Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Select Patient Care Delays and Reusable Medical Equipment Review
Central Texas Veterans Health Care System
Temple, Texas

Report No. 11-03941-61

January 6, 2012

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding patient care delays and reusable medical equipment concerns at the Olin E. Teague Veterans' Medical Center (facility) in Temple, TX. A complainant alleged that:

- Hundreds of scheduled gastroenterology (GI), mammogram, radiation oncology, and breast biopsy fee-basis consults dating back to 2009 place the health of patients at risk.
- Prolonged wait times for GI care lead to delays in diagnosis of colorectal and other cancers.
- Reusable medical equipment issues have not been properly addressed, including unclean scopes that were almost used on patients, equipment failures, and use of new equipment without an approved standard operating procedure.

We substantiated that there are hundreds of fee-basis GI, mammogram, radiation oncology, and breast biopsy consults requiring action; however, we did not find evidence of patient harm due to delays in follow-up actions. We substantiated that there are GI wait times in excess of VHA requirements following initial positive screenings.

In addition, staff indicated that appointments were routinely made incorrectly by using the next available appointment date instead of the patient's desired date. These practices led to inaccurate reporting of GI clinic wait times.

We did not substantiate that reusable medical equipment issues have not been properly addressed.

We recommended that the Medical Center Director:

- Ensure that patients referred for fee-basis care are tracked from initial referral to timely receipt of results to both the provider and the patient from completed appointments.
- Ensure that patients receive timely colorectal cancer screening follow-up as required by VHA Directive.
- Ensure that all staff follow VA policy for scheduling outpatient appointments, and that compliance is monitored.

The Veterans Integrated Service Network and Medical Center Directors concurred with our findings. We will follow up until the planned actions are completed.

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

TO: Director, VA Heart of Texas Health Care Network (10N17)

SUBJECT: Healthcare Inspection – Select Patient Care Delays and Reusable Medical Equipment Review, Central Texas Veterans Health Care System, Temple, Texas

Purpose

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations made regarding patient care delays and reusable medical equipment (RME) concerns at the Olin E. Teague Veterans' Medical Center (facility) in Temple, TX.

Background

The facility is part of the Central Texas Veterans Health Care System in Temple, TX and Veterans Integrated Service Network 17 located in Arlington, TX. This tertiary care facility provides a broad range of inpatient and outpatient healthcare services including outpatient care provided at one outpatient clinic in Austin and four community based outpatient clinics in Brownwood, Bryan/College Station, Cedar Park, and Palestine, TX.

VHA has established requirements for providing priority access to medical care to veterans with service-connected ratings of 50 percent or greater and veterans requiring care for a service-connected disability. VHA monitors timely access to care by using patient requested dates for appointments.[1] A new patient establishes the requested or desired date when answering the appointment scheduler's question "What is the first day you would like to be seen?" VHA's goal is to schedule 98 percent of all specialty care appointments within 14 days from the earliest desired appointment date.[2]

Requests for outpatient specialty care are made using electronic consults in the Computerized Patient Record System. Consults can be scheduled, canceled, or discontinued. A scheduled status indicates that the consult has been accepted and

[1] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
[2] *ECF Technical Manual 1.7*, VHA Office of Analytics and Business Intelligence, March 14, 2011.

that an appointment has been scheduled. A canceled status indicates that the consult has been closed without the service seeing the patient. A discontinued status indicates that the provider who requested specialty care no longer requests or needs to make a consult request. A consult in a scheduled status will change to a completed status when the service has seen and evaluated the patient with a documented progress note in the medical record linked to the consult.

Purchased care, including fee-basis referral, is utilized when services are not available or cannot be economically provided by a VA facility due to capability, capacity, or accessibility concerns. Purchased care must only be considered when the request can be resolved efficiently and results made available to the referring facility in a timely manner. VHA requires these results to be filed or scanned into the patient's medical record.[3]

Colorectal cancer (CRC) is the third most common cancer and the third leading cause of cancer deaths in the United States.[4] CRC screening enables the detection of pre-cancerous polyps so that they may be removed before they become cancerous and the detection of colon cancer at an earlier stage than otherwise might have been the case. VHA requires that veterans with positive CRC screening tests be followed up with a full colonoscopy, unless contraindicated or the primary screening method was colonoscopy.[5] When a diagnostic colonoscopy is indicated, it must be performed within 60 calendar days of the positive screening test.

