



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Delay in Care and Care
Coordination Concerns at the
Cheyenne VA Medical Center
and the Iowa City VA Health
Care System

Wyoming and Iowa



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations regarding a patient's delays in care and lack of care coordination at both the Cheyenne VA Medical Center, Wyoming, (Cheyenne) and the Iowa City VA Health Care System, Iowa (Iowa City).

The OIG received allegations from a confidential complainant alleging (a) Cheyenne did not provide surveillance (follow-up) regarding the patient's cancer diagnosis after a nephrectomy, and (b) Iowa City providers' lack of knowledge about the patient's history of renal cell carcinoma contributed to delays in care.¹ The OIG team also conducted an electronic health record (EHR) review to determine if urology consults at Iowa City were addressed timely.

The OIG substantiated that clinicians at Cheyenne failed to provide timely and proper surveillance for the patient following the diagnosis of renal cell carcinoma and left nephrectomy. Contributing factors included a lack of clear communication among providers through EHR documentation, inaccurate diagnostic coding on the patient's problem list, and limited patient evaluations pertaining only to the provider's specialty.

From fall 2012 through spring 2015, the patient had frequent medical appointments with Cheyenne providers following the diagnosis of renal cell carcinoma and surgery. However, the OIG team found no documentation of renal cell carcinoma surveillance or related discussions. After the diagnosis of renal cell carcinoma, the patient was evaluated on 21 occasions as an outpatient, admitted three times as an inpatient, and received 73 visits by Home Based Primary Care clinicians through 2015.² The OIG team reviewed the patient's EHR and found that greater than eight months elapsed from the initial identification of a left kidney mass in late 2011 until the left nephrectomy in fall 2012.

As of October 2018, the Chief of Quality Management informed the OIG team that an institutional disclosure had not been previously performed for the patient; however, attempts to contact the patient's family were made without successful completion. During interviews, the Chief of Staff and Chief of Quality Management stated that an institutional disclosure should have been considered. Additionally, peer reviews had not been initiated at Cheyenne although the concerns of this patient's care were brought to the attention of Cheyenne leaders in

¹ A nephrectomy is a surgical procedure to remove all or part of the kidney.

² The patient moved from Wyoming to Iowa in 2015.

fall 2017.³ Quality Management staff had the opportunity to review the patient's care prior to the initiation of the OIG inspection in April 2017 and consider whether a peer review was indicated, but peer reviews had not been initiated.

The OIG did not substantiate that Iowa City providers failed to provide care and were unaware of the patient's cancer history. The OIG team found that Iowa City providers documented the history of a left nephrectomy in the patient's EHR progress notes; however, an e-consult to Urology Service for further evaluation was not addressed timely and resulted in a delay in care.

At Iowa City, the OIG team found that the patient's problem list was updated to include renal cell carcinoma but not the history of left nephrectomy. Inclusion of the pertinent medical history may be a useful resource during appointments; however, the omission from the EHR did not result in the provider being unaware of the conditions as evidenced by the documentation of care provided.

In early 2016, the Patient Advocate received two complaints regarding the patient's care. In October 2017, the OIG requested Iowa City managers review and respond to allegations regarding delays in treatment for the patient. According to the Risk Manager, the Patient Advocate complaints and the OIG Case Referral should have triggered alerts to review the patient's EHR and determine if a peer review was warranted. The Risk Manager was not alerted in either occurrence.

Iowa City managers identified processes that contributed to delays in the patient's Urology Clinic e-consults. However, managers did not conduct a review to determine if the processes may have negatively affected other patients at the time of the original OIG Case Referral.⁴ The OIG team reviewed the EHRs of patients who had e-consults submitted and found that clinical care was provided and patients were not negatively impacted; however, Urology Clinic providers did not always appropriately complete the documentation for e-consults as required by the Veterans Health Administration. The OIG team reviewed the reasons for administrative errors, and clinicians and staff interviewed stated that from 2015 to 2017 they had limited knowledge of the purpose and processing steps for e-consults. The OIG team reviewed e-consults for patients with a urological cancer diagnosis when the e-consult was open greater than 30 days to evaluate whether other patients had been negatively affected by the use of e-consults to the Urology Clinic. The OIG team reviewed EHRs for 69 patients with a urological cancer diagnosis and found no indication of patient harm due to the delays.

³ VA OIG Hotline Case Referral No. 2018-00693-HL-0610; The OIG team identified a series of errors contributing to the lack of the patient's appropriate care and treatment that should have led to leaders' consideration of a peer review. These errors included the lack of renal cell carcinoma surveillance; follow-up of the July 2014 CT; and discussion, communication, and monitoring of the renal cell carcinoma by the primary care provider, Home Based Primary Care clinicians, and VA and non-VA urologists.

⁴ Iowa City managers acknowledged a failure to ensure timely processing of e-consults due to staffing shortages and an unclear process for reviewing and triaging e-consults.

The OIG made five recommendations to the Cheyenne Director related to timely surveillance for cancer patients; care coordination and communication between Cheyenne providers and non-VA providers for cancer patients; problem lists documentation; Office of General Counsel consultation regarding institutional disclosure of the patient's care; and initiation of peer reviews for the patient's care.

The OIG made two recommendations to the Iowa City Director related to documentation of patients' problem lists and initiation of peer reviews for the patient's care.

Comments

The Veterans Integrated Service Networks and Cheyenne and Iowa City Directors concurred with the recommendations and provided acceptable action plans. (See Appendixes A through D, pages 20–27 for the Directors' comments.) The Cheyenne Director provided supporting documentation, and the OIG considers recommendation 4 closed. The OIG will follow up on the remaining recommendations and planned actions until they are completed.



