Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Community Based Outpatient Clinics Fiscal Year 2010

Report No. 11-00794-185

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VA Office of Inspector General
Washington, DC 20420

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Contents

Page

Executive Summary i

Introduction 1

Purpose 1

Background 1

Scope and Methodology 2

Inspection Results 6

Issue 1: CBOC Characteristics 6

Issue 2: Quality of Care Measures Based on Medical Record Review 8

Issue 3: Suicide Safety Plan 13

Issue 4: Credentialing and Privileging 13

Issue 5: Environment and Emergency Management 15

Issue 6: CBOC Contract Review 17

Comments 21

Appendixes

A. List of CBOCs Reviewed 22

B. PI II Indicators in the Analysis 23

C. CDCI II Indicators in the Analysis 24

D. Under Secretary for Health Comments 25

E. OIG Contact and Staff Acknowledgments 29

F. Report Distribution 30

Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections completed an evaluation of Veterans Health Administration (VHA) community based outpatient clinics (CBOCs). The purposes of the evaluation were to determine whether: (1) the CBOCs' quality of care measures are comparable to the parent VA medical center (VAMC) clinics,[1]
(2) CBOCs maintain the same standard of care as their parent facility to address the Mental Health (MH) needs of the Operation Enduring Freedom/Operation Iraqi Freedom era veterans, (3) CBOC providers are appropriately credentialed and privileged in accordance with VHA Handbook 1100.19, (4) patients who are assessed to be high risk for suicide have safety plans that provide strategies that help mitigate or avert suicidal crises, (5) applicable CBOCs comply with local and selected VHA standards for reusable medical equipment sterilization and low/high level disinfection, (6) CBOCs are in compliance with standards of operations according to VHA Handbook 1006.1 in the areas of environmental safety and emergency management, (7) the CBOC primary care and MH contracts were administered in accordance with contract terms and conditions, and (8) primary care active panel management and reporting are in compliance with VHA Handbook 1101.02.

Results and Recommendations

CBOCs overall appear to be providing a quality of care that is not substantially different from parent VAMCs. The CBOCs generally met VHA directives and guidelines.

Overall, we found no statistically significant differences between VA-staffed and contract CBOCs performance measure estimated compliance rates. However, estimated VA CBOC compliance rates were slightly higher in VA-staffed CBOCs than in contract CBOCs. Rural contract CBOCs had a higher mean compliance rate than VA-staffed CBOCs, and urban CBOCs average compliance rates were higher for VA-staffed; but, neither was statistically significant.

We found the following areas that needed improvement. We found that (a) only 41 (87 percent) of 47 CBOCs complied with the required CPR training; (b) 12 (26 percent) of the 47 CBOCs did not monitor, collect, or analyze hand hygiene data on a routine basis; (c) 9 (19 percent) of the 47 CBOCs did not consistently secure patients' personal identifiable information (PII); (d) VHA used 4 different pricing models to compensate for MH services at the 18 contract CBOCs; and (e) Primary Care Management Module (PCMM) Coordinators were not effectively managing primary care provider (PCP) assignments, which resulted in 9 (50 percent) of 18 contract CBOCs having patients assigned to more than one PCP.

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

[1] Our emphasis was on comparing VA-staff to contract CBOCs.

Recommendation 1. Emphasize the requirements to define staff that need life support training, systematically track training status, and take appropriate action when training is not maintained.

Recommendation 2. Monitor, collect, and analyze hand hygiene data.

Recommendation 3. Secure and protect patients' PII.

Recommendation 4. Review MH pricing models to determine the most effective compensation for MH services to be implemented in CBOC contracts.

Recommendation 5. Ensure that the PCMM is effectively managed by the Facility Director in conjunction with the PCMM Coordinator to minimize the assignment of patients to more than one PCP.

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

TO: Under Secretary for Health (10)

SUBJECT: Healthcare Inspection—Evaluation of Community Based Outpatient Clinics, Fiscal Year 2010

Introduction

Purpose

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

Background

The Veterans' Health Care Eligibility Reform Act of 1996 was enacted to equip VA with ways to provide veterans with medically needed care in a more equitable and cost-effective manner. As a result, VHA expanded the Ambulatory and Primary Care Services to include CBOCs located throughout the United States. CBOCs were established to provide more convenient access to care for currently enrolled users and to improve access opportunities within existing resources for eligible veterans not currently served.

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

VA policy outlines specific requirements that must be met at CBOCs. The minimum standards were developed in 2001 to ensure that veterans receive one standard of care at all VHA health care facilities. Care at CBOCs must be consistent, safe, and of high quality, regardless of whether it is VA-staffed or contract. CBOCs must comply with VA policy and procedures related to quality, patient safety, and performance.

As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year (FY) 2009, the VA OIG has been systematically reviewing VHA CBOCs since April 2009.

Scope and Methodology

We performed this review based on the inspections of 47 CBOCs from March 15, 2010, through August 27, 2010 (31 VA-owned or leased CBOCs and 16 contract CBOCs[2]). The 47 CBOCs findings were issued in 6 CBOC reports.[3] The CBOCs we visited represented a mix of facility size, geographic location, and Veterans Integrated Service Networks (VISNs). Our review focused on FY 2009 and 2010 activities. We analyzed results and reported deficiencies in each CBOC report.

There are 14 standards that must be met for CBOC operations. Nine of the 14 standards were addressed during our reviews and discussed in this report.[4] The standards can be found in VHA Handbook 1006.1.[5]

VA uses two key performance measures to assess the quality of health care delivery, the Chronic Disease Care Index II (CDCI II) and the Prevention Index II (PI II). These indices measure the degree to which the VA follows nationally recognized guidelines for the treatment and care of patients. This review evaluated PI II (influenza immunization) and CDCI II (diabetes mellitus (DM) and post-traumatic stress disorder (PTSD) screening). Data for the indicators were obtained from the patient medical record and compared to the parent facilities' results. We used the same time period, Quarter (Qtr) 3, FY 2009,[6] and Qtr 1, FY 2010, respectively for comparison. One of the CBOCs in our sample was suspended (July 1–November 30, 2009) during our study months; therefore, we were unable to assess the quality measure scores for this CBOC.

Statistical Methodology. The study population and sample were described in detail in the CBOC informational report.[7] To summarize briefly, the population comprised all patients who were enrolled in VHA CBOCs for their healthcare, after excluding those CBOCs that were included in our FY 2009 review. A three-stage complex probability sample design was used to select patients for performance measure review.

First, 30 out of 135 facilities were selected after stratification into three groups: contract CBOCs only, VA-staffed CBOCs only, and both contract and VA-staffed CBOCs. For each selected facility, two CBOCs were randomly selected if the facility had more than

[2]Originally, there were 29 VA-staffed and 18 contract CBOCS. Two contract CBOC converted to VA-staffed prior to our onsite inspection. One CBOC in our sample was suspended (July1-November 30, 2009) during our study months; therefore, it was not included in the data analysis for performance measures or CBOC characteristics.
[3] Report Numbers: 10-00627-174, 10-00627-239, 10-00627-09, 10-00627-17, 10-00627-208, and 10-00627-209 .
[4] Staffing, Timeliness, Station Numbering, Cost Accounting, and Patient Complaints were omitted from this review.
[5] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.
[6] VHA's comparison dates for Qtr 1, FY 2010, are October 1–November 30, 2009; and Qtr 3, FY 2009, are September 1, 2008–March 31, 2009.
[7] VA Office of Inspector General Report No. 10-00627-124 issued on April 6, 2010.

two; otherwise, all were taken. One contract and one VA-staffed CBOC were sampled in facilities with both types.

