



# Department of Veterans Affairs Office of Inspector General

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## Informational Report

### Community Based Outpatient Clinic Cyclical Reports

**To Report Suspected Wrongdoing in VA Programs and Operations**

**Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time,  
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## **Executive Summary**

As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year 2009, the VA Office of Inspector General is beginning a systematic review of Veterans Health Administration (VHA) community based outpatient clinics (CBOCs). The purpose of this report is to describe the study design of the forthcoming CBOC reviews.

The report describes the CBOC inspection process which consists of four components: (1) CBOC site-specific information gathering and review, (2) medical record reviews for determining compliance with VHA performance measures, (3) onsite inspections, and (4) CBOC contract review.



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

**SUBJECT:** Informational Report – Community Based Outpatient Clinic Cyclical Reports

## **Purpose**

As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year (FY) 2009, the VA Office of Inspector General (OIG) is beginning a systematic review of Veterans Health Administration (VHA) community based outpatient clinics (CBOCs). The purpose of this report is to describe the study design of the forthcoming CBOC reviews.

## **Background**

In January 1994, the VHA hospital in Amarillo, Texas established what was recognized as the first VHA community based clinic, now located in Childress, Texas. Until the establishment of the clinic, VHA had rigid criteria to establish outpatient facilities apart from the hospitals. The clinics had to have a workload of 3,000 visits or more and be located at least 100 miles or 3 hours travel time away from the nearest VHA facility. Subsequently, VHA eliminated its restrictions and encouraged hospital directors to consider contracting with other providers if it was in the best interest of the veteran and the hospital.

By early 1995, VHA operated approximately 175 community based clinics and 172 hospitals. During this time, VHA announced plans to transition from a hospital-based system of care to a healthcare system rooted in primary and ambulatory care.

In February 1995, VHA issued a directive<sup>1</sup> to expand its network of community based clinics. The directive provided guidance for planning and activating VA medical center (VAMC) access points. Access points (CBOCs) were defined as a VA-operated clinic, in a fixed location or mobile clinic, or a VA-funded or reimbursed private clinic, group practice or single practitioner that is geographically distinct or separate from the parent facility. In late 1995, VHA reorganized its facilities into 22 Veterans Integrated Service Networks (VISNs) and encouraged the VISN Directors to develop CBOCs. VISN Directors had decision-making responsibility for CBOCs.

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<sup>1</sup> VHA Directive 10-95-017, *Veterans Health Administration Interim Policy for Planning and Activating Department of Veterans Affairs Access Points*. February 8, 1995.

CBOCs could provide special services or a number of health care services. VISN directors had responsibility to ensure the CBOCs met the following goals:

- Improve convenience of VA care for current users.
- Improve equity of access to veterans by targeting underserved areas.
- Improve efficiency and effectiveness of care.
- Improve access to care for all eligible veterans.

After March 1995, establishment of CBOCs required congressional approval. Public Law 101-144, Appropriations Act 1990, mandated that VA Central Office (VACO) notify Congress of their intent to open a CBOC no later than 14 days prior to taking irrevocable action. VISN Directors submitted a brief summary (white paper) to VACO, describing key operational elements, such as target population, service availability, and cost for each planned clinic. The white paper was used as a means to notify Congress.

In 1996, the directive<sup>2</sup> was revised to require VISNs to establish clinics primarily for current users who live more than 30 minutes from the existing VHA clinic. The white paper was replaced by an annual business plan that provided information on the number of CBOCs to be established, time frames for establishing the clinics, and locations of planned clinics.

In 2001, the directive<sup>3</sup> was revised and provided minimal standards for CBOC operations to include necessary medical staff, access to diagnostic testing and treatment, and referral arrangements needed to ensure continuity of health care for veterans. These standards are included in the current May 2004 directive. The minimum standards will be discussed in detail later in this report.

From 1995–1998, VHA approved more than 230 CBOCs. By the end of FY 1998, there were 139 CBOCs in operation (this number excludes the 175 community based clinics in operation prior to February 1995). Since VHA initiated its CBOC initiative, approximately 600 clinics have opened.

