Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues at the Amarillo VA Health Care System Amarillo, Texas

Report No. 06-02429-62

January 23, 2007

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

We conducted an inspection to determine the validity of allegations that a staff physician is providing substandard eye surgery care resulting in surgical complications and falsification of medical records, the processing of physician credentials is not done in a timely manner, and a physician shortage in Anesthesia Services is putting patients at risk.

We could not substantiate or refute the complainant's allegation regarding substandard eye surgery care. Although the physician had a high complication rate for intraocular lens (IOL) implant surgeries, the facility followed policy and identified various cases for discussion and review through the peer review process. The physician's privileges were not affected; however, he has voluntarily requested not to perform IOL implant surgeries at present. In view of this fact, if the physician should resume performing IOL implant surgeries, the facility should ensure his level of competency. The facility should also continue to monitor the quality of care administered by the physician.

We did not substantiate the allegation of falsified medical records. However, when the physician completed a disclosure of an adverse event form, he did not document the claims process or inform the patient of his right to file an administrative tort claim.

We did not substantiate the allegation that the Administrator of Medical Staff Affairs does not process physician credentials in a timely manner; however, we did substantiate that a provider was performing duties not included in his current privileges. We concluded that if the provider has the acquired skills and experience to accomplish additional duties, they should be part of his privileges.

We did not substantiate that a physician shortage in Anesthesia Services is putting patients at risk.

We made the following recommendations: (1) ensure providers with privileges to perform eye surgery have adequately demonstrated clinical competence to support the granting of requested privileges, (2) ensure providers completing disclosures of adverse events in a patient's medical record explain the claims process and inform patients of their right to file an administrative tort claim, (3) ensure that practitioners providing medical or other patient care services have documented training and experience to support the care provided, and (4) ensure that practitioners providing medical or other patient care services include those services in their requested privileges.

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

TO: Director, Veterans Integrated Service Network (10N18)

SUBJECT: Healthcare Inspection – Quality of Care Issues at the Amarillo VA Health Care System, Amarillo, TX

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding quality of care issues at the Amarillo VA Health Care System (system) in Amarillo, TX.

Background

The OIG Hotline received the following allegations from an anonymous complainant:

A staff physician is providing substandard eye surgery care resulting in surgical complications. Additional interventions by other specialists are necessary to correct the surgical procedures. The physician then tried to cover up his discrepancies by falsifying documentation in the patient's medical record.

The Administrator of Medical Staff Services does not process physician credentials in a timely manner and demands that physicians perform duties outside their scope of practice (a podiatrist has been performing duties in the Amputation and Brace Clinic as well as the Wheelchair Seating Clinic that he is not privileged to perform).

Anesthesia Services has a physician shortage which is putting patients at risk. Although upper management is aware of this issue, it has not been addressed.

Scope and Methodology

To address the allegations, we conducted a site visit from August 7–11, 2006. We interviewed the staff ophthalmologist, Administrator of Medical Staff Services, Chief of Anesthesia, staff anesthesiologist, staff podiatrists, Quality Manager, Chief of Staff, Chief of Prosthetics, Chief of Rehabilitation Services, and other staff involved in this case.

We reviewed policies and procedures, medical records, performance improvement data, cataract surgery complication rates, peer review documents, incident reports, and Credentialing and Privileging (C&P) files. We also reviewed position descriptions and vacancy announcements.

We conducted the review in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Results

Issue 1: Alleged Substandard Eye Surgery Care

We could not substantiate or refute allegations regarding substandard eye surgery care.

The physician completed 48 cases of intraocular lens (IOL) implant surgeries from October 2005 – April 2006, resulting in 9 complications (19 percent). Three of the nine cases underwent peer reviews.

In a memorandum from the physician to the Chief of Staff, dated July 12, 2006, the physician voluntarily requested to discontinue performing IOL implant surgeries. He will continue to provide clinical ophthalmology, oculoplasties, and ophthalmic laser services at the facility. His request is scheduled to go before the Executive Committee of Medical Staff for their review and recommendations.

Issue 2: Alleged Falsification of Medical Records

We did not substantiate the allegation regarding falsified medical records.

On April 12, 2006, the physician performed an IOL implant surgery on a patient. During the surgery, a nurse handed the surgeon an IOL with the wrong lens power. The physician was made aware of the error after the lens implant had been completed but did not have the proper instruments to remove the lens. The physician documented the error in the operation report and informed the patient's wife.

Medical record documentation shows the physician saw the patient the following day and identified a post surgical leak. He turned the case over to the optometrist while he was out of town for a week. The optometrist saw the patient on April 14, 15, 17, and 18. The physician assessed the patient on April 19 and again on April 20. He determined the patient was suffering a post-operative endophthalmitis (inflammation of the eye including intraocular cavities) with corneal edema. He referred the patient to a vitreo-retinal specialist in the community who assessed him that same day.

On April 21, 2006, the physician completed a disclosure of the adverse event (an undesirable occurrence directly associated with care or services provided) in the patient's medical record for implanting the incorrect posterior chamber IOL power. He also documented that the post-surgical wound leak was not related to the incorrect IOL power.

