Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Colonoscopy Management
El Paso VA Health Care System
El Paso, Texas

Report No. 08-00437-135

June 3, 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 VA Office of Inspector General, Office of Healthcare Inspections reviewed allegations regarding follow up of colonoscopy results at the El Paso VA Health Care System (the system), El Paso, TX. The complainant alleged that colonoscopy results are not appropriately followed by primary care providers and that patients may be at risk. The complainant also alleged that patients with abnormal pathology results are not consistently referred for specialty care and that scheduling of referrals is often delayed.

We did not substantiate that patients were adversely affected by inadequate follow up of colonoscopies nor that follow-up care was delayed. However, we identified one patient whose diagnosis may have been delayed due to inadequate follow up of rectal bleeding. Although we did not substantiate delays in scheduling specialty referrals after colonoscopy, we found that there was an inefficient process for dealing with consults generally. System leaders described measures they are taking to alleviate these problems.

We recommended the system implement processes for consistent follow up of pathology reports after endoscopic procedures. We also recommended the system implement measures to ensure that appointments with consultants are scheduled without undue delay. Finally, we recommended the system review the cited case of delayed diagnosis with Regional Counsel to determine the appropriateness of patient or family notification.

The Veterans Integrated Service Network and System Directors agreed with our findings and recommendations and submitted appropriate action plans. We will follow up on proposed actions until they are completed.

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

TO: Director, Veterans Integrated Service Network (10N18)

SUBJECT: Healthcare Inspection – Colonoscopy Management, El Paso VA Health Care System, El Paso, Texas

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding follow-up of colonoscopy results at the El Paso VA Health Care System (the system), El Paso, TX.

Background

The complainant alleged that colonoscopy results are not appropriately followed by primary care providers and that patients may be at risk. The complainant also alleged that patients with abnormal pathology results are not consistently referred for specialty care and that scheduling of referrals is often delayed.

The system provides primary and specialty ambulatory care services to veterans in El Paso and surrounding counties. Additional services are provided by VA consultants, fee-basis specialists, and through an agreement with the William Beaumont Army Medical Center (WBAMC).

Scope and Methodology

We interviewed the complainant and obtained pertinent documents prior to our site visit on January 22–25, 2008. We reviewed patient referrals, medical records, policies, and other documents related to colonoscopy follow-up. During our site visit, we observed processes and interviewed staff.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Inadequate Follow-Up Care after Colonoscopy

We did not substantiate that patients had inadequate follow-up care.

We reviewed the medical records of the seven patients the complainant alleged may have been adversely affected because they did not have appropriate follow-up care after undergoing colonoscopies in 2007. Six of the seven colonoscopy studies revealed no abnormal pathology. The seventh patient was diagnosed with localized colon cancer and promptly referred for specialty care.

Issue 2: Response to Pathology Reports

We were unable to substantiate or refute that patients with abnormal pathology reports are not referred for follow-up care.

The complainant gave us names of an additional six patients who had abnormal pathology reports requiring follow-up. We reviewed the six medical records and found that five of the six patients had appropriate follow-up care. One patient was advised to have follow-up colonoscopy in 6-12 months, but the last documentation of VA care for this patient was 3 weeks after the procedure, 15 months prior to our site visit.

We met with the system's leadership and discussed reports of confusion about who is responsible for checking pathology reports and ensuring follow-up when indicated. System leaders acknowledged that improvements were needed and stated that they would develop and implement a plan to clarify roles and responsibilities related to follow-up of colonoscopies.

Issue 3: Delays in Scheduling

We did not substantiate delays in scheduling specialty referrals after colonoscopy.

At the time of our site visit, the system had six pending consults pertaining to colonoscopy follow-up.[1] Information received after our visit indicated that five of the six consults were scheduled appropriately. The sixth patient chose to seek care elsewhere.

In addition, we found during our site visit that the system had a backlog of over 5,000 consults across all clinical disciplines. Delays were attributed to requests being returned to the ordering providers because of inadequate documentation, inappropriate reasons for referral, and duplicate submissions.

[1] The six patients with pending consults were not the same six patients discussed in Issue 2: Response to Pathology Reports.

Consultant services are scheduled for appointments within the system, with fee-basis providers in the community, or with WBAMC specialists. Referrals to WBAMC have a 30-day window for scheduling; consults not scheduled within 30 days are automatically cancelled without notification of the system. System staff is expected to ascertain the disposition of WBAMC consults and arrange for fee basis services.

We discussed the problem of consult scheduling with the system's leadership. System leaders described measures being taken to alleviate backlogs.

Issue 4: Delays in Diagnosis

During our inspection, we identified one patient whose diagnosis may have been delayed due to inappropriate follow-up. This patient presented with rectal bleeding in 2004. At colonoscopy in 2007, he was found to have localized colon cancer. Chemotherapy was administered and the patient underwent colon resection.

Conclusions

We did not substantiate that patients were adversely affected by inadequate follow-up of colonoscopies nor that follow-up care was delayed. However, we identified one patient whose diagnosis may have been delayed due to inadequate follow up of rectal bleeding.

The system acknowledged that it lacks an effective process for ensuring an appropriate response to colonoscopy results and that scheduling of consults is often delayed. System leaders described measures they are taking to alleviate these problems.

Recommendations

Recommendation 1. We recommended that the VISN Director ensures that the System Director implements processes for consistent follow-up of pathology reports after endoscopic procedures.

The VISN and System Directors concurred with our finding and recommendation. The facility is currently in the process of hiring a Nurse Manager to do oversight and case management for colonoscopy and other cancer related programs. In the meantime, a Registered Nurse has been temporarily assigned to these duties. We find this action plan appropriate and will follow up on planned actions until they are completed.