The predominant staffing model for these early CBOCs was based on the use of VA employees who practiced in VA owned or leased facilities. During this development period, the VA also began issuing Request for Proposals (RFPs) on a competitive basis in order to contract with existing, community based primary care providers in private practice. Some of the early RFPs were actually awarded to academic medical centers that had concurrent contractual relationships with the regional VAMC for graduate medical

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<sup>2</sup> VHA Directive 96-049, *Veterans Health Administration Policy for Planning and Activating Community Based Clinics*. August 7, 1996.

<sup>3</sup> VHA Directive 2001-060, *Veterans Health Administration Policy for Planning and Activating Community Based Clinics*. October 2, 2001.

education training programs. Each CBOC is affiliated with a single VAMC that would be administratively responsible for that CBOC.

## 1. VHA Site Tracking System

The VHA Site Tracking (VAST) System was established to provide accurate and consistent information regarding the number of VHA service sites and the types of services each site provides. The VAST system is the official repository of data on the number and location of VA's sites of health care delivery for medical centers, including CBOCs. For a site to be included in the VAST database, it must have a station number. CBOCs are required to have a unique five-digit station identifier. The station number is assigned at the time that the CBOC is approved.

The Planning Systems Support Group (PSSG), a field unit under Enrollment and Forecasting, VHA Office of Assistant Deputy Under Secretary of Health for Policy and Planning, validates each CBOC site and the service(s) provided.

Although CBOCs continue to open, the peak of expansion occurred from March 1998 through February 1999 when 124 CBOCs opened. The figure below displays the number of active CBOCs for each FY from 1999 through 2008.

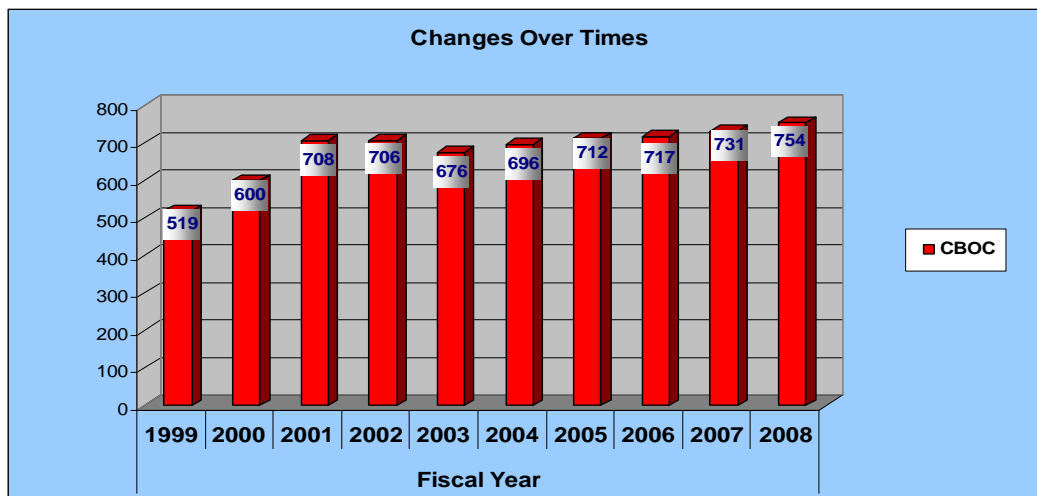


Figure 1. Number of Existing CBOCs (Source: VAST System)

CBOCs fall into five general categories:<sup>4</sup>

- VA-Owned – a CBOC that is owned and staffed by VA.
- Leased – a CBOC where the space is leased (contracted, to include donated space) but is staffed by VA.

<sup>4</sup> Although not used here, CBOCs may also be suspended or closed.

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

Figure 2 shows the distribution of CBOCs by each of these five categories for each VISN.