Stages 1 and 2 of sample selection resulted in 47 CBOCs as one of the selected facilities operated just one CBOC. One of the selected CBOCs discovered to have been in a suspended status from July1–November 30, 2010, was dropped from the study. Consequently, the final number of sampled CBOCs was 46 from the revised 576.

At the third stage of sampling, 50 patients diagnosed with diabetes (ICD-9-CM 250) and independently 75 patients who were 50 years of age or older were randomly selected for each of the 46 CBOCs. If there were 50 or fewer diabetic patients and 75 or fewer patients age 50 or older in a CBOC, all patients were taken. Also, 30 patients who were not diagnosed with PTSD and had a service date after September 11, 2001, were randomly selected for each CBOC with more than 30 such patients.

Data Analysis. Patients who refused to have a procedure performed were considered compliant for the respective performance measures. If a particular performance measure did not apply to a patient, the patient was excluded from analyses for that measure. For example, foot sensation testing would not apply to a patient whose legs were amputated.

Estimates of compliance rates and CBOCs' services characteristics are based on Horvitz-Thompson estimates. The 95 percent confidence intervals (95% CI) were calculated based on logit[8] transformation to ensure that the calculated conference levels contained only the proper range of zero to 100 percent. Performance measures and CBOC characteristics estimates were based on the Horvitz-Thompson estimator.[9] Statistical analyses were conducted using SAS System version 9.2 software (SAS Institute Inc., Cary, NC). The CBOC MAP was produced using ArcGIS software (Environmental Systems Research Institute, Redlands, CA), version 10.

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

1. CBOC Characteristics

We collected CBOC characteristics from an online questionnaire completed by the CBOC Director/Manager. We validated and aggregated the data obtained to determine if any trends and statistical significant difference were found between VA-staffed and contract CBOCs.

[8] Function used in mathematics, especially in statistics.
[9] Cochran, William. Sampling Techniques 3rd Ed. John Wiley & Sons (1977), pp. 259-261.

2. Medical Record Review

For each CBOC, we reviewed the medical records of a random sample of 50 patients with a diagnosis of diabetes, 75 patients who were 50 years of age or older (influenza immunization), and 30 patients with a military service release date after September 11, 2001, without a diagnosis of PTSD selected, unless fewer patients were available. We reviewed the medical records for a probability-based statistical sample of patients within each sampled CBOC to determine compliance with VHA performance measures.

We also reviewed 10 patients, unless fewer were available, assessed to be at high risk for suicide, to determine if clinicians developed safety plans that included all required elements.

3. Onsite Inspections

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

4. Contract Review

We conducted reviews of primary care and mental health (MH) services performed at the contract CBOCs to evaluate the effectiveness of VHA oversight and administration for selected contract provisions relating to quality of care and payment of services. Each CBOC engagement included: a review of the contract, analysis of patient care encounter data, corroboration of information with VHA data sources, site visits, and interviews with VHA and contractor staff.

Primary Care. We reviewed each contract, including amendments, modifications, and addendums, to gain an understanding of the provisions relating to payment and quality performance measures. The provisions included: (1) effective dates of agreements, (2) assignments of responsibility between the VA and the contractor, (3) contractor's reporting requirements, (4) criteria used to define a qualifying visit for billing purposes, (5) billing rates and invoice formats, (6) performance measures, and (7) incentive/penalty provisions.

Mental Health. For this review we did not determine whether the clinics were meeting all standards set forth in VHA MH directive,[10] but focused on the performance measures and payment provisions in the contracts.

Primary Care Management Module. We conducted reviews of Primary Care Management Module (PCMM) administration to assess VHA's management and

[10] VHA Handbook 1160.1 Uniform Mental Health Services in VA Medical Centers and Clinics, dated Sept 11, 2008.

accuracy of the primary care panels. We ran reports to determine the number of patients assigned to each Primary Care Provider (PCP) panel, the number of enrollees assigned to more than one PCP, if there were patients that have been seen at the CBOC but not assigned to a panel, and if there were deceased patients assigned to a panel.

PCMM is a Veterans Health Information and Technology Architecture (VistA) application used to manage PCP workload to balance productivity with quality, access, and patient service. A patient may have more than one PCP assigned in certain cases and requires approval. This application is an important tool in determining the total number of veterans that can be cared for in the VA health care system and aligning the supply of services with demand.

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

Inspection Results

Issue 1: CBOC Characteristics

Figure 1 displays the locations of 576 VA CBOCs subject to review and inspection with the 47 CBOCs sampled.

