans who are enrolled at other VA facilities. This provision allows the VA to pay the contractor for a one-time medical care visit without local enrollment. Without this provision, the patient might be enrolled and potentially incurring the monthly capitation for an entire year. There were no invoices from the contractor or procedures to identify traveling veterans.

3. We found that 1,845 of Phoenix VA HCS patients had more than one PCP. VHA Handbook 1101.02 states that each patient must have only one assigned PCP within the VA system unless approval has been obtained for more than one provider. Patients with two or more PCPs assigned inflate primary care panel sizes and increase medical care costs for contracted care.

Recommendation 10. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director conducts a review of the invoice validation process to improve efficiency and accuracy. Specifically, we recommend that the Phoenix VA HCS provide the list of billable patients to the contractor to eliminate the need to manually verify each patient.

The VISN and VAMC Directors concurred with our finding and recommendation. The Phoenix VA HCS is seeking to incorporate the electronic billable list into the PCMM Coordinator's invoice validation process. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 11. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director conducts a review of the procedures for identifying and invoicing traveling veterans.

The VISN and VAMC Directors concurred with our finding and recommendation. The Phoenix VA HCS conducted a review of the procedures for identifying and invoicing traveling veterans. The contractor's invoice will now list traveling veterans separately for reimbursement. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 12. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director ensures that the PCMM Coordinator performs in accordance with VHA Handbook 1101.02 to reduce the number of veterans assigned to more than one PCP.

The VISN and VAMC Directors concurred with our finding and recommendation. The Phoenix VA HCS will standardize the protocol for primary care assignments. The PCMM Coordinator will run a monthly report to analyze the number of dual enrollees by clinic to ensure that the protocol is followed. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

C. VISN 21, VA Pacific Islands HCS – Maui and Kona

Quality of Care Measures

The Maui and Kona CBOCs' quality measure scores equaled or exceeded the parent facility's quality measures scores. (See Appendix J.)

Credentialing and Privileging

We reviewed the C&P file of five providers and the personnel folder for four nurses at both CBOCs. All providers and nursing staff possess a full, active, current, and unrestricted license. However, we identified the following area that needed improvement.

Ongoing Professional Practice Evaluations

The Maui and Kona CBOCs developed OPPEs; however, written threshold/criteria had not been established. The criteria that would trigger a more in-depth review should be defined in advance, and be objective, measurable, and uniformly applied to all practitioners with similar privileges. OPPEs allow the facility to identify professional practice trends that affect the quality of care and patient safety. OPPEs also serve as a mechanism for providers to assess their performance in relation to those with comparable privileges and seek avenues for improvement, if warranted.

Recommendation 13. We recommended that the VISN 21 Director ensure that the VA Pacific Islands HCS Director requires that service chiefs comply with VHA Handbook 1100.19 and establish threshold/criteria for OPPEs at both CBOCs.

The VISN and VAMC Directors concurred with our finding and recommendation. Measurable triggers will be developed to identify when a more in-depth review or FPPE should be instituted. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment and Emergency Management

Environment of Care

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, infection control, and general maintenance. The clinics met most standards, and the environments were generally clean and safe. However, we identified the following areas that needed improvement.

Fire Hazards

At the Kona CBOC, storage space was limited. Staff frequently used the Clinic Network Center room and mechanical room to store supplies and equipment. The storage of these items in these rooms presents a potential fire hazard. The facility's fire and safety team also identified these findings during their environmental rounds.

The Clinic Network Center room had supplies and/or equipment that were approximately 6 inches away from the ceiling, which would obstruct the function of the sprinkler system in the event of a fire. We also found corrugated boxes that contained supplies and medical equipment in the mechanical room. The current room conditions did not meet the Joint Commission (JC) standard[15] that requires facilities to minimize the risk of harm from fire.

Personally Identifiable Information

At the Maui CBOC, we found multiple documents (laboratory results) with patients' names and SSNs located in the phlebotomy accession room. The room was not locked and not under the direct oversight of staff. According to the HIPAA regulations, control of the environment includes control of confidential patient information; therefore, hard copies of patients' PII should be in a locked desk, cabinet, or container.

Handicap Access

The Kona CBOC provided parking for individuals with disabilities as required by the ADA and allowed patients in wheelchairs or with other assistive devices to independently maneuver to the clinic door. However, there was no doorbell or handicap assist button for patients to attain access to the clinic. Since the entrance door was solid, the patient could not be seen by CBOC staff; therefore, they would not be aware if a patient needed assistance.

Recommendation 14. We recommended that the VISN 21 Director ensure that the VA Pacific Islands HCS Director requires that supplies and equipment are stored in the appropriate areas at the Kona CBOC.

The VISN and VAMC Directors concurred with our finding and recommendation. Compliance for storage of supplies and equipment will be monitored during administrative rounds. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 15. We recommended that the VISN 21 Director ensure that the VA Pacific Islands HCS Director requires that all PII is secured and protected at the Maui CBOC.

[15] The JC Standard EC.02.03.01, October 2009.

The VISN and VAMC Directors concurred with our finding and recommendation. Staff were reminded to keep patient information private and confidential. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 16. We recommended that the VISN 21 Director ensure that the VA Pacific Islands HCS Director improve access for disabled veterans at the Kona CBOC.

The VISN and VAMC Directors concurred with our finding and recommendation. A wireless door bell and signage will be installed at the front door of the Kona CBOC. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical emergencies are handled, including MH emergencies. Both CBOCs had policies that outlined management of medical and MH emergencies. Our interviews revealed staff at each facility articulated responses that accurately reflected the local emergency response guidelines.

Suicide Safety Plans

Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. Safety plans should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Additionally, safety plans must include information about how patients can access professional help 24 hours a day, 7 days a week.

We reviewed the medical records of 11 patients (8 at Kona and 3 at Maui). At the Kona CBOC we found that one record had been identified as high risk for suicide; however, a safety plan was not developed for this patient. VHA[16] specifically requires that a safety plan be completed and a copy be provided to the patient. The sole act of providing a copy of the safety plan does not guarantee that the patient will not engage in a self-injurious act. However, without a copy of the safety plan, adherence to the written arrangements, which aim to provide options in a time of crisis, cannot be assured.

Recommendation 17. We recommended that the VISN 21 Director ensure that the Pacific Island HCS requires that safety plans are developed for patients at high risk for suicide at the Kona CBOC.

[16] VA Deputy Under Secretary for Health Memorandum, *Patients at High Risk for Suicide*, April 24, 2008.

