Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 11-03653-67

Community Based Outpatient Clinic Reviews Montrose, CO Bellevue, Lincoln, and Norfolk, NE

January 18, 2012

Washington, DC 20420

Why We Did This Review

The VA OIG is undertaking a systematic review of the VHA's CBOCs to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care.

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

Veterans are required to receive one standard of care at all VHA health care facilities. Care at CBOCs needs be consistent, safe, and of high quality, regardless of model (VA-staffed or contract). CBOCs are expected to comply with all relevant VA policies and procedures, including those related to quality, patient safety, and performance.

Glossary

ADA	Americans with Disabilities Act
C&P	credentialing and privileging
CBOC	community based outpatient clinic
CPRS	Computerized Patient Record System
CT	Computerized Tomography
DM	Diabetes Mellitus
EKG	electrocardiogram
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HCS	Health Care System
HF	Heart Failure
MH	mental health
MRI	Magnetic Resonance Imaging
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PA	physician assistant
PCP	primary care provider
PET	Positron Emission Tomography
STFB	Short-Term Fee Basis
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

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Executive Summary

Purpose: We conducted inspections of four CBOCs during the weeks of October 17 and October 31, 2011. We evaluated select activities to assess whether the CBOCs operated in a manner that provides veterans with consistent, safe, high-quality health care. Table 1 lists the sites inspected.

VISN	Facility	CBOC
19	Grand Junction VAMC	Montrose
23	VA Nebraska-Western Iowa HCS	Bellevue
		Lincoln
		Norfolk

Table 1. Sites Inspected

Recommendations: The VISN and Facility Directors, in conjunction with the respective CBOC managers, should take appropriate actions to:

Grand Junction VAMC

- Ensure Montrose CBOC clinicians document risk levels for diabetic patients in CPRS in accordance with VHA policy.
- Ensure Montrose CBOC clinicians document interventions related to prescribing therapeutic footwear and/or orthotics to diabetic patients identified at high risk (Level 2 or 3) for extremity ulcers and amputation.
- Ensure Montrose CBOC clinicians document foot care education provided for diabetic patients in CPRS.
- Ensure Montrose CBOC patients are sent written notification when STFB consults are approved.

VA Nebraska – Western Iowa HCS

- Ensure Bellevue, Lincoln, and Norfolk CBOC clinicians document risk levels for diabetic patients in CPRS in accordance with VHA policy.
- Ensure Bellevue, Lincoln, and Norfolk CBOC clinicians document foot care education provided for diabetic patients in CPRS.
- Ensure that FPPEs are initiated on the first clinical start day for all newly hired physicians at the Lincoln CBOC.
- Compare relevant MH practitioner-specific data to the aggregate data of those privileged practitioners who hold the same or comparable privileges at the Lincoln and Norfolk CBOCs.
- Submit OPPE results to the medical staff's Executive Committee for review and ensure that minutes reflect the documents reviewed and the rationale for re-privileging practitioners at the Bellevue, Lincoln, and Norfolk CBOCs.

- Ensure privileges are facility, service, and provider specific and based on the practitioner's qualifications at the Bellevue, Lincoln, and Norfolk CBOCs.
- Ensure scopes of practice are facility specific at the Bellevue, Lincoln, and Norfolk CBOCs.

Comments

The VISN and facility Directors agreed with the CBOC review findings and recommendations and provided acceptable improvement plans. (See Appendixes B–E, pages 15–24 for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives. The purposes of this review are to:

- Evaluate the extent CBOCs have implemented the management of DM-Lower Limb Peripheral Vascular Disease in order to prevent lower limb amputation.
- Assess STFB authorization and follow up processes for outpatient radiology consults including CT, MRI, and PET scan in an effort to ensure quality and timeliness of patient care in CBOCs.
- Evaluate whether CBOCs comply with selected VHA requirements regarding the provision of mammography services for women veterans.
- Evaluate the continuity of care for enrolled CBOC patients discharged from the parent facility in FY 2011 with a primary discharge diagnosis of HF.
- Determine whether CBOC providers are appropriately credentialed and privileged in accordance to VHA Handbook 1100.19.[1]
- Determine whether CBOCs are in compliance with standards of operations according to VHA policy in the areas of environmental safety and emergency planning.[2]

Scope. The review topics discussed in this report include:

- Management of DM-Lower Limb Peripheral Vascular Disease
- STFB Care
- Women's Health
- HF Follow-up
- C&P
- Environment and Emergency Management

For detailed information regarding the scope and methodology of the focused topic areas conducted during this inspection, please refer to Report No. 11-03653-283 *Informational Report Community Based Outpatient Clinics Cyclical Report FY 2012*, September 20, 2011. This report is available at http://www.va.gov/oig/publications/reports-list.asp.

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

[1] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.
[2] VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.