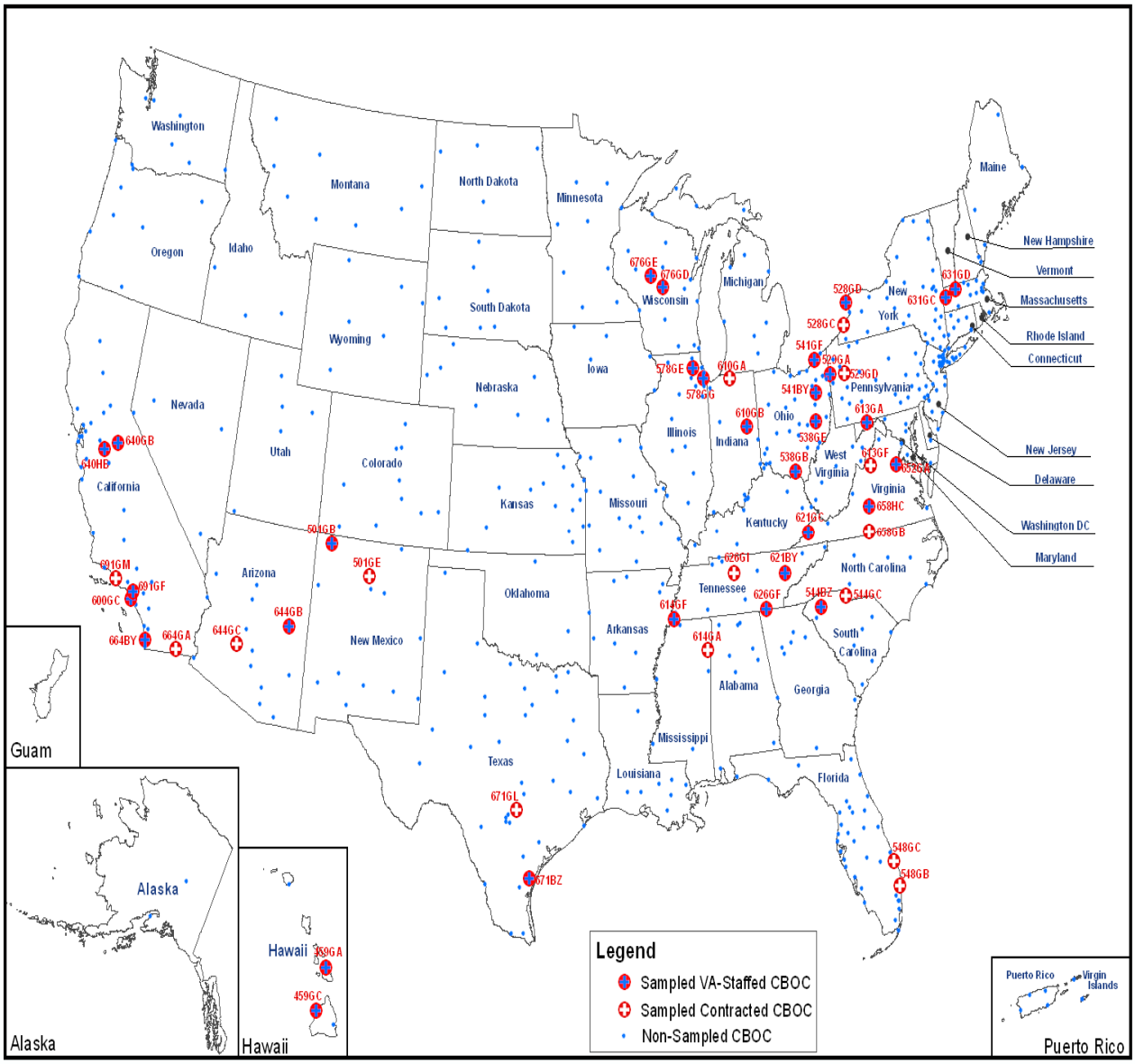

Figure 1. CBOC Map

The study population[11] constitutes all patients who were enrolled in the CBOCs for their health care. VA-staffed CBOCs had a greater number of urban locations

[11] Of the 576 CBOCs initially in the study population, one CBOC was suspended (July1-November 30, 2009) during our study months; therefore, was not include in the data analysis for CBOC characteristics or performance measures.

(58 percent) whereas contract CBOCs had a greater number of rural locations (70 percent). (See Figure 2.)

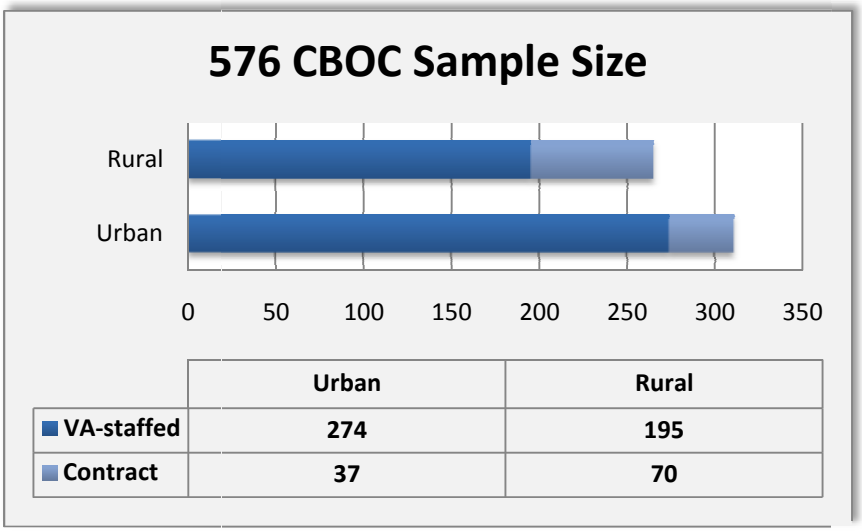

Figure 2. Urban and Rural by CBOC Type (Source: VHA Site Tracking (VAST) System)

Of the 46 CBOCs in our sample, there were 12 VA-staffed and 8 contract CBOCs in rural locations and 19 VA-staffed and 7 contract CBOCs in urban locations.

The average number of patients (study population) seen at 438 VA-staffed CBOCs was 4,669 (range 28 to 45,481) and at the 138 contract CBOCs was 2,346 (range 111 to 9,351). Figure 3 displays uniques by CBOC type and location. Of the sampled CBOCs, the average number of unique patients seen at the 31 VA-staffed CBOCs was 5,754 (range 858 to 32,293) and at the 15 contract CBOCs was 3,771 (range 611 to 8,874).

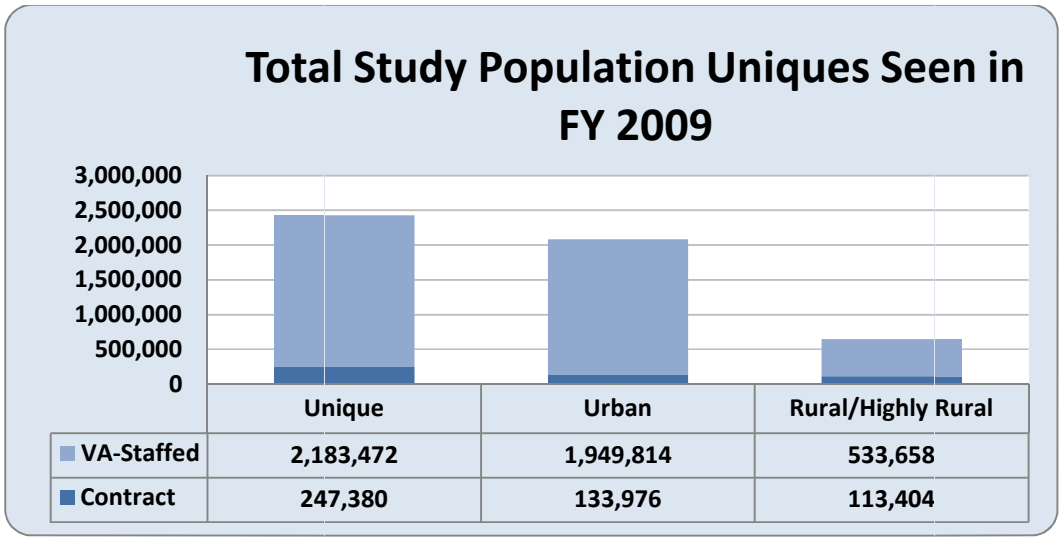

Figure 3. Enrollees by CBOC Type and Location (Source: VAST System)

Table 1 shows the sample counts and VA estimate of VA-staffed and contract CBOCs with each type of service listed. VA-staffed CBOCs consistently had higher estimates; however, the differences between estimates for VA-staffed and contract CBOCs were not statistically significant except for addiction counselors. Approximately 52.4 percent of VA-staffed CBOCs had addiction counselors compared to about 2.4 percent of contract CBOCs.

	VA Staffed CBOCs				Contract CBOCs			
	Sample (Size=31)		95% Confidence Limits		Sample (Size=15)		95% Confidence Limits	
Characteristic	Number Sites with Service Provided	Estimated VA Percent	Lower	Upper	Number Sites with Service Provided	Estimated VA Percent	Lower	Upper
Social Worker Service	20	82.8	61.87	93.48	6	36.0	11.65	70.50
Addiction Counselor	11	52.4	16.36	86.12	1	2.4	0.30	16.36
EKG	28	97.6	91.68	99.35	13	90.5	61.64	98.26
Radiology	8	23.2	7.33	53.42	3	11.9	3.15	35.75
Telemental Health	24	90.9	78.44	96.47	9	57.3	25.90	83.75
Teleretinal	15	49.2	15.05	84.07	3	16.6	3.99	48.82
Women Health	11	43.7	22.82	67.02	2	19.0	3.98	56.98

Table 1. Services at CBOCs

Conclusion

VA-staffed and contract CBOCs had comparable characteristics. Contract CBOCs provided care to more patients in rural locations. VA-staffed CBOCs served a higher percentage of patients in urban areas. We collected this data for informational purposes only.

