Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 12-03852-109

Community Based Outpatient Clinic Reviews at Spokane VA Medical Center Spokane, WA

February 15, 2013

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 to be consistent, safe, and of high quality, regardless of model (VA-staffed or contract). CBOCs are expected to comply with all relevant VA policies and procedures, including those related to quality, patient safety, and performance.

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Glossary

C&P	credentialing and privileging
CBOC	community based outpatient clinic
CDC	Centers for Disease Control and Prevention
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
IT	information technology
LIP	licensed independent practitioner
MH	mental health
NC	noncompliant
NCP	National Center for Health Promotion and Disease Prevention
OIG	Office of Inspector General
OI&T	Office of Information and Technology
PCP	primary care provider
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WH	women's health

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Executive Summary

Purpose: We evaluated select activities to assess whether the CBOCs operated in a manner that provides veterans with consistent, safe, high-quality health care.

For the EHR review component of the WH and vaccinations topic areas, patients were randomly selected from all CBOCs assigned to the respective parent facilities.

The C&P, EOC, and emergency management onsite inspections were only conducted at the randomly selected CBOCs. We conducted an onsite inspection of the CBOCs during the week of November 5, 2012 (see Table 1).

VISN	Facility	CBOC Name	Location
20	Spokane VAMC	Coeur d'Alene	Coeur d'Alene, ID
		Wenatchee	Wenatchee, WA

Table 1. Sites Inspected

Review Results: The review covered the following topic areas.

- WH
- Vaccinations
- C&P
- EOC
- Emergency Management

We made recommendations in four review areas.

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

- Ensure that patients with cervical cancer screening results are notified of results within the defined timeframe and that notification is documented in the EHR.
- Ensure that the WH Liaisons collaborate with the Women Veterans Program Manager.
- Ensure that clinicians administer pneumococcal vaccinations when indicated.
- Ensure that clinicians document all required pneumococcal vaccination administration elements and that compliance is monitored.

- Ensure the service chief's documentation in VetPro reflects documents reviewed and the rationale for re-privileging at the Coeur d'Alene and Wenatchee CBOCs.

- Ensure that fire and life safety inspections are conducted annually at the Coeur d'Alene and Wenatchee CBOCs.

- Ensure that the Chief of OI&T evaluates the use of the IT closet and implements required measures at the Coeur d'Alene CBOC.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the CBOC review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 12–16, 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

- Evaluate whether CBOCs comply with selected VHA requirements regarding the provision of cervical cancer screening, results reporting, and WH Liaisons.
- Evaluate whether CBOCs properly provided selected vaccinations to veterans according to CDC guidelines and VHA recommendations.
- Determine whether CBOC providers are appropriately credentialed and privileged in accordance with 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 and Methodology

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the reviews, we assessed clinical and administrative records as well as completed onsite inspections at randomly selected sites. Additionally, we interviewed managers and employees. The review covered the following five activities:

- WH
- Vaccinations
- C&P
- EOC
- Emergency Management

Methodology

To evaluate the quality of care provided to veterans at CBOCs, we conducted EHR reviews for the WH and vaccinations topic areas. For WH, the EHR reviews consisted of a random sample of 50 women veterans (23–64 years of age). For vaccinations, the EHR reviews consisted of random samples of 75 veterans (65 and older) and 75 additional veterans (all ages), unless fewer patients were available, for tetanus and

[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.

pneumococcal, respectively. The study populations consisted of patients from all CBOCs assigned to the parent facility.[3]

The C&P, EOC, and emergency management onsite inspections were only conducted at the randomly selected CBOCs. Two CBOCs were randomly selected from the 56 sampled parent facilities, with sampling probabilities proportional to the numbers of CBOCs eligible to be inspected within each of the parent facilities.[4]

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

This report is available at http://www.va.gov/oig/publications/default.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.

[3] Includes all CBOCs in operation before October 1, 2011.
[4] Includes 96 CBOCs in operation before October 1, 2011, that had 500 or more unique enrollees.

CBOC Profiles

To evaluate the quality of care provided to veterans at CBOCs, we designed reviews with an EHR component to capture data for patients enrolled at all of the CBOCs under the parent facility's oversight.[5] The table below provides information relative to each of the CBOCs under the oversight of the respective parent facility.