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Contents

Executive Summary	i
Abbreviations	v
Introduction.....	1
Scope and Methodology	5
Case Summary	6
Inspection Results	9
Issue 1: Cheyenne Surgery Follow-up Care.....	9
Issue 2: Iowa City Patient’s Cancer History and Care	13
Issue 3: Iowa City E-Consult Concerns in the Urology Clinic	15
Conclusion	17
Recommendations 1–7	19
Appendix A: VISN 19 Director Comments.....	20
Appendix B: Cheyenne Director Comments	21
Appendix C: VISN 23 Director Comments.....	24
Appendix D: Iowa City Director Comments	25
OIG Contact and Staff Acknowledgments	28
Report Distribution	29

Abbreviations

CT	computed tomography
EHR	electronic health record
HBPC	Home Based Primary Care
HCS	Health Care System
MRI	magnetic resonance imaging
MSA	medical support assistant
OIG	Office of Inspector General
PCP	primary care provider
RCC	renal cell carcinoma
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations regarding a patient's delays in care and lack of care coordination at the Cheyenne VA Medical Center, Wyoming, (Cheyenne) and the Iowa City VA Health Care System, Iowa (Iowa City).

Background

Facility Profiles

Cheyenne is part of Veterans Integrated Service Network (VISN) 19. Cheyenne provides inpatient services in medicine and surgery, as well as outpatient services in medicine, surgery, and psychiatry, and is affiliated with the University of Northern Colorado Medical School and University of Wyoming Family Practice Residency Program. Cheyenne operates 22 hospital beds, including 16 medical beds and 6 surgical beds, and supports a 50-bed Community Living Center.

Iowa City is part of VISN 23. Iowa City is a comprehensive tertiary care healthcare center, teaching hospital, and research facility, and is affiliated with the Roy J. and Lucille A. Carver College of Medicine at the University of Iowa. Iowa City operates 93 beds, including 43 medicine/neurology beds, 25 surgical beds, 10 intensive care beds, and 15 psychiatry beds. Additionally, it operates nine community based outpatient clinics in Bettendorf, Waterloo, Dubuque, Cedar Rapids, Ottumwa, and Decorah, Iowa; and Galesburg, Quincy, and Sterling, Illinois.

Renal Cell Carcinoma

Renal cell carcinoma (RCC), which originates within the renal cortex, constitutes approximately 85 percent of primary renal neoplasms (cancer). Definitive therapy can often be curative when patients with RCC present with localized disease. Surgery is curative in most patients with RCC who do not have metastases and is the preferred treatment for patients with stages I, II, and III.⁵

⁵ Stage I and stage II renal cancers are still contained within the kidney. Stage III cancers have grown into nearby large veins or have spread to nearby lymph nodes; The American Cancer Society medical and editorial content team, "Treatment Choices by Stage for Kidney Cancer." *American Cancer Society*. November 2017. <https://www.cancer.org/cancer/kidney-cancer/treating/by-stage.html>. (The website was accessed on June 13, 2018.)

Treatment may require a radical nephrectomy, although a partial nephrectomy to preserve renal parenchyma is preferred for appropriately selected patients.⁶ The choice of surgical procedure depends upon the extent of disease, as well as patient-specific factors such as age and comorbidity.⁷ Surgery may be done through a conventional approach or by a minimally invasive approach, such as laparoscopy.⁸

Observation remains the standard of care for RCC following a nephrectomy. Up to 30 percent of patients with localized tumors experience relapse with the lungs being the most common site of distant recurrence. The average time to relapse is within two years, but most occur within five years. The National Comprehensive Cancer Network recommends that patients be seen every six months for the first two years and annually thereafter.⁹ Each visit should include a history, physical examination, blood work, and abdominal and chest imaging; frequency of follow-up visits are determined based upon the stage of the disease.¹⁰

Clinical Consults

A clinical consult is a request for clinical services on behalf of a patient. Clinical consults are used as two-way communication between requesting and receiving providers seeking opinions, advice, or expertise regarding evaluation or management of a patient's specific problem. Clinical consults are typically addressed through a face-to-face visit with the patient scheduled for an appointment in the clinic; however, the receiving service may complete the request without the need for an appointment. The Veterans Health Administration (VHA) has set a goal for receiving services to review each clinical consult, to complete a patient contact attempt within two days of the consult create date, and to complete the appointment within 30 calendar days of the patient indicated date.¹¹

⁶ A nephrectomy is a surgical procedure to remove all or part of the kidney; parenchyma is the essential and distinctive tissue of an organ.

⁷ Michael B. Atkins, MD, UpToDate, "Overview of the treatment of renal cell carcinoma." *UpToDate*. July 2018. <https://www.uptodate.com/contents/overview-of-the-treatment-of-renal-cell-carcinoma2> (The website was accessed on August 30, 2018.)

⁸ Laparoscopy is surgery using a fiberoptic instrument inserted through an incision in the abdominal wall; "Laparoscope." Merriam-Webster.com. <https://www.merriam-webster.com/dictionary/laparoscope>. (The website was accessed on July 19, 2018.)

⁹ Chittoria MD, Namita, Rini MD, Brian I., Renal Cell Carcinoma." *Cleveland Clinic Center for Continuing Education*. August 2013. <http://www.clevelandcliniced.com/medicalpubs/diseasemanagement/nephrology/renal-...3/22/2018> (This website was accessed on March 22, 2018.)

¹⁰ Chittoria, Namita MD, "Renal Cell Carcinoma," 7.

¹¹ VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended on September 23, 2016; The patient indicated date (PID) has replaced clinically indicated date and preferred date. Clinically indicated date is the date a healthcare provider deemed an appointment clinically appropriate, while preferred date is the date a patient requests outpatient healthcare services.

In addition, VHA policy states that consults are to be reviewed, scheduled, or completed within VA's established timeframe and procedures are established to track and process clinical consultation requests that are without action within seven days of the request.¹² The same standards of consult management apply to consults submitted as clinical consults or as e-consults to ensure timely completion.

E-Consults

E-consults are used to enhance the delivery of specialty care services by providing an alternative to face-to-face visits with the goal of improving access, communication, and coordination of care for the veteran. Providers submit specialty care e-consults with the expectation that the specialist will use information provided in the request, and/or review the electronic health record (EHR) to complete the consult. All communications should be documented in the EHR. Consult receiving services are expected to initiate consult responses or scheduling as soon as possible, but no later than seven calendar days following the consult create date. As with clinical consults, e-consults should be completed within 30 days of the patient indicated date.¹³

Allegations

On October 6, 2017, the OIG received allegations from a confidential complainant regarding proper follow-up care for a veteran who received care at Cheyenne and Iowa City. On February 21, 2018, the OIG contacted the complainant to discuss and clarify the submitted allegations. The following outlines the complainant's primary concerns and specific allegations:

- After the patient's surgery, Cheyenne clinicians failed to provide timely and proper follow-up care from 2012 through 2015.
 - Upon clarification with the complainant, the primary concern with Cheyenne was the lack of surveillance from 2012 through 2015 regarding the patient's cancer diagnosis after the nephrectomy surgery.¹⁴ The complainant did not recall any conversations about the RCC during the patient's post-surgical care at Cheyenne.
- Iowa City providers failed to provide care and were unaware of the patient's cancer history.