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

For the CBOC performance evaluation presented in this report, a subset of PI II and CDCI II indicators were assessed (see Appendix B and C). We reviewed 2,068 DM; 3,012 influenza immunization; and 568 PTSD medical records. There were exceptions for certain indicators; therefore, denominators may vary in the reported results. A large number of the CBOCs had less than 30 PTSD patients that met our criteria; therefore, we could not determine a 95% CI for most individual CBOCs, and we were not able determine a statistically significant difference between VA-staffed to contract CBOCs.

We found patients who refused lab test and procedures (9 foot sensation testing, 6 foot inspections, 7 foot pulse evaluations, 1 HgbA1c testing, 1 LDL-C testing, 1 retinal eye exam, and 413 influenza immunizations). The 413 patients that refused influenza immunization accounted for approximately 14 percent of the sample.

VA CBOCs Compared to VA. Based on the PI II and CDCI II indicators, CBOCs overall appear to be providing a quality of care that is not substantially different from parent VAMCs, although some individual CBOCs are not providing the same quality as affiliated parents on all indicators. When individual CBOCs were compared to their affiliated parent VAMCs, performance was more variable. We uses the parent VAMCs performance measures. We obtained the parent facility performance measure scores from http://vaww.pdw.med.va.gov/MeasureMaster/MMReport.asp.

Table 2 shows, for reference purposes, actual VAMCs' performance measures and the estimated performance measures and confidence intervals for VA CBOCs. Because we were looking at provider compliance, patient refusals are counted as compliant. To demonstrate the impact of treating patient refusals as compliant, we compared VA CBOC estimated compliance to VA using our criteria. All VA CBOCs' estimates were above 90 percent.

	VA		VA CBOCs			
					95% CI Limits	
Performance Measure	**N[12]**	**Percent**	**n[13]**	**Percent**	**Lower**	**Upper**
Diabetes (Outpatient)						
Foot Inspection	4,651	93	2,022	97.2	95.98	98.00
Foot Pedal Pulse	4,651	90	1,982	95.6	94.08	96.69
Foot Sensory Exam	4,630	89	1,890	92.4	89.36	94.60
HbgA1c	3,512	98	2,020	98.5	96.25	99.38
LDL-C Measured	3,511	97	2,009	98.3	95.14	99.42
Renal Testing	3,512	95	2,024	98.6	96.90	99.35
Retinal Eye Exam	3,510	91	1,827	92.8	89.47	95.17
Influenza						
Age 50-64	4,453	70	1,176	90.5	87.80	92.67
Age 65 and older	4,341	82	1,514	93.8	91.27	95.58
Behavioral Health Screening						
PTSD - Screening	10,006	98	538	97.4	91.75	99.21

Table 2. VA Performance Scores and Estimated VA CBOCs' Performance Scores When Patient Refusal Considered Compliant

[12] The "N" values for VA are the total number of patients for the performance measures, that is, the denominators for computing the percents.

[13] The "n" value for VA CBOCs is the number of sampled patients in compliance for the corresponding performance measure. Patient refusal is counted as compliant. The total numbers of sampled VA CBOC patients are 2,068 for diabetes measures; 3,012 for influenza immunization; and 538 for PC-PTSD screen. Three VA CBOC patients were excluded for foot inspection and for foot pedal pulse, 4 were excluded for foot sensory, and 15 were excluded for influenza immunization (visit preceded availability of vaccine).

Since VA counted patient refusals as noncompliant, we adjusted our analysis to match VA. We compared VA CBOC DM and influenza immunization estimated compliance to VA. The results are displayed in Table 2.1.

	VA		VA CBOCs			
					95% CI Limits	
Performance Measure	**N[14]**	**Percent**	**n[15]**	**Percent**	**Lower**	**Upper**
Diabetes (Outpatient)						
Foot Inspection	4,651	93	2,016	96.9	95.66	97.79
Foot Pedal Pulse	4,651	90	1,975	94.8	93.62	95.71
Foot Sensory Exam	4,630	89	1,881	91.5	88.86	93.55
HbgA1c	3,512	98	2,019	97.9	96.36	98.83
LDL-C Measured	3,511	97	2,008	97.8	95.66	98.87
Renal Testing	3,512	95	2,024	98.6	96.90	99.35
Retinal Eye Exam	3,510	91	1,827	92.8	89.47	95.17
Influenza						
Age 50-64	4,453	70	920	70.5	60.10	79.15
Age 65 and older	4,341	82	1,357	86.1	82.15	89.25

Table 2.1. VA Performance Scores and Estimated VA CBOCs' Performance Scores When Patient Refusal Considered Noncompliant

VA-staffed Compared to Contract CBOCs. Performance measures estimates for VA-staffed CBOCs and for contract CBOCs are presented in Table 3. All measures had an estimated performance score 90 percent or above for VA-staffed CBOCs. For contract CBOCs, estimates for retinal eye exam and influenza immunization for both age groups, were below 90 percent. Differences between estimates for VA-staffed and contract CBOCs were not statistically significant.

[14] The "N" values for VA are the total number of patients for the performance measures, that is, the denominators for computing the percents.

[15] The "n" value for VA CBOCs is the number of sampled patients in compliance for the corresponding performance measure. Patient refusal is counted as compliant. The total numbers of sampled VA CBOC patients are 2,068 for diabetes measures; 3,012 for influenza immunization; and 538 for PC-PTSD screen. Three VA CBOC patients were excluded for foot inspection and for foot pedal pulse, 4 were excluded for foot sensory, and 15 were excluded for influenza immunization (visit preceded availability of vaccine).

Performance Measure	VA-staffed n	VA-staffed Percent	VA-staffed 95% CI Limits Lower	VA-staffed 95% CI Limits Upper	Contract n	Contract Percent	Contract 95% CI Limits Lower	Contract 95% CI Limits Upper
Diabetes (Outpatient)								
Foot Inspection	1,390	97.0	95.73	97.93	632	98.5	95.53	99.47
Foot Pedal Pulse	1,363	95.7	94.08	96.82	619	94.7	84.51	98.35
Foot Sensory Exam	1,304	92.3	89.04	94.72	586	92.7	83.16	97.01
Renal Testing	1,390	98.6	96.56	99.41	634	98.6	97.08	99.32
LDL-C Measured	1,380	98.4	94.47	99.54	629	97.7	95.99	98.66
Retinal Eye Exam	1,270	93.3	89.72	95.71	557	88.2	84.25	91.33
HbgA1c	1,388	98.5	95.84	99.46	632	98.3	97.32	98.96
Influenza Immunization								
Age Group								
50-64	851	90.8	88.01	92.95	325	86.1	78.65	91.30
65 and older	1,019	94.1	91.97	95.75	495	89.9	81.69	94.72

Table 3. VA-staffed and Contract CBOCs Estimated Performance Scores[16]

Rural compared to Urban CBOCs. No statistically significant differences were found between VA-staffed and contract CBOCs estimates when controlling for geographic location. Influenza immunization (50-64 age group) is the sole measure with an estimated performance score below 90 percent for VA-staffed urban CBOCs. Urban contract CBOCs, retinal eye exam and influenza immunization (both age groups), were below 90 percent. (See Table 4.)