CBOC Characteristics

We formulated a list of CBOC characteristics that includes identifiers and descriptive information. Table 2 displays the inspected CBOCs and specific characteristics.

	Montrose	Bellevue	Lincoln	Norfolk
VISN	19	23	23	23
Parent Facility	Grand Junction VAMC	VA Nebraska-Western IA HCS	VA Nebraska-Western IA HCS	VA Nebraska-Western IA HCS
Type of CBOC	VA	VA	VA	VA
Number of Uniques,[3] FY 2011	1,620	1,930	14,733	2,393
Number of Visits, FY 2011	7,012	7,033	134,798	8,984
CBOC Size[4]	Mid-size	Mid-size	Very Large	Mid-size
Locality	Rural	Urban	Urban	Rural
Full-Time Employee Equivalents PCP	1.5	1.69	9.86	1.96
Full-Time Employee Equivalents MH Provider	0	0	11.2	0.80
Types of Providers	PA PCP	PA PCP	PCP Licensed Clinical Social Worker PA PCP Psychiatrist, Psychologist Dentist Audiologist	PCP Nurse Practitioner Psychologist
Specialty Care Services Onsite	Yes	No	Yes	No
Tele-Health Services	Tele-Mental Health Tele-Retinal	Tele-Mental Health Tele-Retinal Imaging Tele-Audiology Tele-MOVE Tele-Medicine	Tele-Mental Health Tele-Retinal Imaging Tele-Audiology Tele-MOVE Tele-Medicine	Tele-Mental Health Tele-Retinal Imaging Tele-Audiology Tele-MOVE Tele-Medicine
Ancillary Services Provided Onsite	Laboratory EKG	Laboratory EKG	Laboratory EKG Pharmacy Physical Medicine Radiology Vascular Studies Cardiopulmonary Services	Laboratory EKG

[3] http://vaww.pssg.med.va.gov/

[4] 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).

Mental Health CBOC Characteristics

Table 3 displays the MH Characteristics for each CBOC reviewed.

	Montrose	Bellevue	Lincoln	Norfolk
Provides MH Services	**No**	**No**	**Yes**	**Yes**
Number of MH Uniques, FY 2011	**129**[5]	**94**	**3,936**	**299**
Number of MH Visits	**212**	**348**	**27,132**	**1,240**
General MH Services	**NA**	**NA**	**Diagnosis & Treatment Plan Medication Management Psychotherapy Post-Traumatic Stress Disorder Military Sexual Trauma**	**Psychotherapy**
Specialty MH Services	**NA**	**NA**	**Consult & Treatment Psychotherapy MH Intensive Case Management Social Skills Post-Traumatic Stress Disorder Military Sexual Trauma Homeless Program Substance Use Disorder**	**Psychotherapy**
Tele-Mental Health	**Yes**	**Yes**	**Yes**	**Yes**
MH Referrals	**Another VA Facility**	**Another VA Facility**	**Another VA Facility Fee Basis**	**Another VA Facility**

[5] Mental Health Services provided through Tele-Mental Health Services.

Results and Recommendations

Management of DM-Lower Limb Peripheral Vascular Disease

VHA established its Preservation-Amputation Care and Treatment Program in 1993 to prevent and treat lower extremity complications that can lead to amputation. An important component of this program is the screening of at-risk populations, which includes veterans with diabetes. Table 4 shows the areas reviewed for this topic. The facilities identified as noncompliant needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The parent facility has established a Preservation-Amputation Care and Treatment Program.[6]
	The CBOC has developed screening guidelines regarding universal foot checks.
	The CBOC has developed a tracking system to identify and follow patients at risk for lower limb amputations.
	The CBOC has referral guidelines for at-risk patients.
Montrose Bellevue Lincoln Norfolk	The CBOC documents education of foot care for patients with a diagnosis of DM.[7]
	There is documentation of foot screening in the patient's medical record.
Montrose Bellevue Lincoln Norfolk	There is documentation of a foot risk score in the patient's medical record.
Montrose	There is documentation that patients with a risk assessment Level 2 or 3 received therapeutic footwear and/or orthotics.

Table 4. DM

VISN 19, Grand Junction VAMC – Montrose

Risk Level Assessment. Montrose CBOC clinicians did not document a risk level in CPRS for 14 of 24 diabetic patients reviewed. VHA policy[8] requires identification of high-risk patients based upon foot risk factors that would determine appropriate care and/or referral.

[6] VHA Directive 2006-050, *Preservation Amputation Care and Treatment (PACT) Program*, September 14, 2006.
[7] VA/DoD Clinical Practice Guideline, *Management of Diabetes Mellitus (DM)*, August 2010.
[8] VHA Directive 2006-050.