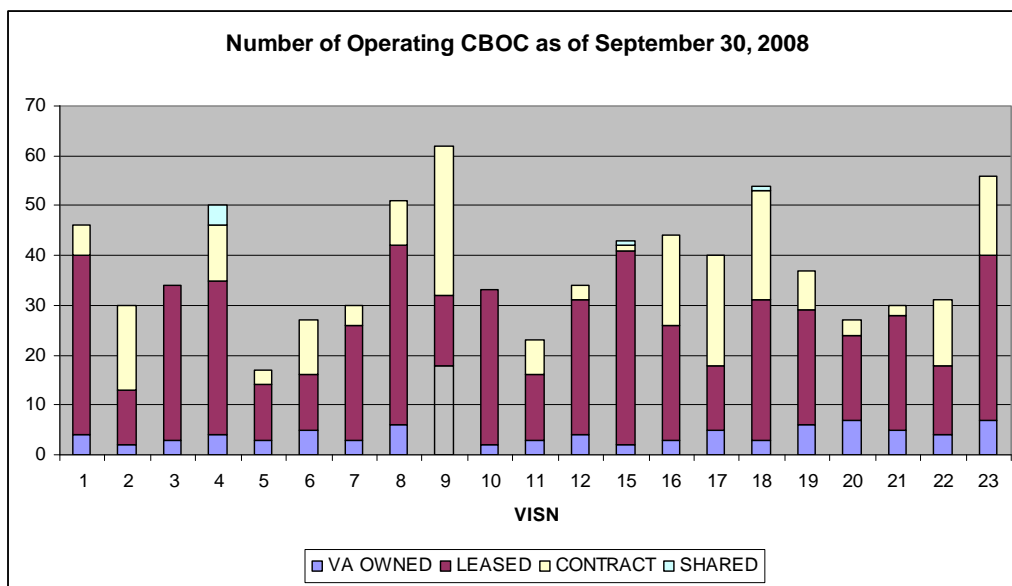


Figure 2. Operating CBOC by Station Type

Figure 3 displays the numerical and percentage breakdown of the CBOCs by station type in relation to the total number of CBOCs (September 30, 2008, report published by PSSG VAST).

Type of CBOC Station	Number of CBOC Type	Percentage
Leased	478	63.5
Contracted	204	27.0
VA Owned	72	9.5
<b>Totals</b>	<b>754</b>	<b>100</b>

Figure 3. Type of CBOC



## 2. Minimum Standards for CBOC Operations

VA policy outlined specific requirements that must be met at CBOCs. The minimum standards were developed in 2001 to ensure that veterans receive one standard of care at all VHA health care facilities. Care at CBOCs must be consistent, safe, and of high quality, regardless of whether it is VA-staffed or contract. CBOCs must comply with VA policy and procedures related to quality, patient safety, and performance. There are 14 standards that must be met for CBOC operations. Only 9 out of the 14 standards will be addressed during our reviews this fiscal year and discussed in this report.<sup>5</sup> These are the same standards in effect today under VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.

### Services

Depending on the number and needs of veterans in a designated area, the scope of services may vary. However, at a minimum, CBOCs must provide primary care and mental health services.

- Primary Care Services, at a minimum, include intake initial assessment; health promotion (screening and counseling); disease prevention; management of acute minor illnesses and chronic bio-psychosocial conditions; pharmacy management; referrals for specialty, rehabilitation, and other levels of care; follow-up care; and patient and caregiver education.
- Mental Health Services, at a minimum, include screening and prevention of mental disorders and diagnostic evaluation for mental illness and substance abuse; pharmacotherapy, psychotherapy and/or psychosocial counseling; and referrals for inpatient or residential care, direct care, or access to consultation for complex problems (i.e., post-traumatic stress, substance abuse treatment, sexual trauma counseling, and patient and/or family education).

### Quality Management

CBOC performance objectives were established, which addressed issues such as analyses of care at the CBOCs and credentialing and privileging (C&P) of licensed independent and dependent providers. At a minimum, CBOCs must be incorporated into the parent facility's Quality Management (QM) program where identified quality care issues are addressed. Furthermore, VA-staffed CBOCs must adhere to the standards set by the Joint Commission.

VISN Directors are responsible for the ongoing monitoring of CBOCs and ensuring that consistent, quality care is delivered according to VA regulations, policies, and

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<sup>5</sup> We are omitting Staffing, Timeliness, Station Numbering, Cost Accounting, and Patient Complaints.

procedures. They evaluate whether CBOCs are meeting their business purposes and overall goals and objectives.

The Office of Quality and Performance (OQ&P) evaluates and provides feedback on CBOC performance semi-annually with regards to clinical indicators such as:

- Patient Satisfaction Surveys.
- Preventive Care.
- Clinical Guidelines.