¹² VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008 was in effect during this review period and was replaced by VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016. Both the 2008 and 2016 directives have the same or similar language regarding seven days for a facility to act on a consult.

¹³ VHA Directive 1232(1).

¹⁴ Surveillance is close and continuous observation or testing. "Surveillance" Meriam-Webster.com. <https://www.merriam-webster.com/dictionary/surveillance>. (The website was accessed on July 18, 2018.)

- Iowa City’s providers lacked knowledge about the patient’s history of RCC. The complainant did not understand how providers at Iowa City did not have access to the records and stated “[the] ball was dropped somewhere.”

During the OIG team’s initial review of the complaint, an additional issue from a previous OIG Case Referral was discussed and designated for review. Specifically, the OIG team conducted an EHR review to determine if urology consults at Iowa City were addressed timely as described in the September 18, 2017, Iowa City’s response to an OIG Case Referral.¹⁵

¹⁵ This is in response to OIG VA OIG Hotline Case Referral Case No, 2017-4727-HL-1698. This is a separate case referral from the original complaint.

Scope and Methodology

The OIG initiated the healthcare inspection on February 7, 2018, and conducted an onsite visit at Cheyenne on April 2–5, 2018.

The OIG team interviewed Cheyenne’s Chief of Staff, Associate Director Patient Care Services, Chief of Quality Management, Risk Manager, an inpatient attending provider, a urologist, a Home Based Primary Care nurse, and Care in the Community staff. On April 11, the OIG team interviewed the patient’s primary care provider (PCP) by telephone.

The OIG team conducted telephone interviews with the complainant and Iowa City’s Chief of Specialty Care, administrative officers for Medicine and Surgery, the Chief of Urology, a PCP, a Urology nurse practitioner, the Group Practice Manager, the Specialty Medicine Nurse Manager, Care in the Community staff, a social worker, a case manager, and medical support assistant (MSA) managers.

The period of data review for this report was late 2011 through early 2018. The OIG team reviewed the patient’s EHR; relevant VHA, Cheyenne, and Iowa City policies; and applicable committee meeting minutes. The OIG team reviewed Iowa City e-consult data from January 1, 2015, through March 1, 2018. Iowa City managers previously identified process issues with urology e-consults during this timeframe but had not determined if delays impacted patient care.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to substantiate or not substantiate an allegation when the available evidence is insufficient to determine whether or not an alleged event or action took place.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The patient, who was in his/her early 80s, had a history that included chronic obstructive pulmonary disease and atrial fibrillation.¹⁶ In late 2011, the patient was seen at Cheyenne and found to have a 3.7 centimeter renal mass in the left kidney on computed tomography (CT) imaging.¹⁷ In early 2012, magnetic resonance imaging (MRI) revealed the renal mass as “suspicious for malignancy.”¹⁸ Further CT imaging demonstrated a 4.3 x 3.2 centimeter renal mass, concerning for RCC, and the patient was referred to urology at the VA Eastern Colorado Health Care System.¹⁹

During a spring 2012 appointment at VA Eastern Colorado Health Care System, the patient was noted to have “multiple abnormal bone lucent areas consistent with metastatic disease or myeloma.”²⁰ In early summer 2012, the patient was evaluated by the Cheyenne Oncology Service provider who wrote that the “[P]atient has only non-specific findings on [his/her] bone films with nothing diagnostic of multiple myeloma or a secondary malignancy.” In summer 2012, the same Oncology provider documented “we have completed medical evaluation for multiple myeloma and [he/she] does not have it.” The oncologist advised urology follow-up of possible renal mass as soon as possible.

In fall 2012, the patient underwent a left nephrectomy at a non-VA hospital and was diagnosed with RCC, stage T3, a papillary subtype.²¹ There was tumor extension into the renal sinuses but tissue margins were uninvolved by cancer, and regional lymph nodes were negative.²² The nephrectomy was uneventful “but was complicated by an immediate post-operative incarcerated inguinal incisional hernia” and the patient was returned to the operating room for surgical management of an obstructed bowel.²³

¹⁶

The OIG uses gender neutral language to protect patients’ privacy; Chronic obstructive pulmonary disease is a lung disease characterized by chronic obstruction of the lungs that interferes with normal breathing; Atrial fibrillation is a heartbeat in which the rhythm is irregular and may be rapid.

¹⁷ A CT is a cross-sectional, three-dimensional image of an internal body part used for diagnostic purposes.

¹⁸ MRI uses magnetic fields and radio waves to produce cross sectional images of soft tissues and bones.

¹⁹ VA Eastern Colorado Health Care System is located in Aurora, Colorado.

²⁰ Bone lucent areas are areas on an x-ray that appear darker than the surrounding bone area, indicating a reduced density of bone; Multiple Myeloma is a cancer of the plasma cells, a key component of the immune system.

²¹ Stage T3a RCC designates tumor extending into the renal vein, or its segmental branches, or into the peri-renal and/or renal sinus fat, but not beyond Gerota’s fascia (a layer of connective tissue encapsulating the kidneys and adrenal glands); Papillary RCC represents 15 to 20 percent of RCC diagnoses.

²² Renal sinus is a cavity in the kidney.

²³ An incarcerated intestinal hernia occurs when the contents of a hernia become trapped in the abdominal wall (incarcerated); its blood supply may be compromised or completely cut-off.

In mid fall 2012, a Cheyenne urologist saw and advised the patient to “return [to] urology in one month,” but that visit was not scheduled, and no follow-up letters or phone calls were documented in the EHR.