The VISN and VAMC Directors concurred with our finding and recommendation. The Suicide Prevention Team conducted training to the Kona CBOC staff for the development of safety plans and the importance of the plan being completed and provided to the patient. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

D. VISN 21, VA Palo Alto HCS – Sonora and Modesto

Quality of Care Measures

The Sonora CBOC met or exceeded the parent facility quality measure scores except for DM foot pedal pulse and foot sensory examination with monofilament. The Modesto CBOC met or exceeded the parent facility's quality measure scores except for the DM foot pedal pulse, foot sensory examination with monofilament, low-density lipoprotein-cholesterol (LDL-C), glycosylated hemoglobin molecule (HgbA1c), and renal testing. (See Appendix K.)

Credentialing and Privileging

We reviewed the C&P files of five providers and two nurses at the Sonora CBOC and five providers and four nurses at the Modesto CBOC. All providers possess a full, active, current, and unrestricted license. All nurses' licenses and education requirements were verified and documented. Facility managers implemented FPPE for new providers and developed service-specific criteria for OPPEs. However, we identified the following areas that needed improvement.

Privileges

The Professional Standard Board (PSB) granted internal medicine core clinical privileges at both CBOCs for procedures that were not performed, such as lumbar puncture, thoracentesis,[17] and cardioversion.[18] In addition, designated physicians at both clinics perform gynecological pelvic examinations; however, we did not find the procedure listed in privileging documents. VHA Handbook 1100.19 requires that facility managers grant clinical privileges that are facility specific, setting specific, and provider specific.

Cardiopulmonary Resuscitation Training

Two providers from the Sonora CBOC and one provider from the Modesto CBOC did not have current cardiopulmonary resuscitation (CPR) training. VHA policy[19] requires that all providers attain CPR training every two years. Managers are required to ensure that all clinically active staff, including mid-level providers, have CPR training.

Recommendation 18. We recommended that the VISN 21 Director ensures that the VA Palo Alto HCS Director requires that the PSB grant privileges appropriate for the services provided at the Sonora and Modesto CBOCs.

[17] An invasive procedure to remove fluid or air from the pleural space (body cavity that surrounds the lungs) for diagnostic or therapeutic purposes.
[18] Procedure where an electrical shock is delivered to the heart to convert an abnormal heart rhythm back to a normal rhythm.
[19] VHA Directive 2008-008, *Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) Training for Staff*, February 6, 2008.

The VISN and VAMC Directors concurred with our finding and recommendation. A process is in place to remove the provider privileges that are deemed to be inappropriate for the services provided at the CBOCs. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 19. We recommended that the VISN 21 Director ensures that the VA Palo Alto HCS Director requires that all designated staff at the Sonora and Modesto CBOCs maintain current CPR training as required by VHA policy.

The VISN and VAMC Directors concurred with our finding and recommendation. A new policy requiring CPR certification for all clinically active social workers is being developed. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Environment and Emergency Management

Environment of Care

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, IC, and general maintenance. Both CBOCs met review criteria, and the environments were generally clean and safe. However, we identified the following areas that needed improvement.

Fire Drills

We found no documentation that managers conducted fire drills annually at the Modesto CBOC clinic. We found documented summaries of fire drills conducted in 2007 and 2009; however, we found no documentation of fire drills conducted in 2006 and 2008. According to the National Fire Protection Association (NFPA),[20] staff must conduct, critique, and document fire drills every 12 months from the date of the last drill. Without documented evidence of fire drills, management is not able to determine staff's competency to carry out fire emergencies.

Safety Risks Assessment

At the Modesto CBOC (MH location) in a patient care area, we found multiple electrical cords and cables from electronic devices that could be used to cause harm to self or others. Clinic managers reported there had been no behavioral incidents in the last year and that patients had been assessed for appropriateness to the program's level of care. However, a risk assessment had not been conducted to assess if the area posed a risk to patients and/or staff. The JC requires organizations to identify and manage safety risks.[21]

[20] Life Safety Code 2006, 6.1.11.1, A .6.1.11.1
[21] The JC Standard EC.02.01.01.

Risks associated with the physical environment include those that might contribute to suicide or acts of violence.

Handicap Access

The Modesto CBOC is located within a commercial building with doorways that allow independent entry and exit. The CBOC (primary care clinic) is located on the third floor. The entrance door to the CBOC had a handle that met ADA guidelines; however, the door was solid and patients could not be seen by CBOC staff. Therefore, staff would not be aware if patients needed assistance. There was no handicap assist button for patients to enter or exit the clinic. While on site, we observed a patient in an electric wheelchair who encountered difficulty leaving the clinic. The patient was unable to operate his wheelchair and hold the door open.

Hand Hygiene

The parent facility's IC plan (FY 2010) includes a component for hand hygiene observation in all outpatient clinical areas. Prior to April 2010, clinicians in the Sonora and Modesto CBOCs had no formal process for collecting hand hygiene data and reporting results to managers. Managers identified the issue, and staff collected 3rd Qtr, FY 2010 hand hygiene data for both CBOCs. In addition, managers reviewed the data which was included in the August 2010 IC minutes. The action plan implemented by facility managers is appropriate; therefore, we made no recommendation.

Recommendation 20. We recommended that the VISN 21 Director ensures that the VA Palo Alto HCS Director ensures that fire drills be conducted at the Modesto CBOC as required by NFPA policy.

The VISN and VAMC Directors concurred with our finding and recommendation. The importance of the Drill Evaluation Sheet was reinforced to ensure fire drills are recorded. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Recommendation 21. We recommended that the VISN 21 Director ensures that the VA Palo HCS Director requires managers to conduct an environmental safety risk analysis to determine if there are safety hazards at the Modesto CBOC.

The VISN and VAMC Directors concurred with our finding and recommendation. An environmental safety risk analysis will be included as part of the semi-annual EOC rounds. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or SOP defining how medical and MH emergencies are handled. Both CBOCs had a policy for emergency management that detailed how medical and MH emergencies would be handled. During the onsite interviews, staff at both CBOCs articulated the local emergency response guidelines.

Suicide Safety Plans

Safety plans should have patient and/or family input, be behavior oriented, and identify warning signs preceding crisis and internal coping strategies. Safety plans should also identify when patients should seek non-professional support, such as from family and friends, and when patients need to seek professional help. Additionally, safety plans must include information about how patients can access professional help 24 hours a day, 7 days a week.

We reviewed medical records of 12 patients (3 at Sonora and 9 at Modesto CBOCs) assessed to be at high risk for suicide. We found that clinicians developed safety plans that included all required documentation elements. However, 3 (25 percent) of 12 patients did not receive a copy of the safety plan. The parent facility's local policy,[22] as well as VHA, requires that patients receive a copy of the plan. Prior to our visit, managers had identified the issue and were implementing an action plan for improved compliance. Managers amended the safety plan template to include a section that indicates staff provided a copy of the plan to the patient.

