Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Contract Community Based Outpatient Clinic Issues New Mexico VA Health Care System Albuquerque, New Mexico

Report No. 11-00588-189

June 8, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to determine the validity of allegations regarding patient care at contract community based outpatient clinics (CBOCs) affiliated with the New Mexico Veterans Affairs Healthcare System. The confidential complainant alleged that:

- Contract issues negatively impacted patient care.
- A CBOC physician underwent three level-III peer reviews (PRs) following the death of a patient.
- From April to September 2010, four patients with positive colorectal cancer (CRC) screening tests were not referred to a gastrointestinal specialist to determine the cause for bleeding.
- There were numerous complaints from veterans unable to get access to care when needed.

We substantiated the allegation that contract issues negatively impacted patient care. Although not required by the contract, the facility contracting office directed that communication be routed through their staff, which caused delays in handling patient care matters.

We did not substantiate that there were three level-III PRs assigned to a CBOC physician. However, we did find issues related to PR timeliness and confidentiality when the results were communicated to facility contracting staff.

We did not substantiate the allegation regarding positive CRC screenings for four patients. We found the facility was not timely in referring patients for colonoscopies following positive CRC screening tests; however, they had an acceptable action plan.

We substantiated that there were issues with access to care at the CBOC. The extent of the problem could not be determined because the CBOC did not follow Veterans Health Administration requirements for scheduling patients and monitoring access, and the facility patient advocates did not document and track patient complaints.

We recommended that the Network Director ensure free and direct clinical information between the facility and El Centro Family Health staff. We also recommended that facility managers assure timeliness and confidentiality of peer reviews; and that CBOCs follow Veterans Health Administration requirements for monitoring access to care and patient satisfaction.

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

TO: Director, VA Southwest Health Care Network (10N18)

SUBJECT: Healthcare Inspection – Contract Community Based Outpatient Clinic Issues, New Mexico VA Health Care System, Albuquerque, New Mexico

Purpose

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made by a confidential complainant regarding patient care at two contract community based outpatient clinics (CBOCs) affiliated with the New Mexico Veterans Affairs Healthcare System (facility).

Background

The facility is located in Albuquerque, New Mexico and is a member of Veterans Integrated Service Network (VISN) 18. The facility operates 310 beds and oversees 10 CBOCs that provide services in New Mexico and southwest Colorado.

This inspection relates to contract care provided by El Centro Family Health (ECFH) staff at the Espanola and Las Vegas, NM CBOCs. ECFH provided contracted primary and mental health outpatient care to about 1800 enrolled veterans under the current contract since January 1, 2005, and for 15 years under previous contracts. The most recent contract included 4 option years, which extended the service through December 31, 2009. Through a series of contract extensions and an interim contract, ECFH is expected to continue to provide contracted care through March 2011.

In November 2010, a confidential complainant alleged that:

- Contract issues negatively impacted patient care.
- A CBOC physician underwent three level-III peer reviews (PRs)[1] following the death of a patient.

[1] A PR is a process that requires evaluation of a physician's competence and conduct by another physician or professional group. A level-III PR means that the reviewer(s) would have definitely managed the subject case differently.

- From April to September 2010, four patients with positive colorectal cancer (CRC) screening tests were not referred to a gastrointestinal (GI) specialist to determine the cause of bleeding.
- There have been numerous complaints from veterans not being able to get access to care when needed.

Scope and Methodology

We conducted a site visit January 10–13, 2011, and interviewed key facility staff, including contracting staff, as well as ECFH contracted staff and management. In preparation for this site visit, we reviewed the contract (beginning January 1, 2005) and the contracting office's correspondence files with ECFH. We also reviewed selected patient medical records, pertinent medical center documents, performance measure data, and applicable facility and Veterans Health Administration (VHA) policies.

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

Inspection Results

Issue 1: Contract Issues Impacted Patient Care

We substantiated the allegation that contract issues negatively impacted patient care.

The facility contracting office, under the guidance of the network contracting office, is responsible for administering the contract and for addressing performance issues. Although the contract does not contain any provisions that prohibit clinical and quality management communication between providers, the facility contracting office directed that all communication between the system and ECFH go through the contracting office. Our interviews with both facility and contractor clinical staff corroborated that they were not allowed to speak directly unless the Contracting Officer's Technical Representative or another contracting office representative was present.

We found that the requirement for all communication to go through the contracting office caused undue delays and negatively impacted patient care. Providers expressed frustration that coordination of patient health care was impacted by the communication limits placed on them. The exchange of clinical information between providers is essential for the optimum coordination of patient care.

Recommendation 1: We recommended that the Network Director ensure coordination of patient care through sharing pertinent clinical information directly between the facility and clinical staff at all CCBOCs.

Issue 2: Physician with Multiple Level-III Peer Reviews

We did not substantiate that a CBOC physician underwent three level-III PRs following the death of a patient. The facility took appropriate actions following the notification of a patient death at a non-VA medical facility; however, we found opportunities for improvement in the PR process.

