

**For Internal Use
FACT SHEET
Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Gastrointestinal (GI) Clinic
Charlie Norwood VA Medical Center
October 2012**

Summary Statement

The Charlie Norwood VA Medical Center (CNVAMC) identified a large number of pending gastroenterology (GI) consults. After notifying VA Central Office, the facility took immediate steps to accommodate more patients. Those steps included adding Saturday and Sunday clinics to increase availability. It also identified individuals in the community who could provide services to Veterans, and moved forward with putting in place fee agreements with those providers. The first priority was to take care of the Veterans.

VA Central office also deployed a team of subject matter experts to the facility. Based on the recommendations of this team, CNVAMC rapidly ramped up their ability to serve more Veterans. CNVAMC's goal is to provide needed GI procedures to all of the Veterans known to be at high risk for an unidentified medical condition by October 31, 2012. CNVAMC will continue to search its databases for other Veterans who may have been waiting for a GI procedure as they care for those already identified.

Background:

- In August 2012, VISN 7 initiated a review of the colonoscopy data at the Charlie Norwood VA Medical Center (CNVAMC), Augusta, GA based on a similar review of this issue at another VISN 7 VHA facility. This review was conducted using nursing, Quality Management, physician and data analyst resources and revealed a delay in screening, surveillance and diagnostic (GI) endoscopies both in-house and non-VA fee basis
- On September 1, 2012, VA Central Office (VACO) was notified of the situation and a conference call was held immediately with the Deputy Under Secretary for Health for Operations and Management (DUSHOM), the Acting Chief Medical Officer in VISN 7 and other clinical staff at VACO, VISN and VAMC. From this conversation it was decided that a VACO subject matter expert (SME) panel would be deployed to assess the current consult delay and help the facility develop action plans to eliminate the delay, establish effective and inclusive

processes to schedule and perform needed procedures, and review documentation to determine the need for clinical disclosure.

- An intensive concurrent review of all patients waiting for endoscopy studies was initiated. A retrospective review is also occurring with assistance from the DUSHOM clinical team to ensure that all patients dating back to 2006 have had appropriate follow up for a positive fecal occult blood test.
- Review of records identified 4503 unresolved consults for GI endoscopy; including 340 GI consult requests in the diagnostic category; 1304 in the surveillance category; and 2859 screening category
- The CNVAMC deadline for completing all of the GI procedures for patients at high risk of having an undiagnosed medical condition was established as October 31, 2012.
- VISN, VAMC, and facility leadership took additional steps and ordered an immediate review of the previous two years of Cancer Registries and positive pathology reports for GI Malignancies to ascertain whether any additional adverse events had occurred due to a delay in diagnosis and treatment.
- After a careful retrospective case review, Quality Management staff recommended 53 cases for physician review. Of the 53 cases, the facility identified 5 cases that will require institutional disclosure, and the 48 remaining cases were forwarded for an external review with an expected completion date of November 2, 2012 to determine if an adverse event had occurred and whether institutional disclosures were needed.

Chronology of Actions Taken:

- 1) Immediate steps were taken in September to effectively triple procedure capacity to 30 per day. Personnel were re-aligned and improvements were made to increase staff support and patient communication. Non-VA Care partner facilities within the community were asked to assist in the reduction of consult delays. Their collective participation was intended to create 60 procedural opportunities per day.
- 2) In September 1, 2012, immediate steps were taken to increase the internal capacity to perform GI endoscopy procedures. Personnel were re-aligned and improvements were made to increase staff support and patient communication
- 3) On September 15, 2012, a Saturday and Sunday endoscopy procedure clinic opened to increase in-house capacity staffing 4 full time GI procedure suites; using two operating rooms and identifying additional equipment both on lease and loan. Saturday and Sunday clinics will remain functional and productive until CNVAMC consult delays have been eliminated.
- 4) During the week of October 8, 2012 a review of existing procedures, capacity and partner response indicated a pending shortfall of completed procedures in spite of CNVAMC's now 40+ per day capacity. With VISN and VACO support of

both additional assigned staff and loaned equipment that input could be increased even further. VA Central Office arranged for staff across the VA to be detailed to Augusta during the month of October to speed up the process of getting all Veterans scheduled. The facility's goal is to complete all necessary GI procedures for patients by October 31.

- 5) On October 12, 2012, CNVAMC requested VACO assistance in obtaining support for increasing GI procedures at the medical center by requesting assistance of available VA GI staff from across the nation.

