Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Administrative Review Issues VA Nebraska Western Iowa Health Care System Omaha, Nebraska

Report No. 07-03010-53 January 7, 2008

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

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Executive Summary

The purpose of the review was to determine the validity of allegations that part-time physicians were not working required hours, and that providers were not responding to consults in a timely manner at the Omaha Division of the Nebraska Western Iowa Health Care System (the system). On August 8, 2007, the OHI Hotline Division received allegations that part-time physicians at the Omaha Division were not working required hours and that no one was monitoring their attendance. The complainant further alleged that consults were significantly backlogged, some over a year old, with no process in place to assure timeliness.

We did not substantiate the allegation that part-time physicians were not working their required hours, and the system did not monitor their time and attendance. We determined that physicians were compliant with part-time attendance rules and regulations and were working according to their schedules. The system has an adequate process in place to monitor part-time physician time and attendance and local policy and procedures are compliant with Veterans Health Administration (VHA) mandates.

We did not substantiate a significant backlog of consults or consults that physicians had not responded to in over a year. The system has appropriate processes in place to track timeliness of consults and documents action taken when delays occur.

Because we did not substantiate any allegations, we made no recommendations.

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

TO: Director, Veterans Integrated Service Network (10N23)

SUBJECT: Healthcare Inspection – Alleged Administrative Review Issues, VA Nebraska Western Iowa Health Care System, Omaha, Nebraska

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections, conducted an evaluation to determine the validity of allegations that part-time physicians were not working required hours, and that providers were not responding to consults in a timely manner at the Omaha Division of the Nebraska Western Iowa Health Care System (the system).

Background

The system includes two divisions located in Omaha and Grand Island, NE, and is part of Veterans Integrated Service Network (VISN) 23. The Omaha VA Medical Center is a tertiary care facility that provides primary and specialized outpatient health care and acute inpatient medical, surgical, and psychiatric care. The system has a large outpatient facility located in Lincoln, NE, and community based outpatient clinics (CBOCs) in Norfolk and North Platte, NE. The system provides services to a veteran population of approximately 172,500.

The system is affiliated with University of Nebraska and Creighton University Colleges of Medicine, with residents rotating through programs in medicine and surgery. The system maintains a major clinical research facility on site. In addition to providing inpatient care at the system, physicians often have responsibilities at multiple sites.

On August 8, 2007, the OHI Hotline Division received allegations that part-time physicians at the Omaha Division were not working required hours and that no one was monitoring their attendance. The complainant further alleged that consults were significantly backlogged, some over a year old, with no process in place to assure timeliness.

Scope and Methodology

We reviewed the allegations during the system's Combined Assessment Program visit from August 6–10, 2007. We interviewed managers responsible for monitoring attendance of part-time physicians, and interviewed staff responsible for consults, appointments, and the electronic wait list. We reviewed the system's performance measurement scores for clinic access, data on wait times, and relevant system policies and procedures. We conducted the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Part-Time Physician Time and Attendance

We did not substantiate the allegation that part-time physicians were not working their required hours, and the system did not monitor their time and attendance.

During any given pay period, physicians have core and non-core hours. Core hours are fixed times when the physician must be present, unless granted approved leave. Non-core hours are those times when the physician has the ability to request changes to the hours worked, based on demands for their time. These work hours are coordinated with VA patient care requirements.

The administrative officer (AO) for the Chief of Staff is the person responsible for monitoring the time and attendance of physicians. We interviewed the AO and learned the system utilizes a computer generated randomization process to select the part-time physicians who will be monitored each month and the method of monitoring. There are two methods used for monitoring. One is a physical review where the AO actually observes the presence of the physician in the scheduled work area. If the physician is scheduled to work at one of the remote facilities or CBOCs, the AO assigns this duty to another administrative staff member at that location. The second method is an electronic verification where the AO accesses the computer system to determine if the physician has logged on for the date assigned to work. Since physicians document patient care in the computerized patient record system, the physician would be required to log on to the computer to document the care or oversight of care.

Once the monthly list is generated, the AO prepares a spreadsheet with each physician's name, audit method, specialty, and days scheduled to work. The AO utilizes this spreadsheet to document the date of audit and audit findings.

If the physician is not located physically or electronically, the AO notes this on the spreadsheet and contacts the service chief supervising the part-time physician. Occasionally, an error in scheduling occurs. An example would be a physician who has applied for and been granted leave but the schedule was not corrected. In these instances,

the service chief provides the documentation supporting the circumstances and the AO notes this in the monthly report.

Notations in the monthly report also indicate actions taken with non-compliant physicians. Of the 76 physicians reviewed in April 2007, one was non-compliant with local policy for part-time physician time and attendance. The physician was not on duty, did not claim hours on the timecard, and was not paid for time, but did not request leave until after the audit date. Local policy requires leave be requested and approved in advance of scheduled duty times. The AO notified the service chief and noted the feedback and actions taken.