VHA has established requirements for the proper reprocessing of RME, including endoscopes used during colonoscopy procedures, to ensure patient and staff safety.[6] Requirements include the development of device-specific standard operating procedures for reprocessing RME according to manufacturer's guidelines, competency assessment of staff prior to initial use of RME, and a quality management program that ensures appropriate and safe reprocessing.

In August 2011, OIG's Hotline Division received allegations of patient care delays and RME concerns. A complainant alleged that:

- Hundreds of scheduled gastroenterology (GI), mammogram, radiation oncology, and breast biopsy fee-basis consults dating back to 2009 place the health of patients at risk.
- Prolonged wait times for GI care lead to delays in diagnosis of colorectal and other cancers.

[3] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.
[4] American Cancer Society, http://www.cancer.org, accessed September 8, 2011.
[5] VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007.
[6] VHA Directive 2009-004, *Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities*, February 9, 2009.

- RME issues have not been properly addressed, including unclean scopes almost used on patients, equipment failures, and use of new equipment without an approved standard operating procedure.

The complainant also cited personnel and resource allocation issues that were outside of OHI's purview and are not addressed in this report.

Scope and Methodology

We interviewed the complainant as well as facility managers, clinicians, and other employees with knowledge of the issues raised by the allegations during an onsite inspection on August 30–September 1, 2011. We reviewed patient medical records, pertinent facility documents, and performance measure data available through VHA Support Service Center.[7]

We conducted the inspection 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: Delays in Patient Care

Fee-Basis Process

We substantiated that there are hundreds of fee-basis GI, mammogram, radiation oncology, and breast biopsy consults in a scheduled status.

Table 1 shows the number of consults by status and specialty for FY 2010 as of August 15, 2011.[8]

Table 1. Facility Fee-Basis Consults for FY 2010.

Status	All Facility Services	GI	Mammogram	Radiation Oncology	Breast Biopsy
Discontinued	2682	903	162	78	14
Completed	6868	1319	361	188	60
Scheduled	542	163	14	66	1
Cancelled	14	3	0	1	0
Total	10106	2388	537	333	75

We reviewed all 244 GI, mammogram, radiation oncology, and breast biopsy consults that were in a scheduled status as of August 15, 2011, to determine if the patients were

[7] VHA Support Service Center maintains VA data for the purpose of health care delivery analysis and evaluation.
[8] Data provided by facility management.

harmed due to delays in follow-up actions. We found no evidence of patient harm in 231 (95 percent) of 244 records reviewed. Of the 231 patients, 230 either were offered or had received treatment. One GI patient died at an outside hospital from a cardiac arrest prior to the scheduled appointment. We could not determine harm in the remaining 13 (5 percent) cases because there was no medical record documentation to show that procedures were performed.