VISN	Parent Facility	CBOC Name	Locality[6]	Uniques, FY 2012[7]	Visits, FY 2012[8]	CBOC Size[9]
20	Spokane VAMC	Coeur d'Alene	Urban	3,834	19,696	Mid-Size
		Wenatchee	Rural	2,482	11,864	Mid-Size

Table 2. Profiles

[5] Includes all CBOCs in operation before October 1, 2011.
[6] http://vaww.pssg.med.va.gov/
[7] http://vssc.med.va.gov
[8] http://vssc.med.va.gov
[9] Based on the number of unique patients seen as defined by VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008, 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).

WH and Vaccination EHR Reviews Results and Recommendations

WH

Cervical cancer is the second most common cancer in women worldwide.[10] Each year, approximately 12,000 women in the United States are diagnosed with cervical cancer.[11] The first step of care is screening women for cervical cancer with the Papanicolaou test or "Pap" test. With timely screening, diagnosis, notification, and treatment, the cancer is highly preventable and associated with long survival and good quality of life.

VHA policy outlines specific requirements that must be met by facilities that provide services for women veterans.[12] We reviewed EHRs, meeting minutes and other relevant documents, and interviewed key WH employees. Table 3 shows the areas reviewed for this topic. The review elements marked as noncompliant needed improvement.

NC	Areas Reviewed
	Cervical cancer screening results were entered into the patient's EHR.
	The ordering VHA provider or surrogate was notified of results within the defined timeframe.
X	Patients were notified of results within the defined timeframe.
	Each CBOC has an appointed WH Liaison.
X	There is evidence that the CBOC has processes in place to ensure that WH care needs are addressed.

Table 3. WH

There were 26 patients who received a cervical cancer screening at the Spokane VAMC CBOCs.

Patient Notification of Normal Cervical Cancer Screening Results. We reviewed 26 EHRs of patients who had normal cervical cancer screening results and determined that 5 patients were not notified within the required 14 days from the date the pathology report became available.

WH Liaison. We found no evidence that the WH Liaisons at the Coeur d'Alene and Wenatchee CBOCs collaborated with the parent facility's Women Veterans Program Manager.

[10] World Health Organization. Cancer of the cervix. Retrieved from: http://www.who.int/reproductivehealth/topics/cancer.
[11] U.S. Cancer Statistics Working Group. *United States Cancer Statistics: 1999-2008 Incidence and Mortality Web-based report.*
[12] VHA Handbook 1330.01, *Health Care Services for Women Veterans,* May 21, 2010.

Recommendations

1. We recommended that managers ensure that patients with cervical cancer screening results are notified of results within the defined timeframe and that notification is documented in the EHR.

2. We recommended that the parent Facility Director ensures that the WH Liaisons collaborate with the Women Veterans Program Manager.

Vaccinations

The VHA NCP was established in 1995. The NCP establishes and monitors the clinical preventive services offered to veterans, which includes the administration of vaccinations.[13] The NCP provides best practices guidance on the administration of vaccinations for veterans. The CDC states that although vaccine-preventable disease levels are at or near record lows, many adults are under-immunized, missing opportunities to protect themselves against diseases such as tetanus and pneumococcal.

Adults should receive a tetanus vaccine every 10 years. At the age of 65, individuals that have never had a pneumococcal vaccination should receive one. For individuals 65 and older who have received a prior pneumococcal vaccination, one-time revaccination is recommended if they were vaccinated 5 or more years previously and were less than 65 years of age at the time of the first vaccination.

We reviewed documentation of selected vaccine administrations and interviewed key personnel. Table 4 shows the areas reviewed for this topic. The review elements marked as noncompliant needed improvement.

NC	Areas Reviewed
	Staff screened patients for the tetanus vaccination.
	Staff screened patients for the pneumococcal vaccination.
X	Staff properly documented vaccine administration.
	Managers developed a prioritization plan for the potential occurrence of vaccine shortages.

Table 4. Vaccinations

<u>Pneumococcal Vaccination Administration</u>. The CDC recommends that at the age of 65, individuals that have never had a pneumococcal vaccination should receive one.[14] For individuals 65 and older who have received a prior pneumococcal vaccination, a one-time revaccination is recommended if they were vaccinated 5 or more years previously and were less than 65 years of age at the time of the first vaccination. We reviewed four EHRs for patients with pre-existing conditions who received their first vaccine prior to the age of 65. In three patients' EHRs we did not find documentation indicating that both vaccinations had been administered.