However, the physician did not explain the claims process or inform the patient of his right to file an administrative tort claim.

Issue 3: Alleged Credentialing and Privileging Irregularities

We did not substantiate the allegation that physician credentials are not processed in a timely manner. However, we did substantiate that the podiatrist is performing duties which are not included in his current privileges.

We reviewed a sample of eight credential files. The files were completed and processed in a timely manner and were well organized.

We interviewed the podiatrist who has been performing duties as the amputation, brace, and wheelchair seating clinic physician since 1994. His duties consist of prescribing artificial limbs and braces and assessing patients' wheelchair needs to authorize the purchase of manual and/or electric wheelchairs.

We concluded that if the podiatrist has the acquired skills and experience to accomplish additional duties, they should be part of his privileges.

Issue 4: Alleged Staffing Issues

We did not substantiate the allegation that a physician shortage in Anesthesia Services is putting patients at risk.

There is currently one vacancy for a staff anesthesiologist position which has been advertised on an ongoing basis since 2004. The Chief of Anesthesiology and the sole staff anesthesiologist told us that in addition to their operating room duties, they are called to assist in code situations when intubations are difficult and cannot be accomplished by the respiratory therapists or the emergency room (ER) physicians. However, they told us this rarely happens because the respiratory therapists are highly skilled at intubating patients and all of the ER physicians have been trained by the anesthesiologists to ensure they are proficient in that area. Both anesthesiologists denied knowledge of any emergency situations where patients were placed at risk or suffered an adverse outcome related to the lack of an anesthesiologist. In addition, risk management had not received any patient incident reports related to the physician shortage in Anesthesia Services.

Conclusion

We could not substantiate or refute the complainant's allegation regarding substandard eye surgery care. Although the physician had a high complication rate for IOL implant surgeries, the facility followed policy and identified various cases for discussion and review through the peer review process. Peer reviews were conducted by a physician of the same specialty at another VA facility and documentation supports appropriate action was taken in all cases. The physician's privileges were not affected, but he has

voluntarily requested not to perform IOL implant surgeries at present. In view of this fact, if the physician should resume performing IOL implant surgeries, the facility should ensure his level of competency. The facility should also continue to monitor the quality of care administered by the physician.

The physician followed VHA Directive 2005-049 (*Disclosure of Adverse Events to Patients*, dated October 27, 2005); however, when the physician completed the disclosure of adverse event form in the patient's medical record, he did not explain the claims process or inform him of his right to file an administrative tort claim.

In the case of the podiatrist we found no pertinent documentation to support his role as the amputation, brace clinic, and wheelchair seating physician. However, years of experience have provided him with the skills to fulfill these duties as expressed by his colleagues and the interdisciplinary team members involved in these clinics. While recognizing this, the provisions of VHA Handbook 1100.19 indicate a practitioner is granted permission by the institution to independently provide medical or other patient care services, within the scope of the practitioner's license and on an individual's clinical competence as determined by peer references, professional experience, health status, education, training, licensure, and registration.

Recommendations

We recommend the VISN Director ensure the System Director and Chief of Staff take action to:

1. Ensure that provider appointments with privileges to perform eye surgery have adequately demonstrated clinical competence to support the granting of requested privileges.

2. Ensure that providers completing disclosures of adverse events in a patient's medical record explain the claims process and inform them of their right to file an administrative tort claim.

3. Ensure that practitioners providing medical or other patient care services have documented training and experience to support the care provided.

4. Ensure that practitioners providing medical or other patient care services include those services in their requested privileges.

VISN and System Director Comments

The VISN and System Director concurred with the recommendations, and corrective actions are underway.

Assistant Inspector General for Healthcare Inspections Comments

The VISN Director and System Director concurred with our recommendations and submitted an acceptable improvement plan. We will follow up until all actions have been implemented.

(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: September 28, 2006

From: Network Director, VISN 18 (10N18)

Subject: **Healthcare Inspection–Quality of Care Issues at the Amarillo VA Health Care System**

To: Director, Dallas Audit Operations Division

I concur with the attached facility response on the recommendations for improvement contained in the Healthcare Inspection review at the Amarillo VA Health Care System. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2692.

Patricia A. McKlem

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

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

OIG Recommendations

Recommendation 1. We recommend the VISN Director ensure the System Director and Chief of Staff take action to ensure that provider appointments with privileges to perform eye surgery have adequately demonstrated clinical competence to support the granting of requested privileges.

Concur **Target Completion Date:** 12/29/06

See facility Director's comments

Recommendation 2. We recommend the VISN Director ensure the System Director and Chief of Staff take action to ensure that providers completing disclosures of adverse events in a patient's medical record explain the claims process and inform them of their right to file an administrative tort claim.

Concur **Target Completion Date:** 12/29/06

See facility Director's comments

Recommendation 3. We recommend the VISN Director ensure the System Director and Chief of Staff take action to ensure that practitioners providing medical or other patient care services have documented training and experience to support the care provided.