Augusta GI Action Plan: Chronology of Events

Chronology	Actions Taken	Outcome
August 2012	VISN Acting CMO and QMO conducted a clinical quality site visit during which the GI delay data was reviewed with Augusta leadership.	Facility leadership was immediately charged with completing an IB that detailed the steps of validation of delay, stratifying risk, assessing and increasing capacity, adopting approved data management practices.
August 2012	CNVAMC, Chief of Staff notified Facility leadership of consult delay status.	CNVAMC Director established a GI Task Force to develop remediation plan to identify systematic issues within GI.
September 2012	VACO began daily conference calls with Augusta to monitor and management GI delay resolution process.	Daily calls monitoring the progress of delay resolution process as stated above: validation of data, risk stratification, scheduling and completion of procedures.
September 2012	CNVAMC Director assigned staff to identify delay status for all GI specific consults.	Diagnostic, surveillance and screening colonoscopy groups are identified and quantified
September 2012	CNVAMC Increased access.	Week of 9-3, <u>72</u> available appointments Week of 9-24, <u>190</u> available appointments
September 12- 14	SME Team from VACO embed with Augusta	Throughput recommendations adopted. Equipment requests submitted.
September 14, 2012	VACO began regular calls with Augusta which are now scheduled on Monday, Wednesday and Friday.	Augusta required to submit daily GI tracking data and weekly tracking spreadsheet.
September 2012	Augment volume of procedures performed by incorporating surgeons	Surgeons will perform procedures to augment capacity.

	into provider mix.	
September 7	Develop additional in-house capacity via Saturday Clinic.	Adding an additional 20 patient capacity per week.
September 2012	Developed negotiated agreements in the community.	Minimum of 30 cases per day. Explore the need for additional resources.
September 2012	Pursued addition of 12 endoscopes and 2 towers to expand GI capability into the OR and maximize the endoscopy suite throughput.	Needed to accommodate increased internal demand.
September 14, 2012	Enhanced Pharmacy support.	Incorporating additional Pyxis machine.
September 2012	Primary care teams begin contact with patients/screening options explained.	FOBT test kits in the mail.
September 2012	Providers follow up calls to patients refusing colonoscopy.	Educate patients on the possible ramifications of not having the procedure. Provider will generate a CPRS note documenting the telephone encounter.
September 4 – 28	DUSHOM and VISN provide extensive support for intra VHA clinical team to conduct procedures and ongoing reviews for GI delay.	Expanded internal capacity.
October 4	Received 2 additional towers, 9 additional gastroscopes and 12 colonoscopies	
October 15	Daily goal increased to as many as 90 GI procedures. Saturday and Sunday clinics open. Weekend clinics will remain open until consult delay is eliminated	All call for volunteer staff from sister facilities. Equipment leasing and short term borrowing explored
October 31	Goal date to address high risk GI consult delay	Weekly tracking of progress
November 2	53 cases sent out, for review with rush priority for completion	10-19-12 (Two) returned that confirmed CNVAMC opinion that no institutional disclosure is required. The remaining cases will be returned by November 2 to determine if an adverse event had occurred and whether institutional disclosures were needed

CNVAMC clinical teams are conducting on-going reviews to determine if any Veteran experienced an adverse event due to delay of GI care. As Veterans in this category are identified, every effort is being made to contact the Veteran to deliver the needed care, and if indicated, provide adverse disclosure counseling.

As new consults continue to be submitted, Veterans that require a GI procedure will be identified and given the appropriate care. A clinical risk criterion has been established to aid in stratifying the pending consults to prioritize scheduling.

Point of Contact for more Information:

Pete Scovill Public Information Officer, Charlie Norwood VA Medical Center, CNVAMC
706-823-1733.

**Department of Veterans Affairs
William Jennings Bryan Dorn VA Medical Center (Dorn VA)
GI Institutional Disclosures/ GI Backlog
Internal Fact Sheet
September 2, 2012**

Summary Statement:

In July 2011, an estimated backlog of 2500 Gastro-intestinal (GI) consults was identified. Despite efforts to mitigate the backlog and remain current with the influx of consults, in late December 2011, a review of pending examinations revealed a continued backlog of approximately 3000 Veterans requiring both diagnostic and screening -GI endoscopy procedures.

In January 2012, actions were undertaken by the current executive team to address the backlog, increase case management capability, correct systematic issues and address resource needs. Internal capacity was increased, the DOD affiliate capacity was increased and additional Non-VA (FEE) providers were identified to address the backlog.

In May 2012, a Veteran was found to have an adverse event due to a delay in GI care and an institutional disclosure was made. A retrospective case review was completed on other Veterans who may have potentially been harmed due to a delay in care. Ten additional cases were identified for institutional disclosure.

In early August 2012, a subject matter expert (SME) clinical team provided consultation on GI processes, and in mid August 2012, a SME team from the office of Deputy under Secretary for Health for Operations and Management (DUSHOM) was deployed to assist with further development of action plans to eliminate the backlog.

