Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00992-71

Healthcare Inspection

Pulmonary Medicine Clinic Appointment Cancellations William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina

January 6, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review of Pulmonary Medicine Clinic appointment cancellations in calendar years 2013–2014 at the William Jennings Bryan Dorn VA Medical Center (facility), Columbia, SC. The purpose of this inspection was to determine whether facility managers had assessed the history and causes of the appointment cancellations, taken appropriate actions to evaluate and provide follow-up for patients affected by the cancellations, and implemented process improvements to prevent recurrence of similar conditions.

We confirmed that facility managers had evaluated the history and contributing causes of the Pulmonary Medicine Clinic appointment cancellations.

We confirmed that facility managers had conducted an evaluation of patients affected by the Pulmonary Medicine Clinic appointment cancellations. Due to the protected nature of the facility's review, we are unable to discuss the results. We reviewed 50 patients whose appointments were cancelled and found they had received appropriate follow-up.

We confirmed that process improvements, including the hiring of pulmonologists as well as the use of non-VA medical care providers, were implemented. Facility managers had also augmented the Pulmonary Medicine Clinic staff and implemented processes to improve communication.

We made no recommendations.

Comments

The Interim Veterans Integrated Service Network and Facility Directors concurred with our report. See Appendixes A and B, pages 5–6 for the Directors' comments.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review of Pulmonary Medicine Clinic appointment cancellations in calendar years 2013–2014 at the William Jennings Bryan Dorn VA Medical Center (facility), Columbia, SC. The purpose of this inspection was to determine whether facility managers had assessed the history and causes of the appointment cancellations, taken appropriate actions to evaluate and provide follow-up for patients affected by the cancellations, and implemented process improvements to prevent recurrence of similar conditions.

Background

The facility provides primary and specialty medical, surgical, extended, and mental health care. It has 95 operating hospital beds and 75 community living center beds. The facility operates seven community-based outpatient clinics in Anderson, Florence, Greenville, Orangeburg, Rock Hill, Spartanburg, and Sumter, SC. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of about 410,000 throughout South Carolina.

Pulmonary Medicine – Pulmonary medicine is the branch of medicine that deals with the causes, diagnosis, prevention, and treatment of diseases affecting the lungs such as asthma, chronic obstructive pulmonary disease, and lung cancer.[1]

Pulmonary Nodules – Pulmonary nodules are lesions in the lung that may be benign or cancerous. Large or irregularly shaped nodules are more likely to be cancerous. Depending on the size of the nodule and its characteristics, providers can recommend either an immediate biopsy or they can follow the nodule over time with repeat computed tomography (CT) scans (often referred to as surveillance) to determine whether the lesion is growing.

Facility Policy on Clinic Cancellation or Deactivation – Medical Center Memorandum 544-1311, *Outpatient Clinic Profile Establishment and Maintenance*, August 31, 2010, describes the expectations for notification and rescheduling when appointments are cancelled due to clinic deactivation. In general, providers must give ample notice when clinics will be cancelled and ensure action is taken to reschedule patients within 30 days of the desired appointment date. The Service Chief or designee is responsible for ensuring adequate staffing levels in the clinics, and the Service line designee is responsible for coordinating the rescheduling of canceled clinics.

Protected Quality Reviews – VHA policy outlines quality management activities that may generate confidential documents protected from disclosure under Title 38 of the United

[1] http://www.medicinenet.com/script/main/art.asp?articlekey=23547, retrieved March 25, 2015.

States Code (USC), Section 5705 (5705-protected).[2] The activities must be described in advance and in writing by the Under Secretary for Health, VISN Director, or facility Director. Under 38 USC 5705, VHA may not communicate to patients or their personal representatives information that is obtained from quality management activities.

On November 10, 2014, facility leadership notified VISN 7 leaders via an Issue Brief (IB) that multiple Pulmonary Medicine Clinic appointment cancellations were being reviewed for "potential adverse impacts due to delayed care."

Scope and Methodology

The review period for this inspection was from November 7, 2014, to April 21, 2015.

We reviewed relevant facility policies and procedures, IBs, Resource Management Board meeting minutes, and internal review documents. We reviewed a random sample of 50 electronic health records of patients with cancelled appointments. We interviewed the Chief of Pulmonary Medicine Service, the Pulmonary Medicine Clinic nurse manager, the Pulmonary Medicine Clinic nurse case manager, the acting Chief of Human Resources, the Systems Redesign Coordinator, and the former administrative officer (AO) for Medical Service.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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.

[2] VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activities That Can Generate Confidential Documents,* November 7, 2008. This VHA Directive expired November 30, 2013, and has not yet been updated.