Recommendation 22. We recommended that the VISN 21 Director ensures that the VA Palo Alto HCS Director requires that managers monitor staff compliance to local policy and VHA suicide safety plan requirements at the Sonora and Modesto CBOCs.

The VISN and VAMC Directors concurred with our finding and recommendation. A check box was added to the suicide safety plan template for providers to document when patients receive a copy of their suicide safety plan. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

[22] VA Palo Alto HCS, *Management of Patients with Suicidal and Self-Harming Behaviors,* HCS Memorandum No: 11-10-51, February 19, 2010.

Appendix A

VISN 18 Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 8, 2010

From: Director, VISN 18 (10N18)

Subject: **Healthcare Inspection – CBOC Reviews: Farmington and Espanola, NM; and Show Low and Buckeye, AZ**

To: Director, CBOC/Vet Center Program Review, Office of Healthcare Inspections (54F)

Attached are the responses provided by the New Mexico VA Health Care System and the Phoenix VA Health Care System in follow up to the OIG Healthcare Inspection CBOC Reviews conducted in Farmington and Espanola, New Mexico, and Show Low and Buckeye, Arizona.

Questions may be referred to Sally Compton, Executive Assistant to the VISN 18 Network Director, at 602.222.2699.

(original signed by:)

Susan P. Bowers

New Mexico VA HCS Director Comments

Department of Veterans Affairs **Memorandum**

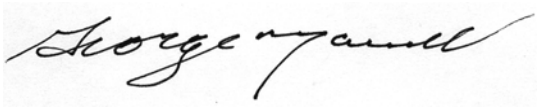
Date: 10/08/10

From: Director, New Mexico VA HCS (501/00)

Subject: **Healthcare Inspection – CBOC Review: Farmington and Espanola, NM**

To: Director, VISN 18 (10N18)

I concur with the findings from the OIG CAP visit conducted August 23-27, 2010, with the exception of Recommendation 6. Attached are responses with action plans as appropriate for each recommendation.



George Marnell

New Mexico VA HCS Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director requires that all designated CBOC staff at the Farmington and the Espanola CBOCs maintain current BLS certification.

Concur **Target Completion Date: 9/19/2010**

The NMVAHCS Clinical Executive Board (CEB) charged a team to evaluate the BLS/ACLS process in May 2010. Recommendations were approved by the CEB in August 2010 and included the following: (1) More specific information regarding who is required to maintain BLS/ACLS certification; (2) A requirement that BLS/ACLS be incorporated into LMS annual training and is being tracked by the Education Service; and (3) That consequences for non-compliance are clear. While the compliance rates for the NMVAHCS improved to over 96% for BLS training compliance by August 2010, we are still in the process of implementing to achieve 100% compliance. The provider in Farmington completed the BLS training requirement in September 2010.

Recommendation 2. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director requires all printers at the Espanola CBOC be located in secure areas to ensure PII is protected.

Concur **Target Completion Date: 11/15/2010**

The Region 1 OI&T staff will move the printer. The Rural Health staff and Information Security Officers will incorporate this issue into their review and audit process for all of the CBOCs and document recommendations when printers need to be moved. Follow-up and letters of correction will be completed through the COTR to the Contracting Office, as necessary.

Recommendation 3. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director requires that the Espanola CBOC collect, analyze, and report hand hygiene data as required by the CDC.

Concur **Target Completion Date: 12/31/2010**

During a consultation visit in June 2010, the NMVAHCS staff provided the hand hygiene data collection tool to the Espanola Contract staff and trained them in how to use the tool. Contracting, in partnership with the NMVAHCS staff, sent a letter of correction to the contractor regarding the hand hygiene compliance data in August 2010 (before the OIG visit). Beginning in the first quarter of FY2011, the NMVAHCS is requiring 30 observations per quarter to be submitted to the Infection Control Practitioner. Infection Control will analyze and report the data using the already developed process.

Recommendation 4. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director requires safety plans are developed at the Farmington CBOC for all patients identified as high risk for suicide.

Concur **Target Completion Date: 11/15/2010**

Targeted education will be provided to the Farmington CBOC Behavioral Health staff regarding the timely completion of the suicide prevention plan and what to do if the Veteran is not available or refuses to have a suicide prevention plan completed. The Suicide Prevention Coordinator will provide additional support to CBOC Behavioral staff when Veterans refuse to complete a Suicide Safety Plan.

Recommendation 5. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director provides contract oversight in accordance with terms and conditions in the Espanola CBOC contract, to include enforcing penalties as necessary and requiring the contractor to reformat the invoice to comply with contract requirements.

Concur **Target Completion Date: 10/1/2010**

Immediately after the OIG visit, the NMVAHCS Rural Health COTR implemented a new process to review the performance measures against the requirements in the existing contract. The Rural Health Business Manager is reviewing all of the Data Accountability Checklists to determine performance and penalty calculations. Deductions for failure to perform at

the specific contract level for the July/August 2010 timeframe have been deducted from the September 2010 invoice. The Rural Health Business Manager is also partnering with Contracting to review the contract for required compliance with terms and conditions and notice will be sent to the Contractor of any additional findings related to non-compliance. The COTR met with the Espanola Contract staff to provide education on the correct invoice format in September 2010. The COTR will monitor these invoices for the life of the contract.

Recommendation 6. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director reviews the invoice validation process for all contract CBOCs to ensure there are adequate controls and proper validation before payment.

Concur **Target Completion Date: 11/30/2010**

The Rural Health Business Manager implemented a new invoice validation process in June 2009 that is consistent and deployed across all of the contract CBOCs. The invoice validation process includes verification of the required primary care visit once every 12 month period. To enhance this process, if non-compliance is detected during any monthly invoice audit, the sample size will be expanded (above 10%) by the COTR to satisfy the accuracy of the invoice. VHA has the authority to send a bill of collection if invoice inaccuracies are discovered during any monthly invoice audit.

The PCMM Coordinator and the COTR have developed and implemented an immediate communication process to carefully review deaths and transfers of enrolled Veterans, allowing for timely removal of invoiced enrollees.

Recommendation 7. We recommended that the VISN 18 Director ensure that the New Mexico VA HCS Director has a process to provide improved oversight and coordination of contracted primary care.

Concur **Target Completion Date: 12/01/2010**

NMVAHCS Leadership and Contracting implemented a Contracting Council in July 2010 to improve oversight and coordination of all contracting activities, including contracted primary care. Rural Health, in partnership with Contracting, developed a new Statement of Work which provides for improvements in quality, compliance, access, and accurate

billing. The new Statement of Work includes clear penalties for non-compliance and enhanced reimbursement for exceeding performance expectations. This process will guide all other contract CBOCs statements of work.