Recommendation 2. We recommended that the VISN Director ensure that the System Director implements measures to ensure that appointments with consultants are scheduled without undue delay.

The VISN and System Directors concurred with our finding and recommendation. Follow-up colonoscopies are now scheduled by the colonoscopists without further

referral by Primary Care. A set of standing orders for required surgery and oncology consults, treatments, and clinical visits is being developed to eliminate the need for additional orders. A fee basis referral program has been initiated for consults that cannot be scheduled at the system within 30 days and the system is recruiting another colonoscopist. We find these action plans appropriate and will follow up until they are completed.

Recommendation 3. We recommended the VISN Director ensure that the System Director reviews the cited case of delayed diagnosis with Regional Counsel to determine the appropriateness of patient or family notification.

The VISN and System Directors concurred with our finding and recommendation. The system has referred this case to the Regional Counsel and anticipate the completion of any required notification by June 30, 2008. We find this action plan appropriate and will follow up on planned actions until they are completed.

Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 5–9, for the full text of comments.) We will follow up on all planned actions until they are completed.

(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: May 8, 2008

From: Network Director, VISN 18 (10N18)

Subject: **Healthcare Inspection – Colonoscopy Management, El Paso VA Health Care System, El Paso, Texas**

To: Director, Dallas Healthcare Inspections Division (54DA)

Director, Management Review Office (10B5)

I concur with the attached facility draft responses to the recommendations for improvement contained in the Healthcare Inspection – Colonoscopy Management review at the El Paso VA Health Care System. If you have any questions or concerns, please contact Joan Funckes, Executive Assistant to the Network Director, VISN 18, at 602-222-2699.

Susan P. Bowers

VISN Director's Comments to Office of Inspector General's Report

The following VISN Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the VISN Director ensure that the System Director implements processes for consistent follow up of pathology reports after endoscopic procedures.

Concur **Target Completion Date:** July 31, 2008

Recommendation 2. We recommended that the VISN Director ensure that the System Director implements measures to ensure that appointments with consultants are scheduled without undue delay.

Concur **Target Completion Date:** July 31, 2008

Recommendation 3. We recommended the VISN Director ensure that the System Director reviews the cited case of delayed diagnosis with Regional Counsel to determine the appropriateness of patient or family notification.

Concur **Target Completion Date:** June 30, 2008

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 7, 2008

From: Director, El Paso VA Health Care System (756/00)

Subject: **Healthcare Inspection – Colonoscopy Management, El Paso VA Health Care System, El Paso, Texas**

To: Director, Veterans Integrated Service Network (10N18)

My staff and I have reviewed the draft Healthcare Inspection – Colonoscopy Management, El Paso VA Health Care System and have attached our comments in the template provided by the OIG.

Should you have any questions concerning our response, please contact me at (915) 564-7901.

Bruce E. Stewart

System Director's Comments to Office of Inspector General's Report

The following System Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the System Director implements processes for consistent follow up of pathology reports after endoscopic procedures.

Concur **Target Completion Date:** July 31, 2008

Corrective Actions: We have temporarily assigned an RN from the Ambulatory Surgery Unit to assist the Colonoscopists and the Oncology Physician to closely monitor pathology reports for colonoscopy patients. The RN, the Oncologist and the Colonoscopists review all pathology reports each month. The RN notes the number of reports received and the number reviewed. This facility is currently in the process of hiring a Nurse Manager to perform oversight and case management for colonoscopy and other cancer related programs. We estimate the new position will be filled by July 31, 2008.

Recommendation 2. We recommend that the VISN Director ensure that the System Director implements measures to ensure that appointments with consultants are scheduled without undue delay.

Concur **Target Completion Date:** July 31, 2008

Corrective Actions:

1) Follow up colonoscopy is now scheduled by the Colonoscopists without additional referral by Primary Care. Follow up is defined as any patient requiring additional testing within 3 to 6 months. **Complete**

2) A consult bundle will be developed for Oncology & Surgical consults. A bundle is a group of known required consults, treatments, and clinical visits rolled into one consult to eliminate the need for multiple returns to the Primary Care Provider for additional orders. We expect this to be completed by **June 1, 2008**.

3) The facility has initiated a Fee Base referral program for all appropriate consults that cannot be scheduled at our facility within 30 days. **Complete**

4) Colonoscopists are reviewing pathology reports and submit all appropriate consults in accordance with treatment plans. **Complete**

5) The Colonoscopists, Chief of Surgical Service and the Ambulatory Surgery Unit Nurse Manager are increasing the number of procedures performed at our facility. The facility is in the early stages of recruiting another Colonoscopist and the required support staff. Additionally, the Chief of Surgical Service is negotiating with our part-time Colonoscopist to convert him to full-time. We anticipate resolution by **July 31, 2008**.

Recommendation 3. We recommend the VISN Director ensure that the System Director reviews the cited case of delayed diagnosis with Regional Counsel to determine the appropriateness of patient or family notification.

Concur **Target Completion Date:** June 30, 2008

Corrective Actions: The facility has referred this case to the Regional Counsel to determine the appropriateness of patient or family notification. All available information has been forwarded to the Regional Counsel. We anticipate a response soon and anticipate the completion of any required notification by **June 30, 2008**.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Wilma Reyes, Healthcare Inspector Dallas Office of Healthcare Inspections (214)253-3334
Acknowledgments	Marilyn Walls, Healthcare Inspector Jerome Herbers, M.D., Medical Consultant

Appendix D

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