### Performance Measures

Through performance measures, VHA demonstrates to Congress and the public how VHA health care meets or exceeds community standards for patient satisfaction, access, quality, and efficiency applicable to the specific communities in which VA facilities operate. For this reason, VHA emphasizes performance measures that allow for comparison with national and local private sector measures as well as comparison with current performance evaluation trends supported by the Joint Commission. VHA's Performance Measurement program includes performance measure data abstracted from the service the patient received during their CBOC encounter/visit. In addition, CBOC patients are included in national and local patient satisfaction surveys.

### Patient Safety

CBOCs are required to report adverse events to the parent facility's safety officer or risk manager. They are required to follow procedures outlined in the National Center for Patient Safety Handbook.<sup>6</sup> The Handbook provides an outline that VHA can use to minimize the chance of adverse events following medical care. The areas covered in the Handbook include identifying and reporting adverse events, review and analysis of reported events, and informing patients of adverse events.

### Emergencies

Each CBOC must have a local policy or standard operating procedure defining how health emergencies, including mental health emergencies, are handled. CBOCs must maintain appropriate emergency response capability. The parent facility is responsible for determining the type of equipment (e.g., Automatic External Defibrillators (AEDs) or a crash cart) that need to be located at the CBOC sites. CBOCs that do not have Advance Cardiac Life Support trained providers, appropriate supplies, and a Code team are required to have an AED at their site.

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<sup>6</sup> VHA Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, January 20, 2002.

### Workload Reporting

All workload that occurs at CBOCs must be entered in the Veterans Health Information System and Technological Architecture (VistA) databases and submitted to the Austin Automation Center using the five-digit station identifier. All patient records must be stored in the Computerized Patient Record System (CPRS) to its maximum potential.

### Accessibility

CBOCs are required to comply with the Americans with Disabilities Act as it applies to disabled veterans and special patient populations.

### Regulatory and Accrediting Standards

CBOCs must comply with general environmental safety regulations set by the Occupational Safety and Health Administration (OSHA) and the Joint Commission. They also need to comply with the Joint Commission's Ambulatory Care Standards.

### Contracting

VA medical centers contract with non-VA health care providers for CBOC primary health care services and facilities. For the purposes of this review, contract CBOCs are defined as having established contracts or sharing agreements with non-VA health care providers who provide certain services to eligible VA beneficiaries. CBOC contracts must meet VHA requirements as outlined by the VHA Logistics Office and the Office of Patient Care Services.

There are three statutes that authorize contract CBOCs.

- Title 38 United States Code (U.S.C.) § 8153 – allows the VA to obtain health care resources such as health care providers, other entities, or individuals. The contract may be used to contract professional services alone or a comprehensive practice to include the physical plant where the services are provided.
- Title 38 U.S.C. § 7409 – authorizes VA to enter into contracts with schools of medicine, dentistry, podiatry, optometry, and nursing. Also included in this statute are clinics and other groups or individuals capable of providing medical specialist services to VA facilities.
- Title 38 U.S.C. § 8111 – authorizes VA to enter into agreements with the Department of Defense (DoD) to share health care resources. This statute may be used to establish CBOCs at DoD facilities using DoD personnel, VA personnel, or a combination of DoD and VA personnel.

### **3. Review Purpose and Objectives**

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

1. Determine whether CBOC quality of care measures—selected Prevention Index II (PI II) and Chronic Disease Care Index II (CDCI II)—are comparable to the parent facility clinics.
2. Determine whether CBOC providers are appropriately credentialed and privileged in accordance with VHA Handbook 1100.19.<sup>7</sup>
3. Determine whether CBOCs maintain the same standard of care as their parent facility to address the Mental Health (MH) needs of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) era veterans.
4. Determine whether CBOCs are in compliance with standards of operations according to VHA Handbook 1006.1<sup>8</sup> in the areas of (a) environmental safety and (b) emergency management plan.
5. Determine the effect of CBOCs on veterans' perception of care.
6. Determine whether CBOC contracts were administered in accordance with contract terms and conditions.