We reviewed 10 months of part-time physician time and attendance monitoring reports with the following findings:

Month	Total Part-Time Physicians	Physical Review	Electronic Review	Number Failed
Oct-06	65	40	25	0
Nov-06	71	37	34	0
Dec-06	73	42	26	0
Jan-07	73	39	32	0
Feb-07	73	49	22	0
Mar-07	73	41	28	0
Apr-07	76	43	32	1
May-07	77	42	34	1
Jun-07	74	39	30	1
Jul-07	72	36	36	0
Total Reviews	**727**	**408**	**299**	**3**

Managers monitored system part-time physicians every month during the 10 months prior to our review by either physical observation (56 percent of reviews) or by electronic review of medical records (41 percent of reviews). These reviews included physicians on core hours and non-core hours. We noted three failures during the 10 months of reviews, with each failure reported to the Chief of Staff and service chief for follow-up actions. Each of these was a failure of managers to update the schedule to reflect leave.

On August 9, 2007, we obtained a list of part-time physicians scheduled to be on duty. We selected a random sample of six physicians from medicine and mental health for physical verification of attendance during core hours. We verified that all six were present and working in their assigned patient care areas.

We determined that physicians were compliant with part-time attendance rules and regulations and were working according to their schedules. The system has an adequate

process in place to monitor part-time physician time and attendance and local policy and procedures are compliant with VHA mandates.

Issue 2: Timeliness of Consult Responses

We did not substantiate a significant backlog of consults or consults that physicians had not responded to in over a year.

VHA policy requires patients who are: (a) service connected for the condition generating the consult, (b) service connected for 50 percent or greater, or (c) veterans of Operation Iraq Freedom or Operation Enduring Freedom, be given appointments within 30 days. All other veterans are to be given an appointment within 120 days. Those that cannot be given appointments according to these timeframes are placed on an electronic waitlist and clinic staff monitor the list daily for opportunities to remove from the waitlist.

There are approximately 4,900 consults generated each month within the system. In order to manage the large volume of consults, there are designated staff in each specialty area that are responsible for tracking consults in their assigned area.

We interviewed staff responsible for this tracking in medicine, surgery, and mental health services. We found evidence that staff tracked consults daily. An electronic order generates the consult, which is then automatically printed on a designated printer in each specialty area. The assigned consult staff pulls the printed requests each day. Clinic managers take actions daily to schedule an appointment, send the consult to a clinician for review, or add the patient's name to the electronic waitlist, as required by local policy. Clinic staff note these actions in the electronic consult package. Reports from the electronic consult package display the number of consults that are pending, active, scheduled, and incomplete. This enables service staff to monitor and track consult workload.

The service staff submits monthly reports to the Chief of Staff for review. The system also sends reports every 3 months to the VISN, where specific action plans are required for those patients that exceed timeframes defined in VHA policy.

In addition to interviewing staff responsible for tracking consults, we reviewed the report submitted to the VISN for July 2007. Although the system appeared to have management controls in place to monitor and reduce the risk of consult delays, we noted that the system had identified timeliness issues with access to sleep studies. The system has a two-bed sleep study laboratory and is in the process of expanding to four beds. The system was contracting as many sleep studies to the private sector as possible, but availability was limited. The system now refers consults as far away as the Grand Island Division. VISN staff is aware of the system's delays in obtaining sleep studies.

The system provided us with electronic consult reports from which we randomly selected consults from February, March, and April 2007 for Urology, Mental Health, and

Hematology to review for timeliness. We noted the veteran's eligibility status to apply the timeframes outlined in VHA directives. We reviewed 11 percent of consults generated and determined that all met VHA requirements.

We also reviewed the system VHA performance measure data for clinic wait times and found the percentage of patients seen in 30 days of desired date for specialty care ranged from 91–93 percent during fiscal year 2007.

Conclusion

We did not substantiate the allegations that part-time physicians were not working required hours and that the system was not monitoring their time and attendance. The system complies with VHA policy for monitoring part-time physician time and attendance, and reviews indicate physicians are adhering to their schedules.

We did not substantiate the allegation that consults were significantly backlogged. The system has appropriate processes in place to track timeliness of consults and documents action taken when delays occur.

Because we did not substantiate any allegations, we made no recommendations.

Comments

The VISN and Health Care System Directors agreed with the findings (see Appendixes A and B, pages 6–7 for the full text of their comments).

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 15, 2007

From: Director, Veterans Integrated Service Network (10N23)

Subject: **Alleged Administrative Review Issues, VA Nebraska Western Iowa Health Care System, Omaha, NE**

To: Director, Kansas City Office of Healthcare Inspections (54KC)

Director, Management Review Office (10B5)

I have reviewed and concur with the System Director's comment.

ROBERT A. PETZEL, M.D.

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 15, 2007

From: Director, VA Nebraska Western Iowa Health Care System (636/00)

Subject: Alleged Administrative Review Issues, VA Nebraska Western Iowa Health Care System, Omaha, NE

To: Director, Veterans Integrated Service Network (10N23)

We have no comments on the report.

AL WASHKO

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, Director Kansas City Regional Office of Healthcare Inspections (816) 426-2016
Acknowledgments	Jennifer Kubiak, Project Manager Dorothy Duncan, Associate Director Marilyn Stones, Program Support Assistant

Appendix D

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