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Office of Healthcare Inspections

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Healthcare Inspection

Gastroenterology Consult Delays
William Jennings Bryan Dorn
VA Medical Center
Columbia, South Carolina

September 6, 2013

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review to evaluate policies and practices related to gastroenterology (GI) consult and resource management at the William Jennings Bryan (WJB) Dorn VA Medical Center (the facility) in Columbia, SC. The purpose of the review was to determine whether deficient practices contributed to or caused delays in care, and whether facility leaders appropriately addressed clinical managers' concerns.

We substantiated the allegations and found additional factors that contributed to the events. Veterans Integrated Service Network (VISN) and facility leaders became aware of the GI consult backlog in July 2011 involving 2,500 delayed consults, 700 of them "critical." A funding request was made at that time and the VISN awarded the facility $1.02M for fee colonoscopies in September 2011. However, facility leaders did not assure that a structure for tracking and accountability was in place and by December, the backlog stood at 3,800 delayed GI consults. The facility developed an action plan in January 2012 but had difficulty making progress in reducing the backlog. An adverse event in May 2012 prompted facility leaders to re-evaluate the GI situation, and facility, VISN, and Veterans Health Administration leaders aggressively pursued elimination of the backlog. This was essentially accomplished by late October 2012. However, during the review "look-back" period, 280 patients were diagnosed with GI malignancies, 52 of which had been associated with a delay in diagnosis and treatment. The facility completed 19 institutional disclosures and 3 second-level reviews are still pending. As of May 2013, nine patients and/or their families had filed lawsuits.

A confluence of factors contributed to the GI delays and hampered efforts to improve the condition. Specifically, the facility's Planning Council did not have a supportive structure; Nursing Service did not hire GI nurses timely; the availability of Fee Basis care had been reduced; low-risk patients were being referred for screening colonoscopies, thus increasing demand; staff members did not consistently and correctly use the consult management reporting and tracking systems; critical VISN and facility leadership positions were filled by a series of managers who often had collateral duties and differing priorities; and Quality Management was not included in discussions about the GI backlogs.

The GI consult backlog has been the subject of multiple reviews and recommendations, and overall, the conditions have improved and the GI backlog has resolved. However, continued vigilance is needed to ensure that the conditions do not recur. We recommended that the VISN, in accordance with the Administrative Investigative Board conclusions and recommendations, take appropriate action in relationship to facility leadership deficits contributing to the GI consult backlog.

Comments

The VISN Director concurred with our recommendation and provided an acceptable action plan. (See Appendixes A, pages 15–17 for the Director's comments.) We will follow up on the planned actions until they are completed.

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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to evaluate policies and practices related to gastroenterology (GI) consult and resource management at the William Jennings Bryan (WJB) Dorn VA Medical Center (the facility) in Columbia, SC. The purpose of the review was to determine whether deficient practices contributed to or caused delays in care, and whether facility leaders appropriately addressed clinical managers' concerns.

Background

The facility provides a broad range of inpatient and outpatient medical, surgical, mental health, and long-term care services. It has 95 operating hospital beds and 75 community living center beds. Outpatient care is also provided at seven community based outpatient clinics located in Anderson, Florence, Greenville, Orangeburg, Rock Hill, Spartanburg, and Sumter, SC. The facility serves a veteran population of about 410,000 throughout South Carolina and is part of Veterans Integrated Service Network (VISN) 7.

Importance of colorectal cancer (CRC) screening. CRC is the third most common cancer and the second leading cause of cancer deaths in the United States. A July 2010 Centers for Disease Control and Prevention publication reported that more than 22 million Americans remain unscreened for CRC despite the availability of effective screening tests.[1]

In almost all cases, CRC develops from pre-cancerous polyps (abnormal growths) in the colon or rectum. Screening tests can detect polyps and/or bleeding from polyps so that they may be removed before they turn into cancer. Colonoscopies have the potential to reduce mortality due to CRC by 70-80 percent. In 2008, the U.S. Preventive Services Task Force and other federal agencies developed and endorsed updated screening guidelines for the prevention of CRC for *asymptomatic* adults aged 50 and older.[2] The recommended screening tests include:

- Fecal occult blood test (FOBT) and fecal immunochemical test (FIT), which detect blood in a stool sample.
- Flexible sigmoidoscopy examination, which allows physicians to visually inspect the interior walls of the rectum and the lower part of the colon using a thin, flexible, lighted tube called a sigmoidoscope.
- Colonoscopy examination, which allows physicians to visually inspect the interior walls of the rectum and the entire colon using a thin, flexible, lighted tube called a colonoscope. Samples of tissue or cells may be collected for closer examination, and most polyps may be removed.

[1] CDC *Vitalsigns* is a monthly publication from the National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control.
[2] The 2008 USPSTF CRC screening recommendations are an update of the 2002 guidelines.