## **Study Design**

### **1. Study Population**

The study population consists of all veteran patients who were enrolled in CBOCs for their health care. To identify the study population, we first obtained a list from PSSG's VAST data file of all VHA CBOCs as of December 3, 2008. We then excluded the CBOCs that were not operational (closed or suspended), leaving a total of 679/731 CBOCs as our potential sample population. In order to ensure that each CBOC would have sufficient performance measure data for review, we elected to select CBOCs that were open and operational on and before September 30, 2007. Thus, 618 CBOCs were included for this review. The study population constitutes all patients who were enrolled in these CBOCs for their health care.

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<sup>7</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

<sup>8</sup> VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.

## 2. Sample Design

Because CBOCs within a same parent facility share the same leadership and because our objective to compare quality of patient care received at CBOCs staffed by VA with that by contracted staff, the sample design consisted of three stages for selecting the probability-based random sample of patients with stratification and unequal probability of selection. With probability sampling, each patient in the study population has a known, positive probability of selection. This property of probability sampling avoids selection bias and enabled us to use statistical theory to make valid inferences from the sample to the study population.

The 618 CBOCs included in the review were under the administrative leadership of 135 VHA parent facilities, with the number of CBOCs within each parent facility ranging from 1 to 12. We categorized each of the 135 parent facilities into one of the following three strata of staffing type:

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

In the first stage of sampling, we statistically randomly selected 30 VHA parent facilities from the universe of 135 parent facilities, stratified by staffing type. Eight VHA parent facilities were sampled from the “Contract” stratum and from the “VA” stratum, respectively, and 14 were sampled from the “Both” stratum.

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

The third stage of sampling was used for selecting patients from the 58 CBOCs for the patient medical chart review. We randomly selected 50 patients diagnosed with diabetes (ICD-9-CM 250) and independently 50 patients diagnosed with ischemic vascular disease

(see list of ICD-CM codes below)<sup>9</sup> from each of the 58 CBOCs that had enrolled more than 50 subjects. All patients were included if the CBOC had 50 such patients or fewer. An additional 30 patients with a service date after September 11, 2001, and who did not have a post-traumatic stress disorder (PTSD, ICD-9-CM: 309-81) clinical encounter during the study period (October 1, 2007 – November 30, 2008) were sampled for chart review. All patients were included if the CBOC had 30 such patients or fewer.

This was a complex, multistage sample design that included stratification, clustering, and unequal probabilities of selection.

## **Methodology**

CBOC inspection consists of four components: (1) CBOC site-specific information gathering and review, (2) medical record reviews for determining compliance with VHA performance measures, (3) onsite inspections, and (4) CBOC contract review.

### **1. Document Request**

We notify the Medical Center Director (MCD) 8 weeks prior to the onsite visit of the CBOCs selected for review. The letter includes instruction for completing an online survey and a list of documents we need to conduct the review. The documents include (1) CBOC local policies; (2) list of diabetic patients; (3) list of hyperlipidemia screening patients; (4) list of OEF/OIF era veterans; and (5) copies of the CBOC contract and modifications for Primary Care Services, invoices, and payment schedules covering 1st quarter, FY 2009. We request that the facility create a secured SharePoint and place the documents there for our review.

### **2. Medical Record Review**

For each CBOC, a random sample of 50 patients with a diagnosis of diabetes, 50 patients with a diagnosis of ischemic vascular disease, and 30 patients with a service date after September 11, 2001, without a diagnosis of PTSD will be selected, unless fewer patients are available. We will review the medical records of these selected patients to determine compliance with VHA performance measures.

### VHA Performance Measures

VA uses two key performance measures to assess the quality of health care delivery, the CDCI II and the PI II. These indices measure the degree to which the VA follows nationally recognized guidelines for the treatment and care of patients. The CDCI II

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<sup>9</sup> Acute Myocardial Infarction, CABG (36.1, 36.2), PCI (00.66), CAD (414.2, 429.2), Stable Angina (411.xx, 413.xx), Lower Extremity Arterial Disease (440.20, 440.24, 440.29, 443.9), Transient Cerebral Ischemic (435), Stroke (433-434, 435.6, 437.0, 437.1, 438.0-438.42, 438.5, 438.9), Atheroembolism (444,445), Abdominal Aortic Aneurysm (441), Renal Artery Atherosclerosis (440.1).

focuses on the care of patients with ischemic heart disease, hypertension, chronic obstructive pulmonary disease, diabetes mellitus (DM), major depressive disorder, schizophrenia, and tobacco cessation. The PI II focuses on primary prevention and early detection recommendations for nine diseases or health factors that significantly determine health outcomes: pneumococcal pneumonia; influenza; tobacco and alcohol consumption; screenings for colorectal, breast, cervical, and prostate cancer; and cholesterol levels.