[16] The diabetes measures are based on sample patient totals of 1,424 and 644 for VA-staffed CBOCs and contract CBOCs, respectively. Two VA-staffed and one contract CBOC patients were excluded for foot inspection and foot pedal pulse. Four patients were excluded for foot sensory; three from VA-staffed CBOCs and one from contract CBOCs. Influenza measures, age group 50-64 years, are based on sample patients total of 951and 394 for VA-staffed and contract CBOCs, respectively; and age group 65 yrs and older are based on sample patients total of 1,100 VA-staffed and 915 contract CBOCs, respectively. Fifteen patients were excluded: 3 VA-staffed and 7 contract CBOC patients (50-64 years old) and 1 VA-staffed and 4 contact CBOC patients (65 and older).

	VA-staffed				Contract			
	n	Percent	Lower Limit 95% CI	Upper Limit 95% CI	n	Percent	Lower Limit 95% CI	Upper Limit 95% CI
Rural								
Foot Inspection	543	98.4	90.46	99.77	321	98.7	89.34	99.86
Foot Pedal Pulse	534	96.6	82.49	99.42	318	97.4	80.53	99.71
Foot Sensory Exam	498	91.0	71.45	97.60	317	97.6	84.34	99.68
Renal Testing	533	96.6	84.50	99.35	320	98.5	95.72	99.46
LDL-C Measured	524	95.2	74.54	99.27	314	96.6	95.17	97.61
Retinal Eye Exam	478	90.2	75.52	96.52	284	88.8	82.87	92.86
HbgA1c	530	96.2	76.31	99.50	319	98.3	96.52	99.19
Influenza 50-64	315	95.0	92.06	96.94	208	92.4	75.99	97.88
Influenza 64 and older	423	96.4	92.73	98.21	264	94.0	67.57	99.16
Urban								
Foot Inspection	847	96.7	95.26	97.71	311	98.1	94.31	99.36
Foot Pedal Pulse	829	95.4	93.41	96.86	301	91.2	70.28	97.86
Foot Sensory Exam	806	92.7	89.43	94.96	269	86.2	71.66	93.87
Renal Testing	857	99.0	96.77	99.70	314	98.7	94.94	99.69
LDL-C Measured	856	99.1	97.01	99.73	315	99.1	96.22	99.78
Retinal Eye Exam	792	94.0	90.11	96.44	273	87.5	79.27	92.78
HbgA1c	858	99.0	97.48	99.61	313	98.3	96.52	99.22
Influenza 50-64	536	89.6	85.06	92.83	117	82.0	77.33	85.90
Influenza 64 and older	596	93.6	89.71	96.14	231	88.2	81.04	92.86

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

Conclusion

Although not statistically significant, estimated VA CBOC compliance rates are consistently slightly higher in VA-staffed CBOCs than in contract CBOCs. Rural contract CBOCs had a higher mean compliance rate than VA-staffed CBOCs, and urban CBOCs average compliance rates were higher for VA-staffed; but, neither was statistically significant. We made no recommendations.

Issue 3: Suicide Safety Plan

Comprehensive safety planning is a clinical intervention that can serve as a valuable adjunct to suicide risk assessment. "A safety plan is a prioritized written list of coping strategies and support sources that patients can use during or preceding suicidal crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as well as a list of individuals or agencies that veterans can contact in order to help them lower their imminent risk of suicidal behavior."[17] The essential elements of a comprehensive plan are: (1) identification of the warning signs that precede a suicidal crisis, (2) identification and use of internal coping strategies, (3) identification of when it is time to socialize with family members or others who may offer support or distraction from the crisis, (4) identification of when it is time to contact family members or others who may offer help to resolve the crisis, and (5) identification of when it is necessary to contact professional agencies. The patient should have input into each step of the plan and be given a copy of the agreed upon plan, and the plan should be maintained in the patient's medical record.

The review showed that 199 (92 percent) of 216 of the medical records had documented evidence of safety plans that fully met the criteria. The deficiencies identified by inspectors for the remaining records were that safety plans did not contain all the essential elements, were not completed timely, or were not completed at all.

Conclusion

Most CBOC staff were developing suicide safety plans that contained the essential elements of a comprehensive plan; therefore, we made no recommendations. Specific recommendations were made in the individual CBOC reports.

Issue 4: Credentialing and Privileging

All VHA health care professionals who are permitted by law and the facility to provide patient care services independently must be credentialed and privileged. The C&P program is used by medical centers to ensure that clinical providers have the appropriate professional license(s) and other qualifications to practice in a health care setting and that they practice within the scopes of their licenses and competencies.

We reviewed the C&P folders of 198 providers, utilizing VetPro[18] to conduct our initial review, to include verifying education and training, licensure, and type of appointment. Provider privileges or scope of practice and physician quality profiles were examined on-site. We also assessed the life support training records of all providers.

[17] Stanley, Barbara and Brown, Gregory K., *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version,* August 20, 2008.
[18] VetPro is VHA's electronic credentialing system.

A. Life Support Training

VHA expects that each facility will have a policy that defines the staff that need to have current cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) training, a mechanism to ensure compliance, and consequences if needed training is not maintained.[19] We found 41 (87 percent) of 47 CBOCs complied with the required CPR training. We recommended that VHA ensures that CPR training is maintained and tracked and that appropriate actions are taken when training is not maintained.

B. Scope of Privileges

We found 9 (19 percent) of 47 CBOCs granted clinical privileges for procedures that exceeded the services provided at the CBOC setting. Although VHA clinical privileges must be facility and provider specific, it is the setting in which care is delivered that dictates the type(s) of care, treatment, and procedure that a practitioner will be authorized to perform. Granting of privileges improved slightly from our FY 2009 report. Since there was some improvement and VHA's action plan for FY 2009 is still in process, we made no recommendations.

C. Practitioner Evaluations

We found evidence that 42 (90 percent) of 47 CBOC developed Ongoing Professional Practice Evaluations (OPPEs). However, we found three CBOCs had not developed written threshold/criteria that would trigger a more in-depth review. We also found that two CBOCs did not consistently prepare Focused Professional Practice Evaluations (FPPEs). OPPEs and FPPEs allow the facility to identify professional practice trends that impact the quality of care and patient safety. No trends were identified. Specific recommendations were made in individual CBOC reports for the five CBOCs.

Conclusion

The CBOC generally met VHA directives and guidelines and followed the Joint Commission standards. We identified improvement in the privileges granted to providers, and no trends were identified for OPPEs or FPPE; however, increase compliance with life support training is needed.

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

Recommendation 1: Emphasize the requirements to define staff that need life support training, systematically track training status, and take appropriate action when training is not maintained.