The Veterans Health Administration (VHA) requires all eligible veterans at average or high risk[3] for CRC who may benefit to be offered CRC screening. Unless the primary screening method is colonoscopy, any positive screening tests (FOBTs, FITs, sigmoidoscopies) must be followed up with a diagnostic colonoscopy, unless contraindicated. If indicated, a diagnostic colonoscopy must be performed within 60 days of the positive screening test.

GI procedure rooms and staffing.

Gastroenterologists and other specially trained physicians perform endoscopies (e.g. colonoscopy or sigmoidoscopy) for the purposes of disease screening, diagnosis, and/or treatment. Endoscopies are performed in specially equipped procedure rooms by teams comprised of a physician endoscopist, one or two GI nurses, and a GI technician. Additional nurses cover the pre- and post-op clinic areas.

Endoscopy takes an average of 30–45 minutes, including pre-procedure preparation and moderate sedation administration. The facility's GI Clinic receives an average of 150 consults per week; about 75–85 percent are for endoscopic procedures. Colonoscopy consults are triaged by a nurse practitioner or GI provider who determines whether to schedule a clinic visit or a procedure.

At the time of the complaint, the facility had four procedure rooms but usually operated only three due to insufficient staffing.

Allegations

In 2011–2012, the facility was unable to respond timely to thousands of GI consults and several patients experienced delayed diagnosis and treatment as a result. The facility, VISN, and VHA implemented corrective actions, but some problems persisted. On September 20, 2012, a confidential complainant alleged that efforts to address the GI backlog had been fraught with problems and that the situation was "worse." Specifically, the complainant alleged that:

- Nursing leadership failed to fill critical GI nurse positions.
- Non-clinical staff and leaders were making clinical decisions regarding patient care and were not permitting clinical leaders to participate in decision-making. As a result, patient care was being compromised and the department is in "chaos."
- Of $1M in funds given by the VISN to pay for Fee Basis[4] colonoscopies, only $200K was actually spent for this service.

[3] Those with a family history of CRC in first-degree relatives and those with a personal history of adenomatous polyps or inflammatory bowel disease.
[4] Fee basis care is non-VA/private sector care paid for by VA when the service is not available in a timely manner within VHA due to capability, capacity, or accessibility.

Consolidated Timeline of Events

The facility has periodically experienced GI consult delays, notably in about 2000 and again around 2006–2007. In the past, the facility has been able to reduce the backlogs through fee basis referrals and sharing agreements.

In FY 2009, a GI performance improvement team made recommendations for improvement and a FOBT WorkGroup developed an action plan; however, it did not appear that the recommendations were implemented.

In late 2009–2010, multiple staff changes negatively impacted the GI Service's ability to respond timely to consult requests and positions were not being backfilled at that time. The facility was not meeting the 60-day timeframe for completing diagnostic colonoscopies after a positive CRC screening, and GI Service was often scheduling procedures 4–5 months in the future.

In July 2011, the GI section chief reported his concerns about the growing backlog of GI consults to his supervisor, and the Chief of Medicine (CoM) notified his supervisor and other facility leaders about the need for prompt actions to address about 2,500 backlogged consults, 700 of them "critical." In early August, the acting Associate Director requested more than $12M from the VISN to pay fee claims and purchase fee colonoscopies and echocardiograms. The funding was received in September and included $1.02M for fee colonoscopies.

The Business Office was not informed that any of the VISN funding had been earmarked for GI cases and did not obligate funds for this purpose. From August–December 2011, the facility spent less than 100K[5] on GI fee care for about 250 patients as part of their already established GI fee consult process. The facility did not have a list of the original 700 patients reportedly needing urgent consults so could not tell us whether any of the 250 patients who did receive GI fee care were part of that 700.

In December, the facility closed one of its GI procedure rooms due to a shortage of nursing staff and the GI Service cancelled all procedures for this room; an estimated 700 patients who had been scheduled would now also need to be authorized for fee colonoscopies in the community.[6] At that time, there were more than 3,880 GI consultations pending action.

In January 2012, a GI Task Force developed a plan that included conducting an initial review of pending GI consults to determine urgency and appropriate scheduling, temporarily reassigning staff, increasing capacity by opening additional endoscopy suites and utilizing sharing agreements, and adding Saturday clinics. The last phase of the plan involved developing an emergency fee care contract for GI services within the community to address any surplus consults. While the facility worked to implement the action plan, progress in some areas was slow.

[5] The VACO site visit team reported this number to be $108K.
[6] The estimated 700 cancellations involved procedures scheduled to the 3rd endoscopy room several months in the future.

In February 2012, the OIG conducted a routine Combined Assessment Program review[7] which noted that patients with positive CRC screening results were not routinely receiving follow-up diagnostic testing within the required timeframe (60 days).

