



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-04473-132

Healthcare Inspection

Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies Captain James A. Lovell Federal Health Care Center North Chicago, Illinois

March 3, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoiqhotline@va.gov

Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations of mismanagement of gastroenterology (GI) services and other quality of care deficiencies at the Captain James A. Lovell Federal Health Care Center (facility), North Chicago, IL.

We received multiple allegations of “turmoil and chaos” at the facility related to a recent reorganization of senior leadership. We focused on prioritization of GI services, alleged quality of care deficiencies, requests for unnecessary GI procedures, and the lack of coordination of non-VA GI care.

We substantiated the allegations that facility gastroenterologists had been directed by facility leaders to prioritize care in favor of active duty service members and that scheduled GI procedures were limited to four per day. However, we found that the facility leaders’ decision to prioritize care in favor of service members was made in accordance with a 2010 Department of Defense/VA Executive Agreement that outlines terms of operation for the facility and that veterans were receiving care when necessary through the Non-VA Medical Care Program. We also found that the facility had plans to increase its capacity for GI procedures in early 2015.

We substantiated a significant lapse in the management of a patient’s low blood sugar. However, we found the facility had appropriately addressed the issue.

We did not substantiate the allegations that an increase in falls, pressure ulcers, urinary tract infections, elopements, diversions, and wrong site procedures occurred as a result of senior leaders’ mismanagement after a reorganization in spring 2014 or that facility leaders requested that GI staff perform unnecessary procedures. We also did not substantiate that the facility lacked a process for coordinating non-VA GI care. However, we did find inconsistencies in the posting of non-VA GI procedure results into the VA electronic health record.

We recommended that the Facility Director ensure that documentation of procedure results from non-VA GI care providers is obtained and available in the electronic health record for review in a timely and consistent manner.

The Veterans Integrated Service Network and Facility Directors concurred with our findings and recommendation and provided an acceptable improvement plan. (See Appendixes A and B, pages 11–13, for the Directors’ comments.) We will follow up on the planned action until completed.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations regarding alleged mismanagement of gastroenterology (GI) services and other quality of care deficiencies at the Captain James A. Lovell Federal Health Care Center (facility), North Chicago, IL.

Background

The facility was chartered as a 5-year Demonstration Project on October 1, 2010, after the Department of Defense (DoD) and VA agreed to merge the North Chicago VA Medical Center and Naval Health Clinic Great Lakes, resulting in a fully integrated Federal Health Care Center. The facility operates under a single authority to provide care to active duty service members, veterans, and dependents (military families, including spouses and children). The Executive Agreement (EA), which outlines the terms of the integration, identifies the VA as the lead partner, with accountability for overall operation of the facility, and specifies that a VA Senior Executive Service appointee will serve as Director.¹ The EA further states that a Department of the Navy Captain will serve as the Deputy Director, responsible for daily operations. By law, an evaluation of the Project must be submitted to Congress 180 days after the end of the 5-year period.²

The facility is part of Veterans Integrated Service Network (VISN) 12, Great Lakes Health Care System, and provides comprehensive acute medical inpatient and outpatient care to more than 75,000 active duty service members, their families, and veterans, as well as more than 44,000 Navy recruits per year. The facility operates 88 hospital beds, 154 community living center (CLC) beds, and 143 residential rehabilitation beds. It also provides outpatient care at community based outpatient clinics in Evanston and McHenry, IL and Kenosha, WI; a Vet Center in Evanston, IL; four Navy recruit/DoD clinics on campus; and occupational health services at five Occupational Health Medicine Department branch offices.³

The facility is affiliated with the Rosalind Franklin University School of Medicine and Science, the Chicago Medical School, and the University of Illinois at Chicago. It also

¹ DoD/VA. 2010. Executive Agreement for the Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Project Federal Health Care Center.

[http://www.tricare.mil/tma/congressionalinformation/downloads/2010310/111-288%20Section%201701\(d\)\(1\)%20FHCC%20EA.pdf](http://www.tricare.mil/tma/congressionalinformation/downloads/2010310/111-288%20Section%201701(d)(1)%20FHCC%20EA.pdf). Accessed October 11, 2014.

² The facility has contracted with Knowesis, an analytics and information management company, to conduct the evaluation. See <http://www.knowesis-inc.com/analytics>, accessed October 13, 2014.