In summer 2014, 22 months after the nephrectomy and the diagnosis of RCC, the patient was admitted to Cheyenne complaining of weakness and abdominal discomfort. During that hospitalization, a chest x-ray revealed “a small opacity in the medial right lung apex,” and the radiologist recommended a chest CT to further evaluate the x-ray finding. The hospitalist noted the patient’s history of RCC in 2012 and there was now a pulmonary nodule on chest x-ray.²⁴ The hospitalist stated, “will do CT chest/abdomen/pelvis to determine if there is evidence of metastases or new malignancy in the lung,” but CT imaging was not done. The patient was not seen again by a urologist at Cheyenne, VA Eastern Colorado Health Care System, or a non-VA facility prior to relocating out of state in early 2015.

During the 29 months following the patient’s diagnosis of RCC in fall 2012 and up until the patient’s move out of state in early 2015, the patient was seen by a PCP at Cheyenne on six separate occasions. The history of nephrectomy and diagnosis of RCC was cited at the first two visits, which occurred within five weeks of the surgery. The PCP did not reference RCC, or related issues, in any of the four subsequent clinic visits (late 2012, spring 2013, late 2013, and early 2014). There was no documented surveillance conducted by Cheyenne providers in the time period following the patient’s nephrectomy to monitor renal function, local cancer recurrence, or development of metastases.

In spring 2015, the patient established care with a PCP at an Iowa City community based outpatient clinic. In summer 2015, the PCP entered an e-consult to the Urology Service noting that the patient had a previous left nephrectomy due to renal cancer and requested that urology providers “please evaluate and treat.” No action was taken on the PCP’s urology e-consult until late 2015, five months after the request for care. In early 2016, the Iowa City urologist saw the patient and noted the patient’s history of RCC and that there was likely no follow-up after the diagnosis was made in 2012. MRI imaging of the abdomen, obtained the day of the urology appointment, was compatible with recurrent malignant disease at the nephrectomy site and at the left adrenal gland.²⁵ The patient was referred to the oncology service at Iowa City.

Ten days later, the patient was seen by an oncologist who noted likely disease recurrence at the nephrectomy site and adrenal gland, and an additional concern of metastasis to the right upper lobe of the lung. The Oncology note documented that, “[at Cheyenne] [he/she] apparently did not have any further follow-up scans. In the VA records we could not find any follow-up surveillance scans, either.” The patient was evaluated by a Radiation Oncology Service resident

²⁴ Cleveland Clinic defines “A pulmonary nodule is a small round or oval-shaped growth in the lung.” These can be benign or malignant. <https://my.clevelandclinic.org/health/diseases/14799-pulmonary-nodules>. (The website was accessed on May 22, 2018.)

²⁵ An adrenal gland is part of a pair of endocrine organs located near the kidney.

at Iowa City in spring 2016. The patient initially declined the Radiology Oncology Service recommendations for treatment, but in summer 2016, the patient decided to proceed with radiation therapy. The patient received radiation a month later, but by early 2017, experienced further progression of metastatic disease. During spring and summer 2017, the patient was managed at Iowa City with cancer immunotherapy (pembrolizumab); however, it was a rapidly progressive, widespread disease.²⁶ The patient was recommended for hospice care in summer 2017 and died a month later.

²⁶ Immunotherapy is a type of treatment which helps the body's own immune system destroy harmful cells (in this case, cancer cells).

Inspection Results

Issue 1: Cheyenne Surgery Follow-up Care

The OIG substantiated that clinicians at Cheyenne failed to provide timely and proper surveillance for the patient following the diagnosis of RCC and left nephrectomy. Contributing factors included a lack of clear communication among providers through EHR documentation, inaccurate diagnostic coding on the patient's problem list, and limited patient evaluations pertaining only to the provider's specialty.

From fall 2012 through spring 2015, the patient had frequent medical appointments with Cheyenne providers following the diagnosis of RCC and surgery. However, the OIG team found no documentation of RCC surveillance or related discussions.

After the diagnosis of RCC, the patient was evaluated on 21 occasions as an outpatient, admitted three times as an inpatient, and received 73 visits by Home Based Primary Care (HBPC) clinicians through 2015.²⁷

VA Urology

In fall 2012, the urologist documented, "Return urology one month." However, a follow-up urology appointment was not scheduled for the patient at Cheyenne. The OIG team determined that there was no documentation that instructions were provided to the patient for future scheduling, or if urology staff followed up with the patient. The OIG team inquired about provider responsibilities related to patient monitoring following surgical treatment and RCC surveillance processes. The urologist stated that, usually, the provider completing the surgery determines the follow-up plan. However, in the event this was not possible, RCC surveillance would be the urologist's responsibility. The urologist said that the patient should have received RCC surveillance and acknowledged that the patient did not receive it through the non-VA provider.

Primary Care

From fall 2012 through early 2014, the PCP evaluated the patient six times. At the time of the OIG review, the PCP was no longer employed by Cheyenne; however, the OIG team conducted a telephone interview with the PCP on April 11, 2018. The PCP did not have access to the patient's EHR and was unable to recall the specific patient during the interview. When asked about management of RCC surveillance, the PCP said that this was the responsibility of the provider who performed the nephrectomy. However, the PCP acknowledged responsibility for

²⁷ The patient moved out of the Cheyenne catchment area in 2015 and moved to Iowa; The VHA HBPC model targets patients with complex chronic diseases that worsen over time and provides interdisciplinary care that is longitudinal and comprehensive rather than episodic and single-problem focused.

oversight of the patient's care and ensuring that necessary appointments were scheduled. The PCP also agreed surveillance was indicated for patients who had RCCs but provided no explanation for why it did not occur for the patient.

Patients with stage II RCC are in the moderate- to high-risk category for cancer recurrence.²⁸ The American Urological Association recommends that a person with surgical management of RCC be evaluated periodically after surgery to assess the recurrence of the disease, success of the surgery, evidence of leftover disease (residual), and ongoing or potential post-operative complications.²⁹

HBPC

In summer 2012, the patient began HBPC services. The assigned HBPC registered nurse conducted a brief review of the problem list. The nurse stated that patient visits focused on immediate problems, which were predominantly related to wound care. In spring 2014, an HBPC nurse practitioner made an EHR entry which documented a history of "kidney removal." There was no documentation related to the indication for kidney removal nor any reference as to surveillance of RCC.