This review will evaluate PI II (hyperlipidemia screening) and CDCI II (DM and PTSD screening). Data for the indicators will be obtained from the patient medical record and compared to the parent facilities' results. We will use the same time period, Quarter 1, FY 2009,<sup>10</sup> for comparison.

The OQ&P identifies the cases for review by the External Peer Review Program (EPRP)<sup>11</sup> abstractors. EPRP is designed to provide medical centers and outpatient clinics with diagnosis and procedure-specific quality of care information. It provides a database for analysis and internal and external comparison of clinical care. Data used for these analyses are abstracted from a random sample of both paper and electronic medical records. EPRP data is primarily used for quality improvement, evaluation, and benchmarking with external organizations.

This review will follow the same process used by EPRP to collect the selected performance measure data. It is important to note that when OQ&P identifies cases for review at a VAMC, patients who have been seen in CBOCs are not excluded as long as they meet the VAMC sampling requirements. Therefore, a small number of CBOC patients may be included in the parent facilities' performance measure reports.

### *Hyperlipidemia Screening*

Cholesterol testing is recommended as a screening test to be done on all adults at least once every five years. It is frequently done in conjunction with a routine physical exam and ordered in combination with other tests, including high-density lipoprotein cholesterol (HDL-C), low-density lipoprotein cholesterol (LDL-C), and triglycerides. This test is often called a lipid profile.

Cholesterol testing may be ordered more frequently for those who have one or more risk factors for heart disease. Major risk factors include:

- Cigarette smoking.
- Age (men 45 years or older or women 55 years or older).
- Hypertension (blood pressure of 140/90 or higher or taking high blood pressure medications).

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<sup>10</sup> VHA's comparison dates for Quarter 1, FY 2009, are October 1–November 30, 2008.

<sup>11</sup> The External Peer Review Program is a contracted review of care, specifically designated to collect data to be used to improve the quality of care delivered.

- Family history of premature heart disease (heart disease in an immediate family member—male relative under age 55 or female relative under age 65).
- Pre-existing heart disease or already having had a heart attack.
- DM.

Hyperlipidemia screening has shown to provide good indicators of whether someone is likely to have a heart attack or stroke caused by blockage of blood vessels or hardening of the arteries (atherosclerosis). This monitor is met if patients had their total cholesterol tested (fasting or non-fasting) within the past 2 years prior to the study interval (October 1 – November 30, 2008).

### *Diabetes Mellitus*

VHA diabetes-specific measures included annual foot examination (inspection, palpation, and sensory evaluation); annual eye examination by an eye care specialist; a urine protein test, including a microalbumin test; and the percentage of patients with LDL-C assay. Other measures we did not assess included the percentages of patients with an annual hemoglobin A1c (HbA1c), patients with an HbA1c greater than (>) 9 percent or not done, and a blood pressure less than 140/90 millimeters of mercury (mmHg). The indicators we will evaluate are listed in Figure 4.

<b>Diabetes Mellitus Indicators</b>	<b>Definition</b>
<b>Foot inspection</b>	The proportion of diabetics, excluding bilateral amputees, with chart documentation of visual inspection of feet in the past year.
<b>Foot pulse checked</b>	The proportion of diabetics, other than bilateral amputees, with chart documentation of examination of pedal pulses in the past year.
<b>Foot Sensation</b>	The proportion of diabetics, other than bilateral amputees, with documentation of foot sensory with monofilament in the past year.
<b>Retinal eye exam</b>	The proportion of diabetics with chart documentation of a retinal examination by an eye specialist in the past year.
<b>LDL-C measured</b>	The proportion of diabetics with chart documentation of a full lipid panel in the past year.
<b>Nephropathy screening</b>	The proportion of diabetic patients having a nephropathy screening test during the past year or documented evidence of nephropathy.