Therapeutic Footwear/Orthotics. Montrose CBOC clinicians did not document that therapeutic footwear or orthotics were prescribed for two of six diabetic patients identified at high risk (Level 2 and 3) for extremity ulcers and amputation.

Foot Care Education Documentation. Montrose CBOC clinicians did not document foot care education for 13 of 24 diabetic patients reviewed in CPRS.

Recommendation 1. We recommended that Montrose clinicians document a risk level for diabetic patients in CPRS in accordance with VHA policy.

Recommendation 2. We recommended that Montrose clinicians document interventions related to prescribing therapeutic footwear and/or orthotics to diabetic patients identified at high risk (Level 2 or 3) for extremity ulcers and amputation.

Recommendation 3. We recommended that Montrose clinicians document foot care education for diabetic patients in CPRS.

VISN 23, VA Nebraska-Western Iowa HCS – Bellevue, Lincoln, and Norfolk

Risk Level Assessment. Bellevue CBOC clinicians did not document a risk level for 28 of 30 (93 percent) diabetic patients reviewed. Lincoln CBOC clinicians did not document a risk level for all 27 diabetic patients reviewed. Norfolk CBOC clinicians did not document a risk level for all 24 diabetic patients reviewed. VHA policy[9] requires identification of high-risk patients with a risk level, based upon foot risk factors that would determine appropriate care and/or referral.

Foot Care Education Documentation. Bellevue CBOC clinicians did not document foot care education for 26 of 30 (86 percent) diabetic patients reviewed in CPRS. Lincoln CBOC clinicians did not document foot care education for 19 of 27 diabetic patients reviewed. Norfolk CBOC clinicians did not document foot care education for 15 of 24 diabetic patients reviewed.

Recommendation 4. We recommended that Bellevue, Lincoln, and Norfolk clinicians document a risk level for diabetic patients in CPRS in accordance with VHA policy.

Recommendation 5. We recommended that Bellevue, Lincoln, and Norfolk clinicians document education of foot care for diabetic patients in CPRS.

STFB Care

The Fee Program assists veterans who cannot easily receive care at a VAMC. The program pays the medical care costs of eligible veterans who receive care from non-VA providers when the VAMCs are unable to provide specific treatments or provide treatment economically because of their geographical inaccessibility.

[9] VHA Directive 2006-050.

We reviewed STFB care to determine whether CBOC providers appropriately ordered and followed up on outpatient radiology procedures (CT, MRI, and PET scan). Table 5 shows the areas reviewed for this topic. The facility identified as noncompliant needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	The facility has local policies and procedures regarding non-VA care and services purchased by authority that describe the request, approval, and authorization process for such services.[10]
	The provider documented a justification for using Fee Basis status in lieu of providing staff treatment as required by VHA policy.[11]
	The date the consult was approved does not exceed 10 days from the date the consult was initiated.
	The non-VA care referral requests for medical, dental, and ancillary services were approved by the Chief of Staff, Clinic Chief, Chief Medical Administration Services, or an authorized designee.[12]
Montrose	Patients were notified of consult approvals in writing as required by VHA policy.[13]
	A copy of the imaging report is in CPRS according to VHA policy.[14]
	There is evidence the ordering provider or surrogate practitioner reviewed the report within 14 days from the date on which the results are available to the ordering practitioner.
	There is evidence the ordering provider or other licensed healthcare staff member informed the patient about the report within 14 days from the date on which the results are available to the ordering practitioner.[15]
	Fee basis payments to PCPs are in accordance with VA reimbursement policies.

Table 5. STFB

VISN 19, Grand Junction VAMC – Montrose

There were two patients who received services through a STFB consult at the Montrose CBOC.

Patient Consult Notification. We found no evidence that the two patients at the Montrose CBOC were sent written notification of the STFB consult approvals.

[10] VHA Chief Business Office Policy 1601F. *Fee Service.* http://vaww1.va.gov/cbo/apps/policyguides/index.asp; VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006; VHA Manual M-1, PART I, Chapter 18, *Outpatient Care – Fee*," July 20, 1995.
[11] VHA Handbook 1907.01.
[12] VHA Chief Business Office Policy 1601F.
[13] VHA Manual M-1, PART I, Chapter 18.
[14] VHA Handbook 1907.01.
[15] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Recommendation 6. We recommended that patients at the Montrose CBOC are sent written notification when STFB consults are approved.

VISN 23, VA Nebraska-Western Iowa HCS – Bellevue, Lincoln, and Norfolk

There were two patients who received services through a STFB consult at the Lincoln CBOC, and staff were compliant with the review areas. There were no patients at the Bellevue or Norfolk CBOCs who met the criteria for this review.

Women's Health Review

Breast cancer is the second most common type of cancer among American women, with approximately 207,000 new cases reported each year.[16] Each VHA facility must ensure that eligible women veterans have access to comprehensive medical care, including care for gender-specific conditions.[17] Timely screening, diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. Table 6 shows the areas reviewed for this topic.