Appendix C

Phoenix VA HCS Director Comments

Department of Veterans Affairs **Memorandum**

Date: 10/08/10

From: Director, Phoenix VA HCS (644/00)

Subject: **Healthcare Inspection – CBOC Review: Show Low and Buckeye, AZ**

To: Director, VISN 18 (10N18)

1. The recommendations made during the Office of Inspector General Health Inspection CBOC Program Review (Show Low and Buckeye) conducted August 23-25, 2010 have been reviewed and implementation plans and subsequent actions are being completed.

2. We would like to thank the OIG Health Inspection Review Team that conducted our review. The team, led by Mr. Bruce Barnes including members Murray Leigh, and Susan Zarter was consultative and professional. They provided feedback to our staff.

3. If you have any questions, please contact me at 602.277.5551, Ext 7891 or Kathleen Shepard, Chief Quality Management, at Ext 7100.

(original signed by:)

GABRIEL PEREZ
Medical Center Director

Phoenix VA HCS Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 8. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director implements the recommendation to upgrade the panic alarm system at the Show Low CBOC.

Concur **Target Completion Date: December 15, 2010**

In order to ensure the safety of the Show Low CBOC, permission was requested and granted informally by the leasor on October 5, 2010, to make building modifications in order to upgrade the panic alarm system. By October 18, 2010, the VISN 18 Contracting Office will send a formal supplemental lease agreement to document the permission granted by the leasor. When the formal supplemental lease agreement is signed by the leasor, then the leasee (PVAHCS) will perform the upgrade on the panic alarm system. The Statement of Work outlines the nature and scope of the work to be performed. Quality Management will collaborate with the CBOC quarterly to monitor the completion of the panic alarm installation.

Recommendation 9. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director requires that modifications to the entrance doors be made to improve access for disabled veterans at the Buckeye CBOC.

Concur **Target Completion Date: February 7, 2011**

To comply with the American Disability Act (ADA) contractual issue, a letter of concern will be issued on October 12, 2010, to HealthNet to address the needed modifications to the entrance door hardware and controls to improve disabled Veteran access to the Buckeye clinic. Per the draft letter of concern, the landlord must respond by October 29, 2010. Quality Management and the COTR will monitor quarterly.

Recommendation 10. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director conducts a review of the invoice validation process to improve efficiency and accuracy. Specifically, we recommend that the Phoenix VA HCS provide the list of billable patients to the contractor to eliminate the need to manually verify each patient.

Concur **Target Completion Date: February 7, 2011**

On October 5, 2010, per the Inspector General's surveyor recommendation, PVAHCS sent an e-mail to the Primary Care Management Module (PCMM) Coordinator at the Loma Linda VAHCS requesting information regarding their electronic system. PVAHCS is seeking to incorporate the electronic billable list into the PCMM Coordinator's invoice validation process. The Information Security Officer and technology department will install the system locally. PVAHCS will continue to seek out an electronic process at other VA facilities should the Loma Linda VAHCS system not be compatible with PVAHCS system. The COTR and Quality Management will monitor quarterly.

Recommendation 11. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director conducts a review of the procedures for identifying and invoicing traveling veterans.

Concur **Target Completion Date: Complete**

PVAHCS conducted a review of its process using the Standard Operating Procedure for traveling Veterans presenting at a PVAHCS contract CBOC. The contractor's invoice will list traveling Veteran patients separately for reimbursement each month for traveling patients seen and/or treated during that month. Upon examination of the HealthNet invoices, HealthNet has not submitted a separate invoice for traveling Veterans during the past two (2) years. Additionally, PVAHCS initiated and provided a traveling Veteran instructional guide to PVAHCS enrollment clerks and HealthNet.

Recommendation 12. We recommended that the VISN 18 Director ensure that the Phoenix VA HCS Director ensures that the PCMM Coordinator performs in accordance with VHA Handbook 1101.02 to reduce the number of veterans assigned to more than one PCP.

Concur **Target Completion Date: May 2, 2011**

The PHVAHCS will standardize the method or protocol for all Outpatient Primary Care Clinics related to primary care assignments throughout the facility. The PCMM Coordinator will provide training to the Clinic Leads and Medical Administrative Officers (MAO) related to the correct method to review and enter primary care assignments into VISTA. The Clinic Leads and MAOs will provide training to all front line staff and ensure that the protocol is followed. The PCMM Coordinator will run a monthly report to analyze the number of dual enrollees by clinic to ensure that the protocol is followed. Feedback will be provided to the Clinic Leads and MAOs. Quality Management will monitor quarterly.

Appendix D

VISN 21 Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 13, 2010

From: Director, VISN 21 (10N21)

Subject: **Healthcare Inspection – CBOC Reviews: Maui and Kona, HI; and Sonora and Modesto, CA**

To: Director, CBOC/Vet Center Program Review, Office of Healthcare Inspections (54F)

1. I have reviewed the draft report for the Healthcare Inspection of the Maui, Kona, Sonora and Modesto CBOC's and concur with all of the recommendations made that identify opportunities for improvement. The action plan from the two facilities is provided.

2. The VISN appreciates the opportunity to provide comments and would like to thank your staff for being thorough and professional during the visit.

(original signed by:)

Sheila M. Cullen

Appendix E

Pacific Islands HCS Director Comments

Department of Veterans Affairs **Memorandum**

Date: 12 October 2010

From: Director, VA Pacific Islands HCS (459/00)

Subject: **Healthcare Inspection – CBOC Review: Maui and Kona, HI**

To: Director, VISN 21 (10N21)

1. The following attachment is the Director's comments submitted in response to the recommendations in the Office of Inspector General Report.

2. If you have any additional questions you can contact me at 808-433-0100.

(original signed for:)

James E. Hastings, MD, FACP

VA Pacific Islands HCS Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 13. We recommended that the VISN 21 Director ensure that the VA Pacific Islands HCS Director requires that service chiefs comply with VHA Handbook 1100.19 and establish threshold/criteria for OPPEs.

Concur **Target Completion Date: November 30, 2010**

As part of the facility's Ongoing Provider Practice Evaluation (OPPE) process, triggers that are measurable will be developed that will identify when a more in- depth review or Focus Provider Practice Evaluation (FPPE) should be instituted. Those triggers will be approved by the Medical Staff and applied across the system to include the providers at the CBOCs.

Recommendation 14. We recommended that the VISN 21 Director ensure that the VA Pacific Islands HCS Director requires that supplies and equipment are stored in the appropriate areas at the Kona CBOC.