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

Issue 5. Environment and Emergency Management

A. Environment of Care

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

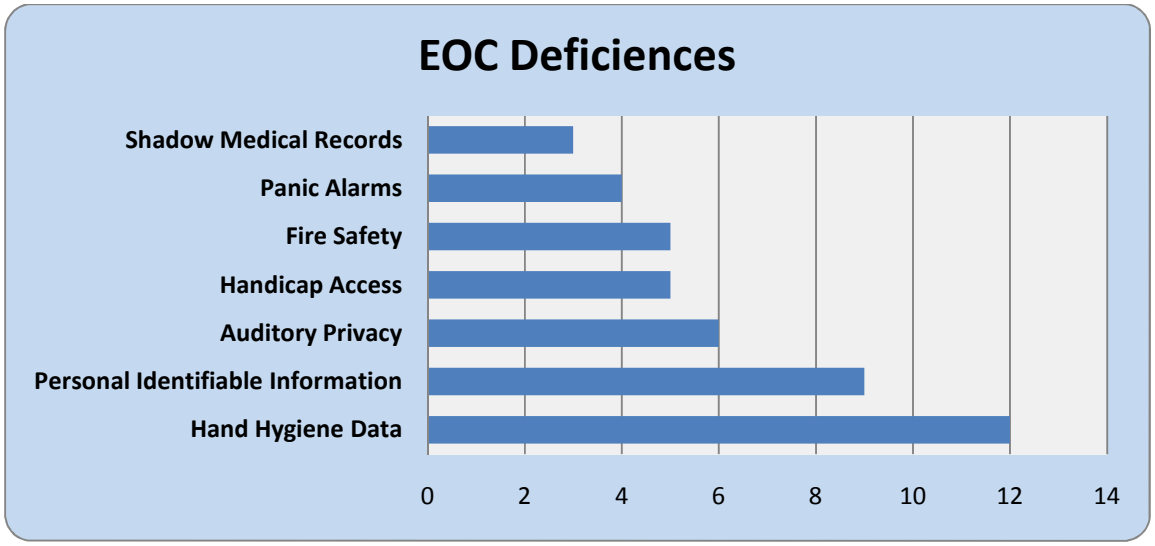

Figure 4. EOC Deficiencies

Hand Hygiene Data. Twelve (26 percent) of the 47 CBOCs did not monitor, collect, or analyze hand hygiene data on a routine basis. The Center for Disease Control and Prevention recommends that hand hygiene be a component of the healthcare facilities' infection control program. We recommended that CBOCs' hand hygiene data is monitored, collected, and analyzed.

Personally Identifiable Information. We found nine (19 percent) CBOCs did not consistently secure patient's personal identifiable information (PII). This represents an increase from our FY 2009 report. PII was left unsecured on an unsecured fax machine, on shelves in unsecure room, and visible from employees' computers. Although we found no consistent trend in how the PII was inappropriately secured, VHA needs to ensure the security of patient data. We recommended that VHA ensure that all PII is secured and protected.

Auditory Privacy. Most of the 47 CBOCs we inspected had very small patient waiting areas. At 6 (13 percent) of the CBOCs, we found the waiting room seats were located next to or in close proximity to the check-in windows. Patients communicated with staff and provided PII through open-glass or sliding-glass windows where auditory privacy was compromised. There were no instructions to incoming patients to allow patients a zone of audible privacy during the check-in process. Since there was some

improvement and VHA's action plan for FY 2009 is still in process, we made no recommendations.

Handicap Accessibility. Five (11 percent) of the 47 CBOCs we inspected were partially or were not handicap accessible to disabled veterans. The Americans with Disabilities Act[20] and the Joint Commission require that buildings and grounds are suitable to service disabled individuals. These results represent an improvement compared to those in our FY 2009 report, and VHA's action plan is still in process; therefore, we made no recommendations.

Fire Safety. We found no documentation for annual fire drills or annual safety inspections at five CBOCs. We did not identify a specific trend; therefore, we made no recommendations.

Panic Alarms. Four (8 percent) CBOCs did not have a panic alarm system or did not perform a vulnerability risk assessment to determine if a panic alarms system was needed. These results represent an improvement compared to those in our FY 2009 report; therefore, we made no recommendations.

Shadow Medical Records. We found that three (6 percent) CBOCs kept paper medical records in addition to the computerized patient record system (CPRS). The hard copy medical records contained documents such as test results and hospitalization summaries from non-VA facilities. At one CBOC, the clinical impression and medications differed from the documentation in CPRS. No trend was identified, and we made specific recommendations in the individual CBOC reports; therefore, we made no recommendations.

B. Emergency Management

VHA Handbook 1006.1 requires each CBOC to have a local policy or standard operating procedure defining how medical and MH emergencies are handled. All the CBOCs we inspected were in compliance with VHA policy. This was a marked improvement from our FY 2009 report. We commend VHA on this accomplishment.

Conclusion

CBOCs met most standards, and the environments were generally clean and safe. Safety guidelines were generally met, and risk assessments were in compliance with VHA standards. VHA has made improvements in many of the EOC areas identified as needing improvement. VHA needs to ensure that CBOC staff monitor and collect hand hygiene data and secure and protect patient's PII.

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

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

Recommendation 2. Monitor, collect, and analyze hand hygiene data.

Recommendation 3. Secure and protect patient's PII.

Issue 6: CBOC Contract Review

Two CBOC categories changed prior to our on-site visits. For the purpose of the contract CBOC review and since the review was retrospective, the CBOC category is maintained as contract even though they had converted to VA-staffed CBOCs. Therefore, the total number of contract CBOCs is 18 compared to the 15 CBOCs[21] discussed in Issues 1 and 2.

A. Primary Care

To assess VHA's oversight of contracted primary care, we focused on contract provisions relating to quality of care and payment for services. Overall, we found that a majority of the contracted CBOCs in our sample were effectively managed and had adequate oversight to ensure veterans received quality medical care. VHA had processes in place to monitor quality performance measures and to ensure proper payments were made. However, we did find instances where VHA could improve. We found discrepancies for the following reasons: (1) overpayments due to inactive enrollees, (2) performance measures not monitored or enforced, (3) additional payments for services previously included in the contract, and (4) lease payments outside of the contract. Table 5 shows these findings by category for the 18 CBOCs that totaled $624,300.

Category	CBOCs with findings In Percentages	Findings Dollar Amount
Overpayments Due to Inactive Enrollees	**28**	**$565,000**
Performance Measures Not Monitored or Enforced	**17**	**$50,000**
Additional Payments for Services Previously Included in the Contract	**6**	**$7,200**
Lease Payments Outside of Contract	**6**	**$2,100**
Total Identified		**$624,300**

Table 5. Summary of Findings by Category

Overpayments Due to Inactive Enrollees. We found that 5 (28 percent) of 18 contract CBOCs did not have effective processes in place to identify inactive enrollees on the contractor's invoice, which resulted in overpayments in excess of $565,000. Under a capitated rate contract, VHA pays a monthly flat rate for each currently enrolled primary care patient. An inactive patient is one who has not had a qualifying office visit within a

[21] The third contract CBOC was in a suspended status for 5 months prior to our onsite visit.

certain time period defined in the contract, usually 12 months. Overpayments occurred when VHA paid for inactive patients, patients that have moved to a new location, or patients that have died.

Performance Measures Not Monitored or Enforced. We found that 3 (17 percent) of 18 contract CBOCs were not monitoring quality performance measures. In two of the cases, the measures met contract requirements; therefore, no penalty was applied. In the third case, the VHA and the Contracting Officer were not aware that a penalty clause was in the contract. Once identified, the Contracting Officer took steps to apply $50,000 in penalties due to the contractor's consistently poor performance.

Additional Payments for Services Previously Included in the Contract. We found 1 (6 percent) of 18 contract CBOCs was paying the contractor for courier services, which were identified as a service included in the capitated rate of the primary care contract.

Lease Payments Outside of Contract. We found that 1 (6 percent) of 18 CBOCs was paying additional rental fees that were not covered under the contract or a separate lease agreement.