Noncompliant	Areas Reviewed
	Patients are referred to mammography facilities that have current Food and Drug Administration or State-approved certifications.
	Mammogram results are documented using the American College of Radiology's BI-RADS code categories.[18]
	The ordering VHA provider or surrogate was notified of results within a defined timeframe.
	Patients are notified of results within a defined timeframe.
	The facility has an established process for tracking results from mammograms performed off-site.
	Fee Basis mammography reports are scanned into VistA.
	All screening and diagnostic mammograms were initiated via an order placed into the VistA radiology package.[19]
	Each CBOC has an appointed Women's Health Liaison.
	There is evidence that the Women's Health Liaison collaborates with the parent facility's Women Veterans Program Manager on women's health issues.

Table 6. Mammography

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[16] American Cancer Society, Cancer Facts & Figures 2009.
[17] VHA Handbook 1330.01, *Healthcare Services for Women Veterans*, May 21, 2010.
[18] The American College of Radiology's Breast Imaging Reporting and Database System is a quality assurance guide designated to standardize breast imaging reporting and facilitate outcomes monitoring.
[19] VHA Handbook 1330.01.

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

C&P

We reviewed C&P folders to determine whether facilities had consistent processes to ensure providers complied with applicable requirements as defined by VHA policy.[20] Table 7 shows the areas reviewed for this topic. The facilities identified as noncompliant needed improvement. Details regarding the findings follow the table.

Noncompliant	Areas Reviewed
	There was evidence of primary source verification for each provider's license.
	Each provider's license was unrestricted.
	There were two efforts made to obtain verification of clinical privileges (currently or most recently held at other institutions) for new providers.
Lincoln	New providers' FPPEs were implemented on first clinical start day.
	There was evidence that the provider was educated about FPPE prior to its initiation.
Lincoln	FPPE results were reported to the medical staff's Executive Committee.
	Prior to the start of a new privilege, criteria for the FPPE were developed.
	FPPEs are initiated for performance monitoring, which include criteria developed for evaluation of the practitioners when issues affecting the provision of safe, high-quality care are identified.
Bellevue Lincoln Norfolk	Service Chief, Credentialing Board, and/or Medical Staff's Executive Committee list documents reviewed and the rationale for conclusions reached for granting licensed independent practitioner privileges.
Bellevue Lincoln Norfolk	Privileges granted to providers are facility, service, and provider specific.
	The determination to continue current privileges are based in part on results of OPPE activities.
	The OPPE and reappraisal process included consideration of such factors as clinical pertinence reviews and/or performance measure compliance.

[20] VHA Handbook 1100.19.

Noncompliant	Areas Reviewed (continued)
Lincoln Norfolk	Relevant provider-specific data was compared to aggregated data of other providers holding the same or comparable privileges.
Bellevue Lincoln Norfolk	Scopes of practice are facility specific.

Table 7. C&P

VISN 23, VA Nebraska-Western Iowa HCS – Bellevue, Lincoln, and Norfolk

FPPE. Managers did not implement an FPPE on the first clinical start day for a newly hired MH practitioner at the Lincoln CBOC. The FPPE was initiated 10 months later. Additionally, we did not find evidence that FPPE results were reported to the medical staff's Executive Committee. VHA policy[21] requires that an FPPE be initiated for all physicians who have been newly hired and reported to the medical staff's Executive Committee for consideration in making the recommendation on privileges.

OPPE. We did not find evidence of relevant aggregated MH practitioner-specific data for three of six physicians reviewed at the Lincoln and Norfolk CBOCs. VHA policy[22] requires that relevant practitioner-specific data needs to be compared to the aggregate data of those privileged practitioners that hold the same or comparable privileges.

Documentation of Privileging Decisions. We did not find adequate documentation in the Credentialing Committee or the Executive Committee minutes to support committee decisions for privileging practitioners at the Bellevue, Lincoln, and Norfolk CBOCs. VHA policy[23] requires that the request for privileges, along with the credentialing committee recommendation, must be submitted to the medical staff's Executive Committee for review and that minutes must reflect the documents reviewed and the rationale for the stated conclusion.

Clinical Privileges. We found clinical privileges were granted for procedures that were not performed at the Bellevue, Lincoln, or Norfolk CBOCs. These privileges included endotracheal intubation and paracentesis. VHA policy[24] requires that privileges granted to an applicant must be facility specific and based on the procedures and types of services that are provided within the health care facility.