In May 2012, a patient (referred to as the index patient in the remainder of this report) presented to the facility's Emergency Department complaining of a GI-related issue and was ultimately diagnosed with cancer.[8] In reviewing this case, the facility found a delay in GI care which resulted in patient harm and completed an institutional disclosure to the patient the following month. The patient expired in August 2012.

In June 2012, a complainant made allegations to the OIG concerning insufficient nurse staffing, delayed diagnosis and treatment in the oncology and GI specialties, an ineffective Planning Council, and non-responsiveness of facility leaders to clinical concerns. The OIG requested VHA's Office of the Medical Inspector (OMI) to evaluate the allegations.

In August 2012, the facility underwent four external reviews. An expert panel was convened to assess process and patient flow issues in GI Service. The OMI reviewed allegations involving nurse staffing and duties, the environment of care, equipment maintenance, and delays in diagnosis and treatment in GI Clinic. A VA central Office (VACO) subject matter expert (SME) team conducted a site visit to assist in identifying patients from the GI backlog list who were "in need of GI services" and arranged for additional GI physicians, nurses, and technicians from across VHA to work down the GI consult backlog during September. Also, a VHA task force on specialty care assessed GI Service's physician productivity, access, and staffing concerns.

Also in August, the facility reported via an Issue Brief that it had made substantial progress in developing emergency contracts and non-VA care agreements for GI services; hired additional nurses, GI technicians, and clerks; opened the fourth procedure room; and continued with Saturday clinics. A new FOBT Coordinator position was created and pending selection, and the service agreement between Primary Care and GI Service was changed to reflect FIT testing as the appropriate protocol for low risk patients.

In September 2012, the OIG received additional allegations (as enumerated on page 2) that the facility's actions to address the GI consult backlog had caused "chaos" within the GI Service.

In late October 2012, the Deputy Under Secretary for Operations and Management (DUSHOM) chartered an Administrative Investigation Board (AIB) to "conduct a thorough investigation into allegations of clinical mismanagement" related to the GI consult backlog. The AIB was completed on March 25, 2013, and essentially confirmed that facility leaders had not taken prompt actions to address the issues.

[7] Report No. 12-00371-157, *Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina,* April 18, 2012.
[8] In this case, the patient had a sore throat and difficulty swallowing and was later diagnosed with esophageal cancer.

After identifying and reviewing the index patient's case in May, the facility conducted a review of the 2011 and 2012 Cancer Registries and Positive Pathology for GI Malignancies. As of May 28, 2013, there were 280 patients diagnosed with GI malignancies, 52 of which were associated with a delay in diagnosis and treatment. The facility conducted 19 institutional disclosures providing patients and their family members with specific details of the adverse event or delay of care and their right to file a claim. Three additional cases are being reviewed for possible disclosure. The remaining 30 cases did not meet criteria for institutional disclosure as determined by clinical staff during a second-level review.

As of July 2013, the GI consult backlog had been fully addressed. The facility is monitoring the timeliness of diagnostic colonoscopy after positive CRC screening, and in January–February 2013, the facility's compliance with this standard was 91 and 96 percent, respectively.

Scope and Methodology

We conducted a site visit November 5–9, 2012, and February 25–28, April 22–25, and May 6–9, 2013. We interviewed the complainant; the VISN 7 Director, former and current acting Chief Medical Officers (CMOs), and Chief Financial Officer (CFO); leaders for the Subspecialty Productivity and Access Team and the GI Clinic Flow SME; facility Director, Chief of Staff (CoS), Chief Nurse Executive (CNE), former and current CoMs, Chief of GI, several gastroenterologists and GI nurses, GI case managers, clinic scheduling clerks, Chief of the Business Office, Chief of Finance, Chief of HRMS, Quality Manager, and other staff knowledgeable about the issues.

We reviewed the AIB and its testimony. We reviewed VISN Issue Briefs; the GI status report updates and action plans; Planning Council, Health Systems Council, and Consult Management meeting minutes; Power Point training presentations; the VISN 7 Financial review report; Fee Basis authorizations and budgets; internal and external efficiency reports; and email communications.

Our review focused primarily on events and actions between July 2011 when facility and VISN leaders first became aware of the GI backlog through August 2012 when aggressive VACO actions were initiated to address the backlog. We did not review the clinical issues associated with the backlogged GI consults as the facility, VISN, and VHA had already conducted an extensive evaluation of these issues and had assessed individual cases to determine patient harm and need for disclosure.

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

During the course of this review, we interviewed more than 20 clinical providers and administrative staff about the GI consult delays and asked for their perspectives on the possible root causes contributing to the failure. The narrative that emerged spans many years and involves a variety of complex factors.