**Figure 4 - Diabetes Indicators**

Foot Care. More than 60 percent of non-traumatic lower-limb amputations in the United States occur among people with diabetes. Comprehensive foot care programs can reduce amputation rates by 45 to 85 percent.



Eye Care. Diabetes is the leading cause of new cases of blindness among adults age 20-74, and diabetic retinopathy<sup>12</sup> causes 12,000 to 24,000 new cases of blindness each year. Detection and treatment of diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50 to 60 percent.

Lipid Profile. Heart disease is the leading cause of diabetes-related deaths. Adults with diabetes are at risk for heart disease death and stroke about two to four times higher than adults without diabetes. Improved control of cholesterol and lipids (HDL, LDL, and triglycerides) can reduce cardiovascular complications by 20 to 50 percent. Patients must have had a full lipid panel in the 12 months prior to the study interval (October 1 – November 30, 2008).

Renal Testing. Kidney damage from diabetes is called diabetic nephropathy. It begins long before symptoms appear. An early sign is small amounts of protein in the urine. If the damage continues, the kidneys could fail. Diabetes is the most common cause of kidney failure in the United States. People with kidney failure need either dialysis or a kidney transplant. Evidence supports that screening and early treatment for diabetic nephropathy is associated with a reduced risk and decreased rate of progression to end stage renal disease.

This measure is intended to assess if diabetic patients are monitored for nephropathy. The indicators include: 1) documentation of existing nephropathy, 2) macroalbumin testing, 3) microalbumin testing,<sup>13</sup> or 4) evidence of angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy.<sup>14</sup>

### *Mental Health*

PTSD is a serious and often chronic response to overwhelmingly stressful events. The disorder is associated with increased rates of morbidity, poor health-related quality of life, and functional impairment.

PTSD is the mental health disorder most commonly associated with combat and is central to VA's mission;<sup>15</sup> and therefore, the VA requires regular screening for PTSD. Screening for PTSD is the first and most essential step in identifying and engaging veterans with PTSD. It is crucially important that VA be proactive in identifying new PTSD and intervening early in order to prevent chronic PTSD and its complicating disorders and functional problems whenever possible.

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<sup>12</sup> Retinopathy is a general term that refers to some form of non-inflammatory damage to the retina of the eye.

<sup>13</sup> Both macroalbumin and microalbumin tests evaluate urine for the presence of a protein called albumin.

<sup>14</sup> Both ACE inhibitor and ARB therapy medications are used to treat hypertension and heart failure.

<sup>15</sup> VHA Directive 2005-055. *Implementation of the National Clinical Reminder for Afghan and Iraq Post-Deployment Screening*; dated December 1, 2005.

Attention to PTSD in medical settings is the key to providing treatment to this population because primary care, rather than specialty mental health services, is the point of contact with the health care system for the majority of individuals with PTSD. Patients are most likely to present to primary care with unexplained somatic and/or psychological symptoms (for example, sleep disturbance, night sweats, fatigue, or difficulty with memory or concentration).

For the patient to be considered “screened,” a standard four-question Primary Care PTSD (PC-PTSD) screen developed by the National Center for PTSD is used. Evidence of responses to all four questions, summary score, and positive/negative results must be documented in the medical record. Screening must be accomplished annually for the first 5 years after most recent date of service separation from military duty; subsequent screening should be done every 5 years. Patients excluded from this measure include those with a recognized diagnosis of PTSD in the past 12 months, as evidenced by at least one clinical encounter or documented moderate or severe cognitive impairment.

A positive response to the screen does not necessarily indicate that a patient has PTSD. However, a positive response does warrant further investigation of trauma symptoms. Patients who screened positive for PTSD should be interviewed to determine the presence of risk factors that would indicate a need for urgent intervention of suicidal ideation.

The indicators for this measure include: 1) patients screened at required intervals for PTSD, 2) positive result of the PC-PTSD screen in the medical record, and 3) suicide risk evaluation completed within 24 hours. Patients eligible for PTSD suicide risk evaluation were screened after October 1, 2008.

### **3. Onsite Inspections**

We will be onsite at each CBOC for 1 to 1 1/2 days. As part of the onsite visit, we will inspect the CBOC for environment of care (EOC) issues and emergency management procedures, review CBOC providers’ C&P files and supporting documentation, and interview and discuss their compliance with VHA performance measures and FY 2008 Survey of Healthcare Experiences of Patients (SHEP) data to determine patients’ perceptions of the care they received at the CBOCs.