Concur **Target Completion Date: October 29, 2010**

The supplies and equipment identified during the visit were removed by the IRM staff. Requests are being generated by the CBOC Administrative Officer to purchase the recommended storage racks, shelving and plastic storage bins for better organization. Compliance monitoring will be performed during unannounced administrative rounds under the direction of the Associate Director and the CBOC Administrative Officer will also monitor compliance and report findings to Environment of Care committee monthly.

Recommendation 15. We recommended that the VISN 21 Director ensure that the VA Pacific Islands HCS Director requires that all PII is secured and protected at the Maui CBOC.

Concur **Target Completion Date: Aug. 25, 2010 – completed**

Documentation was secured the same day as the finding. The employee was required to review Privacy and HIPAA regulations to ensure that they understood and complied with regulations. In addition, a review was conducted at morning CBOC meetings to keep staff up to date on keeping patient information private and confidential.

Recommendation 16. We recommended that the VISN 21 Director ensure that the VA Pacific Islands HCS Director improve access for disabled veterans at the Kona CBOC.

Concur **Target Completion Date: November 30, 2010**

As an interim measure Engineering Service will install a wireless door bell at the front door for disabled veterans needing assistance, as well as posting signage informing the veterans to ring the bell for assistance, if needed by October 20, 2010. Long term plan is to work with Contracting and the landlord to install an ADA automatic door closure.

Recommendation 17. We recommended that the VISN 21 Director ensure that the VA Pacific Islands HCS Director requires that safety plans are developed for patients identified as high risk for suicide at the Kona CBOC.

Concur **Target Completion Date: October 30, 2010**

The Suicide Prevention Team conducted suicide prevention training to the Kona CBOC staff which included development of safety plans and the importance of the plan being completed and provided to the patient. A facility policy addressing VA PIHCS's process in identifying and managing patients at high risk for suicide has been completed and is presently in HR pending union review and Director's signature. The Suicide Prevention Team, as part of their performance improvement program monitor patient's flagged as high risk for suicide weekly for the first 30 days post flag placement. Criteria being monitored include completed follow-up appointments and evidence of the safety plan initiation and whether the plan was provided to the patient. Findings from this monitoring activity will be reported quarterly to the Performance Measures Work Group.

Appendix F

Palo Alto HCS Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 8, 2010

From: Director, VA Palo Alto HCS (640/00)

Subject: **Healthcare Inspection – CBOC Review: Sonora and Modesto, CA**

To: Director, VISN 21 (10N21)

1. VAPAHCS appreciates the opportunity to review the OIG Report on the CBOC Review of our Sonora and Modesto CBOCs.

2. Please find attached our response to each recommendation provided in the report.

3. If you have any questions regarding the response to the recommendations in the report, feel free to call me at (650) 858-3939.

(original signed by:)

Elizabeth Joyce Freeman
Director

VA Palo Alto HCS Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 18. We recommended that the VISN 21 Director ensure that the VA Palo Alto HCS Director requires that the PSB grant privileges appropriate for the services provided at the Sonora and Modesto CBOCs.

Concur **Target Completion Date: April 13, 2011**

A process is in place to remove the privileges for each CBOC provider that is deemed not to be appropriate for the services provided at the clinic. Pelvic exams are considered part of the core privileges for internal medicine and family practice physicians. To meet the intent of the finding, we implemented a process to maintain gender specific proficiency per guidelines in VHA Handbook 1330.01, Health Care Services for Women Veterans, published May 21, 2010. This process includes assigning female Veterans to designated Women's Primary Care Providers, with a 10% panel target per provider. When demand for female Veteran primary care is below the target, regular women's health training opportunities are created to ensure provider proficiency.

Recommendation 19. We recommended that the VISN 21 Director ensure that the VA Palo Alto HCS Director requires that all designated staff at the Sonora and Modesto CBOCs maintain current CPR training as required by VHA policy.

Concur **Target Completion Date: November 1, 2010**

Consistent with VHA Directive 2008-008 and our local healthcare system memorandum, physicians, mid-level providers and nurses are required to have BLS certification. The three staff identified by the OIG were Social Workers, providing care in a mental health setting at the Sonora and Modesto clinics. Social workers receive CPR on line training but are not certified as are other clinical providers. A new policy requiring certification for all clinically active social workers is being developed.

Recommendation 20. We recommended that the VISN 21 Director ensure that the VA Palo Alto HCS Director ensures that fire drills be conducted at the Modesto CBOC as required by NFPA policy.

Concur **Target Completion Date: Consider this closed.**

It was discovered that fire drills at the Modesto CBOC may not have been conducted in 2006 and personnel action was taken after that discovery. Records do exist for the 2007 and 2009 drills. The 2008 drills were recorded as complete in VAPAHCS Safety Office records; however, the Drill Evaluation Sheet could not be located at the Modesto CBOC. The importance of the Drill Evaluation Sheet was reinforced as a tool to document staff competency. This action item has been completed.

Recommendation 21. We recommended that the VISN 21 Director ensure that the VA Palo Alto HCS Director requires managers to conduct an environmental safety risk analysis to determine if there are safety hazards at the Modesto CBOC.

Concur **Target Completion Date: December 31, 2010**

As part of the semi-annual Environment of Care rounds an environmental safety risk analysis will be included. A work order was submitted on October 5, 2010 for Office of Information and Technology to secure the electrical cords and cables. Target completion date: November 1, 2010.

The Modesto CBOC facility entrance is located within a public building; therefore, the use of an automatic door is not allowed due to fire protection and egress requirements. VAPAHCS will install an assistance bell, which will chime within the service counter area of the clinic. This bell will alert the CBOC staff to a patient outside the clinic door requiring assistance. Target completion date: December 31, 2010.

Recommendation 22. We recommended that the VISN 21 Director ensure that the VA Palo Alto HCS Director requires that managers monitor staff compliance to local policy and VHA suicide safety plan requirements at the Sonora and Modesto CBOCs.

Concur **Target Completion Date: March 31, 2011**

While our practice is such that each patient receives a copy of their suicide safety plan, there was inconsistent documentation to show this occurred prior to June 2010. After June, 2010 a check box was added to the suicide safety plan template that prompts providers to include this in their documentation. A quality assurance audit tool has been developed to audit compliance. Beginning October, 2010, quarterly chart audits will be performed which will document that both a suicide safety plan was completed and a copy was given to the patient. The audit will include 5 patients per outpatient provider and will be incorporated into the service level chart auditing QA process. 100% compliance will be achieved by Quarter 2, FY2011.