We ultimately substantiated the allegations and found additional factors that contributed to the events. While we determined that facility leaders did not act promptly when first becoming aware of the GI backlog, they did take actions starting in January 2012. The facility had difficulty making progress, in part because of data discrepancies (e.g., the list of patients with GI consults was frequently being revised), staffing constraints, fee care limitations, and the availability of colonoscopy slots with community contractors. The facility's open/active GI consult situation did not improve from December 2011 (3,800) to June 2012 (4,505).

During the AIB, the former CoS testified that two things prompted leadership to reexamine the GI consult situation. The first was when the index patient was identified—he "was a real patient, he suffered, he is now deceased." The second was when the facility "…went from January to the end of May and we didn't make any progress. We didn't increase significantly the backlog but we didn't decrease the backlog either."

Issue 1. Management of GI-Related Deficiencies

The complainant described an environment where Nursing leaders were refusing to fill important GI nursing positions without explanation and with no back-up plan; non-clinical facility leaders were making clinical decisions without seeking clinical input; and funds provided for fee basis colonoscopies were not used for that purpose. The complainant reported that the GI Service was in "chaos" insofar as facility leaders implemented a corrective action plan that placed patients at risk for unnecessary preparations and procedures, and also committed to a remediation deadline that was unworkable.

Allegation 1. GI Staffing

We substantiated that GI staffing was not optimal and that critical nursing positions went unfilled for months. It was difficult to determine specifically when some critical positions were vacant, primarily because interviewees recalled dates and events differently or documentation was sparse. However, most GI managers and clinicians we interviewed relayed similar accounts of staffing deficiencies, positions not being backfilled, and difficulty getting approval for new hires. During the AIB, the former CoS testified that the GI Service lacked nurses and clerks, and that the problem was "fairly long standing." We found several factors contributed to this condition:

Planning Council

The facility's Planning Council[9] was the coordinating body for the review of current and planned resources including human resources. The former CoS testified during the AIB that "The Planning Council which had to do with requests for new FTEs [full-time employees], was primarily an administrative committee rather than having clinical staff on it, so it was hard to get clinical staff through this committee." The CNE also told us that the Council's membership was heavily administrative. Our review of Planning Council minutes for FY 2011 reflected that the administrative membership outnumbered the clinical membership by 4:1. Further, the AIB concluded that responsible committees "…were not effective in approving vacancies to meet patient care needs and in fact contributed to the delay in approving/hiring new staff."

The facility has addressed the structure and membership of the Planning Council (now called the Resource Management Board) and there is a more equal balance of clinical and administrative members.

Human Resources (HR) Prioritization List (Formerly the "Request to Commit" System)

The facility utilized a hiring prioritization list to permit HR personnel to focus their time and energy on recruitment and processing of applicants that were mission-critical as defined by the individual Services' priority listing. Because the nursing staff working in the GI Service are organizationally aligned under Nursing Service, Nursing Service designates the hiring priority.

Multiple interviewees told us that GI nurse staffing did not rank high enough to be included on the Nursing Service priority list. We found that critical GI positions were not always announced and filled timely. For example, the previous GI nurse manager retired in July 2009, but the position was not announced until September 2011, and the selectee did not begin duty until February 12, 2012. For more than 2 years, this critical role was filled by an "acting" GI nurse manager. Further, in late 2009-early 2010, VISN and facility leaders agreed that the facility needed a FOBT coordinator. The position was approved but was later rescinded. A FIT coordinator[10] position was not approved until August 2012 or hired until September 2012.

Multiple interviewees referenced the "priority list" as a major obstacle to securing needed clinical resources.

Hiring Process[11]

The former CoS testified in reference to hiring that it was taking "a considerable period of time to bring new staff on board." From the time of selection, it often took several

[9] Medical Center Memorandum 544-708, *Planning Council,* March 2, 2011.
[10] The facility elected to use FIT testing rather than FOBT testing.
[11] The AIB concluded that the entire Nursing Service was limited to one support HR Specialist, and that HR was understaffed compared with VISN and national averages and the national VHA staffing goals.

months to complete the selectee's reference checks and VetPro (credentialing and privileging) requirements, and then secure approval through the Professional Standards Board (PSB).

HR provided information showing that a GI registered nurse (RN) position was announced on March 10, 2011. The certification listing the qualified applicants was sent to Nursing Service on April 20, with a response required date of May 11. However, Nursing Service did not return the certification with their selections to HR until September 19, and the selectees[12] did not enter on duty until January 3 and February 12, 2012, respectively.

On February 8, 2012, the CoM forwarded a memorandum to the Planning Council requesting to recruit a clinical nurse case manager and a data manager to support the CRC screening, tracking, and surveillance program. The Council denied the positions but did authorize a clinical nurse (case) manager position to be assigned to Primary Care to manage CRC-related patient tracking and coordination. While that position was approved in February, it was not filled until July even though the selectee transferred from another position in Primary Care and would not have required reference checks, VetPro completion, or PSB approval.