Concur **Target Completion Date:** 12/29/06

See facility Director's comments

Recommendation 4. We recommend the VISN Director ensure the System Director and Chief of Staff take action to ensure that practitioners providing medical or other patient care services include those services in their requested privileges.

Concur **Target Completion Date:** 12/29/06

See facility Director's comments

Appendix B

Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 27, 2006

From: Director, Amarillo VA Health Care System (504/00)

Subject: **Healthcare Inspection–Quality of Care Issues at the Amarillo VA Health Care System**

To: Director, Veterans Integrated System Network 18 (10N18)

Enclosed, please find our response to the OIG Healthcare Inspection for Quality of Care Issues at the Amarillo VA Health Care System, conducted August 7-11, 2006.

I concur with the findings and submit actions to address each recommendation.

BYRON K. JAQUA, CPA, CHE

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

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

OIG Recommendations

Recommendation 1. We recommend the VISN Director ensure the System Director and Chief of Staff take action to ensure that provider appointments with privileges to perform eye surgery have adequately demonstrated clinical competence to support the granting of requested privileges.

Concur **Target Completion Date:** 12/29/06

At the time of initial appointment, providers are credentialed and privileged in accordance to VHA Handbook 1100.19. Competency is determined by reviewing peer comments, personal history of other hospitals where applicant previously held or currently holds clinical privileges, licensure, NPDB, and any adverse events reported. For reprivileging, the same information above is reviewed in addition to surgical case log, and any adverse events reported. The Amarillo VA Health Care System (AVAHCS) Medical Staff Bylaws define the responsibilities of clinical service chiefs to monitor and evaluate the quality of care provided in the service. This includes access, efficiency, effectiveness and appropriateness of care and treatment of patients served by the service and the clinical/professional performance of all individuals in the service. Service Chiefs are responsible to assure individuals with clinical privileges competently provide service within the scope of privileges granted. In addition, Service Chiefs are responsible for continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the service. They are also responsible for maintaining quality control, and continuing assessment and improvement of the quality of care and services provided. In particular, complication rates are routinely reviewed.

The AVAHCS will provide re-education to all medical and dental staff members regarding credentialing and privileging practices and expectations, in accordance to VHA Handbook 1100.19, during the 2006 annual Medical and Dental Staff meeting. This education will be incorporated into the existing annual mandatory training for clinical practitioners, which is accompanied by a signature page.

Recommendation 2. We recommend the VISN Director ensure the System Director and Chief of Staff take action to ensure that providers completing disclosures of adverse events in a patient's medical record explain the claims process and inform them of their right to file an administrative tort claim.

Concur **Target Completion Date:** 12/29/06

In compliance with VHA Directive 2005-049, and facility Medical Center Memorandum (MCM) 105-03, cases resulting in serious injury or death, or those involving potential legal liability, require a formal institutional disclosure process, including mandatory documentation in the Computerized Patient Record System (CPRS), utilizing the progress note titled "Disclosure of Adverse Event Note."

The Amarillo VA Healthcare System will offer re-education to all clinical practitioners regarding "Disclosure of Adverse Events" and will incorporate this training into the existing annual mandatory training for clinical practitioners, which is accompanied by a signature page.

Internal monitoring for compliance with VHA Directive 2005-049 and MCM 105-03, "Disclosure of Adverse Events" will be occurrence driven.

Recommendation 3. We recommend the VISN Director ensure the System Director and Chief of Staff take action to ensure that practitioners providing medical or other patient care services have documented training and experience to support the care provided.

Concur **Target Completion Date:** 12/29/06

Upon application for clinical privileges, credentials for each practitioner are reviewed in conjunction with their education, training and experience. For additional privileges, not considered to be core or standard for the clinical service, the practitioner must present documentation of training and/or experience to support the request for clinical privileges. Any additional assigned duties, encompassing the skills and/or experience of a practitioner, will also be incorporated into the practitioner's privileges.

The AVAHCS will provide education to all medical and dental staff members regarding the assignment of additional duties during the 2006 annual Medical and Dental Staff meeting.

Recommendation 4. We recommend the VISN Director ensure the System Director and Chief of Staff take action to ensure that practitioners providing medical or other patient care services include those services in their requested privileges.

Concur **Target Completion Date:**

At the time of a new assignment for any provider, a formal determination will be made by the Chief of Staff as to whether the assignment requires a new specific delineation of privileges or a change in privileges.

Core Privileges and site/setting specific privileges are currently being finalized for all clinical services at the Amarillo VA Health Care System. The new system of privileges has a basic description for core privileges which providers all apply for. Specific procedures for each clinical area are identified and listed separately for individual providers to apply for.

The AVAHCS will provide education to all medical and dental staff members regarding the core and site/setting specific privileging process during the 2006 annual Medical and Dental Staff meeting.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Wilma Reyes, Healthcare Inspector Dallas Office of Healthcare Inspections (214) 253-3334
Acknowledgments	Linda DeLong, Director Karen Moore, Associate Director Roxanna Osegueda Marilyn Walls George Wesley, M.D.

Appendix D

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