CBOC Characteristics

CBOC Station Number	CBOC Name	Parent VA	Specialty Care	Cardiology	Women's Health	Podiatry	Optometry	Orthopedics	Gastrointestinal	Rheumatology	Dermatology
501GB	Farmington, NM	New Mexico VA HCS	Yes	No	Yes	No	No	No	No	No	No
501GE	Espanola, NM	New Mexico VA HCS	Yes	No	Yes	No	No	No	No	No	No
644GB	Show Low, AZ	Phoenix VA HCS	Yes	No	No	Yes	No	No	No	No	No
644GC	Buckeye, AZ	Phoenix VA HCS	No	No	No	No	No	No	No	No	No
459GA	Maui, HI	VA Pacific Islands HCS	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No
459GC	Kona, HI	VA Pacific Islands HCS	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
640GB	Sonora, CA	VA Palo Alto HCS	No	No	No	No	No	No	No	No	No
640HB	Modesto, CA	VA Palo Alto HCS	No	No	No	No	No	No	No	No	No

Specialty Care Services

CBOC Station Number	CBOC Name	Parent VA	Laboratory (draw blood)	Radiology	Onsite Pharmacy	Physical Medicine (OT/PT)	EKG
501GB	Farmington, NM	New Mexico VA HCS	Yes	No	No	No	Yes
501GE	Espanola, NM	New Mexico VA HCS	Yes	No	No	No	Yes
644GB	Show Low, AZ	Phoenix VA HCS	Yes	No	No	No	No
644GC	Buckeye, AZ	Phoenix VA HCS	Yes	No	No	No	No
459GA	Maui, HI	VA Pacific Islands HCS	Yes	No	No	No	Yes
459GC	Kona, HI	VA Pacific Islands HCS	Yes	No	No	No	Yes
640GB	Sonora, CA	VA Palo Alto HCS	Yes	No	No	No	Yes
640HB	Modesto, CA	VA Palo Alto HCS	Yes	No	No	No	Yes

Onsite Ancillary Services

CBOC Station Number	CBOC Name	Internal Medicine Physician	Primary Care Physician	Nurse Practitioner	Physician Assistant	Psychiatrist	Psychologist	Licensed Clinical Social Worker	Addition Therapist
501GB	Farmington, NM	Yes	No	No	No	No	No	Yes	No
501GE	Espanola, NM	No	Yes	Yes	No	No	No	Yes	No
644GB	Show Low, AZ	Yes	No	Yes	No	No	No	Yes	No
644GC	Buckeye, AZ	Yes	No	No	No	No	No	No	No
459GA	Maui, HI	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
459GC	Kona, HI	Yes	No	Yes	No	Yes	No	Yes	Yes
640GB	Sonora, CA	Yes	Yes	No	No	No	No	Yes	No
640HB	Modesto, CA	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

Providers Assigned to the CBOC

CBOC Station Number	CBOC Name	Parent VAs	Mental Health Care Services	Primary Care Physicians	Psychologist	Psychiatrist	Licensed Clinical Social Worker	Addiction Counselor	Nurse Practitioner
501GB	Farmington, NM	New Mexico VA HCS	Yes	Yes	Yes	Yes	Yes	No	No
501GE	Espanola, NM	New Mexico VA HCS	Yes	Yes	No	Yes	Yes	No	No
644GB	Show Low, AZ	Phoenix VA HCS	Yes	No	No	No	Yes	No	No
644GC	Buckeye, AZ	Phoenix VA HCS	No	No	No	No	No	No	No
459GA	Maui, HI	VA Pacific Islands HCS	Yes	Yes	Yes	Yes	Yes	Yes	Yes
459GC	Kona, HI	VA Pacific Islands HCS	Yes	No	No	Yes	Yes	Yes	Yes
640GB	Sonora, CA	VA Palo Alto HCS	Yes	No	No	No	Yes	No	No
640HB	Modesto, CA	VA Palo Alto HCS	Yes	No	Yes	Yes	Yes	Yes	No

Mental Health Clinicians

CBOC Station Number	CBOC Name	Parent VA	Miles to Parent Facility
501GB	Farmington, NM	New Mexico VA HCS	189
501GE	Espanola, NM	New Mexico VA HCS	93
644GB	Show Low, AZ	Phoenix VA HCS	184
644GC	Buckeye, AZ	Phoenix VA HCS	38
459GA	Maui, HI	VA Pacific Islands HCS	250
459GC	Kona, HI	VA Pacific Islands HCS	150
640GB	Sonora, CA	VA Palo Alto HCS	136
640HB	Modesto, CA	VA Palo Alto HCS	93

Miles to Parent Facility

Quality of Care Measures
New Mexico VA HCS[23] – Farmington and Espanola

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr4 Percentage*
Influenza Vaccination, 50−64	**66**	**National**	**4,843**	**6,973**	**69**
	66	501 New Mexico VA HCS	43	63	**68**
		501GB Farmington	26	30	**87**
		501GE Espanola	22	30	**73**

Influenza Vaccination, 50−64 Years of Age, 4th Qtr, FY 2009

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 65 or older	**83**	**National**	**5,460**	**6,499**	**84**
	83	501 New Mexico VA HCS	41	45	**91**
		501GB Farmington	37	43	**86**
		501GE Espanola	29	41	**71**

Influenza Vaccination, Age 65 or Older, 4th Qtr, FY 2009

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Outpatient Foot Inspection	**National**	**4,321**	**4,651**	**93**
	501 New Mexico VA HCS	36	38	**95**
	501GB Farmington	47	47	**100**
	501GE Espanola	38	41	**93**

DM Foot Inspection, FY 2010

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr1 Percentage*
DM - Outpatient - Foot Pedal Pulses	**National**	**4,208**	**4,651**	**90**
	501 New Mexico VA HCS	36	38	**95**
	501GB Farmington	47	47	**100**
	501GE Espanola	35	41	**85**

Foot Pedal Pulse, FY 2010

[23] http://vaww.pdw.med.va.gov/MeasureMaster/MMReport.asp Note: Scores are weighted. The purpose of weighting is to correct for the over-representation of cases from small sites and the under-representation of cases from large sites. It corrects for the unequal number of available cases within each organizational level (i.e., CBOC, facility) and protects against the calculation of biased or inaccurate scores. Weighting can alter the raw measure score (numerator/denominator) in different ways, particularly measures with small "N"(s). Raw scores can go up or down depending on which cases pass or fail a measure. Sometimes the adjustment can be quite significant.