The following table shows the authorized and actual FTE from FY 2011 to FY 2012 and FY 2013 as of about the 2nd quarter.

2011		**2012**		**2013**	
Authorized FTE	Actual FTE	Authorized FTE	Actual FTE	Authorized FTE	Actual FTE
25.7	20.7	33.6	22.6	35.7	28.8

∗ *FTE includes physicians, nurses, and clerical staff.*

Based on consult tracking data and interviews with GI clinical managers, the GI staffing situation as of April 2013 appears to be sufficient to manage demand at this time; however, adequate staffing must be maintained to prevent future GI delays and backlogs. While conditions have substantially improved, important GI positions are still in flux. For example, the GI Section Chief stepped down in December 2012 and the GI nurse manager stepped down in late May 2013 citing concerns over resources and support.

Allegation 2. Decision-Making and Patient Care

We were unable to determine whether non-clinical staff and facility leaders were making clinical decisions regarding patient care without input of the clinical experts and process

[12] Nursing Service selected two nurses from this certification. One of the original selectees withdrew her application so an alternate applicant was selected.

owners. It did appear, however, that due to a lack of appropriate clinical triage, some patients were scheduled for procedures that were not indicated.

The complainant alleged that non-physicians, including clerical staff, were giving medical directions to patients related to preparation for their procedures, and as a result, patients were taking needless laxatives or double doses of laxatives, or came into the facility for unnecessary colonoscopies. However, no one could provide us with a list of patients who had allegedly been given improper instructions by non-clinical staff. We confirmed a case where the patient completed an unnecessary preparation (taken needless laxatives) for a colonoscopy that was not indicated; however, we could not determine the extent of the problem beyond this case. We reviewed Patient Advocate reports for FY 2012 and found no evidence of patient complaints related to this issue.

In September 2012, an influx of gastroenterologists, GI nurses, and GI technicians from other VHA medical centers came to the facility to assist in reducing the colonoscopy backlog. The facility opened OR space for the additional endoscopy procedures and leased equipment to meet the backlog elimination deadline in late October. According to the complainant, the GI clinicians had no input into this "blitz" effort; rather, it was being coordinated by non-clinicians.

The complainant perceived that the GI Service was "in chaos" because non-clinicians were making clinical decisions. We confirmed that facility leadership committed to, and basically met, a remediation deadline of October 26, 2012. While this blitz approach was likely "chaotic" at times, we did not find evidence that patients were harmed as a result of it.

Allegation 3. Use of Fee Care Funds

We substantiated that VISN 7 gave the facility $1.02M in early September 2011 to use to address the GI backlog but that only approximately $275,000 was actually used for this purpose through August 2012. The Business Office was not aware that the additional monies were "earmarked" to address the GI backlog and obligated the funds as usual.

The VISN 7 CFO told us that although the facility was given $1.02M expressly to address the GI backlog, they did not have to report back to the VISN on how the funds were used. The CFO reported that facilities may use their discretion to determine how to best meet the needs of their patients; however, fee care was specifically identified as a mechanism to reduce the backlog.

The facility authorized about 250 GI-related fee referrals from August–December 2011 as part of the already established 1358 (a VA document used to obligate funding for goods and services) obligations. The facility did not have a list of the original 700 patients reportedly requiring urgent GI consults so could not tell us: (1) whether any of

the 250 patients who did receive GI fee care were part of that 700, or (2) whether any of the 700 patients actually received fee colonoscopies during the Fall of 2011.[13]

In January 2012, the GI Task Force determined that another 700 patients[14] cancelled from the 3rd endoscopy room also required fee referrals for GI procedures in the community. On January 10, however, the former CoS sent an email to the Business Office indicating not to "…send out anymore non-VA care GI requests for endoscopy until further notice." He stated they were in the process of "…attempting to internalize as many of these 700 cases as possible." Data provided by the facility's Business Office reflects that about 100 patients received colonoscopies via fee care between January 1–March 29, 2012. In-house colonoscopies during this same time period decreased from the previous quarter.

Issue 2. Other Contributing Factors

Fee Care Program

The increased GI demand at a time when GI staffing was down and fee resources were reduced contributed to the GI backlog.

Growth in Demand for Medical Services. In anticipation of a budget shortfall, the acting VISN Director requested a complete financial review. On September 2, 2011, a VHA-led financial review team issued its report of financial management practices in VISN 7. That report commented on, among other things, the growth and cost of the fee care program VISN-wide. Specifically, "VISN 7 leads the country in FY 2011 in adding new unique patients (5.9 [percent] growth rate) and this has challenged their capacity to absorb new workload in house (19,000 new unique patients through May of 2011)." As a result, "VISN 7 has addressed improving access by sending increasing numbers of patients into the private sector to obtain specialty care… The cumulative effect since 2009 of increasing pre-authorized outpatient care has been a rapid and unsustainable increase in purchased care." Since 2006, the facility's fee program has grown 433 percent, with an average fee cost per unique patient of $831 (130 percent of the national norm). The financial review team recommended a reorganization of the delivery model to "bring both inpatient and ambulatory care (especially specialty care) in house."