Cheyenne Admission

In summer 2014, the patient was admitted to Cheyenne. During this admission, a chest x-ray was completed, and a lung nodule was found. The attending physician noted this finding and documented a plan for a CT scan. When interviewed by the OIG team, the attending physician acknowledged that a CT was not ordered or completed as documented in the treatment plan.

Problem List Documentation

The OIG team determined that the patient's RCC diagnosis was not accurately documented on the problem list. "Anomaly of the Kidney NEC [Not Elsewhere Classifiable]" was documented instead. Providers use problem lists to document information about the patient's medical history and medical diagnoses that may require ongoing care or were resolved. VHA policy stipulates that the problem list should be initiated by the third visit and maintained by the practitioner.³⁰ Additionally, the following elements must be included: known significant diagnosis, conditions, pertinent past procedures, allergies to foods or medications, current medications, and significant

²⁸ Donat, Sherri Machele, Mireya Diaz, Jay Todd Bishoff, et al., "Follow-up for Clinically Localized Renal Neoplasms," American Urological Association Guidelines (2013): 1-29. [http://www.auanet.org/guidelines/follow-up-for-clinically-localized-renal-neoplasms-\(2013\)](http://www.auanet.org/guidelines/follow-up-for-clinically-localized-renal-neoplasms-(2013)). (The website was accessed on April 10, 2018.)

²⁹ Post-operative complications include loss of kidney function and post-operative condition(s) from the surgery that may require intervention. [http://www.auanet.org/guidelines/follow-up-for-clinically-localized-renal-neoplasms-\(2013\)](http://www.auanet.org/guidelines/follow-up-for-clinically-localized-renal-neoplasms-(2013)). (The website was accessed on April 10, 2018.)

³⁰ A practitioner is an individual at any level of professional specialization who requires a public license or certification to practice the delivery of care to patients. A practitioner can also be referred to as a provider.

procedures performed outside the VHA.³¹ During an interview with the urologist, the OIG team inquired if “Anomaly of the Kidney NEC” was the appropriate entry to make based on the patient’s history. The urologist stated that he did not know how to make an entry into the problem list and could not recall how it was entered in this case.

Incidental Findings for Cheyenne

The OIG team reviewed the patient’s EHR and found that over eight months elapsed from the initial identification of a left kidney mass in late 2011 until the patient’s left nephrectomy in fall 2012.

The patient initially refused further clinical evaluation when first informed of the left kidney mass. In spring 2012, an MRI was completed. The patient was referred to the VA Eastern Colorado Health Care System’s Urology Clinic, and a urologist ordered a CT scan, which was completed the following month. The test results raised a clinical suspicion of multiple myeloma.

Approximately 7 weeks later, an oncologist at Cheyenne evaluated the patient. The oncologist documented, “Probable renal cell carcinoma involving the left kidney and need for surgery. ... There is no proof [of] any other malignant process to date.”

The patient was seen by a non-VA urologist for surgical evaluation on June 18 and the left nephrectomy was performed in fall 2012.

The Chief of Staff told the OIG team that the elapsed time was too long to respond to a cancer diagnosis and reviewed the patient’s care; however, he did not comment on the reason for the delay. The Cheyenne urologist also acknowledged the suspicion of multiple myeloma contributed to the delay in treating the RCC.

Institutional Disclosure

The Cheyenne Chief of Staff, Chief of Quality Management, and Risk Manager informed the OIG team that as of April 2018, an institutional disclosure had not been previously considered for the patient. However, the Chief of Staff and Chief of Quality Management stated that an institutional disclosure should have been considered.

³¹ VHA Handbook 1907.01, *Health Information and Health Records*, September 19, 2012. This directive was rescinded and replaced by VHA Handbook 1907.01, *Health Information and Health Records*, July 22, 2014, which did not include any changes related to this topic.

VHA and Joint Commission require that patients, and when appropriate, their families, be informed of unanticipated outcomes related to an adverse event that occurred during care.³² Institutional disclosure is a formal process by which facility leaders, together with clinicians and other appropriate individuals, inform patients and their families that an adverse event occurred during the patient's care. Cheyenne leaders, who determined whether an institutional disclosure was warranted, may not have been aware of the lack of RCC surveillance until receipt of the OIG Case Referral in October 2017.³³ The OIG team determined that the Cheyenne leaders had not taken any steps to conduct an institutional disclosure as of April 2018.

Peer Review

The OIG team determined that peer reviews had not been performed at Cheyenne although the concerns of this patient's care were brought to the attention of Cheyenne leaders in October 2017.³⁴ Quality Management staff had the opportunity to review the patient's care prior to the initiation of the OIG inspection in April 2017 and consider whether a peer review was indicated; however, peer reviews had not been initiated.

VHA policy states that each facility must establish and maintain a peer review process for quality management purposes relevant to the care provided by individual health care providers.³⁵ Additionally, peer reviews should be considered for unexpected or negative occurrences, executive concerns, and other facility group's concerns.³⁶

The OIG team reviewed the patient's EHR and identified a series of errors contributing to the lack of the patient's appropriate care and treatment. These errors included the lack of RCC surveillance; follow-up of the summer 2014 CT; and discussion, communication, and monitoring of the RCC by the PCP, HBPC, and VA and non-VA urologists. The Chief of Staff agreed that peer reviews should have been considered for this patient's care. In April 2018, through interviews and document review, and in October, through correspondence with the quality management chief, the OIG determined that Cheyenne had not initiated peer reviews related to this case.³⁷

³² VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012. This handbook is scheduled for recertification on or before the last working date of October 2017; "Introduction to Hospital Culture and System Performance Expectations, Standard LD.03.04.01," *The Joint Commission E-dition*. <https://e-dition.jcrinc.com/MainContent.aspx>. (The website was accessed on July 12, 2017.); Adverse events are untoward incidents, diagnostic or therapeutic misadventures, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services provided within the jurisdiction of the Veterans Healthcare System.

³³ VA OIG Hotline Case Referral No. 2018-00693-HL-0610; Cheyenne VAMC, WY, and Iowa City VA HCS, IA.

³⁴ VA OIG Hotline Case Referral No. 2018-00693-HL-0610.

³⁵ VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This directive is expired and has not yet been replaced.

³⁶ VHA Directive 2010-025.