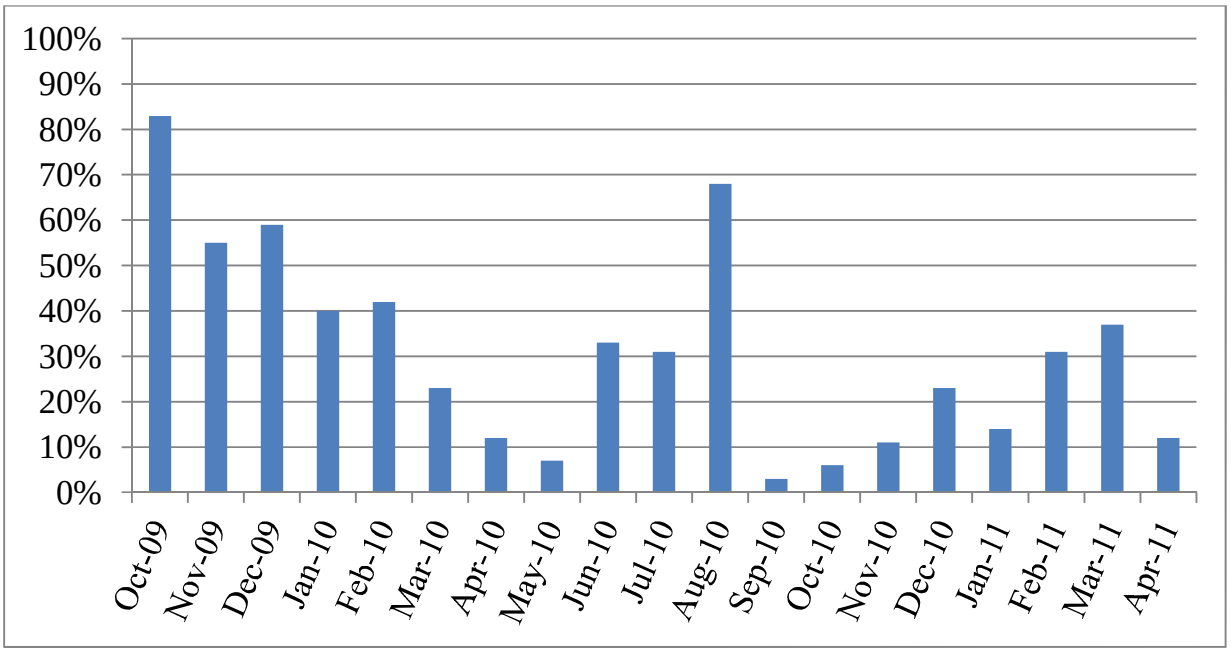
The facility policy in place during FY 2010 did not adequately address the responsibility for tracking patient referrals or timeliness of follow-up for authorized fee-basis care. A revised local policy addressing these issues was approved August 26, 2011.

Excessive Wait Times and Delayed Cancer Diagnosis

We substantiated GI wait times in excess of VHA requirements for CRC screening and diagnosis.

We reviewed facility reports documenting the percentage of patients who had a VA-performed colonoscopy within 60 days of a positive fecal occult blood test (FOBT).[9] This group of patients excluded those patients who refused colonoscopy, chose non-VA follow-up, or were deemed clinically inappropriate for colonoscopy. Figure 1 shows the percentage of these patients seen within the required 60 days of a positive FOBT by month for FY 2010 through the most recently available report in FY 2011.

Figure 1. Percentage of Patients with VA Colonoscopies within 60 Days of Positive FOBT Result.



[9] An FOBT is a CRC screening test that uses chemicals on stool samples to find blood that cannot be seen with the naked eye.

To assess delays in diagnosing CRC, we reviewed medical records for all outpatients diagnosed with CRC at the facility from January 2010 to August 2011. We compared the timeliness observed for those diagnosed after a diagnostic colonoscopy for a positive FOBT result to those diagnosed after a screening or diagnostic colonoscopy[10] for other reasons. Tables 2 and 3 show the wait times experienced by the two groups in calendar years 2010 and 2011, respectively.

Table 2. Observed CRC Diagnosis Timeliness in 2010.

	Average Days from GI Consult to GI Clinic Appointment	Average Days from GI Clinic Appointment to Colonoscopy	Average Days from GI Consult to Colonoscopy
Positive FOBT Result (N=30)	48	39	87
Other (N=23)	41	41	81

Table 3. Observed CRC Diagnosis Timeliness in 2011.

	Average Days from GI Consult to GI Clinic Appointment	Average Days from GI Clinic Appointment to Colonoscopy	Average Days from GI Consult to Colonoscopy
Positive FOBT Result (N=9)	35	79	114
Other (N=13)	44	50	94

Scheduling Practices

We found incorrect patient desired dates entered by scheduling staff for GI clinic appointments.

Staff indicated that appointments were routinely made incorrectly by using the next available appointment date instead of the patient's desired date. These practices led to inaccurate reporting of GI clinic wait times. Despite facility reports showing that 96 percent or more of GI appointments were scheduled within 14 days of new patients' desired dates in FY 2011, all staff interviewed acknowledged wait times of up to several months.

Issue 2: RME Concerns

We did not substantiate that RME issues are not properly addressed.