VHA should continue their efforts to mitigate issues regarding overpayments due to inactive enrollees, enforcement and monitoring of performance measures, and other contractual matters. Similar issues were noted in our FY 2009 report.[22] We identified some of the causal factors for these overpayments and made recommendations. We recommended that VHA review the oversight process and implement steps to standardize contract provisions and improve the invoice approval process. VHA concurred with the findings and assembled a workgroup to study and implement improvements. These efforts are still in the process; therefore, we made no additional recommendations.

B. Mental Health

Overall, we did not find significant discrepancies regarding compliance with the MH payment provisions in the contracts. Each contract varied in the provisions for payment, as there is no standard within VHA to pay for these services at the CBOCs. We found four different pricing models used to provide MH services at the 18 CBOCs in our sample: (1) combined capitated rate, that includes primary care and MH services; (2) separate capitated rate for MH as part of the primary care contract or a separate MH contract; (3) fixed rate per visit; and (4) hourly rate—charge based on provider type and time.

[22] VA Office of Inspector General Report No. 10-03103-12, *Evaluation of Community Based Outpatient Clinics Fiscal Year 2009*, October 21, 2010.

Table 6 shows a summary of the type of pricing models we identified.

MH Pricing Models	Number of CBOCs	Percentage
Combined Capitated Rate	14	78
Separate Capitated Rate	2	10
Fixed Rate per Visit	1	6
Hourly Rate	1	6
Total	**18**	**100**

Table 6. Types of MH Pricing Models

We found that 14 out of 18 CBOC contracts had a combined capitated rate that included primary care and MH services such as telemental health, supplies, equipment, support staff, and work space for VA to provide MH services at the CBOC. While the VA provided the MH services at most of these CBOCs, we found two where the contractor provided more comprehensive MH services. The combined capitated rate payment option resulted in greater expense to the VA when the contractor provided MH services because the rate was increased for all enrollees regardless of utilization of services.

For example, one CBOC added MH services to the primary care contract; thereby, increasing the capitated rate paid to the contractor for all enrolled patients. The contractor provided a psychiatrist (part time), psychologist, administrative support, and space to support these services. However, VA providers performed all the group therapy at the CBOC, which represented about 57 percent of the MH encounters. The contractor was paid approximately $900,000 per year to provide individual therapy services for the remaining 43 percent of the MH encounters.

Two of 18 CBOCs had a separate MH capitated rate for each patient using MH services. This pricing model required additional administration to validate the invoices; however, it allowed for more control over costs by only paying for enrollees that utilized MH services and had specific requirements for an enrollee to qualify for payment.

One CBOC was paid a fixed rate per MH visit. This CBOC had 17,851 primary care visits and 18,849 MH visits in calendar year 2009. The national average of annual MH visits per MH patient as reported by the VHA Support Service Center (VSSC) for FY 2009 was 2.42 while this CBOC had an average of 9 visits per MH patient. This CBOC's average number of visits per patient was 3.5 times higher than the national average. The contract made no distinction for payment between individual therapy and group therapy, resulting in the fixed per visit rate being paid for each person in a group therapy session. We found that approximately 30 percent of the CBOC's total MH encounters was for group therapy. The cost to provide MH services to less than 2,000 patients at this CBOC was approaching $2,000,000 for the year.

One CBOC paid its contractor an hourly rate based on the type of provider. The contractor was paid a different rate depending on if the patient was seen by a psychiatrist, psychologist, or licensed clinical social worker. This type of pricing

required additional administration to validate the invoices, however, in this case, the processes for tracking and validating were adequate.

The appropriate pricing models should be based upon factors including rate structure, category of MH providers, group versus individual therapy needs, and expected usage. Cost comparisons should be performed based upon expected initial costs compared to actual historical costs to determine the effectiveness of the pricing model and if the VA can provide services more effectively. We recommended that MH pricing models are reviewed to determine the most effective compensation for MH services in CBOC contracts.

C. Primary Care Management Module

We performed inquiries of PCMM Coordinators to review the processes used to update PCMM patient panels for transfers to other facilities, deaths, and duplicate enrollments and to ensure that software service patches were current. We reviewed reports from the VSSC for active and unique enrollees to compare against the number of invoiced enrollees. Additionally, we reviewed VSSC reports on duplicated PCP assignments to assess if the PCMM Coordinators were monitoring duplicate enrollees.

Table 7 represents, from reports issued over the prior year, the current status of duplicated PCP assignments of parent facilities.

VISN	Parent Name	Number of Duplicate Assignments	Number of Active Enrollees
11	(610) Northern Indiana HCS, IN	896	38,128
2	(528) Western New York, NY	2,661	31,353
8	(548) West Palm Beach, FL	4,581	55,884
9	(614) Memphis, TN	1,391	40,100
9	(626) Middle Tennessee HCS, TN	2,782	64,970
18	(644) Phoenix, AZ	1,908	57,389
22	(600) Long Beach, CA	2,998	39,555
22	(664) San Diego, CA	1,901	51,624
22	(691) West Los Angeles, CA	4,734	69,723

Table 7. Duplicate PCP Assignments

VHA Handbook 1101.02 specifies limited conditions whereby a patient can have more than one PCP, generally for the management of complex primary care. Some duplicate enrollees had not had a visit to their primary assigned VAMC in the last 2 years and no future appointment recorded. At one VAMC, dual enrollments were approximately 9 percent of the patients reported on the active panel.

Inflated primary care panels directly impact PCP workload and performance reporting and could result in contractor overpayments if the duplicated enrollees are listed on the panels of contract CBOCs. VHA needs to more effectively manage primary care panels

for duplicated PCP assignments. We recommended that VHA ensure PCMM Coordinators manage the PCMM in accordance with the guidelines established in VHA Handbook 1101.02 to ensure that the number of duplicated enrollees is minimized.

Conclusion

VHA's oversight of contracted primary care for the majority of the contract CBOCs in our sample demonstrated effective management of primary care contracts in accordance with contract terms and conditions. VHA needs to implement a more effective process to analyze the cost of providing MH services to veterans to ensure that VA resources are used effectively. VHA also needs to implement a more effective process to minimize the number of multiple PCP assignments in PCMM.

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

Recommendation 4. Review MH pricing models to determine the most effective compensation for MH services to be implemented in CBOC contracts.

Recommendation 5. Ensure that the PCMM is effectively managed by the Facility Director in conjunction with the PCMM Coordinator to minimize the assignment of patients to more than one PCP.

Comments

The Under Secretary for Health concurred with the findings and recommendations. The implementation plan is acceptable, and we will follow up until all actions are complete.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

List of CBOCs Reviewed

614GA Smithville, TN
614GF Memphis, TN
621GY Knoxville, TN
621GC Norton, VA
626GF Chattanooga, TN
626GI Vine Hill, TN
671BZ Corpus Christi, TX
671GL New Braunfels, TX
600GC Long Beach, CA
600GD Whittier, CA
664BY Mission Valley, CA
664GA Imperial Valley, CA
691GF East Los Angeles, CA
691GM Oxnard, CA
548GB Delray Beach, FL
548GC Stuart, FL
538GB Portsmouth, OH
538GE Cambridge, OH
541BY Canton, OH
541GF Painesville, OH
610GA South Bend, IN
610GB Muncie, IN
631GC Pittsfield, MA
631GD Greenfield, MA
528GC Dunkirk, NY
528GD Niagara Falls, NY
529GA Mercer County, NY
529GD Clarion County, NY
613GA Cumberland, WV
613GF Harrisonburg, WV
652GA Fredericksburg, WV
658GB Danville, VA
658HC Lynchburg, VA
544BZ Greenville, SC
544GC Rock Hill, SC
578GE Elgin, IL
578GG Oak Lawn, IL
676GD Wisconsin Rapids, WI
676GE Loyal, WI
501GB Farmington, NM
501GE Espanola, NM
644GB Show Low, AZ
644GC Buckeye, AZ
459GA Maui, HI
459GC Kailua-Kona, HI
640GB Sonora, CA
640HB Modesto, CA

Appendix B

***Category*/Indicator**	**Definition**
Immunization	
Influenza	Proportion of patients 50 years or older chart documenting patients receiving influenza immunizations between September 1, 2008, and March 31, 2009.