³⁷ The primary care provider for this patient no longer worked at the facility.

Recommendations

Recommendation 1: The Cheyenne VA Medical Center Director ensures timely surveillance for cancer patients.

Recommendation 2: The Cheyenne VA Medical Center Director improves processes for care coordination and communication between Cheyenne VA Medical Center providers and non-VA providers for cancer patients.

Recommendation 3: The Cheyenne VA Medical Center Director ensures that processes are strengthened to ensure documentation of problem lists in accordance with Veterans Health Administration policy.

Recommendation 4: The Cheyenne VA Medical Center Director confers with the Office of Chief Counsel in accordance with Veterans Health Administration Handbook 1004.08 regarding institutional disclosures and takes action as necessary.

Recommendation 5: The Cheyenne VA Medical Center Director determines if peer reviews are warranted for this patient's care and the peer reviews are performed as indicated.

Issue 2: Iowa City Patient's Cancer History and Care

The OIG did not substantiate that Iowa City providers failed to provide care and were unaware of the patient's cancer history. The OIG team found that an Iowa City provider documented the history of a left nephrectomy in the patient's EHR progress notes; however, an e-consult to Urology Service for further evaluation was not addressed timely and resulted in a delay in care.

In spring 2015, during the patient's initial appointment at the Bettendorf Community Based Outpatient Clinic, the PCP documented "Lt Nephrectomy (due to cancer)" in the progress note.

Four months later, after receipt of the patient's kidney ultrasound, the PCP sent the patient a letter with notification of the results and the plan to refer to Urology Service for further evaluation. The PCP submitted a routine e-consult to Urology Service, which referenced a right renal lesion seen on ultrasound, with history of left nephrectomy due to left renal cancer.³⁸ The e-consult documentation also shows a request for evaluation and treatment.

The patient was scheduled for an appointment 146 days later. In early 2016, the patient was evaluated in the Urology Clinic, totaling 182 days until e-consult completion.

The Iowa City PCP stated being unaware that the e-consult remained open and never noticed delays in the completion of other service-related evaluations. Further, the PCP assumed that the Urology Clinic had difficulty contacting the patient and ensuring compliance because the PCP had experienced similar difficulties.

³⁸ A routine consult indicates the patient should be seen in accordance with the clinically indicated date or patient's indicated date.

The OIG team's review of Urology Service processes, effective at the time of the patient's e-consult, revealed concerns that may have contributed to the delay in care. All Urology Service clinical and e-consults were programmed to print at the Urology Clinic front-desk printer. The Urology MSA's responsibility was to acknowledge receipt of the e-consult in the patient's EHR and place the printed copy in a folder designated for a Urology Service provider's review, typically a nurse practitioner or resident. The urology provider triages the consult and documents written instructions on the printed copy for the MSA to follow. The MSA then attempts to contact the veteran for scheduling purposes.

The OIG team was informed guidance was unclear in the Urology Clinic as to who was assigned primary responsibility for reviewing e-consults, and providers did not receive alerts when e-consults were submitted.

Urology e-consult management relied upon staff to address the clinic's incoming consults; however, frequent turnover of key staff contributed to delays from 2014 through 2016. During this time, the Urology Service did not have a full-time urologist, and the Urology Clinic experienced turnover in nurse practitioners and MSA supervisors. This instability, combined with the reliance on residents, who rotate through the department every four to six months, contributed to delays in consult management.

Incidental Findings for Iowa City

Problem List Documentation

The OIG team found that the patient's problem list was updated by Iowa City providers to include RCC but not the history of left nephrectomy. Inclusion of the pertinent medical history may be a useful resource during appointments; however, the omission from the EHR did not result in the provider being unaware of the conditions as evidenced by the documentation of care provided.

According to Iowa City policy, the PCP is required to update the summary problem list for a patient by the end of the third visit.³⁹ Problem list documentation includes significant diagnoses and conditions, significant operative and invasive procedures, adverse allergic and drug reactions, and current medications.

Peer Review

The OIG team found two complaints regarding the patient's care were submitted to the Patient Advocate in early 2016. Additionally, in fall 2017, the OIG requested Iowa City managers review and respond to allegations regarding delays in treatment for the patient. According to the Iowa City Risk Manager, the Patient Advocate complaints and the OIG Case Referral should

³⁹ Medical Center Memorandum (MCM) 18-073, *Health Information Management and Patient Health Records*, January 2, 2018.

have triggered alerts to review the patient's EHR and prompt staff to determine if a peer review was warranted. The Risk Manager was not alerted in either occurrence.

VHA policy states that each facility must establish and maintain a program of peer review for quality management purposes relevant to the care provided by providers.⁴⁰ Iowa City policy states that "any issue with possible quality, performance, or other circumstances may be considered for peer reviews."⁴¹ Peer review referrals may be generated for a number of reasons. The Patient Advocate will send a notification to the Risk Manager if concerns or questions arise regarding a patient's care. Executive concerns, such as an OIG Case Referral, can also initiate a peer review.

Recommendations

Recommendation 6: The Iowa City VA Health Care System Director ensures that processes are strengthened to ensure documentation of problem lists in accordance with Veterans Health Administration policy.

Recommendation 7: The Iowa City VA Health Care System Director determines if peer reviews are warranted for this patient's care and the peer reviews are performed as indicated.

Issue 3: Iowa City E-Consult Concerns in the Urology Clinic

Iowa City managers identified concerns that contributed to delays in processing the patient's Urology Clinic e-consults. However, Iowa City managers did not conduct a review to determine if the concerns may have negatively affected other patients at the time of the original OIG Case Referral.

In December 2017, Iowa City managers sent documentation in response to an OIG Case Referral acknowledging a failure to ensure timely processing of e-consults due to staffing shortages and an unclear process for reviewing and triaging e-consults.⁴² The document also noted that the Urology Clinic implemented process changes designed to ensure e-consults were reviewed weekly.⁴³ However, the Iowa City managers' response did not address if EHR reviews had been conducted to identify negative outcomes for other patients. The OIG team conducted an additional evaluation of the OIG Case Referral concerns to determine if facility changes corrected the previous conditions and whether other patients had been negatively affected.