[13] VHA Handbook 1120.05, *Coordination and Development of Clinical Preventive Services*, October 13, 2009.
[14] Centers for Disease Control and Prevention, http://www.cdc.gov/vaccines/vpd-vac/.

Documentation of Pneumococcal Vaccination. Federal Law requires that documentation for administered vaccinations include specific elements, such as the vaccine manufacturer and lot number of the vaccine used.[15] We reviewed the EHRs of 32 patients who received a pneumococcal vaccine administration at the parent facility or its associated CBOCs. We did not find documentation of all the required elements related to pneumococcal vaccine administration in 20 EHRs.

Recommendations

3. We recommended that managers ensure that clinicians administer pneumococcal vaccinations when indicated.

4. We recommended that managers ensure that clinicians document all required pneumococcal vaccination administration elements and that compliance is monitored.

[15] Childhood Vaccine Injury Act of 1986 (PL 99 660) sub part C.

Onsite Reviews
Results and Recommendations

CBOC Characteristics

We formulated a list of CBOC characteristics that includes identifiers and descriptive information for the randomly selected CBOCs (see Table 5).

	Coeur d'Alene	Wenatchee
VISN	20	20
Parent Facility	Spokane VAMC	Spokane VAMC
Types of Providers	Licensed Clinical Social Worker Licensed Professional Counselor Nurse Practitioner PCP	Clinical Pharmacist Licensed Clinical Social Worker PCP Psychiatrist
Number of MH Uniques, FY 2012	595	336
Number of MH Visits, FY 2012	3,181	2,199
MH Services Onsite	Yes	Yes
Specialty Care Services Onsite	None	None
Ancillary Services Provided Onsite	Laboratory	Laboratory
Tele-Health Services	Dermatology Retinal Imaging	Cardiology Dermatology MH MOVE[16] Retinal Imaging

Table 5. Characteristics

[16] VHA Handbook 1120.01, *MOVE! Weight Management Program for Veterans*, March 31, 2011.

C&P

We reviewed C&P folders, scopes of practice, meeting minutes, and VetPro information and interviewed senior managers to determine whether facilities had consistent processes to ensure that providers complied with applicable requirements as defined by VHA policy.[17] Table 6 shows the areas reviewed for this topic. The CBOCs identified as noncompliant needed improvement. Details regarding the findings follow the table.

NC	Areas Reviewed
	Each provider's license was unrestricted.
New Provider	
	Efforts were made to obtain verification of clinical privileges currently or most recently held at other institutions.
	FPPE was initiated.
	Timeframe for the FPPE was clearly documented.
	The FPPE outlined the criteria monitored.
	The FPPE was implemented on first clinical start day.
	The FPPE results were reported to the medical staff's Executive Committee.
Additional New Privilege	
	Prior to the start of a new privilege, criteria for the FPPE were developed.
	There was evidence that the provider was educated about FPPE prior to its initiation.
	FPPE results were reported to the medical staff's Executive Committee.
FPPE for Performance	
	The FPPE included criteria developed for evaluation of the practitioners when issues affecting the provision of safe, high-quality care were identified.
	A timeframe for the FPPE was clearly documented.
	There was evidence that the provider was educated about FPPE prior to its initiation.
	FPPE results were reported to the medical staff's Executive Committee.
Privileges and Scopes of Practice	
Coeur d'Alene Wenatchee	The Service Chief, Credentialing Board, and/or medical staff's Executive Committee list documents reviewed and the rationale for conclusions reached for granting LIP privileges.
	Privileges granted to providers were setting, service, and provider specific.
	The determination to continue current privileges were based in part on results of Ongoing Professional Practice Evaluation activities.

[17] VHA Handbook 1100.19.

NC	Areas Reviewed (continued)
	The Ongoing Professional Practice Evaluation and reappraisal process included consideration of such factors as clinical pertinence reviews and/or performance measure compliance.

Table 6. C&P

Documentation of Privileging Decisions. According to VHA, the list of documents reviewed and the rationale for conclusions reached by the service chief must be documented.[18] For two of three LIPs at the Coeur d'Alene CBOC and for one of the two LIPs at the Wenatchee CBOC, we did not find service chief documentation in VetPro of the documents reviewed and the rationale for conclusions reached.

Recommendation

5. We recommended that the service chief's documentation in VetPro reflects documents reviewed and the rationale for re-privileging at the Coeur d'Alene and Wenatchee CBOCs.