VHA defines PR as:

> An organized process carried out by an individual health care professional or select committee of professionals, to evaluate the performance of other professionals. In the health care setting, PR is applied to a broad array of activities of varying characteristics; this includes, but is not limited to: reviews done for Quality Management; Management Reviews like Administrative Investigation Boards (AIB); Clinical Practice reviews; Ongoing Professional Practice Evaluations (OPPE); Tort Claims; and National Practitioner Data Bank (NPDB) reporting.[2]

VHA requires that the need for PR be determined for a variety of reasons including when a patient dies at a non-VA facility.[3] Upon notification that a CBOC-managed patient died at non-VA facility, facility clinicians screened the case and determined that a PR was required. Subsequent to the PR, the facility performed additional performance monitoring on the subject physician using Focused Professional Practice Evaluation[4] (FPPE) with nomenclature similar to that used in PRs, which gave an impression of multiple reviews.

VHA requires that all PRs be completed within 120 days and that "PRs conducted as part of a quality management program may not be disclosed outside of the quality management process." To maintain the integrity of the PR process for the continuous improvement of patient care, confidentiality must be maintained when individual providers, patients, or other employees are identified. Therefore, PRs should be communicated from the PR committee to the provider's service chief and then to the provider.

The facility took 7 months to complete the PR. The facility completed the initial peer review within the 45-day VHA requirement. However, the facility did not have a defined process for communicating PR results to contract providers. The facility took an additional 3 months to notify the contract provider of the PR results. The facility disclosed the PR results outside of the quality management process to contracting staff

[2] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
[3] VHA Directive 2010-025.
[4] According to VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008, FPPE may be used when there is a question about a physician's ability to provide safe, high quality patient care.

before communicating the results to the subject physician, which violated the confidentiality provision of PR.

Recommendation 2: We recommended that facility managers ensure that there is a well-defined process for communicating level II and III PRs to contract providers in a manner that supports the confidentiality and timeliness of the PR quality management process.

Issue 3: Positive Colorectal Cancer Test Patients

We did not substantiate the allegation that patients with positive CRC screening tests were not referred to a gastrointestinal specialist for follow-up evaluations.

VHA requires that a screening colonoscopy be completed within 60 days of a positive CRC test.[5] A patient with a positive CRC test must undergo a screening colonoscopy to confirm any suspicion of cancer.

We reviewed the medical records of the four subject patients. We found three patients with positive CRC tests had consultations to GI service. The fourth patient did not have a positive CRC test. We found that clinicians appropriately screened for and managed positive CRC test results by consulting with specialty providers. However, in the three subject cases the facility did not meet the 60-day requirement for screening colonoscopy following a positive CRC screening test. The facility showed evidence of adequate action plans implemented to meet the 60-day timeframe; therefore, we made no recommendations.

Issue 4: Patient Complaints about Access to Care

We substantiated the allegation that patients had complaints about access to care.

According to the contract, ECFH is expected to follow VHA performance criteria for access and patient satisfaction. Therefore, ECFH staff is expected to monitor the percent of unique primary care patients on the access list waiting more than 14 days from their desired date for an appointment[6] and report patient complaints according to requirements.[7]

VHA requires that access to care be measured and monitored.[8] ECFH serves veteran and non-veteran patients, and uses a scheduling-software package that differs from that of the facility. The ECFH software does not allow for measurement of access to care as required by VHA. In contrast, the facility scheduling-software[9] does allow for

[5] VHA Directive 2007-004, *Colorectal Cancer Screening*, January12, 2007.
[6] VHA Office of Quality and Performance, *FY 2011 Technical Manual*, Oct 1, 2010.
[7] VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006.
[8] VHA Office of Quality and Performance, *FY 2011 Technical Manual*, October 1, 2010.
[9] The facility uses VA software and client-server technology, Veterans Health Information Systems and Technology Architecture (VistA).

measurement of access to care. Patient care may be negatively impacted by inadequate access to care. Because the ECFH staff did not measure access to care as required by VHA, it was not possible to obtain a clear picture of CBOC scheduling issues.

VHA also requires that facility patient advocates receive and electronically record patient complaints, compliments, and other patient issues in the Patient Advocate Tracking System (PATS).[10] Management is responsible for evaluating PATS data to identify opportunities for facility improvements and integrate the information with the facility, VISN, and national quality management reports. We substantiated that there were numerous complaints about access to care at the CBOC, and interviews with key facility staff confirmed this finding. We also found that PATS was not being used in accordance with VHA requirements and documentation of complaints and reports on access wait times was lacking. Facility staff reported complaints, but there were only two documented complaints in the PATS during fiscal year 2010. We found that facility staff did not follow VHA guidelines on the use of the PATS and, therefore, were not able to determine the number or the nature of complaints. Moreover, managers were unaware of patient concerns, and opportunities for improvement were missed.

Recommendation 3: We recommended that the facility ensure that all CBOCs adopt the facility scheduling software package and monitor access to care, as required by VHA.

Recommendation 4: We recommended that facility staff follow VHA's guidelines on the PATS.

Conclusions

Although the contract did not contain language prohibiting direct contact between staff, the facility implemented this requirement, which caused preventable delays in communication of clinical matters, including delays in handling PRs on a CBOC physician. We found the subject physician's cases were reviewed according to protocol; however, we did find issues related to PR timeliness and confidentiality.