We found that a MH provider at the Lincoln CBOC was granted privileges for non-service specific procedures such as arterial puncture, catheter insertion, debridement, repair and closure of minor lacerations and skin defects, incision and drainage for minor abscesses, lumbar puncture, and proctoscopy. Additionally, the privileges granted to the MH provider were not facility specific and were granted for the

[21] VHA Handbook 1100.19.
[22] VHA Handbook 1100.19.
[23] VHA Handbook 1100.19.
[24] VHA Handbook 1100.19.

entire VA Nebraska-Western Iowa HCS. VHA policy[25] requires that delineation of privileges granted must be provider specific. Additionally, the privileges must be facility specific and based on the procedures and types of services that are provided within the health care facility.

Scopes of Practice. We found that the functional duties approved for PAs were for procedures not performed at the Bellevue, Lincoln, or Norfolk CBOCs. These procedures included tracheal suction via tracheostomy and gastric lavage. Other procedures that were approved for PAs considered qualified included administering digital block anesthesia and biopsy with excision of superficial skin lesions. VHA policy[26] states that privileges must not exceed the types of services that are provided within the health care facility.

Recommendation 7. We recommended that FPPEs are initiated on the first clinical start day for all newly hired physicians at the Lincoln CBOC.

Recommendation 8. We recommended that the Lincoln and Norfolk CBOCs compare relevant MH practitioner-specific data to the aggregate data of those privileged practitioners who hold the same or comparable privileges.

Recommendation 9. We recommended that OPPE results are submitted to the medical staff's Executive Committee for review and that minutes reflect the documents reviewed and the rationale for re-privileging practitioners at the Bellevue, Lincoln, and Norfolk CBOCs.

Recommendation 10. We recommended that practitioners at the Bellevue, Lincoln, and Norfolk CBOCs are granted privileges that are facility, service, and provider specific.

Recommendation 11. We recommended that scopes of practice are facility specific at the Bellevue, Lincoln, and Norfolk CBOCs.

Environment and Emergency Management

EOC

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, infection control, and general maintenance. Table 8 shows the areas reviewed for this topic.

Noncompliant	Areas Reviewed
	There is handicap parking, which meets the ADA requirements.
	The CBOC entrance ramp meets ADA requirements.
	The entrance door to the CBOC meets ADA requirements.

[25] VHA Handbook 1100.19.
[26] VHA Directive 2004-029, *Utilization of Physician Assistants*, July 2, 2004.

Noncompliant	Areas Reviewed (continued)
	The CBOC restrooms meet ADA requirements.
	The CBOC is well maintained (e.g., ceiling tiles clean and in good repair, walls without holes, etc.).
	The CBOC is clean (walls, floors, and equipment are clean).
	The patient care area is safe.
	The CBOC has a process to identify expired medications.
	Medications are secured from authorized access.
	There is an alarm system or panic button installed in high-risk areas as identified by the vulnerability risk assessment.
	Privacy is maintained.
	IT security rules are adhered to.
	Patients' personally identifiable information is secured and protected.
	There is alcohol hand wash or a soap dispenser and sink available in each examination room.
	The sharps containers are less than ¾ full.
	There is evidence of fire drills occurring at least annually.
	There is evidence of an annual fire and safety inspection.
	Fire extinguishers are easily identifiable.
	The CBOC collects, monitors, and analyzes hand hygiene data.
	Staff use two patient identifiers for blood drawing procedures.
	The CBOC is included in facility-wide EOC activities.

Table 8. EOC

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

Emergency Management

VHA policy requires each CBOC to have a local policy or standard operating procedure defining how medical emergencies, including MH, are handled.[27] Table 9 shows the areas reviewed for this topic.

Noncompliant	Areas Reviewed
	There is a local medical emergency management plan for this CBOC.
	The staff can articulate the procedural steps of the medical emergency plan.
	The CBOC has an automated external defibrillator onsite for cardiac emergencies.

[27] VHA Handbook 1006.1.

Noncompliant	Areas Reviewed (continued)
	There is a local MH emergency management plan for this CBOC.
	The staff can articulate the procedural steps of the MH emergency plan.

Table 9. Emergency Management

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

HF Follow-Up

The VA provides care for over 212,000 patients with HF. Nearly 24,500 of these patients were hospitalized during a 12-month period during FYs 2010 and 2011. The purpose of this review is to evaluate the continuity of care for enrolled CBOC patients discharged from the parent facility in FY 2011 with a primary discharge diagnosis of HF. The results of this topic review are reported for informational purposes only. After the completion of the FY 2012 inspection cycle, a national report will be issued detailing cumulative and comparative results for all CBOCs inspected during FY 2012. The results of our review of the selected CBOCs discussed in this report are found in Appendix A.