Measure	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – Outpatient Foot Sensory Exam Using Monofilament	**National**	**4,126**	**4,630**	**89**
	501 New Mexico VA HCS	35	38	**92**
	501GB Farmington	47	47	**100**
	501GE Espanola	36	41	**88**

Foot Sensory, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – Retinal Eye Exam	**70**	**National**	**3,181**	**3,510**	**91**
	70	501 New Mexico VA HCS	25	31	**81**
		501GB Farmington	38	47	**81**
		501GE Espanola	34	41	**83**

Retinal Exam, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – LDL-C	**88**	**National**	**3,413**	**3,511**	**97**
	88	501 New Mexico VA HCS	28	31	**90**
		501GB Farmington	46	47	**98**
		501GE Espanola	39	41	**95**

Lipid Profile, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – HbgA1c	**93**	**National**	**3,452**	**3,512**	**98**
	93	501 New Mexico VA HCS	30	31	**97**
		501GB Farmington	47	47	**100**
		501GE Espanola	41	41	**100**

HbgA1c Testing, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM - Renal Testing	**88**	**National**	**3,371**	**3,512**	**95**
	88	501 New Mexico VA HCS	31	31	**100**
		501GB Farmington	47	47	**100**
		501GE Espanola	40	41	**98**

Renal Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
Patient Screen with PC-PTSD	**95**	**National**	**9,761**	**10,006**	**98**
	95	501 New Mexico VA HCS	105	109	**96**
		501GB Farmington	5	5	**100**
		501GE Espanola	5	5	**100**

PTSD Screening, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
***Patient Screen with PC-PTSD with* timely Suicide Ideation/Behavior Evaluation**	**75**	**National**	**239**	**379**	**64**
	75	501 New Mexico VA HCS	1	4	**25**
		501GB Farmington	*	*	*
		501GE Espanola	*	*	*

PTSD Screening with Timely Suicide Ideation/Behavior Evaluation, FY 2010

Null values are represented by *, indicating no eligible cases.

Quality of Care Measures
Phoenix VA HCS[24] – Show Low and Buckeye

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 50−64	**66**	**National**	**4,843**	**6,973**	**69**
	66	644 Phoenix VA HCS	50	68	**74**
		644GB Show Low	29	36	**81**
		644GC Buckeye	26	40	**65**

Influenza Vaccination, 50−64 Years of Age, 4th Qtr, FY 2009

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 65 or older	**83**	**National**	**5,460**	**6,499**	**84**
	83	644 Phoenix VA HCS	29	33	**88**
		644GB Show Low	30	39	**77**
		644GC Buckeye	22	34	**65**

Influenza Vaccination, Age 65 or Older, 4th Qtr, FY 2009

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Outpatient Foot Inspection	**National**	**4,321**	**4,651**	**93**
	644 Phoenix VA HCS	26	34	**69**
	644GB Show Low	44	44	**100**
	644GC Buckeye	14	15	**93**

DM Foot Inspection, FY 2010

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr1 Percentage*
DM - Outpatient - Foot Pedal Pulses	**National**	**4,208**	**4,651**	**90**
	644 Phoenix VA HCS	26	34	**69**
	644GB Show Low	44	44	**100**
	644GC Buckeye	15	15	**100**

Foot Pedal Pulse, FY 2010

[24] http://vaww.pdw.med.va.gov/MeasureMaster/MMReport.asp Note: Scores are weighted. The purpose of weighting is to correct for the over-representation of cases from small sites and the under-representation of cases from large sites. It corrects for the unequal number of available cases within each organizational level (i.e., CBOC, facility) and protects against the calculation of biased or inaccurate scores. Weighting can alter the raw measure score (numerator/denominator) in different ways, particularly measures with small "N"(s). Raw scores can go up or down depending on which cases pass or fail a measure. Sometimes the adjustment can be quite significant.

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – Outpatient Foot Sensory Exam Using Monofilament	**National**	**4,126**	**4,630**	**89**
	644 Phoenix VA HCS	26	34	**69**
	644GB Show Low	44	44	**100**
	644GC Buckeye	14	15	**93**

Foot Sensory, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – Retinal Eye Exam	**70**	**National**	**3,181**	**3,510**	**91**
	70	644 Phoenix VA HCS	23	26	**79**
		644GB Show Low	38	44	**86**
		644GC Buckeye	13	15	**87**

Retinal Exam, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – LDL-C	**88**	**National**	**3,413**	**3,511**	**97**
	88	644 Phoenix VA HCS	24	26	**100**
		644GB Show Low	43	44	**98**
		644GC Buckeye	14	15	**93**

Lipid Profile, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM – HbgA1c	**93**	**National**	**3,452**	**3,512**	**98**
	93	644 Phoenix VA HCS	25	26	**100**
		644GB Show Low	43	44	**98**
		644GC Buckeye	15	15	**100**

HbgA1c Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Renal Testing	**88**	**National**	**3,371**	**3,512**	**95**
	88	644 Phoenix VA HCS	25	26	**98**
		644GB Show Low	43	44	**98**
		644GC Buckeye	14	15	**93**

Renal Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
Patient Screen with PC-PTSD	**95**	**National**	**9,761**	**10,006**	**98**
	95	644 Phoenix VA HCS	30	36	**76**
		644GB Show Low	3	3	**100**
		644GC Buckeye	*	*	*

PTSD Screening, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
***Patient Screen with PC-PTSD with* timely Suicide Ideation/Behavior Evaluation**	**75**	**National**	**239**	**379**	**64**
	75	644 Phoenix VA HCS	0	2	**0**
		644GB Show Low	*	*	*
		644GC Buckeye	*	*	*

PTSD Screening with Timely Suicide Ideation/Behavior Evaluation, FY 2010

Null values are represented by *, indicating no eligible cases.

Quality of Care Measures
VA Pacific Islands HCS[25] – Maui and Kona

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 50−64	**66**	**National**	**4,843**	**6,973**	**69**
	66	459 VA Pacific Islands HCS	31	59	**53**
		459GA Maui	32	35	**91**
		459GC Kona	15	22	**68**

Influenza Vaccination, 50−64 Years of Age, 4th Qtr, FY 2009

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 65 or older	**83**	**National**	**5,460**	**6,499**	**84**
	83	459 VA Pacific Islands HCS	25	33	**76**
		459GA Maui	29	30	**97**
		459GC Kona	18	20	**90**

Influenza Vaccination, Age 65 or Older, 4th Qtr, FY 2009

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Outpatient Foot Inspection	**National**	**4,321**	**4,651**	**93**
	459 VA Pacific Islands HCS	19	20	**99**
	459GA Maui	47	49	**96**
	459GC Kona	45	47	**96**

DM Foot Inspection, FY 2010

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr1 Percentage*
DM - Outpatient - Foot Pedal Pulses	**National**	**4,208**	**4,651**	**90**
	459 VA Pacific Islands HCS	17	20	**82**
	459GA Maui	44	49	**90**
	459GC Kona	45	47	**96**

Foot Pedal Pulse, FY 2010

[25] http://vaww.pdw.med.va.gov/MeasureMaster/MMReport.asp Note: Scores are weighted. The purpose of weighting is to correct for the over-representation of cases from small sites and the under-representation of cases from large sites. It corrects for the unequal number of available cases within each organizational level (i.e., CBOC, facility) and protects against the calculation of biased or inaccurate scores. Weighting can alter the raw measure score (numerator/denominator) in different ways, particularly measures with small "N"(s). Raw scores can go up or down depending on which cases pass or fail a measure. Sometimes the adjustment can be quite significant.