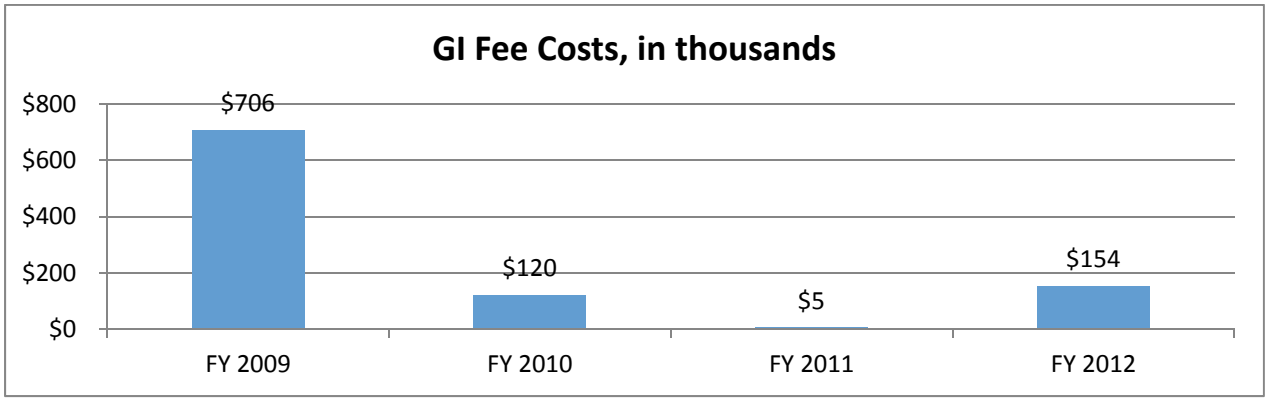
Fee Payments and Access. In FY 2011, the facility had a backlog of unpaid fee authorizations. According to the Chief of the Business Office, the problems may have occurred because the facility had an overlap where they were using two authorization/invoice payment systems while they were transitioning to a new system. Many community providers stopped accepting VA patients and it "took a lot of service

[13] In late August 2011, the CoM e-mailed the acting Associate Director and copied the CoS, Deputy CoS, and Chief of the Business Office, describing what he thought to be the status of the GI and echocardiogram fee referrals, and wrote, "I have asked GI and Cards [Cardiology] to hold on feeing out until we get confirmation of numbers (on cases that can be safely deferred until after the first of the year.)" It is unknown whether this e-mail had any impact on fee referrals at that time.

[14] The original estimate of 700 patients was later revised upward to 857 patients.

recovery to re-establish the links within the community." The facility received additional funding from the VISN in September 2011 to address the outstanding fee care bills.

Fee Usage. VHA's task force on subspecialty productivity and access evaluated the facility's use of community fee care for GI-related procedures using specified current procedural terminology (CPT) codes. The chart below shows the change in the availability of/use of this resource between FY 2009–FY 2012.



We could not independently duplicate, and the facility's data did not approximate, the data as described in the graph. The discrepancies could be due to data retrieval techniques, date ranges used, and the timing of invoice payments. In any event, all analyses of fee care data showed a reduction in the use of fee care in FY 2010–2011 in comparison to other years.

In prior years, GI fee referrals had helped to reduce backlogs. We understand that there was a concerted effort to reduce all fee care and bring those services back "in-house," so the timing of this effort, in the context of increasing demand and reduced GI staff, contributed to the backlog.

In June 2012, the facility implemented a non-VA care coordination (NVCC) program to better manage fee and other community-based care through use of a case management model. Nurses and clerks coordinate patients' appointments with community providers, secure after-visit documentation of the services provided and care recommendations, and assure that provider invoices are linked to appropriate clinical documentation for bill payment purposes.

GI Service Demand

FIT is an annual screening test for CRC that requires close tracking and follow-up to assure that patients with positive screening results are scheduled for, and receive, diagnostic colonoscopies within 60 days of a positive result. We were told that in 2009–2010, when VHA expanded the CRC screening options for low-risk patients to be screened via colonoscopy, many primary care providers "defaulted" to colonoscopy as the primary screening method for all patients regardless of risk level. As part of its review in August 2012, VHA's task force on productivity and access calculated the

facility's GI workload; the data showed a bolus of colonoscopies in FY 2010. The facility has since revised its CRC screening practices for low-risk patients.

Consult Management

The facility did not utilize the electronic consult management package or electronic waiting list (EWL) appropriately, and facility leaders did not monitor the status of GI and other consults facility-wide.