Heart Failure Follow-Up Results

Areas Reviewed			
CBOC Processes			
Guidance	***Facility***	***Yes***	***No***
The CBOC monitors HF readmission rates.	**Grand Junction VAMC**		
	Montrose CBOC	X	
	VA Nebraska-Western Iowa HCS		
	Bellevue		X
	Lincoln CBOC	X	
	Norfolk CBOC	X	
The CBOC has a process to identify enrolled patients that have been admitted to the parent facility with a HF diagnosis.	**Grand Junction VAMC**		
	Montrose CBOC	X	
	VA Nebraska-Western Iowa HCS		
	Bellevue	X	
	Lincoln CBOC	X	
	Norfolk CBOC	X	
Medical Record Review Results			
Guidance	***Facility***	***Numerator***	***Denominator***
There is documentation in the patients' medical records that communication occurred between the inpatient and CBOC provider regarding the HF admission.	**Grand Junction VAMC**		
	Montrose CBOC	2	3
	VA Nebraska-Western Iowa HCS		
	Bellevue	NA*	NA
	Lincoln CBOC	0	2
	Norfolk CBOC	1	1
A clinician documented a review of the patients' medications during the first follow-up primary care or cardiology visit.	**Grand Junction VAMC**		
	Montrose CBOC	2	3
	VA Nebraska-Western Iowa HCS		
	Bellevue	NA	NA
	Lincoln CBOC	1	2
	Norfolk CBOC	1	1
A clinician documented a review of the patients' weight during the first follow-up primary care or cardiology visit.	**Grand Junction VAMC**		
	Montrose CBOC	2	3
	VA Nebraska-Western Iowa HCS		
	Bellevue	NA	NA
	Lincoln CBOC	1	2
	Norfolk CBOC	1	1

Heart Failure Follow-Up Results

Medical Record Review Results (continued)			
Guidance	***Facility***	***Numerator***	***Denominator***
A clinician documented a review of the patients' restricted sodium diet during the first follow-up primary care or cardiology visit.	**Grand Junction VAMC**		
	Montrose CBOC	2	3
	VA Nebraska-Western Iowa HCS		
	Bellevue	NA	NA
	Lincoln CBOC	1	2
	Norfolk CBOC	1	1
A clinician documented a review of the patients' fluid intake during the first follow-up primary care or cardiology visit.	**Grand Junction VAMC**		
	Montrose CBOC	0	3
	VA Nebraska-Western Iowa HCS		
	Bellevue	NA	NA
	Lincoln CBOC	0	2
	Norfolk CBOC	0	1
A clinician educated the patient, during the first follow-up primary care or cardiology visit, on key components that would trigger the patients to notify the provider.	**Grand Junction VAMC**		
	Montrose CBOC	2	3
	VA Nebraska-Western Iowa HCS		
	Bellevue	NA	NA
	Lincoln CBOC	1	2
	Norfolk CBOC	1	1

*There were no patients at the Bellevue CBOC that met the criteria for this informational topic review.

VISN 19 Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 29, 2011

From: Director, Rocky Mountain Network (10N19)

Subject: **CBOC Review: Montrose, CO**

To: Director, Denver Office of Health Care Inspections (54DV)

Director, Management Review Service (VHA 10A4A4)

I have reviewed the submitted corrective actions submitted by Grand Junction VAMC and concur with the action plan and timeline.

(original signed by:)
Glen W. Grippen
Director, Rocky Mountain Veterans Integrated Services Network

Grand Junction VAMC Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 29, 2011

From: Director, Grand Junction VAMC (575/00)

Subject: **CBOC Review: Montrose, CO**

To: Director, Rocky Mountain Network (10N19)

I have reviewed the submitted corrective actions and concur with the findings and recommendations.

(original signed by:)
Terry S. Atienza
Director, Grand Junction VAMC

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that Montrose clinicians document a risk level for diabetic patients in CPRS in accordance with VHA policy.

Concur

Target date for completion: January 31, 2012

Facility Response:

Staff will document a risk level for diabetic patients in CPRS on an annual basis, per policy. The above changes are implemented facility wide, therefore requiring staff training and education.

The Diabetic Foot Exam Clinical Reminder has been updated to include risk assessment as a required field. Reminder activated following staff training.

Medical Center Memorandum No. 112-10 PRESERVATION-AMPUTATION CARE AND TREATMENT PROGRAM is currently being revised to reflect changes as appropriate.

Clinical Staff education will be completed and required annually to include review of VHA DIRECTIVE 1006-050 PRESERVATION-AMPUTATION CARE AND TREATMENT CARE AND TREATMENT (PACT) PROGRAM.

Monthly monitoring of compliance has been established via a process whereby the Clinical Application Coordinator will generate reports forwarded to the ACNS of Ambulatory Care Service, the Section Chief of Primary Care and Podiatry.

A quarterly report will be submitted to Quality Management and Clinical Executive Board. Initial report 01/31/2012 and subsequently ongoing.