As of September 1, 2012, actions are underway to manage and resolve all backlogged GI cases by September 30, 2012 and moving forward new processes are in place to assure Veterans receive timely preventative and diagnostic care.

Background:

- In July 2011, Dorn VAMC Chief of Medicine informed Facility Leadership that the internal GI endoscopy examination capacity was not sufficient to meet Gastro-intestinal (GI) endoscopy needs and a backlog of cases was growing. Additional resources were requested to include funding and supplemental staffing to refer the most urgent GI cases to community partners, manage internal capacity and mitigate the backlog of 2500 consults. In August 2011, VISN 7 authorized \$1 million for authorized Non-VA Care (FEE) for 700 critical consults. The mitigation plan used a balance of community resources (Fee care) with internal facility scheduling and Veteran preference to meet the GI demand and reduce the back log. From August through December

252 cases were authorized to be sent to the community and other cases were completed internally.

- In late December 2011, Dorn VAMC Medicine Service notified the executive team, one of three endoscopy procedures rooms would be closed due to staff shortages and a national shortage of the sedation drug Versed. A group of GI cases would need to be canceled internally and sent to the community for authorized Non-VA care. The GI backlog was reported at over 3000 and procedure availability at Dorn was booked to April 2012.

In early January 2012, The Dorn VAMC Medical Center Director established a GI Task Force to develop a remediation plan to identify systematic issues in GI

care. A detailed timeline of actions and responses taken from January 2012 to September 2, 2012 is included in the Response Taken/Chronology of Actions taken. (Section follows).

While multiple actions were immediately taken to address the GI backlog and increase both case management capabilities and in-house capacity, a Veteran was identified to have experienced an adverse event due to a delay in GI care.

On May 15, 2012, a Veteran arrived at the William Jennings Bryan Dorn VA Medical Center (Dorn VAMC) Emergency Department with a primary complaint of throat soreness and difficulty swallowing. The Veteran was determined to have esophageal cancer.

- After a thorough review of the Veteran's medical record, the Chief of Staff determined that an adverse event had occurred due to a delay in care. On June 13, 2012, an Institutional Disclosure was made to this Veteran. Dorn VAMC Leadership took immediate action to review the 2011 and 2012 Cancer Registries and Positive Pathology Reports for GI Malignancies to ascertain whether any additional adverse events had occurred due to a delay in diagnosis and treatment. After a careful retrospective case review, Quality Management staff recommended 26 cases for physician review. Of the 26 cases, the facility identified 10 additional cases for institutional disclosure, and the 16 remaining cases were forwarded for an external review to determine if an adverse event had occurred and whether Institutional Disclosures needed to be given. These reviews will be completed by September 15, 2012. As of August 29, 2012, Institutional Disclosures have been given to 10 of the 11 Veterans. The final disclosure will be completed by September 15, 2012.
- As of September 1, 2012, actions are underway to manage and resolve all backlogged GI cases by September 30, 2012 and moving forward new

processes are in place to assure Veterans receive timely preventative and diagnostic care.

Statement:

The Department of Veterans Affairs (VA) is committed to serve our Nations Veterans. Our Veterans can be assured the VA remains committed to providing safe, high quality and timely care.

The William Jennings Bryan Dorn VA Medical Center is committed to ensuring that Veterans obtain timely preventative screenings, in addition to surveillance and diagnostic Gastro-intestinal (GI) procedures and timely diagnosis and treatment of GI malignancies.

Dorn VAMC is committed to communicating any adverse events that may have occurred due to a delay in GI Care. Ongoing reviews are being conducted to determine if any Veteran experienced an adverse event due to delay in GI care. As Veterans in this group are identified, all efforts are made to contact the Veteran to deliver the needed care and provide adverse disclosure counseling.

Response Taken:

In late December, when new leadership arrived at Dorn VAMC, a significant amount of backlogged GI Consults were found to exist, multiple actions were taken to address the backlog and increase both case management capabilities and in-house capacity.

Chronology of Actions Taken:

1. In January 2012, nursing staff temporarily reassigned to re-open a third GI procedure room. The room opened on January 23, 2012. A full capacity review was completed to assess additional resource needs. A group of higher risk patients were sent for Non-VA care authorization. However, when internal capacity was thought to have increased, those authorizations were cancelled and patients scheduled internally for better care coordination.
2. In February 2012, a Team of nurses and mid-level providers assigned to begin reviewing consults and working with GI staff to schedule in to available capacity. Negotiations began with community providers in Columbia and Augusta to supplement capacity to see patients immediately on authorized Non-VA care. New GI Nurse Manager is hired.
3. In March 2012, a Clinical risk criterion was established to aid in stratifying the backlog to prioritize scheduling.
 - a. Highest risk patients managed internally.
 - b. Intermediate risk and Intermediate High Risk patients sent to non-VA providers
 - c. Wait list established for low risk patients.