During its initial evaluation of the GI consult status and deficiencies, the GI Task Force determined that clerks and other responsible personnel were not using the correct consult tracking categories.[15] The facility also found that staff were not properly linking progress notes and other reports to consults, so they were not being closed out correctly in the computerized patient record system (CPRS). Through an administrative review process, the facility removed duplicate consult requests, identified those pending community fee care, and closed-out in CPRS those consults that had actually been addressed but not correctly documented or linked. Clinical staff then triaged the remaining consults into priority groups for further action.

Electronic waiting list. In addition, the facility was not using the EWL as required. The EWL is VHA's official wait list and is used to list patients waiting to be scheduled, or waiting for a panel assignment. In general, the EWL is used to keep track of patients with whom the clinic does not have an established relationship (e.g., the patient has not been seen before in the clinic).[16]

Consult tracking functions. The Consult Tracking System offers a variety of reports; however, the GI Service had not routinely generated any of these reports. Had these consult tracking reports been generated, they would have provided facility leaders with a clear indication of the growing backlog. The former CoS testified that the facility did not monitor the consult process "the way we should have," and that the facility leaders left this task to the GI Clinic and the Department of Medicine.

Leadership Stability, Communication, and Competing Priorities

As the GI situation at the facility was unfolding, critical leadership positions were filled by a series of managers. Over the past few years, there have been three VISN Directors and at least three VISN CMOs, five Medical Center Directors, three Associate Medical Center Directors, and four CoMs. Many of these leaders served in an acting or interim capacity and had significant collateral assignments at the time. While we acknowledge that the CoS and CNE had been stable in their positions for more than 10 years, their actions did not provide the critical leadership and continuity needed in this case.

[15] The GI Task Force believed and documented that 310 of the estimated 700 patients that had been sent to Fee Service for processing had been scheduled.

[16] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010

Clinical and administrative leaders should have understood the urgent nature of the GI consult backlog and the need for effective and timely actions to resolve it. The facility did request and receive VISN funding to support GI fee referrals in the community. However, facility leadership did not communicate to the Business Office that additional funds were available and earmarked specifically to address the GI consult backlog did not create a structure to assure that the 700 "critical" cases received the needed services, and did not track the remainder of the backlogged GI consults to assure they were appropriately addressed. Leadership deferred management of these cases to the Service and section chiefs, but did not provide adequate human resources to support this effort.

Quality Management Activities and Involvement

VISN and facility leaders became aware of the GI consult backlog in July 2011 and the facility initiated a GI Task Force in January 2012 to evaluate the issues and develop an action plan. Despite this, the [acting] Quality Manager was "…excluded from discussions regarding clinical backlogs and did not become aware of the GI Clinic backlog until the OIG visit in February of 2012."

The OMI also noted in their report, "The Medical Center leadership and clinical staff had not involved the Patient Safety, Quality Management, Risk Management, and Veterans Affairs Surgical Quality Improvement Program (VASQIP) staff in the issue of the gastroenterology (GI) backlog until identifying the index Veteran. Improved communication might have heightened the urgency of concern in their response to GI systems issues."

Conclusions

VISN and facility leaders became aware of the GI consult backlog involving 2,500 delayed consults, 700 of them "critical," in July 2011. A funding request was made at that time and the VISN awarded the facility $1.02M for fee colonoscopies in September 2011; however, facility leaders did not assure that a structure for tracking and accountability was in place. By December, the backlog stood at 3,800 delayed GI consults. The facility developed an action plan in January 2012 but did not make progress in reducing the backlog. An adverse event in May 2012 prompted facility leaders to re-evaluate the GI situation, and facility, VISN, and VHA leaders aggressively pursued elimination of the backlog. This was essentially accomplished by late October 2012. However, during the review "look-back" period, 280 patients were diagnosed with GI malignancies, 52 of which had been associated with a delay in diagnosis and treatment. The facility completed 19 institutional disclosures and 3 second-level reviews are still pending. As of May 2013, nine patients and/or their families had filed lawsuits. The remaining 30 cases did not meet criteria for institutional disclosure as determined by clinical staff during a second-level review.

The facility had experienced GI consult delays in the past but had been able to address the backlogs. In this case, however, a confluence of factors "set the stage" for the GI backlog and hampered efforts to improve the condition:

- The membership of the facility's Planning Council, which approved staffing requests, consisted largely of non-clinical personnel. Clinical FTE positions were difficult to get approved.

- Despite repeated requests, Nursing Service did not promptly hire GI nurses, and critical positions went unfilled for long periods.

- The 2011 Financial Review Team reported that the facility's fee care program has grown 433 percent since 2006, and facility leaders made a concerted effort to reduce all fee care and bring those services back "in-house." The fee care program had been used in the past to address backlogs.