EOC and Emergency Management

EOC

To evaluate the EOC, we inspected patient care areas for cleanliness, safety, infection control, and general maintenance. We reviewed relevant documents and interviewed key employees and managers. Table 7 shows the areas reviewed for this topic. The CBOC identified as noncompliant needed improvement. Details regarding the findings follow the table.

NC	Areas Reviewed
	The CBOC was Americans with Disabilities Act-compliant, including: parking, ramps, door widths, door hardware, restrooms, and counters.
	The CBOC was well maintained (e.g., ceiling tiles clean and in good repair, walls without holes, etc.).
	The CBOC was clean (walls, floors, and equipment are clean).
	Material safety data sheets were readily available to staff.
	The patient care area was safe.
	Access to fire alarms and fire extinguishers was unobstructed.
	Fire extinguishers were visually inspected monthly.
	Exit signs were visible from any direction.
	There was evidence of fire drills occurring at least annually.
	Fire extinguishers were easily identifiable.
Coeur d'Alene Wenatchee	There was evidence of an annual fire and life safety inspection.

[18] VHA Handbook 1100.19.

NC	Areas Reviewed (continued)
	There was an alarm system or panic button installed in high-risk areas as identified by the vulnerability risk assessment.
	The CBOC had a process to identify expired medications.
	Medications were secured from unauthorized access.
	Privacy was maintained.
	Patients' personally identifiable information was secured and protected.
	Laboratory specimens were transported securely to prevent unauthorized access.
	Staff used two patient identifiers for blood drawing procedures.
Coeur d'Alene	IT security rules were adhered to.
	There was alcohol hand wash or a soap dispenser and sink available in each examination room.
	Sharps containers were less than 3/4 full.
	Safety needle devices were available for staff use (e.g., lancets, injection needles, phlebotomy needles)
	The CBOC was included in facility-wide EOC activities.

Table 7. EOC

<u>Fire and Life Safety</u>. The Joint Commission requires that fire safety equipment and fire safety building features are maintained and inspected in order to identify conditions that do not meet the National Fire Protection Agency Life Safety Code 101.[19] We did not find evidence of annual fire and life safety inspections at the Coeur d'Alene and Wenatchee CBOCs. Management acknowledged the inspections had not been conducted as required.

<u>IT Security</u>. According to VA, an access log must be maintained that includes name and organization of the person visiting, signature of the visitor, form of identification, date of access, time of entry and departure, purpose of visit, and name and organization of person visited.[20] At the Coeur d'Alene CBOC, we inspected the IT closet and found that an access log was not maintained.

Recommendations

6. We recommended that fire and life safety inspections are conducted annually at the Coeur d'Alene and Wenatchee CBOCs.

7. We recommended that the Chief of OI&T evaluates the use of the IT closet and implements required measures at the Coeur d'Alene CBOC.

[19] Joint Commission Standard EC 02.03.05.
[20] VA Handbook 6500, *Information Security Program*, August 4, 2006.

Emergency Management

VHA policy requires each CBOC to have a local policy or standard operating procedure defining how medical emergencies, including MH, are handled.[21] Table 8 shows the areas reviewed for this topic.

NC	Areas Reviewed
	There was a local medical emergency management plan for this CBOC.
	The staff articulated the procedural steps of the medical emergency plan.
	The CBOC had an automated external defibrillator onsite for cardiac emergencies.
	There was a local MH emergency management plan for this CBOC.
	The staff articulated the procedural steps of the MH emergency plan.

Table 8. Emergency Management

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

[21] VHA Handbook 1006.1.

VISN 20 Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 22, 2013

From: Network Director, VISN 20 (10N20)

Subject: **CBOC Reviews at Spokane VAMC**

To: Director, 54SE Healthcare Inspections Division (54SE)

Director, Management Review (VHA 10AR MRS OIG CAP CBOC)

1. Thank you for the opportunity to provide a status report on the draft findings
from the Community Based Outpatient Clinic Reviews, Spokane, Washington.

2. Attached please find the facility concurrences and responses to each of the findings from the review.

3. If you have additional questions or need further information, please contact Susan Gilbert, Survey Coordinator, VISN 20 at (360) 567-4678.