- Non-VA care agreements were signed with a provider in Columbia and Doctors Hospital in Augusta, Georgia.
 - Expanded MACH sharing agreement finalized to increase procedural capacity for VA patients.
 - Completed internal procedure volume increases by 87 cases from the January level.
4. In April 2012, a continued review of consults to help eliminate the existing backlog. One dedicated nurse case manager and two administrative clerks assigned to coordinate care of GI patients receiving Non-VA care referrals and notify Dom providers of pathology results received for patients getting care in the community.
 5. In May 2012, Staff supplied to manage daily volume of GI procedures. Additional community capacity is negotiated with more community partners, however the community resources were stretched, which limited additional capacity.
 6. In June 2012, all requested vacant and additional clinical staff is approved for immediate recruitment. Clinical case management and clerk support increased to ensure that patients were scheduled timely and care was appropriately managed. Saturday endoscopy procedure clinic opened to increase in-house capacity. 150 individual patients tracked through the GI endoscopy suite to assess any flow issues and bottlenecks from check-in to patient discharge.
 7. In July 2012, the consult risk stratification process was amended to further prioritize scheduling and enhanced consult tracking tools developed. A VACO SME panel is convened and approves the risk stratification process. All backlogged consults are reviewed and stratified. It was determined at that time that there were 3572 open consults prior to July 13, 2012. Facility requests an external management review to assess the processes in the current GI program and to make recommendations for improvement. Flow maps developed to better staff communication and simplify processes.
 8. In August 2012, an external review conducted by 1 physician and 1 Nurse Practitioner from the Baltimore VA and an RN Manager from the Pittsburgh VA Medical Center. Report provided and appropriate recommendations are being implemented. Facility RCA chartered to review GI processes.

Other actions completed in August:

- Four emergency contracts drafted to provide contractually guaranteed capacity in the private practice community (currently in price negotiations-target for award September 17, 2012)
- Total of 7 Non-VA care agreements are put in place with private practices throughout South Carolina and Charlotte, North Carolina.

- Two Nurse case managers and additional clerks added to coordinate care with community providers and ensure that Dorn providers are notified of pathology results for appropriate follow up.
- Five extra procedure days added to the current sharing agreement with MACH (capacity expanded to 120 VA procedures per month)
- The fourth GI room at Dorn is opened and put into operation and Saturday clinics continue.
- Physician staffing augmented with additional intermittent hours and one MD position at final stages of recruitment. Four Nurse Case Manager positions are filled, a new Fecal Occult Blood Test (FOBT) Coordinator position created and selection pending, three of four GI Tech positions filled, eight of nine RN positions filled, and two of three LPN positions filled. There is adequate staffing to run four rooms on a daily basis.
- Service agreement signed by Medicine and Primary Care to change screening protocol to Fecal Immunochemical Test (FIT) testing for low risk patients. Individual provider use of GI consults is monitored to ensure appropriate use.
- Consult tracking reporting mechanism under revision to ensure executive leadership is informed of timely management of all consults.

On August 13 - 16, the VHA Office of the Medical Inspector conducted a site visit and the GI program was reviewed. A final report has not been issued. On August 20 - 22, 2012, the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) deployed an expert team to assess the current GI backlog and help the facility develop action plans to eliminate the backlog, establish effective and inclusive processes to schedule and perform needed procedures, and review documentation to determine the need for clinical disclosure. A concurrent review is currently on-going by the DUSHOM clinical team to ensure that all GI patients dating back to 2006 have had a procedural consult if clinically indicated. The National Subject Matter Experts determined that any GI consult beyond 5 years old was no longer clinically relevant.

Virtually all known GI consults have been screened, risk stratified and delineated by the date of the consult (those placed prior to July 13, 2012 and those placed July 13 - August 31, 2012). Daily progress reports are being tracked by executive leadership, the VISN, and VACO.

Status as of September 3, 2012: (these numbers are subject to change)

Risk Category	Consult Placed Prior to July 13, 2012	Consult Placed July 13-August 31, 2012
High Risk Consults (Grp A)	1419*	188
Procedures completed	237	-
Procedure Scheduled at Dorn (by 9/30)	679	-
<i>Consult Sent for Non-VA Care Provider</i>	223	188
<i>Procedure Scheduled in Community</i>	43	-
<i>Pending Procedure in Community (vendor in process of scheduling)</i>	53	-
Intermediate Risk Consults (Grp B)	348	173
Procedure completed (as of 8/31)	150	-
Procedure scheduled	144	-
Low Risk Consults (Grp C)	166**	44**
Procedure Scheduled	25	-
FIT Tests Mailed**	To be determined	44
Lowest Risk Consults (Grp D&E)	889**	138
Procedure scheduled	303	-
FIT Tests Mailed**	To be determined	To be determined
Uncategorized Consults (Hepatology, Discontinued, Duplicates)	750	-
Total Consults	3572	543

*223 of the Grp A consults were clinically determined to no longer need procedure. Being verified by QM. 24 refused procedure and remaining are receiving certified letters due to incorrect contact information

**On July 31, 2012, clinical leadership in Primary Care agreed to change screening protocol to FIT testing. However, existing procedure appointments that were already in the pre-procedure exam window were not cancelled.