We reviewed the details of specific incidents reported by the complainant. One incident concerned suspicious debris observed while troubleshooting a GI scope. GI management

[10] A diagnostic colonoscopy is performed when signs or symptoms indicate dangerous changes in the colon.

entered an electronic incident report promptly after notification by staff that a scope was not functioning properly and that debris was observed. Appropriate safety measures were taken in response, including immediately removing the scope from the environment and sending the scope for evaluation and repair. Similar reports of fluid in GI scopes and camera issues observed in early FY 2011 also resulted in timely requests for vendor evaluation and repair. An additional incident was reported during the onsite inspection. GI staff observed that a scope had technical issues requiring vendor repair. GI staff tagged the equipment and sent it to Sterile Processing & Distribution to coordinate vendor repair. Sterile Processing & Distribution staff cleaned and processed the scope prior to vendor referral for repair as required but did not re-tag the scope after processing. This resulted in the clean scope returning to GI without vendor repair. Once the scope arrived in GI, staff recognized the scope by its identification number and the lack of sufficient time for vendor repair and brought the issue to management's attention. No patients were affected by these incidents.

We reviewed facility FY 2011 acquisition records for GI scopes. The facility acquired new high-definition versions of models previously used at the facility that required no reprocessing changes, but new standard operating procedures were developed to reflect differences in model numbers and staff competencies were assessed prior to using the scopes.

Conclusions

The fee-basis process has been strengthened, but further effort is needed to address existing and future fee-basis consults so that patients are not lost to follow-up. This includes tracking initial community referrals, patient notification of future appointments, patient attendance at scheduled appointments, and timely receipt of appointment results for scanning into the medical record.

VHA recognized the importance of CRC screening and follow-up in its patient population, made this a priority, and established clear requirements. Although the facility monitored its compliance in meeting VA CRC screening and follow-up timeliness requirements, significant efforts are needed to meet these requirements and to decrease the overall wait time for patients who need GI care.

Although facility leadership was aware of wait time issues for GI services, other specialties may have similar capacity issues that remain unidentified because of inappropriate scheduling practices that have direct impact on the quality of patient care and hide opportunities for improvement from facility leadership.

Although equipment will experience functionality issues during its lifetime, we found facility staff involved with RME to be vigilant in their duties and responsibilities for ensuring that equipment worked properly prior to use, problems were reported timely, and facility processes were followed.

Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that patients referred for fee-basis care are tracked from initial referral to timely receipt of results to both the provider and the patient from completed appointments.

Recommendation 2. We recommended that the Medical Center Director ensure that patients receive timely colorectal cancer screening follow-up as required by VHA Directive.

Recommendation 3. We recommended that the Medical Center Director ensure that all staff follow VA policy for scheduling outpatient appointments, and that compliance is monitored.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with our findings (See Appendixes A and B, pages 8-12, for the full text of their 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

Appendix A

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 14, 2011

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **Healthcare Inspection—Select Patient Care Delays and Reusable Medical Equipment Review, Central Texas Veterans Health Care System, Temple, Texas**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, VHA Management Review Service (10A4A4)

1. Thank you for allowing me to respond to this Healthcare Inspection regarding select patient care delays and the RME review at Central Texas Veterans Health Care System, Temple, Texas.

2. I concur with the recommendation and have ensured that an action plan has been developed.

3. If you have further questions regarding this inspection, please contact Denise B. Elliott, VISN 17 HSS at 817-385-3734.

(*original signed by* :)
Lawrence A. Biro
Director, VA Heart of Texas Health Care Network (10N17)

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 8, 2011

From: Director, Central Texas Veterans Health Care System (674/00)

Subject: **Healthcare Inspection—Select Patient Care Delays and Reusable Medical Equipment Review, Central Texas Veterans Health Care System, Temple, Texas**

To: Director, VA Heart of Texas Health Care Network (10N17)

1. We appreciate the opportunity to review the draft report regarding Selected Patient Care Delays and Reusable Medical Equipment review conducted August 30–September 1, 2011.
2. The recommendations were reviewed and I concur with the findings. Our comments and implementation plan are delineated below. Corrective action plans have been developed or executed for continuous monitoring.
3. We appreciated and benefited from the thorough review of our systems and processes, the consultative approach, and feedback provided to our staff during the recent review. The goal to provide excellent quality of care and services remains our primary mission; this OIG survey validated our quality of care and now provides additional opportunities for process improvement.
4. Should you have questions or require additional information, please do not hesitate to contact Sylvia Tennent, Chief of Quality Management and Improvement Service at: 254-743-0719.