- When VHA expanded the CRC screening options for low-risk patients, many primary care providers "defaulted" to colonoscopy as the primary screening method for all patients regardless of risk level, which increased demand for this service.

- Responsible staff members did not consistently and correctly use the consult management reporting system or EWL, and as a result, did not have data and reports alerting them to the scope of the GI consult backlog problem.

- As the GI situation was unfolding, critical VISN and facility leadership positions were filled by a series of managers who often had collateral duties and differing priorities. While these leaders did not ignore the GI situation, they also did not take immediate and aggressive actions to remediate the condition.

- The [acting] Quality Manager and other key QM managers were excluded from discussions regarding clinical backlogs and did not become aware of the GI backlog until February 2012. Improved communication might have heightened the urgency of concern in response to GI systems issues.

The GI consult backlog has been the subject of multiple internal and external reviews resulting in a myriad of recommendations to improve operations. Overall, the facility has responded to those recommendations and the GI backlog has resolved. We note, however, that the conditions identified in this report were often complex and long-standing, and that responsibility for the various functions was spread across several clinical and administrative areas. As such, ongoing communication and continued vigilance is needed to ensure that the conditions do not recur.

Recommendation

Recommendation 1. We recommend that, in accordance with the Administrative Investigation Board conclusions and recommendations, Veterans Integrated Service Network leaders take appropriate action in relationship to leadership deficits contributing to the gastroenterology consult backlog.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 19, 2013

From: VISN Director (10N7)

Subject: **Healthcare Inspection – Gastroenterology Consult Backlog, William Jennings Bryan Dorn VAMC, Columbia, SC**

To: DUSHOM (10N)

Thru: VHA 10AR MRS OIG Hotlines

1. The VISN 7 Network Office and the Dorn (Columbia) VAMC have reviewed the subject OIG Report and concur with the final recommendation. We confirm that numerous process improvements have been implemented, and that we are actively tracking all of the AIB recommendations through to completion.

2. Specific to this report, I have detailed our plan for completion of the AIB Administrative Recommendations as requested within this report.

3. If there are any questions, please contact Dr. Robin Hindsman, VISN 7 QMO at 678-924-5723.

(original signed by Dr. Robin S. Hindsman, DND for:)
Charles E. Sepich, FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommend that, in accordance with the Administrative Investigation Board conclusions and recommendations, Veterans Integrated Service Network leaders take appropriate action in relationship to leadership deficits contributing to the gastroenterology consult backlog.

Concur

At the William Jennings Bryan Dorn VA Medical Center in Columbia, S.C., the Administrative Investigation Board made three recommendations for administrative action regarding leadership deficits. The VISN Director reviewed the findings and recommendations and has proceeded to take appropriate actions. The status of actions on each recommendation is:

- Administrative Action 1: The subject of this administrative action retired from VHA. No further administrative action is warranted.
- Administrative Action 2: Recommended administrative action on the subject of this recommendation is underway. VHA expects to complete this administrative action by August 30, 2013.
- Administrative Action 3: Recommended administrative actions on the subject of this recommendation have been initiated and, per policy, are under review by the Office of General Counsel. The completion date for Administrative Action 3 will be established when VHA receives General Counsel's recommendations on the proposed actions.

National VHA leadership considers delays in consult responsiveness to be of significant concern. VHA Central Office (VHA CO) leadership took specific steps to address these issues in Columbia as well as system-wide. Specifically in relation to Columbia, VHA CO leadership sent the Office of the Medical Inspector (OMI) to review allegations; sent a VACO subject matter expert (SME) team to conduct a site visit to assist in identifying patients from the GI backlog list who were "in need of GI services"; arranged for additional GI physicians, nurses, and technicians from across VHA to work down the GI consult backlog; created a tasked a group on specialty care to assess GI Service's physician productivity, access, and staffing concerns; and chartered an AIB to "conduct a thorough investigation into allegations of clinical mismanagement" related to the GI consult backlog.

In January 2013, VHA undertook a national review of open consults to gain a better perspective on nation-wide demand for consultative services. This review is still in progress.

VHA found that facilities use the consultation software package in the electronic health record for a variety of purposes, such as for conveying that a patient is interested in talking with a clerk about scheduling an annual physical exam next year. Unclosed consults for administrative services inflate the data on open consults and misrepresent the demand for clinical consultative services. In May 2013, VHA launched an initiative to standardize use of the clinical consultation software package in the electronic health record. Standardized consultation processes will generate more accurate data on demand for and provision of consultative services, which can then be used to inform decisions on resource allocation.

VHA has developed processes and a database for tracking consult resolution. All facilities have certified completion of a look-back review for high-interest unresolved consults. VHA expects consultative services to address all unresolved consults during Fiscal Year 2014.

Appendix B

OIG Contact and Staff Acknowledgments

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Appendix D

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