The DUSHOM and VISN have provided extensive support to find additional VA staff from across Veterans Health Administration (VHA) for an accelerated performance period from September 4 - 28, 2012. Currently, 1419 high risk patients who had

consults placed before July 13, 2012, have been identified for endoscopic procedures and have been contacted to schedule their procedure. With expanded internal capacity, negotiated Non VA Care, and additional MACH capability, Dorn has sufficient resources to complete procedures on all high risk patients by September 30, 2012. Moving forward, implementation of the FIT testing for low risk routine screenings and efficient use of internal and DOD facility capacity for completion of all examinations will assure timely completion of GI screenings and procedures.

Dorn VAMC clinical teams are conducting on-going reviews to determine if any Veteran experienced an adverse event due to delay of GI care. As Veterans in this category are identified, every effort is being made to contact the Veteran to deliver the needed care and if indicated provided adverse disclosure counseling and process is completed.

Point of Contact for more Information: Jill Dietrich, Acting Assistant Director, Dorn VAMC, (803) 695-7981 or Rebecca Wiley, Medical Center Director, Dorn VAMC, (803) 695-7980.

William Jennings Bryan Dorn VA Medical Center
GI Institutional Disclosures
Internal Fact Sheet
August 29, 2012

Summary:

In December 2011, the Dorn VAMC Medicine Service closed one of three operating GI procedural rooms due to sudden staff turnover and a shortage of the drug Versed. To reduce the scheduling impact of GI procedures, the Chief of Medicine proposed sending Veterans out to community providers on Non-VA Care. Upon review of pending GI consults for submission to Non-VA Care, the Chief of Gastroenterology determined that a significant number of open consults existed. This information was brought to Dorn VAMC leadership's attention in January 2012. The Dorn VAMC

Medical Center Director immediately established a GI Task Force to develop a remediation plan to identify systematic issues within GI.

While multiple actions were immediately taken to address the GI backlog and increase both case management capabilities and in-house capacity, a Veteran was identified to have experienced an adverse event due to a delay in GI care.

On May 15, 2012, a Veteran arrived at the William Jennings Bryan Dorn VA Medical Center (Dorn VAMC) Emergency Department with a primary complaint of throat soreness and difficulty swallowing. The Veteran was determined to have esophageal cancer. On October 25, 2011, the Veteran's Primary Care Physician placed a GI Consult for similar complaints, and an appointment was scheduled for April 21, 2012. On February 21, 2012, the Veteran's GI appointment was cancelled due to provider unavailability, and the Veteran was sent a cancellation letter. On May 4, 2012, the GI appointment was rescheduled for July 23, 2012.

After a thorough review of the Veteran's medical record, the Chief of Staff determined that an adverse event had occurred due to a delay in care. On June 13, 2012, an Institutional Disclosure was made to this Veteran. Dorn VAMC Leadership took immediate action to review the 2011 and 2012 Cancer Registries and Positive Pathology Reports for GI Malignancies to ascertain whether any additional adverse events had occurred due to a delay in diagnosis and treatment. After a careful retrospective case review, Quality Management staff recommended 26 cases for physician review. Of the 26 cases, the facility identified 10 additional cases for institutional disclosure, and the 16 remaining cases were forwarded for an external review to determine if an adverse event had occurred and whether Institutional Disclosures needed to be given.

As of August 29, 2012, Institutional Disclosures have been given to 10 of the 11 Veterans. It was discovered that the 11th Veteran died before an Institutional Disclosure could be given, and Quality Management staff is arranging a time with the Veteran's family members to complete the disclosure.

Statement:

Dorn VAMC is committed to communicating any adverse events that may have occurred due to a delay in GI Care. 11 cases have already been identified for Institutional Disclosure, 10 of which have been communicated to the Veterans. 16 cases still need a determination regarding adverse event status. The Dorn VAMC would anticipate that these reviews be finished by September 15, 2012. As of this date, clinical reviews are ongoing to determine how many Veterans have experienced an adverse event.

Dorn VAMC is also committed to ensuring that Veterans obtain timely diagnostic GI procedures, in addition to preventative screenings and surveillance. This includes providing an option of multiple GI screening tools, appropriate access to GI clinics and procedures, and timely diagnosis and treatment of GI malignancies.

