Administrative Closure
Alleged Quality of Care Issues
Rochester Community Based Outpatient Clinic
Rochester, Minnesota
MCI# 2013-00756-HI-0336

On October 9, 2012, a complainant wrote a letter to the Office of Inspector General Hotline Division alleging sentinel close calls, patient safety, and management problems at the Rochester Community Based Outpatient Clinic (the CBOC), Rochester, Minnesota. The alleged sentinel events were referred to the Office of Healthcare Inspections (OHI) for initial review. After a preliminary review, no patient safety problems were identified and it was recommended the case be closed as a "non-case referral".[i] On November 2, before the non-case referral was completed, a second letter[ii] arrived at the OIG Hotline Division from Congressman Tim Walz on behalf of the complainant. The complainant alleged his panel size was too large and contained exceptionally complex patients and reported two additional sentinel patient events.

During a telephone interview on December 5,[iii] the complainant alleged his patients were overly complicated because many have organ transplants and multisystem diseases, and [redacted] He works many overtime hours and still cuts corners causing care to be delayed and jeopardized. For example, it sometimes takes him up to 10 days to respond to patient calls or electronic health record alerts. He is concerned these delays could result in a sentinel event.

On December 5, OHI inspectors interviewed senior medical, nursing, and administrative leaders from the Minneapolis VA Health Care System, Minneapolis, MN (the facility) and from the CBOC via teleconference.[iv] The facility told us they had copies of both letters sent to the OIG. The facility Chief of Staff, told us the complainant was currently [redacted]

VHA baseline expected panel size is 1,200 patients for a full-time physician provider and can be adjusted at the discretion of the facility. The Chief, Primary Care Service Line, reported they determine panel size by the national VA model[v] which adjusts for patient intensity, availability of support staff, and work space among other things. At the CBOC, panel size is gradually increased for new hires until they reach the expected panel size of 1,150—1,200 in the first year. [redacted]

Another factor that affects panel size is Patient Care Intensity,[vii] which measures patient sickness, and anticipated resource demands. A patient care intensity score of 1.0 represents the norm for VHA with higher scores predicting more intensive needs. As of

(b)(3): 5 U.S.C. App 3 (IG Act); (b)(6); below the national norm and the lowest of all five CBOC providers.

The COS reported all 11[viii] cases identified in the first letter to the OIG were investigated. An experienced primary care physician and senior registered nurse were selected to independently review all the allegations. Ten of 11 cases had no significant medical or nursing care findings. In one case,[ix] a process issue regarding the co-management of transplant patients was identified by the reviewers. The patient had inadvertently mixed up his many medications and had been off his transplant anti-rejection medications for four weeks. No physician error was identified.

A study group also evaluated the care and processes in this case. Given the complexities of transplant care, including medication management, the study group recommended[x] all medical services specific to transplant care will be co-managed with a specialist. Patients can still be assigned to CBOC primary care providers for non-transplant medical care, and specialists will manage transplant-related issues.

(b)(3): 5 U.S.C. App 3 (IG Act); (b)(6);
(b)(3): 38 U.S.C. 5701 (b)(6); We contacted the complainant to get the names of two additional cases he believed were sentinel events. The COS and OHI were given the names of four patients for review.[xi] No poor outcomes were identified by the independent reviewers or the OHI inspectors. The reviewers found an administrative issue with a consult closure and sent that case to be reviewed by an administrative board. As a result, changes in the consult closure process were adopted and the COS and Quality Management staff reviewed the administrative results with the involved Service Chief and Specialty Care Line Director.

We determined the complainant's panel size was below the expected CBOC panel size. The complainant's patient intensity average was below the national norm and was the lowest of the five CBOC providers. Patient care issues, identified by the independent reviewers or submitted by the complainant, are being appropriately addressed by the facility. Processes are in place to ensure safe and timely care for transplant patients. We made no recommendations.

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