³ Captain James A. Lovell Federal Health Care Center Trip Pack. June 2014. The Navy recruit clinics include: USS Red Rover, Osborne and Tranquility; the Fisher Branch Health Clinic provides services to DoD and Department of Homeland Security personnel in a 16-state area; the five Occupational Health Medicine Department offices provide a variety of services (for example, pre-employment physicals and fitness for duty evaluations) as well as surveillance and monitoring of occupational risks and operational readiness.

offers training for students in a variety of other disciplines, such as biomedical engineering, pharmacy, nursing, and social work.⁴

In April 2014, OIG received multiple allegations of quality of care deficiencies at the facility. Many of the problems were attributed to a reorganization of leadership positions that reportedly favored Navy personnel over VA personnel. We referred the allegations to VISN leaders and found their response to be adequate.

Over the next several months, we received allegations of abuse of power, harassment of GI staff by facility leaders, turmoil, fraud, waste, and abuse related to a recent increase in the number of executive level positions and additional alleged quality of care deficiencies. Specific allegations included:

- Facility leaders directed GI staff to prioritize patients for procedures without considering the severity of the patients' conditions.
- Due to facility leaders' mismanagement, only four patients could be scheduled for GI procedures per day at the facility.
- The lack of GI resources resulted in referrals of veteran patients to non-VA providers, causing dissatisfaction.
- The care of a CLC patient and a mental health patient was mismanaged.
- An increase in the number of falls, pressure ulcers, urinary tract infections, elopements, diversions related to intensive care unit (ICU) and emergency department (ED) problems, and wrong-site procedures occurred because of mismanagement by senior leaders after a recent reorganization.
- Facility leaders requested that GI staff perform unnecessary procedures.
- The facility lacked a process to coordinate non-VA GI care.

We categorized the list of specific allegations as follows: (1) mismanagement of GI services, (2) quality of care deficiencies, (3) requests for unnecessary GI procedures, and (4) the lack of a process to coordinate non-VA GI care.⁵

Scope and Methodology

We conducted a site visit August 19–20, 2014. We interviewed the Acting Director, the Acting Deputy Director, the Acting Associate Director for Medical Practice/Chief Medical Executive, the Associate Director for Nursing Practice/VHA Nurse Executive, the Acting

⁴ Captain James A. Lovell Federal Health Care Center Trip Pack. June 2014.

⁵ VHA Directive 1601. *Non-VA Medical Care Program*. January 23, 2013. Formerly known as Fee Basis care, Non-VA Medical Care is authorized at non-VA facilities when VA care is not available, in accordance with Title 38 Code of Federal Regulations (CFR) § 17.53.

Associate Director for Specialty Care, facility gastroenterologists, GI department staff, the Associate Chief Nurse of Surgical Services, and the facility's Non-VA Medical Care coordinator.

We reviewed the 2010 EA signed by the Secretaries of the Navy, Defense, and Veterans Affairs, which outlines the terms of operation for the facility; relevant Veterans Health Administration (VHA) and local policies;⁶ facility organizational charts; and facility data on falls, pressure ulcers, urinary tract infections, elopements, diversions, wrong site procedures, and patient referrals to Non-VA Medical Care for GI procedures. We also reviewed the electronic health records (EHRs) of the CLC patient and the mental health patient identified as receiving mismanaged care and the two patients who allegedly underwent unnecessary GI procedures.

We randomly selected 20 of the 79 veteran patients who received GI care outside the facility during the last quarter of fiscal year (FY) 2014 and reviewed their EHRs for documentation of procedure results. We also reviewed emails between facility staff regarding GI patients/issues and relevant articles and reports discussing the Demonstration Project.⁷

We referred allegations of fraud, waste, and abuse to appropriate external and internal agencies. We did not address allegations for which we did not receive specific information of patient harm or threats to patient safety and those we considered adequately addressed after our review of the VISN responses regarding the same or similar allegations.

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

⁶ VHA Directive 2010, 040, *Health Care Resources Sharing with the Department of Defense*, September 16, 2010; VHA Handbook 1660.04, *VA-DOD Direct Sharing Agreements*, October 2, 2008; VHA Directive 1601 *Non-VA Medical Care Program*, January 23, 2013.

⁷ IOM (Institute of Medicine). 2012. *Evaluation of the Lovell Federal Health Care Center Merger: Findings, Conclusions, and Recommendations*. Washington, DC: The National Academies Press; GAO (Government Accountability Office). June 2012. *VA/DOD Federal Health Care Center. Costly Information Technology Delays Continue and Evaluation Plan Lacking*.

Inspection Results

Issue 1: Alleged Mismanagement of GI Services

We substantiated the allegation that facility gastroenterologists had been directed by facility leaders to prioritize care in favor of active service members and that scheduled GI procedures were limited to four per day. However, we found that the facility leaders' decision to prioritize care in favor of service members was made in accordance with the EA, veterans were receiving care when necessary through the Non-VA Medical Care program, and plans to increase capacity for GI procedures performed at the facility were expected in 2015.