Background:

In December 2011, Dorn VAMC Medicine Service closed one of three operating GI procedural rooms due to sudden staff turnover and a shortage of the drug Versed. To reduce the scheduling impact of GI procedures, the Chief of Medicine proposed sending Veterans out to community providers on Non-VA Care. Upon review of pending GI consults for submission to Non-VA Care, the Chief of Gastroenterology determined that a significant number of open consults existed. This information was brought to Leadership's attention in January 2012. The Dorn VAMC Medical Center Director

immediately established a GI Task Force to develop a remediation plan and to identify systematic issues within GI.

Response Taken:

Once the Dorn VAMC discovered that a significant amount of backlogged GI Consults existed, multiple actions were immediately taken to address the backlog and increase both case management capabilities and in-house capacity, including:

- In January -February, an internal capacity was increased by temporarily reassigning nursing support to re-open the closed GI procedure room.
- In March - April, a list of criteria was created to aid in stratifying the backlogged consults into assigned risk categories. Clinical leaders decided to manage high risk Veterans in-house, send out high-intermediate and intermediate risk Veterans to non-VA providers, and establish a wait list for low risk Veterans
- In May-June, six Mid-Level Providers and four Physicians were assigned to review consults to help expedite the stratification process in efforts to eliminate the existing backlog. Negotiated Agreements to accept Veterans on non-VA care were also made with a local community providers in Columbia and Augusta;
- In June, Clinical case management and administrative support were also increased to ensure that Veterans were scheduled timely and care was appropriately managed. Two Saturday endoscopy procedure clinics were opened to increase in-house capacity in June and August, one Saturday per month.
- In July, the consult risk stratification process was amended to ensure that each Veteran was receiving the appropriate follow-up care.

In July - August, Dorn VAMC leadership requested an external management review to assess the processes in the current GI program and to make recommendations for improvement. On August 6 – 7, an external management review was conducted by 1 Physician, 1 Nurse Practitioner, and 1 Registered Nurse from the Baltimore and Pittsburgh VA Medical Centers.

- In August, extra endoscopy procedure days were added in addition to the current sharing agreement in place with Moncrief Army Hospital (MACH) for Dorn providers to use MACH GI suites and support staff. The current agreement provides 120 VA endoscopy procedures per month. Capacity was also increased by operationalizing the fourth GI room at Dorn VAMC and creating additional negotiated agreements with community providers.
- In addition, a high priority scheduling center was established on site to manage the scheduling of backlogged patients and Primary Care providers were educated on the decision to transition to Fecal Immunochemical Test (FIT) testing for low risk patients during this accelerated performance period.
- Facility and VISN leadership, in consultation with Deputy Under Secretary for Health for Operations and Management (DUSHOM), requested support to detail a total of 20 staff from across the system to support an accelerated performance period from September 4-28, 2012.

- Ongoing reviews are being conducted to determine if any Veteran experienced an adverse effect due to a delay in care. As Veterans in this category are identified, every effort is made to contact the Veteran and deliver needed care.

Point of Contact for more Information: Jill Dietrich, Acting Assistant Director, Dorn VAMC, (803) 695-7981.

VHA Issue Brief

VISN 17 – VA North Texas Health Care System (Dallas, Texas)

Issue Title: Unresolved Consults

Date of Report: September 6, 2012

Brief Statement of Issue and Status: VA North Texas Health Care System (VANTHCS) recently learned the organization currently has in excess of 36,000 unresolved consults dating back nearly 10 years. VANTHCS leadership will aggressively address this backlog of unresolved consults and reduce the number to an acceptable level.

Actions, Progress, and Resolution Date: VANTHCS leadership conducted a thorough analysis of the unresolved consult data and determined several should be administratively closed due to reasons such as duplicate consults, Veteran is now deceased, Veteran has not actively received care at VANTHCS for several years, etc. The remaining unresolved consults will be addressed by conducting mandatory consult workgroup meetings with the respective services. The unresolved consult list at VANTHCS will be reduced to an acceptable level no later than September 30, 2012.

To ensure the VANTHCS unresolved consult list does not grow to an unacceptable level again, VANTHCS leadership will conduct consult package training for all current and on-boarding provider staff. In addition, a spreadsheet of all consult services by service will be developed and monitored to ensure that every consult package has the correct note title to close the consult appropriately in the future. Finally, every service will be required to run the consult results tracking (CRT) report on a weekly basis to ensure all consults are accounted for. These actions will be completed and implemented by September 30, 2012.