#### Environment of Care and Emergency Management

EOC is crucial to achieving a safe patient care environment, reducing infection control risks, and improving patient care outcomes. CBOCs must be maintained in a state of cleanliness that fully meets all VHA, OSHA, and Joint Commission standards. We will conduct EOC rounds at each CBOC to ensure that they adhere to American Disabilities Act, National Fire Protection Association regulations, and infection control guidelines.

We will also review each CBOC's local emergency management policy and interview employees to ensure there is a plan in place to address patients who experience a medical or psychological emergency such as seizures, heart attack, suicidal or homicidal ideations, and that staff are aware of the steps they need to implement.

### 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 licenses and other qualifications to practice in a health care setting and that they practice within the scopes of their licenses and competencies. The credentialing, but not privileging, requirements apply to all Advanced Practice Registered Nurses and Physician Assistants even though these practitioners may not practice as licensed independent practitioners.

VetPro is VHA's electronic credentialing system and must be used for credentialing all providers who are granted clinical privileges or are credentialed for other reasons. C&P must be completed prior to initial appointment or reappointment to the medical staff and before transfer from another medical facility.

We will conduct an overall review to assess whether the medical center's C&P process complies with VHA Handbook 1100.19. We will review providers' (maximum of five) C&P folders (electronic and paper) and nursing staff personnel folders (maximum of four). The Handbook outlines requirements that providers reapply for clinical privileges every 2 years and provide appropriate supporting documentation. Privilege applications are then reviewed by the Professional Standards Board, with final approval granted through the clinical service chief, Chief of Staff, and MCD. Clinical privileges are effective for 2 years from the date they are signed by the MCD.

### Veterans' Perception of Care

VHA's mission is to provide patient-centered health care that is comparable with, or better than, care available in the non-VA sector. The Veterans Healthcare Service Standards performance goals are intended to measure patient satisfaction with health care services in select areas. Veteran satisfaction is measured using the SHEP survey. The SHEP survey methodology is customized to inpatients and to ambulatory care services. The outpatient satisfaction measures are calculated from the distribution of responses to a question on the SHEP survey which asks the respondent to rate the overall quality of the care received in the past 12 months. VHA set the performance measure goal for patients reporting overall satisfaction of "very good" or "excellent" at 77 percent for outpatients.

We will obtain FY 2008 SHEP data from VHA and create charts that display each CBOC's performance in relation to the medical center, VISN, and National performance.

We will interview the CBOC and medical center senior managers to assess what actions they are taking to be the provider of choice for the veterans they serve.

#### **4. Contract Community Based Outpatient Clinics**

Approximately 27 percent of the CBOCs are contracted to provide primary health care. Contracts for CBOCs are administered and monitored by the parent facility. We will review how the contract parameters affect the quality of care veterans receive at the contract CBOC. Quality of care issues need to be considered in the context of the contract that provides the guidelines that the contractor needs to follow.

We will verify that the number of enrollees or visits that are reported is consistent with what is actually supported with collaborating documentation. We will accomplish this by:

- Requesting that the Contracting Officer's Technical Representative provide supporting documentation of tracking methodology for number of enrollees or visits.
- Reviewing invoices for number of enrollees or visits.
- Using the Primary Care Management Module (PCMM) and Decision Support System (DSS) data to verify what was reported.
- Verifying what the VA actually paid by crosschecking with payments made and recorded in the Financial Management System.

The number of enrollees is a critical factor when looking at the number and type of providers assigned to a clinic.

#### **Report Timeline**

A report should be issued approximately 60 days after the onsite inspection of the CBOC. The report will cover the inspection of three to four VAMCs' CBOCs, usually two CBOCs per medical center. Each report will cover our findings of the objectives described earlier in this report. The first report will be issued in July 2009 (CBOCs visited in April 2009).

At the end of the fiscal year, we will aggregate the data and report our findings as we compare contract to VA-staff CBOCs, CBOCs to the parent facility, and urban to rural CBOCs. The FY 2009 report will include 39 CBOCs.

*(original signed by:)*

JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
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## OIG Contact and Staff Acknowledgments

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