The OIG team determined that e-consults were printed in error to a printer physically located outside of the Urology Clinic from May through July 2015. E-consults entered before May 2015 and after July 2015 were printed to the designated Urology Clinic printer. In preparation for an

⁴⁰ VHA Directive 2010-025.

⁴¹ MCM 18-092, Peer Review for Quality Management, February 8, 2018.

⁴² VA OIG Case Referral No. 2018-00693-HL-0610.

⁴³ VA OIG Case Referral No. 2018-00693-HL-0610.

interview with the OIG team, the Chief of Urology identified that the e-consult for the subject of this review did not print to the assigned printer in the Urology Clinic. The OIG team identified six additional patients whose e-consults were printed outside the Urology Clinic. After review of the patients' EHRs, the OIG team determined that none of these patients were negatively affected by the delay. E-consults affected by this error were responded to within an average of 61.5 days. The OIG team was unable to determine the cause of this printing error.

The OIG team was informed that although consult tracking reports were generated, the reports did not include e-consults. Urology Clinic managers did not use available reporting mechanisms to identify missed e-consults. Inclusion of e-consults in the tracking reports could have alerted Urology Clinic managers of e-consults that had not been addressed or remained open.

To evaluate whether other patients had been negatively affected by the use of e-consults to the Urology Clinic, the OIG team queried all e-consults submitted to the Urology Clinic at Iowa City from January 1, 2015, through March 1, 2018. The OIG team reviewed the e-consults that remained open greater than 30 days. (see Table 1). Since 2015, Iowa City consistently reduced the number of e-consults that remained open over 30 days each consecutive year.

Table 1. E-Consults

Calendar Year	Number of E-Consults Submitted	Number of E-Consults Open Over 30 Days	Percent of E-Consults Open Over 30 Days
2015	76	55	72%
2016	108	45	42%
2017	118	14	12%
2018	19	1	5%

Source: VA OIG analysis

Note: Calendar year 2018 data was from January 1 through March 1, 2018.

The OIG team reviewed the EHRs of patients who had e-consults submitted and found that clinical care was provided; however, Urology Clinic providers did not always complete the documentation for e-consults. The OIG team reviewed the reasons for administrative errors, and clinicians and staff stated that from 2015 to 2017 they had limited knowledge of the purpose and processing steps for e-consults.

The OIG team reviewed all e-consults for patients with a urological cancer diagnosis when the e-consult was open greater than 30 days to determine if the delay had any impact on their care and treatment. The OIG team reviewed EHRs for 69 patients with a urological cancer diagnosis and found no indication of patient harm due to the delays.

Conclusion

The OIG substantiated that clinicians at Cheyenne failed to provide timely and proper surveillance for the patient following the diagnosis of RCC and the left nephrectomy surgery. Contributing factors included a lack of clear communication among providers through EHR documentation, inaccurate diagnostic coding on the patient's problem list, and limited patient evaluations pertaining only to the provider's specialty.

The OIG team found over eight months' delay since the initial identification of the patient's left kidney mass in late 2011 until the patient's left nephrectomy in fall 2012.

As of October 2018, an institutional disclosure had not been performed for the patient; however, attempts were made to reach the patient's next of kin.

The OIG team determined that peer reviews had not been performed at Cheyenne although the concerns of this patient's care were brought to the attention of Facility leaders in 2017. Quality Management staff had the opportunity to review the patient's care prior to the initiation of the OIG inspection in April 2017 and consider whether a peer review was indicated, yet the peer reviews had not been initiated.

The OIG did not substantiate that Iowa City providers failed to provide care and were unaware of the patient's cancer history. The OIG team found that Iowa City providers documented the history of a left nephrectomy in the patient's EHR progress notes; however, an e-consult to Urology Service was not addressed timely and resulted in a delay in care.

At Iowa City, the OIG team found that the patient's problem list did not include the history of left nephrectomy. Inclusion of the pertinent medical history could have been a useful resource during appointments; however, the omission from the EHR did not result in the provider being unaware of the conditions as evidenced by the documentation of care provided.

The OIG team found two complaints regarding the patient's care were submitted to the Patient Advocate in early 2016. Additionally, in late 2017 the OIG requested Iowa City managers review and respond to allegations regarding delays in treatment for the patient. According to the Risk Manager, the Patient Advocate complaints and the OIG Case Referral should have triggered alerts to review the patient's EHR and determine if a peer review was warranted. The Risk Manager was not alerted in either occurrence.

The OIG team found that managers identified concerns contributing to delays in processing e-consults in the Urology Clinic related to the patient involved in this healthcare inspection. However, managers did not conduct a review to determine if the concerns may have negatively affected other patients at the time of the original OIG Case Referral.

The OIG team reviewed the EHRs of patients who had e-consults submitted and found that clinical care was provided; however, Urology Clinic providers did not always appropriately complete the documentation for e-consults. The OIG team reviewed the reasons for

administrative errors, and clinicians and staff interviewed stated that from 2015 to 2017 they had limited knowledge of the purpose and processing steps for e-consults.

The OIG team reviewed e-consults for patients with a urological cancer diagnosis when the e-consult was open greater than 30 days to evaluate whether other patients had been negatively affected by the use of e-consults to the Urology Clinic. The OIG team reviewed EHRs for 69 patients with a urological cancer diagnosis and found no indication of patient harm due to the delays.

The OIG made seven recommendations.

Recommendations 1–7

Recommendation 1: The Cheyenne VA Medical Center Director ensures timely surveillance for cancer patients.

Recommendation 2: The Cheyenne VA Medical Center Director improves processes for care coordination and communication between Facility providers and non-VA providers for cancer patients.

Recommendation 3: The Cheyenne VA Medical Center Director ensures that processes are strengthened to ensure documentation of problem lists in accordance with Veterans Health Administration policy.

Recommendation 4: The Cheyenne VA Medical Center Director confers with the Office of Chief Counsel in accordance with Veterans Health Administration Handbook 1004.08 regarding institutional disclosures and takes action as necessary.

Recommendation 5: The Cheyenne VA Medical Center Director determines if peer reviews are warranted for this patient’s care and the peer reviews are performed as indicated.

Recommendation 6: The Iowa City VA Health Care System Director ensures that processes are strengthened to ensure documentation of problem lists in accordance with Veterans Health Administration policy.