Update 9.14.2012

A deep dive into the status of all VISN 17 consults revealed that a backlog of unresolved consults over 121 days old also exists at VA Texas Valley Coastal Bend Health Care System (VATVCBHCS). Actions taken to reduce the backlog of unresolved consults over 121 days old at both VANTHCS and VATVCBHCS will be tracked to completion and periodically monitored to ensure sustainment.

VANTHCS Actions to date:

As of 9/14/12 North Texas has administratively closed over 13,000 duplicates/ inactive consults greater than 365. The consults will be scrubbed for appropriate note titles and a list of consults by service will be provided via shared file to all services. Consult training will be conducted on Monday September 17th for all services. The training will consist of how to clear unresolved consults, and how to run the CRT tracking report.

Number of Unresolved Consults (Pending, Active, Partial Results, and Scheduled)

	STATION	31-60 days	61-90 days	91-120 days	121-360 days	>360	Grand Total
9/14/2012	549	5683	3084	2486	11723	490	23466

VATVCBHCS Actions to date:

Beginning the week of September 17, 2012, VATVCBHCS will implement a coordinated action between administrative and clinical staff to review and resolve outstanding consults beginning with those over 360 days. The group will conduct regular "consult parties" to reduce the number unresolved consults. Facility leadership will regularly monitor the list of unresolved consults to ensure consults are adequately addressed. The Office of the Chief of Staff provides weekly report of all consults and sends to all leadership staff for appropriate action to complete the consult. The Consult Management Committee meets biweekly to address particular areas of concern and provides Senior Management with recommended solutions.

To reduce the fee consults a temporary employee has been hired. This employee will ensure reports are received and scanned in order to complete the consult. A "consult review team" has been approved by Senior Management. This team will review fee consults and reach out to patients to determine where and when they received their care. For consults in active status (cancelled or no-show), MAS Supervisors will provide list to providers for appropriate note to re-schedule or discontinue consult. Approval to allow non-providers keys to discontinue consults in specific cases, such as deceased patients, is under review by the Chief of Staff and the Clinical Executive Board.

Number of Unresolved Consults (Pending, Active, Partial Results, and Scheduled)

	STATION	31-60 days	61-90 days	91-120 days	121-360 days	>360	Grand Total
9/14/2012	740	3187	2263	2224	12094	10480	30248

Other Actions:

VISN 17 has implemented a daily report from the Corporate Data Warehouse (CDW) on unresolved consults for each VISN 17 facility. The report is drillable to the patient level to assist VISN 17 facility staff in appropriately resolving these consults.

Healthcare Inspection - Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas (Report No. 12-03594-10). You may view and download this report by clicking on the report title above.

Report Summary: The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding patient care delays at the VA North Texas Health Care System, Dallas, TX. A complainant alleged that a dialysis patient waited more than 4 months for permanent vascular access and that ambulatory monitoring for a cardiac patient was delayed 3 months. We substantiated that these and other patients experienced excessive wait times. For 5 recent referrals for vascular access, the time from referral to completion of a procedure was 89–138 days. For 213 patients scheduled for ambulatory cardiac monitoring, the average wait time was 68 days. We also found that clinicians did not review referral requests, consultation reports were not linked to requests in the electronic health record as required, and that appointment dates requested by patients for vascular and cardiac procedures were incorrectly recorded by scheduling staff. We recommended that the Facility Director ensure that patients receive timely vascular and cardiac care, that providers document review of consults in the electronic health record and link results to consult requests and that staff comply with VHA policy for scheduling outpatient appointments.

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Response Taken:

- A deliberate and methodical approach was developed to reconcile the consults. The methodology developed focuses on patient safety. The methodology developed was reviewed and approved by the Executive Council of the Medical Staff.
- After a thorough analysis of the consult data, some consults were administratively closed due to reasons such as duplicate consults, Veteran is now deceased or Veteran has not actively received care at VANTHCS for several years. This action decreased consult delays to 23,466 as of September 14, 2012.
- The remaining consults were addressed by conducting mandatory consult workgroup meetings with the respective services. Staff experts in consult processes provided hands-on assistance in complex cases. As of October 5, 2012, the delay in consult list at VANTHCS is 17,450.

**Department of
Veterans Affairs**

Memorandum

Date: October 17, 2012

From: Chief Officer, Public Health
for the Clinical Review Board (CRB)

Subj: Physical examination and determination of adverse events—VA Maine HCS
(Podiatry)

To: Principal Deputy Under Secretary for Health (10A)

1. Background

Clinical care provided by a former Maine VA HCS podiatrist was reviewed beginning in January 2010 for the possibility of poor surgical outcomes and performing surgical interventions following minimal evaluation. A site visit conducted by a multidisciplinary team and a secondary medical record review of surgical cases completed in August 2012 resulted in the conclusion that standard of care was not always followed and probable or actual harm had occurred in some cases. The Acting Assistant Deputy Under Secretary for Operations and Management for Clinical Operations for Health convened a subject matter expert (SME) panel on several occasions between August 30 and October 2, 2012. The SME panel recommended that 286 Veterans who received clinical care from the podiatrist be referred for additional clinical examination. This CRB met to determine the scope and requirements of the physical examination and determination of adverse event.