(original signed by:)
Lawrence H. Carroll

Spokane VAMC Director Comments

Department of
Veterans Affairs **Memorandum**

Date: January 17, 2013

From: Director, Spokane VAMC (668/00)

Subject: **CBOC Reviews at Spokane VAMC**

To: Director, VISN 20 (10N20)

1. Please find attached the Spokane VAMC status report on the follow-up to the findings from the Community Based Outpatient Clinic Reviews at Spokane VA Medical Center, Spokane, WA during the week of November 5, 2012.

2. The Spokane VAMC staff is committed to continuously improving processes and care provided to our Veterans and have worked to correct the recommendations identified in the attached report.

3. If you have additional questions, or need additional information, please contact Betty Braddock at 509-434-7300.

(original signed by:)
Linda K. Reynolds, MA, FACHE
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

1. We recommended that managers ensure that patients with cervical cancer screening results are notified of results within the defined timeframe and that notification is documented in the EHR.

Concur

Target date for completion: All actions completed December 2012

- Education was completed with all Patient Aligned Care Team (PACT) staff regarding the requirement for notification of normal results to the Veteran within 14 days.

- The Women's Veterans Program Manager (WVPM) collaborated with:

a. The Clinical Applications Coordinators (CAC) to create and implement a follow-up letter in the electronic health record for clinical staff to use for notifying Veterans of normal cervical screening results.

b. The Women's Health (WH) Liaisons and WH Providers to educate staff on how to address and resolve the Clinical Reminder tool on cervical cancer screening in the electronic health record.

c. The WH Liaisons to develop an electronic tracking mechanism for all WH staff to access and manage cervical cancer screening as part of pre-planning and follow-up of WH visits.

d. Healthcare Administration staff to ensure capture of outside pathology results for incorporation into the VA electronic health record.

2. We recommended that the parent Facility Director ensures that the WH Liaisons collaborate with the Women Veterans Program Manager.

Concur

Target date for completion: All actions completed December 2012

- All WH Liaisons or designated surrogates are required to participate in monthly Women's Health meetings.

- Community Based Outreach Clinic (CBOC) schedules are blocked to allow participation of WH Liaisons and WH Providers to attend WH meetings.

3. We recommended that managers ensure that clinicians administer pneumococcal vaccinations when indicated.

Concur

Target date for completion: All actions completed December 2012

- Training was completed during "morning huddles" with providers and nursing staff. Discussion included indications and dosing of pneumococcal vaccinations to ensure providers and staff were aware of indications and criteria.

- A process was established for intake nurses to ask Veterans age 65 or older if they have ever received a pneumococcal vaccination. If "no", they will automatically be offered the vaccine. If "yes", the vaccination will be verified in the electronic health record as to the age at time of vaccination. If vaccinated prior to age 65, then the need for a booster will be determined.

4. We recommended that managers ensure that clinicians document all required pneumococcal vaccination administration elements and that compliance is monitored.

Concur

Target date for completion: All actions completed November 2012

The Infection Control Nurse collaborated with the facility CAC to add Vaccination Information Sheets (VIS) publication dates to the Clinical Reminders. Staff are not able to exit out of the vaccination reminder without first entering lot numbers.

5. We recommended that the service chief's documentation in VetPro reflects documents reviewed and the rationale for re-privileging at the Coeur d'Alene and Wenatchee CBOCs.

Concur

Target date for completion: All actions completed November 2012

A training session was conducted with all service chiefs on how to complete the service chief assessments in VetPro. As part of the training, service chiefs were given the "Service Chief Approval" document, which is sent with every credentialing file. This document includes a list of information that should be commented on in VetPro to rationalize re-privileging.

6. We recommended that fire and life safety inspections are conducted annually at the Coeur d'Alene and Wenatchee CBOCs.

Concur

Target date for completion: All actions completed September 2012

Spokane VAMC completed annual Life Safety Evaluations and documented findings in the Environmental of Care rounds tracking spreadsheet. Now, the Spokane VAMC documents the Life Safety Evaluations using the Life Safety Code Checklist.

7. We recommended that the Chief of OI&T evaluates the use of the IT closet and implements required measures at the Coeur d'Alene CBOC.

Concur

Target date for completion: All actions completed November 2012

Education was completed with staff that access to the IT closet is limited to those on the approved Access Control List (ACL). A log book, requiring documentation of name, date, and time of staff entering the IT closet was placed in the IT closet.

OIG Contact and Staff Acknowledgments

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