Inspection Results

Issue 1: History and Causes of Pulmonary Medicine Clinic Appointment Cancellations

We confirmed that facility managers had evaluated the history and contributing causes of the Pulmonary Medicine Clinic appointment cancellations, which were primarily attributable to staffing deficiencies and changes in facility and Service-line leadership.

It appeared that several factors beyond the facility's control contributed to staffing deficiencies within the Pulmonary Medicine Service. Specifically, we were told that, for a time, the facility had difficulty recruiting pulmonologists due to negative publicity about VA facilities. We also learned that in August 2013, the AO for Medical Service submitted a request for a $1.6 million contract to fund three full-time pulmonologist positions for 1 year. Facility leadership approved the request and forwarded it to the contracting division in October 2013. As of March 2015, the contract had not yet been awarded.

Issue 2: Case Evaluation and Follow-Up

We confirmed that facility managers had conducted a 5705-protected review of the patients affected by Pulmonary Medicine Clinic appointment cancellations.[3] Due to laws and regulations that do not allow disclosure of the content of 5705-protected information, we cannot discuss the results of the review.

We are able to discuss our review of 50 patients whose appointments were cancelled. Our review found that 40 patients had subsequently received care either from the facility or through the Non VA Coordinated Care Program (NVCC). Of the remaining 10 patients who were not seen, 7 were deceased,[4] 2 had relocated, and 1 declined care.

Issue 3: Process Improvement Actions

We confirmed that process improvements have been implemented. Facility leadership:

- Hired a nurse case manager and realigned a medical support assistant to support clinical and administrative operations in the Pulmonary Medicine Clinic.
- Instituted a daily huddle of Pulmonary Medicine Clinic staff to improve communication.
- Actively recruited, through an open-continuous announcement, for four additional pulmonary medicine providers. In addition to the Chief of Pulmonary Medicine

[3] The facility reviewed all appointment cancellations from the Pulmonary Medicine Clinics between January 1, 2013 and June 18, 2015.
[4] None of the 7 deaths were attributable to cancelled Pulmonary Medicine appointments.

Service and a pulmonologist[5] already on duty, two additional pulmonologists are projected to start in the next several months. The facility continues to interview for the two vacant positions.

- Approved, and is utilizing, NVCC pulmonary providers to deliver routine care to appropriate patients.
- Initiated a provider leave request form to alert supervisors of clinic schedule changes and the number of patients affected.
- Retrained schedulers on the requirements for addressing cancelled appointments.

The Pulmonary Medicine Clinic is now able to schedule new patients within 30 days and has 1–2 urgent appointments available every week. Follow-up patients are scheduled within 3–6 months or as needed.

Conclusions

We confirmed that facility managers had evaluated the history and contributing causes of the Pulmonary Medicine Clinic appointment cancellations, which were primarily a result of staffing deficiencies and changes in facility and Service-line leadership.

We confirmed that facility managers had conducted a 5705-protected review of patients affected by the Pulmonary Medicine Clinic appointment cancellations. We reviewed a random selection of 50 patients and found that the affected patients still requiring pulmonary care had received appropriate follow-up after the initial Pulmonary Medicine Clinic appointment cancellations.

We confirmed that process improvements including the hiring of pulmonologists as well as the use of non-VA medical care providers were implemented. Facility managers had also augmented the Pulmonary Medicine Clinic staff and implemented processes to improve communication.

We made no recommendations.

[5] The pulmonologist started the week of March 2, 2015.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: August 28, 2015

From: Interim Director, VA Southeast Health Care Network (10N7)

Subj: Healthcare Inspection—Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina

To: Director, Atlanta Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the Veterans Affairs (VA) Office of Inspector General Office of Healthcare Inspections draft report on the Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina.

2. Thank you for the opportunity to review the findings as a result of your healthcare inspection of the subject report. I concur with the review and evaluation submitted by the Columbia VAMC.

3. Should you have any questions, please contact Bridget Schausten, Chief, Quality Management, Columbia VAMC, at (803)776-4000, ext. 7731.

for Thomas C. Smith III, FACHE

Attachments

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: August 27, 2015

From: Director, WJB Dorn VA Medical Center, Columbia, SC (544/00)

Subj: Healthcare Inspection— Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina

To: Director, VA Southeast Health Care Network (10N7)

1. Thank you for the opportunity to review and concur on the healthcare inspection report. The subject report reflects a thorough review and evaluation.

2. Please contact me if you have any questions or comments.

Timothy B. McMurry
Medical Center Director

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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