2. Recommendation

The CRB met on October 10, 2012. The VA Maine HCS director reviewed the chronology of events. The Director of Podiatry, Office of Patient Care Services, explained the secondary medical record reviews of cases that resulted in findings of less than standard level of care and at least a potential¹ of harm for 286 Veterans.

The CRB agreed without a vote that those cases determined by medical record review to have had 'no harm' required neither disclosure nor physical examination. In addition, the CRB by unanimous vote (with 2 members temporarily absent from

¹ The CRB agreed that *potential* and *possible* are synonymous terms with regard to these discussions, as both terms are used in background documentation.

the session) agreed that cases where harm was clearly determined to be 'actual' would have institutional disclosure and an offer of physical examination.

The CRB discussed the differences between categories referred to us as "potential harm" (124 surgical cases, 9 outpatient care) or "probable/actual harm" (127 surgical cases, 1 outpatient care). In addition, 25 cases of outpatient care for foot wounds and ulcers were referred by the SME panel as needing further examination, for a total of 286. The CRB questioned whether probable/actual adverse events could be distinguished into two separate categories of actual and probable harm. It was explained that the medical record reviewers at times had difficulty distinguishing potential vs. probable vs. actual harm because of poor documentation. For example, on the assumption that unnecessary surgery is always 'a harm', that 'good' surgery can result in poor outcomes, and that 'bad' or unnecessary surgery might result in good or bad outcomes, if the medical records did not clearly describe the podiatrist's decision to perform surgery or the clinical course following surgery, the reviewers had to judge in which category the case belonged. The CRB discussed whether additional medical record review would be helpful and agreed without a vote that such review would not be likely to supplement the reported findings of the SME panel. However, the CRB did agree that a panel of experts in podiatric care should be convened to review the medical records of the 25 cases of outpatient foot or wound care, so that this review comports with the two-stage review (by the facility and by a panel of experts) conducted on the remainder of the patients and that any of the 286 Veterans who sustained actual harm be identified and referred for immediate institutional disclosure.

Following this discussion, the CRB voted unanimously that large scale disclosure should be offered to all Veterans whose cases are determined to be in the potential and probable/actual harm categories and that the disclosure should offer the Veterans the opportunity to return for follow-up examination. One CRB member was temporarily absent from the session during this vote, and one member stated that providers conducting these follow-up examinations should be educated as to the content of the examination.

The CRB discussed and agreed that four Veterans who had already filed tort claims concerning their care provided by this podiatrist should receive a disclosure and offer of examination if their cases were categorized as having 'potential' or 'probable/actual' harm.

On the question of the scope of the follow-up examination, the CRB voted unanimously that those Veterans that receive a large scale disclosure would be offered an examination to include history, assessment of range-of-motion and functional capability, and plan of future podiatric care (akin to a '2nd opinion'). The CRB opined that these could not be medical legal examinations, which would place undue responsibility on these clinicians.

3. Summary

In summary, the CRB determined that:

- Veterans categorized as having potential or probable/actual harm receive large-scale disclosure and be offered in-person examination and a plan of future podiatric care.
- A panel of podiatric experts be convened to review the medical records of the 25 patients who received outpatient foot and wound care for determination of level of harm.
- If, among either of these groups, there are Veterans judged either on the basis of the medical record review or on the basis of the subsequent examination to have suffered actual harm—significant or permanent disability or death—these Veterans (or their next of kin) should also receive an institutional disclosure.

All CRB members have had an opportunity to review and comment on these recommendations.

Respectfully submitted,

From: Schiffner, Susan
To: VHA 10B
Cc: Schiffner, Susan; Jesse, Robert, MD, PhD (SES EQV); VHA CO 10NC Action
Sent: Mon Jun 11 16:14:04 2012
Subject: Togus Fact Sheet and Report

FYI- Dr. Jesse received a briefing on the attached report from 10NC and Quality today. An Action Plan will be developed in collaboration with the VISN for review in CO.

Fact Sheet is cleared by 10A.

Susan

Susan Schiffner

Clinical Executive

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Attachments:

Site Visit Report - VA Maine HCS (May 15-16 2012) FINAL 6 11 12.docx (68984 Bytes)

Togus Fact Sheet FINAL 6.11.12.docx (23880 Bytes)
Cover Memo - VA Maine HCS Site Visit Report (June 2012)).pdf (256368 Bytes)
Image003.jpg (3451 Bytes)