Table 8. PI II Indicators in the Analysis

Appendix C

***Category*/Indicator**	**Definition**
DM	
Foot inspection	The proportion of diabetics, excluding bilateral amputees, with chart documentation of visual inspection of feet in the past year.
Foot pulse checked	The proportion of diabetics, other than bilateral amputees, with chart documentation of examination of pedal pulses in the past year.
Foot Sensation	The proportion of diabetics, other than bilateral amputees, with documentation of foot sensory with monofilament in the past year.
Retinal eye exam	The proportion of diabetics with chart documentation of a retinal examination by an eye specialist in the past year.
LDL-C measured	The proportion of diabetics with chart documentation of a full lipid panel in the past year.
HbgA1c measured	The proportion of diabetics with chart documentation of an HbgA1c in the past year.
Nephropathy screening	The proportion of diabetic patients having a nephropathy screening test during the past year or documented evidence of nephropathy.
PTSD	
Screened for PTSD at required intervals with Primary Care-PTSD (PC-PTSD)	The proportion of patient not moderately or severely cognitively impaired and did not have a clinical encounter within the past year with PTSD identified as a reason for the visit whose screening was done using the PC-PTSD screen.
Positive PC-PTSD screen with timely suicide ideation/ behavior evaluation	The proportion of patient not moderately or severely cognitively impaired and did not have a clinical encounter within the past year with PTSD identified as a reason for the visit whose screening using the PC-PTSD screen was positive and had a suicide ideation/behavior evaluation by a provider within one day of the positive PTSD screen.

Table 9. CDCI II Indicators in the Analysis

Appendix D

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: May 13, 2011

From: Under Secretary for Health (10)

Subject: OIG Draft Report, Healthcare Inspection – Evaluation of Community Based Outpatient Clinics Fiscal Year 2010 (VAIQ 7103357)

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's five recommendations. Attached is the Veterans Health Administration's corrective action plan for the report's recommendations.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (VHA 10A4A4 Management Review) at (202) 461-7014.

Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Healthcare Inspection - Evaluation of Community Based Outpatient Clinics Fiscal Year 2010 (VAIQ 7103357)

Date of Draft Report: April 7, 2011

Recommendations/ Actions	Status	Completion Date

OIG Recommendations

Recommendation 1: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, emphasize the requirements to define staff that need life support training, systematically track training status, and take appropriate action when training is not maintained.

VHA Comments

Concur

The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will issue a memorandum to emphasize requirements of the Veterans Health Administration (VHA) policy governing cardiopulmonary resuscitation (CPR) training for Veterans Integrated Service Network (VISN) and facility senior managers. The requirements to be emphasized in the memorandum include: 1) defining which staff require life support training; 2) ensuring that written actions are in place for staff who do not comply with policy; 3) ensuring that key staff is identified for oversight and tracking training; and 4) ensuring that appropriate actions are taken when required training is not maintained.

In Process May 31, 2011

Recommendation 2: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, monitor, collect, and analyze hand hygiene data.

VHA Comments

Concur

The DUSHOM will form a workgroup including the Office of the Deputy Under Secretary for Health for Policy and Services (DUSHPS), Infectious Disease Program Office; the National Patient Safety Center, and VISN Quality Managers to develop a standardized process to collect hand hygiene data using a specific tool. This group will also develop a plan to monitor, collect, and analyze hand hygiene data. The plan will include timelines and an implementation strategy. The development of the process, tool, and monitoring plan is expected to be completed by September 30, 2011.

In Process September 30, 2011

Recommendation 3: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, secure and protect patients' PII.

VHA Comments

Concur

VHA Office of Informatics and Analytics (OIA) will work in conjunction with the DUSHOM and the Department of Veterans Affairs Office of Information and Technology (VA OI&T) to provide security updates and briefings on general security and privacy policies for securing personally identifiable information (PII). The briefings will take place during national conference forums such as VHA Privacy Officer Call, Network Director Call, and Chief Medical Officer Call.

In Process May 31, 2011

VHA OIA will work in conjunction with DUSHOM and VA OI&T to ensure that Information Security Office (ISO) security reviews and community-based outpatient clinic (CBOC) security walkthroughs include checks to ensure that proper PII protections are in place. VHA OIA Health Information Governance Security will work with VA OI&T to revise the checklist tools used by the ISO community to conduct security reviews/walkthroughs to address proper PII protections. The target date for completing revised checklist is May 25, 2011.

In Process May 25, 2011

Recommendation 4: We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, review MH pricing models to determine the most effective compensation for MH services to be implemented in CBOC contracts.

VHA Comments

Concur

The DUSHOM's Medical Sharing Office, and the Deputy Under Secretary for Health Policy and Services' (DUSHPS) Office of Patient Care Services (PCS), will review the process for establishing mental health (MH) pricing models and will work towards the standardization of contracting language and statement of work related to the securing of MH resources in CBOCs. The standardized language will be utilized to guide and direct medical centers in the purchase of MH services. The standardized contract language and statement of work will be completed by the end of the 3rd Quarter Fiscal Year (FY) 2011.

In Process August 31, 2011

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure that the PCMM is effectively managed by the Facility Director in conjunction with the PCMM Coordinator to minimize the assignment of patients to more than one PCP.

VHA Comments

Concur

The DUSHPS PCS is in the process of preparing training materials for Primary Care Management Module (PCMM) coordinators to ensure that patients are not assigned to more than one primary care provider. This training will be on-going and the first training session is scheduled for August 23-25, 2011.

In Process First training session August 23-25, 2011

The DUSHPS PCS is also working in conjunction with VA OI&T to create software that will prevent multiple primary care provider assignments by using a single database instead of individual facility applications. This involves a major revision to the software that will take 12 to 19 months. VA OI&T has funded the software, which is scheduled to be rolled-out to the facilities during FY 2013.

In Process On-going

Veterans Health Administration
May 2011

Appendix E

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Marisa Casado, Director, CBOC Program Review Wachita Haywood, Associate Director Annette Acosta, RN Nancy Albaladejo, RN Bruce Barnes Shirley Carlile, BA Lin Clegg, PhD Darlene Conde-Nadeau, NP Marnette Dhooghe, MS Douglas Henao, RD Stephanie Hills, RN Zhana Johnson, CPA Anthony M. Leigh, CPA Kimberly Pugh, RN Reba Ransom, RN Wilma Reyes Annette Robinson, RN Tom Seluzicki, CPA Patrick Smith, MS Marilyn Stones, BS Ann R. VerLinden, RN Cheryl Walker, NP Sue Zarter, RN

Appendix F

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