Measure	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – Outpatient Foot Sensory Exam Using Monofilament	**National**	**4,126**	**4,630**	**89**
	459 VA Pacific Islands HCS	17	20	**82**
	459GA Maui	45	49	**92**
	459GC Kona	40	47	**85**

Foot Sensory, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – Retinal Eye Exam	**70**	**National**	**3,181**	**3,510**	**91**
	70	459 VA Pacific Islands HCS	12	16	**75**
		459GA Maui	47	49	**96**
		459GC Kona	47	47	**100**

Retinal Exam, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – LDL-C	**88**	**National**	**3,413**	**3,511**	**97**
	88	459 VA Pacific Islands HCS	16	16	**100**
		459GA Maui	49	49	**100**
		459GC Kona	46	47	**98**

Lipid Profile, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – HbgA1c	**93**	**National**	**3,452**	**3,512**	**98**
	93	459 VA Pacific Islands HCS	16	16	**100**
		459GA Maui	49	49	**100**
		459GC Kona	47	47	**100**

HbgA1c Testing, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM - Renal Testing	**88**	**National**	**3,371**	**3,512**	**95**
	88	459 VA Pacific Islands HCS	14	16	**84**
		459GA Maui	49	49	**100**
		459GC Kona	47	47	**100**

Renal Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
Patient Screen with PC-PTSD	**95**	**National**	**9,761**	**10,006**	**98**
	95	459 VA Pacific Islands HCS	47	47	**100**
		459GA Maui	26	26	**100**
		459GC Kona	4	4	**100**

PTSD Screening, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
***Patient Screen with PC-PTSD with* timely Suicide Ideation/Behavior Evaluation**	**75**	**National**	**239**	**379**	**64**
	75	459 VA Pacific Islands HCS	0	1	**0**
		459GA Maui	*	*	*
		459GC Kona	*	*	*

PTSD Screening with Timely Suicide Ideation/Behavior Evaluation, FY 2010

Null values are represented by *, indicating no eligible cases.

Quality of Care Measures
VA Palo Alto HCS[26] – Sonora and Modesto

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 50−64	**66**	**National**	**4,843**	**6,973**	**69**
	66	640 VA Palo Alto HCS	49	63	**78**
		640GB Sonora	25	31	**81**
		640HB Modesto	41	53	**77**

Influenza Vaccination, 50−64 Years of Age, 4th Qtr, FY 2009

Measure	*Meets Target*	*Facility*	*Qtr 4 Numerator*	*Qtr 4 Denominator*	*Qtr 4 Percentage*
Influenza Vaccination, 65 or older	**83**	**National**	**5,460**	**6,499**	**84**
	83	640 VA Palo Alto HCS	33	42	**79**
		640GB Sonora	32	41	**78**
		640HB Modesto	18	21	**86**

Influenza Vaccination, Age 65 or Older, 4th Qtr, FY 2009

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
DM - Outpatient Foot Inspection	**National**	**4,321**	**4,651**	**93**
	640 VA Palo Alto HCS	43	48	**93**
	640GB Sonora	45	48	**94**
	640HB Modesto	47	48	**98**

DM Foot Inspection, FY 2010

Measure	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr1 Percentage*
DM - Outpatient - Foot Pedal Pulses	**National**	**4,208**	**4,651**	**90**
	640 VA Palo Alto HCS	43	48	**93**
	640GB Sonora	42	48	**88**
	640HB Modesto	43	48	**90**

Foot Pedal Pulse, FY 2010

[26] http://vaww.pdw.med.va.gov/MeasureMaster/MMReport.asp Note: Scores are weighted. The purpose of weighting is to correct for the over-representation of cases from small sites and the under-representation of cases from large sites. It corrects for the unequal number of available cases within each organizational level (i.e., CBOC, facility) and protects against the calculation of biased or inaccurate scores. Weighting can alter the raw measure score (numerator/denominator) in different ways, particularly measures with small "N"(s). Raw scores can go up or down depending on which cases pass or fail a measure. Sometimes the adjustment can be quite significant.

Measure	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – Outpatient Foot Sensory Exam Using Monofilament	**National**	**4,126**	**4,630**	**89**
	640 VA Palo Alto HCS	41	48	**89**
	640GB Sonora	41	48	**85**
	640HB Modesto	41	48	**85**

Foot Sensory, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – Retinal Eye Exam	**70**	**National**	**3,181**	**3,510**	**91**
	70	640 VA Palo Alto HCS	31	35	**84**
		640GB Sonora	42	48	**88**
		640HB Modesto	40	48	**83**

Retinal Exam, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – LDL-C	**88**	**National**	**3,413**	**3,511**	**97**
	88	640 VA Palo Alto HCS	35	35	**100**
		640GB Sonora	48	48	**100**
		640HB Modesto	46	48	**96**

Lipid Profile, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM – HbgA1c	**93**	**National**	**3,452**	**3,512**	**98**
	93	640 VA Palo Alto HCS	35	35	**100**
		640GB Sonora	48	48	**100**
		640HB Modesto	47	48	**98**

HbgA1c Testing, FY 2010

Measure	Meets Target	Facility	Qtr 1 Numerator	Qtr 1 Denominator	Qtr 1 Percentage
DM - Renal Testing	**88**	**National**	**3,371**	**3,512**	**95**
	88	640 VA Palo Alto HCS	34	35	**99**
		640GB Sonora	48	48	**100**
		640HB Modesto	46	48	**96**

Renal Testing, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
Patient Screen with PC-PTSD	**95**	**National**	**9,761**	**10,006**	**98**
	95	640 VA Palo Alto HCS	58	58	**100**
		640GB Sonora	*	*	*
		640HB Modesto	5	5	**100**

PTSD Screening, FY 2010

Measure	*Meets Target*	*Facility*	*Qtr 1 Numerator*	*Qtr 1 Denominator*	*Qtr 1 Percentage*
***Patient Screen with PC-PTSD with* timely Suicide Ideation/Behavior Evaluation**	**75**	**National**	**239**	**379**	**64**
	75	640 VA Palo Alto HCS	2	3	**81**
		640GB Sonora	*	*	*
		640HB Modesto	*	*	*

PTSD Screening with Timely Suicide Ideation/Behavior Evaluation, FY 2010

Null values are represented by *, indicating no eligible cases.

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