We did not substantiate the allegation about CRC follow-up. However, we found there was delay in the handling of follow-up evaluations. The facility is taking significant steps to support their increased demand for follow-up colonoscopies.

The CBOC did not follow VHA requirements for scheduling patients and monitoring access, and patient advocates did not document and track patient complaints as per VHA policy. We found there were issues with access and patient satisfaction, but it was not possible to determine the extent of the problem due to the lack of documentation. We concluded that in order to provide coordinated patient care the system must ensure that CBOCs comply with implementation of VHA scheduling software and monitor access to

[10] VHA Handbook 1003.4, *Patient Advocacy Program,* September 2, 2005.

care. We also concluded that to identify areas for facility improvement CBOCs must follow VHA systems for tracking and reporting patient satisfaction.

Comments

The VISN and System Directors concurred with the inspection results (see Appendixes A and B, pages 7–10, for the full text of the Directors' comments). We will follow-up on the planned actions until they are complete.

(original signed by:)

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 9, 2011

From: Director, VA Southwest Health Care Network (10N18)

Subject: Healthcare Inspection – Contract Community Based Outpatient Clinic Issues, New Mexico VA Healthcare System, Albuquerque, NM

To: Director, Baltimore Office of Healthcare Inspections (54BA)

Thru: Director, Management Review Service (10B5)

1. I concur with the facility response to the Healthcare Inspection report. Please see Facility Director Comments for specific actions.

2. For questions, please contact Sally Compton, Executive Assistant to the Network Director, VISN 18, at 602.222.2699.

(*original signed by*:)
Susan P. Bowers
Director, VA Southwest Health Care Network (10N18)

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 9, 2011

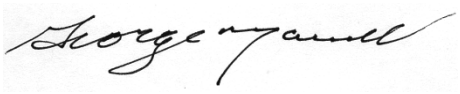
From: Director, New Mexico VA Health Care System (501/00)

Subject: Healthcare Inspection – Contract Community Based Outpatient Clinic Issues, New Mexico VA Healthcare System, Albuquerque, New Mexico

To: Director, VA Southwest Health Care Network (10N18)

1. In response to your request, dated April 16, 2011, please find a response from our facility.

2. If you have any questions or require additional information, please contact Pamela Crowell, Chief, Performance Improvement, at 505-265-1711 (extension 2092).



George Marnell
Director , New Mexico VA Health Care System (501/00)

Director's Comments to Office of Inspector General's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Network Director ensure coordination of patient care through sharing pertinent clinical information directly between the facility and clinical staff at all CCBOCs.

Concur **Target Completion Date:** August 1, 2011 **(10F)**

Facility's Response:

To improve the flow of communications between the facility and clinical staff at all community-based outpatient clinics (CBOCs) and to improve patient care, a specific communication protocol to address this issue will be added to existing Contracting Office Technical Representative (COTR) training. In addition, the Veterans Health Administration (VHA) Procurement and Logistics Office, Medical Sharing Office, is coordinating with VHA Patient Care Services to revise the CBOC template to address communication issues. These changes will be implemented at the Espanola CBOC.

Status: Open

Recommendation 2. We recommended that facility managers ensure that there is a well-defined process for communicating level II and III PRs to contract providers in a manner that supports the confidentiality and timeliness of the PR quality management process.

Concur **Target Completion Date:** May 9, 2011

Facility's Response:

The NMVAHCS has changed the Peer Review Policy to include the following language under procedures: "In the event the Peer Review Committee determines a level II or level III for a provider in a contract CBOC, the Chief of Staff will communicate the Peer Review Committee

Level II or Level III determination directly to the Medical Director of the Contract Community Based Outpatient Clinic."

Status: Closed

Recommendation 3. We recommended that the facility ensure that all CCBOCs adopt the facility scheduling software package and monitor access to care, as required by VHA.

Concur **Target Completion Date:** April 1, 2011

Facility's Response:

The New Mexico VA Health Care System has incorporated this requirement into all Contract CBOC Scopes of Work, including the Northern New Mexico Contract CBOC. The new contractor began work on April 1, 2011, and is using the facility scheduling software package. Additionally, access is monitored and reported every 2 weeks to senior leadership. This report is also monitored monthly at the Systems Redesign Steering Committee.

Status: Closed

Recommendation 4. We recommended that facility staff follow VHA's guidelines on PATS.

Concur **Target Completion Date:** April 15, 2011

Facility's Response:

The NMVAHCS has a standing policy on Patient Complaints and entry of complaints into the PATS. Since January 2011, communication efforts have increased to remind staff to enter complaints into the PATS system, including complaints from the Espanola CBOC. NMVAHCS Rural Health staff completed PATS training in January 2011 and is now entering all compliments, complaints and other patient care issues in the PATS.

Status: Closed

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Murray Leigh, CPA, Project Manager Sonia Whig, LD, Co-Team Leader Zhana Johnson, CPA, Co-Team Leader Melanie Cool, LD Nathan Fong, CPA Donna Giroux, RN Cathleen King, RN Nelson Miranda, LCSW

Appendix D

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