(original signed by:)
Thomas C. Smith, III, FACHE
Director, Central Texas Veterans Health Care System (674/00)

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 Medical Center Director ensure that patients referred for fee-basis care are tracked from initial referral to timely receipt of results to both the provider and the patient from completed appointments.

Concur **Target Completion Date:** Completed

Facility's Response:

CTVHCS agrees that fee-basis process requires strengthening and a process was designed to facilitate real-time tracking of consults from time of initiation to receipt of results. This process was initiated October 1, 2011.

Monthly compliance reports will be submitted to the Medical Staff Executive Council (MSEC) and Executive Leadership Board (ELB) for oversight monitoring.

Status: Closed

Recommendation 2. We recommended that the Medical Center Director ensure that patients receive timely colorectal cancer screening follow-up as required by VHA Directive.

Concur **Target Completion Date:** July 30, 2012

Facility's Response:

CTVHCS agrees patients must receive timely colorectal cancer screening in accordance with VHA Directive 2007-004 and has designed systems to decrease the wait times for GI care. CTVHCS has implemented the following GI measures to address colorectal cancer screening (FOBT positive) backlog to date:

1. A dedicated FOBT positive clinic was opened Nov 1, 2011. New FOBT positive consults are now seen within thirty days in this clinic 89% of the time as of end of November 2011.

2. Beginning October 2011, FOBT positive consults from AOPC and outlying CBOCs are sent to fee-basis whose processing time is usually within 45 days.
3. A third nurse case manager has been added to the case management team for GI (total of three RNs now).
4. The procedure clinic dedicated to FOBT positive cases has next available appointment now at 32 working days from request, which is much better than the four to five months wait time that was present back in July 2011.
5. A nurse practitioner was hired to staff the FOBT clinic.
6. A dedicated GI procedure check-in, processing, and recovery area was approved. This will expedite throughput and increase procedure capacity by 17%.
7. An 8th GI physician position was approved in order to augment staffing to ensure procedure clinics continue to function at capacity despite scheduled leave or absence.

Monthly compliance reports will be submitted to the Medical Staff Executive Council (MSEC) and the ELB for oversight monitoring.

Status: Open

Recommendation 3. We recommended that the Medical Center Director ensure that all staff follow VA policy for scheduling outpatient appointments, and that compliance is monitored.

Concur **Target Completion Date:** December 31, 2011

Facility's Response:

CTVHCS agrees with strengthening the scheduling process and has trained the responsible staff to only schedule appointments within the 14 days of Veteran's desired date. To strengthen the process special training sessions were initiated on December 1, 2011 for all CTVHCS staff with the scheduling key access, to enhance focus on the correct method of using the VISTA software for scheduling in accordance with VHA Directive 2010-027.

In addition, for staff failing to complete this special training during the required timeframe, their scheduling access will be removed until this required training is completed. Medicine Service staff with scheduling

responsibility have completed this training. Scheduling compliance audits are conducted daily to monitor compliance, and monthly reports will be submitted to the MSEC and ELB for oversight monitoring.

Status: Open

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	Cathleen King, MHA, CRRN, Project Leader Larry Ross, MS, Team Leader Gayle Karamanos, MS, PA-C Trina Rollins, MS, PA-C Robert Yang, MD, Medical Consultant Misti Kincaid, BS, Management and Program Analyst

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Heart of Texas Health Care Network (10N17)
Director, Central Texas Veterans Health Care System (674/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: John Cornyn, Kay Bailey Hutchison
U.S. House of Representatives: John Carter, Michael K. Conaway, Lloyd Doggett, Bill Flores, Michael T. McCaul, Lamar Smith

This report is available at http://www.va.gov/oig/publications/reports-list.asp.