Recommendation 2. We recommended that Montrose clinicians document interventions related to prescribing therapeutic footwear and/or orthotics to diabetic patients identified at high risk (Level 2 or 3) for extremity ulcers and amputation.

Concur

Target date for completion: 1/31/2012

Facility Response:

Diabetic Foot Exams resulting in a risk score of 2 or 3 will automatically generate a consult to Podiatry. In order to fulfill the consult, the Podiatrist will be required to document interventions related to prescribing therapeutic footwear and/or orthotics. Staff training required.

Medical Center Memorandum No. 112-10 PRESERVATION-AMPUTATION CARE AND TREATMENT PROGRAM is currently under revision to reflect changes to national policy.

The ACNS of Ambulatory Care Service will review all high risk cases on a monthly basis from the pulled dataset to verify documentation of consult completion and all fallouts will be reviewed with the Section Chief of Primary Care and Podiatry.

A quarterly report will be submitted to Quality Management and Clinical Executive Board.

Recommendation 3. We recommended that Montrose clinicians document foot care education for diabetic patients in CPRS.

Concur

Target date for completion: 1/31/2012

Facility response:

Clinical staff will document via the clinical reminder system, foot care education for diabetic patients on an annual basis. The Diabetic Foot Exam Clinical Reminder has been modified to include a foot care education documentation statement as a required field. Staff education required.

Educational Materials:

• VHA Field Manual for Foot Health

• Krames: Diabetes Keeping Feet Health

Medical Center Memorandum No. 112-10 PRESERVATION-AMPUTATION CARE AND TREATMENT PROGRAM is currently being updated to reflect compliance with national policy.

Clinical staff education will be completed and required annually, for diabetic foot care education and documentation requirements.

Monthly monitoring has been established along with quarterly reporting. Report submitted to Quality Management and Clinical Executive Board. Initial report 01/31/2012 and subsequently ongoing.

Recommendation 6. We recommended that patients at the Montrose CBOC are sent written notification when STFB consults are approved.

Concur

Target date for completion: 2/29/2012

Facility response:

Authorization letters providing written notification when STFB consults are approved and mailed to Veterans and documented in CPRS. The process of generating the letter will begin immediately and result in fewer consults being produced on a daily basis. Complete 12/20/2011.

A form letter is being built in VISTA or CPRS to automate the letter production. Due 02/29/2012.

The SOP for the Fee Basis Clerks will be modified to reflect the process. Staff training required. Due 01/31/2012.

Staff education was completed to include manual process of written notification to patients when STFB consults are approved and staffs involvement in conducting the feasibility of automating the letter. Ongoing staff education required annually. Completed 12/20/2011.

Monthly monitoring of compliance has been established, along with quarterly reports which will be submitted to Quality Management and Clinical Executive Board. Due 01/31/2012 for initial report, and subsequently ongoing.

VISN 23 Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 29, 2011

From: Director, VA Midwest Health Care Network (10N23)

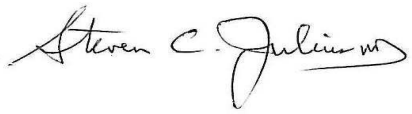
Subject: **CBOC Reviews: Bellevue, Lincoln, and Norfolk, NE**

To: Director, Denver Office of Health Care Inspections (54DV)

Director, Management Review Service (VHA 10A4A4)

Thank you for the opportunity to review and provide comments in regards to the Healthcare Inspection review of VISN 23's CBOC facilities.

We concur with the action plans regarding the recommendations identified in this report.



FOR
Janet P. Murphy, MBA

VA Nebraska-Western Iowa HCS Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 23, 2011

From: Director, VA Nebraska-Western Iowa HCS (636/00)

Subject: **CBOC Reviews: Bellevue, Lincoln, and Norfolk, NE**

To: Director, VA Midwest Health Care Network (10N23)

This is to acknowledge the receipt and review of the findings and recommendations of the Office of Inspector General Healthcare Inspection. Nebraska-Western Iowa Health Care System concurs with the findings and recommendations. Corrective action plans have been developed or implemented for the recommendations.

Our appreciation is extended to the OIG Healthcare Inspection team. We appreciate the thorough review and the opportunity to further improve the quality of care we provide to our Veterans.

NANCY A. GREGORY, FACHE

Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 4. We recommended that Bellevue, Lincoln, and Norfolk clinicians document a risk level for diabetic patients in CPRS in accordance with VHA policy.

Concur

Target date for completion: June 30, 2012

Facility Response:

NWI HCS concurs that a risk level for diabetic patients be documented in the electronic medical record. A team has begun meeting to 1) develop and activate an improved clinical reminder to complete the risk assessment, 2) identify best practices and materials for nursing/staff competency, 3) develop a quick reference guide for providers on the risk level information, and 4) develop a standardized hand-off process regarding the risk level. Once the process has been implemented, an audit of diabetic patients will be done at Bellevue, Lincoln, and Norfolk CBOCS on a monthly basis for 90 days. A performance target of 90% has been set. The results of these audits will be reported to the PACT Steering Committee.