Recommendation 7: The Iowa City VA Health Care System Director determines if peer reviews are warranted for this patient’s care and the peer reviews are performed as indicated.

Appendix A: VISN 19 Director Comments

Department of Veterans Affairs Memorandum

Date: October 31, 2018

From: Director, Rocky Mountain Network (VISN 19)

Subj: Healthcare Inspection—Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System

To: Director, San Diego Office of Healthcare Inspections (54SD)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with *the findings and recommendations* in the OIG report entitled, *Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System*.
2. I concur with the Cheyenne VA Medical Center response and plan of action for each recommendation.

(Original signed by:)

Ralph T. Gigliotti FACHE

Director, VA Rocky Mountain Network (10N19)

Appendix B: Cheyenne Director Comments

Department of Veterans Affairs Memorandum

Date: October 17, 2018

From: Director, Cheyenne VA Medical Center (442/00)

Subj: Healthcare Inspection—Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System

To: Director, Rocky Mountain Network (VISN 19)

1. I have reviewed and concur with *the findings and recommendations* in the OIG report entitled, *Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System*.
2. Please find attached our response to each recommendation provided in this report.
3. If there are any questions regarding the response to the recommendations or any additional information is required, please contact the Chief of Quality Management.

(Original signed by:)

Paul Roberts, MHA, FACHE

Director, Cheyenne VA Medical Center (442/00)

Comments to OIG's Report

Recommendation 1

The Cheyenne VA Medical Center Director ensures timely surveillance for cancer patients.

Concur.

Target date for completion: December 31, 2018

Director Comments

Facility will ensure that any Veteran who has a positive cancer diagnosis will be tracked through the Pathology Case Review workgroup. Monthly reports will be pulled to identify Veterans with a cancer diagnosis to improve the tracking and surveillance via the Oncology clinic.

Recommendation 2

The Cheyenne VA Medical Center Director improves processes for care coordination and communication between Facility providers and non-VA providers for cancer patients.

Concur.

Target date for completion: December 31, 2018

Director Comments

Facility will improve care coordination of the Veteran who has cancer treatment through Care in the Community by a monthly pull of reports that will be routed to the oncology clinic for tracking and oversight by the oncology team. The VA oncology team will be the conduit between Non- VA Care and the primary care provider.

Recommendation 3

The Cheyenne VA Medical Center Director ensures that processes are strengthened to ensure documentation of problem lists in accordance with Veterans Health Administration policy.

Concur.

Target date for completion: December 31, 2018

Director Comments

The process will be strengthened to include the Problem List be printed at the beginning of every primary care and specialty appointment. This change will allow the Veteran and clinician to review the problem list for accuracy and update as needed at each appointment. This process will be emphasized in primary care and specialty staff meetings, as well as General Medical Staff.

Recommendation 4

The Cheyenne VA Medical Center Director confers with the Office of Chief Counsel in accordance with Veterans Health Administration Handbook 1004.08 regarding institutional disclosures and takes action as necessary.

Concur.

Target date for completion: Completed

Director Comments

Three phone attempts were made to contact the deceased's son, as well as a certified letter sent to the address on file, which was returned. Contact was not made and institutional disclosure was not completed.

OIG Comment: The Cheyenne VA Medical Center Director provided sufficient supporting documentation, and the OIG considers this recommendation closed.

Recommendation 5

The Cheyenne VA Medical Center Director determines if peer reviews are warranted for this patient's care and the peer reviews are performed as indicated.

Concur.

Target date for completion: February 9, 2019

Director Comments

Appropriate peer reviews were initiated.

Appendix C: VISN 23 Director Comments

Department of Veterans Affairs Memorandum

Date: November 1, 2018

From: Director, VA Midwest Health Care Network (VISN 23)

Subj: Healthcare Inspection—Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System

To: Director, San Diego Office of Healthcare Inspections(54SD)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with *the findings and recommendations* in the OIG report entitled, *Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System*

(Original signed by:)

Robert P. McDivitt, FACHE
Network Director

Appendix D: Iowa City Director Comments

Department of Veterans Affairs Memorandum

Date: October 26, 2018

From: Director, Iowa City VA Health Care System (584/00)

Subj: Healthcare Inspection—Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System

To: Director, VA Midwest Health Care Network (VISN 23)

1. I have reviewed and concur with *the findings and recommendations* in the OIG report entitled, *Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System*.

(Original signed by:)

Judith L. Johnson-Mekota, FACHE

Director

Comments to OIG's Report

Recommendation 6

The Iowa City VA Health Care System Director ensures that processes are strengthened to ensure documentation of problem lists in accordance with Veterans Health Administration policy.

Concur.

Target date for completion: July 30, 2019

Director Comments

Action Plan: The Iowa City VA Health Care System (ICVAHCS) Health Information Management (HIM) Section provided one on one training to primary care providers in the community based outpatient clinics from February 14–July 11th, 2018 on documentation requirements of the problem list. This training included an educational handout to providers to reinforce how to update the problem list. Additionally, the standardized provider training module on use of the Computerized Patient Record System (CPRS) has been updated to include a section on completing/updating the problem list according to VHA requirements. A monthly audit tool will be developed and administered by our Health Information Management Service (HIMS). The tool will be used to audit existing problem lists to verify compliance with VHA policy and effectiveness of the education that was given to providers. Monthly audits of 40 records will continue until results yield 3 consecutive months where 90% of the problem lists that have been audited are compliant with VHA policy.

Recommendation 7

The Iowa City VA Health Care System Director determines if peer reviews are warranted for this patient's care and the peer reviews are performed as indicated.

Concur.

Target date for completion: January 30, 2019

Director Comments

Iowa City VA HCS Surgery Service Line leadership conducted a fact finding in response to the OIG Hotline submitted on 12/12/2017. The review identified a system gap in the Urology e-consult process which resulted in a lack of timeliness in scheduling the appointment. The Surgery Service Line leadership found no evidence of direct provider care or treatment that impacted the scheduling of the appointment, therefore a peer review was not recommended. The Medical Center Memorandum (e.g. policy) for Peer Review was reviewed and updated. Formal

patient complaints related to delays in treatment or quality of care received from the Patient Advocate, Congressional or OIG inquiry are now included in the list of events that need to be considered for possible protected peer review.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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