Recommendation 5. We recommended that Bellevue, Lincoln, and Norfolk clinicians document education of foot care for diabetic patients in CPRS.

Concur

Target date for completion: June 30, 2012

Facility Response:

NWI HCS concurs that a foot care education for diabetic patients be documented in the electronic medical record. A team has begun meeting to 1) review educational materials provided, and recommend standard products, and 2) develop a standardized process for documentation of foot care education. Once the process has been implemented, an audit of diabetic patients will be done at Bellevue, Lincoln, and Norfolk CBOCS on a monthly basis for 90 days. A performance target of 100% has been set. The results of these audits will be reported to the PACT Steering Committee.

Recommendation 7. We recommended that FPPEs are initiated on the first clinical start day for all newly hired physicians at the Lincoln CBOC.

Concur

Target date for completion: June 30, 2012

Facility Response:

NWI HCS concurs that FPPEs should be initiated on the first clinical start day for all newly hired providers. The FPPE will be included in the newly hired provider orientation packet informing the provider and the service line of the initiation of the FPPE. The Credentialing department will notify the Credentials Committee when the FPPE is due for review. Once the process has been initiated, the Credentialing department will be auditing all newly credentialed providers for 90 days with the results of these audits reported to the Credentials Committee. A performance target of 100% has been set.

Recommendation 8. We recommended that the Lincoln and Norfolk CBOCs compare relevant MH practitioner-specific data to the aggregate data of those privileged practitioners who hold the same or comparable privileges.

Concur

Target date for completion: June 30, 2012

Facility Response:

NWI HCS concurs that relevant mental health practitioner-specific data be compared to aggregate data. The mental health leadership team will be identifying the elements that will utilized on the OPPE. These provider and aggregate elements will include BMI, HbA1C, and Lipid Profiles. The provider and aggregate data will be collected monthly and is due to be automated by March 2012. The service chief will review the data every six months. Performance targets of 90% for BMI, 93% for HgA1C, and 88% for Lipid Profiles have been set. An audit of all providers will be conducted in April when the next scheduled review is to take place. The results of the audit will be reported to the Credentials Committee.

Recommendation 9. We recommended that OPPE results are submitted to the medical staff's Executive Committee for review and that minutes reflect the documents reviewed and the rationale for re-privileging practitioners at the Bellevue, Lincoln, and Norfolk CBOCs.

Concur

Target date for completion: April 30, 2012

Facility Response:

NWI HCS concurs that the OPPE results should be submitted to the Medical Staff Executive Committee and the minutes reflect both the documents reviewed and the rational for re-privileging. The OPPE results will first be reviewed by the Medical Staff Credentials Committee. The Credentials Committee will submit its recommendations for re-privileging to the Executive Committee of the Medical Staff. The Executive

Committee will review the documents and recommendation of the Credentials Committee, discuss the provider's OPPE and make recommendations to the Director for final action. The minutes of the Executive Committee meetings will reflect what documents were reviewed and the rationale for recommending re-privileging action for the providers. An audit of the minutes from the February 2012, March 2012 and April 2012 meetings of the Executive Committee of the Medical Staff will be conducted. The purpose of the audit is to determine if the minutes reflect: a) the documents reviewed (including the OPPE), and b) the rationale for reprivileging, for each provider reviewed for reappointment by the Committee during that time February-April time period. The performance target is that the minutes will reflect a and b for 100% of the providers. The results of these monthly audits will be reported to the Quality Board.

Recommendation 10. We recommended that practitioners at the Bellevue, Lincoln, and Norfolk CBOCs are granted privileges that are facility, service, and provider specific.

Concur

Target date for completion: September 30, 2012

Facility Response:

NWI HCS concurs that privileges should be facility, service and provider specific. All privilege delineation forms will be revised to ensure that they are facility, service and provider specific and based upon the provider's qualifications at the facility where the provider is working. Once the privilege delineation forms have been revised, all provider's privileges at all CBOCs will be audited with the results reported to the Quality Board. A performance target of 100% has been set.

Recommendation 11. We recommended that scopes of practice are facility specific at the Bellevue, Lincoln, and Norfolk CBOCs.

Concur

Target date for completion: September 30, 2012

Facility Response:

NWI HCS concurs that the scopes of practice should be facility specific at the CBOCs. All midlevel providers' scopes of practice will be revised to ensure that they are facility specific at the facility/location where each midlevel provider works. Once the midlevel providers' scopes of practices have been revised, all midlevels providers at all CBOCs will be audited with the results reported to the Quality Board. A performance target of 100% has been set.

OIG Contact and Staff Acknowledgments

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