The facility has a unique mission: "to provide comprehensive, compassionate, patient-centered care to VA and DoD beneficiaries while supporting the highest level of operational readiness."⁸ However, this "merged" mission is complicated by the fact that three departments (DoD, Navy, and VA) are involved, and two of them (VA and DoD) are accountable to the President of the United States and Congress, with different priorities and goals.⁹ As the Institute of Medicine pointed out in its 2012 report, "Ultimately, no matter how seamlessly it conducts its daily business, the Lovell FHCC [the facility] has to report to the Navy and to the DoD on how well it performs as a military treatment facility (MTF) and to the VA on how well it performs as a VA medical center (VAMC)."

To accomplish the facility's mission of operational readiness, VA and DoD have agreed that the facility would, during times of resource constraints, prioritize patient treatment as follows:¹⁰

1. Members of the Armed Forces on Active Duty
2. All Veterans and non-Veteran VA beneficiaries subject to applicable enrollment and eligibility requirements and TRICARE¹¹ Prime enrolled Active Duty dependents
3. TRICARE Prime enrolled retirees, their dependents and survivors
4. TRICARE Standard Active Duty dependents
5. TRICARE Standard retirees, their dependents, and survivors (including TRICARE for Life beneficiaries)

⁸ DoD VA 2010 EA, p. 3.

⁹ IOM, p. 5.

¹⁰ DoD VA 2014 EA, p. 4.

¹¹ TRICARE is a military health care program utilizing military health care and civilian network providers that is available to many military dependents. <http://www.tricare.mil/>. Accessed October 11, 2014.

The facility's GI clinic is located on the third floor of one of the West Campus main buildings.¹² GI procedures, however, are currently performed in one or two rooms located in the Operating Room, which is managed by Surgical Service. GI nursing staff assist facility gastroenterologists with GI procedures, but Surgical Service nursing staff perform post-GI procedure care in the Post Anesthesia Care Unit. Therefore, the number of GI procedures that can be performed is dependent on GI nursing staff, Surgical Service nursing staff, surgical patients that might need GI or other endoscopic procedures, surgical patients that need post anesthesia care, and patients requiring emergent or urgent procedures. Due to staffing shortages and space constraints, gastroenterologists were advised by Surgical Service managers that only four patients could be scheduled each day in order to accommodate Surgical Service schedules and to allow for emergencies.

GI staff were concerned that due to resource constraints an increasing number of veteran patients would be referred to community providers, that veterans would be unhappy with referrals to community providers, and that the facility did not have a process for the coordination of Non-VA Medical Care. While an increased number of veterans was referred to community providers in quarter 3 of FY 2014 in comparison to those referred in quarter 2 of FY 2014,¹³ veterans had not lodged complaints with the facility about the referrals. We were therefore unable to verify veterans' dissatisfaction with referral to community providers. The issue of the non-VA GI care process is addressed below.

Additionally, the facility recently remodeled a suite of rooms outside of the Operating Room area that will be dedicated to endoscopic procedures and not be under the management of the Surgical Service. A new GI nurse manager position was created and staffed, additional GI nursing staff have been hired, and GI nursing staff will perform all peri-procedure care. The anticipated date of full operation of the new GI suite is dependent on funding to complete a remodel/repair of the air circulation system. As of December 1, 2014, the estimated date for opening the GI suite was early 2015. Overall capacity for GI procedures will be greatly enhanced upon the opening of the new dedicated endoscopy suite.

Issue 2: Quality of Care Deficiencies

Alleged Mismanagement of Two Patients

The allegations described deficiencies in the management of a CLC patient's blood sugar levels and a mental health patient's admission process. We substantiated that the CLC patient's blood sugar levels were mismanaged. (See Patient A below.) However, we determined that the facility had taken appropriate steps to address the

¹² The facility comprises the West Campus, essentially the site of the former North Chicago VAMC, and the East Campus, site of the former Naval Station Hospital/Health Clinic.

¹³ According to the numbers that the facility provided us, 64 of 465 veteran patients or 13 percent were referred in quarter 3 compared to 6 of 380 or 1.5 percent in quarter 2.

mismanagement of care. We did not substantiate mismanagement of the mental health patient's admission to the inpatient mental health unit.

Patient A. The patient was a man in his sixties with a history of diabetes, chronic obstructive pulmonary disease, and bipolar disease. He had been a long-term resident of the facility's CLC when he began to develop serious medical illnesses in the spring of 2014. He was hospitalized on three occasions, once for probable infection and twice for sepsis (overwhelming infection). In June, he was evaluated for falls on three occasions.

While Patient A was in the hospital, the facility's endocrinology team (specialists in treating diabetes and other hormone-related diseases) assisted with Patient A's diabetes management and continued to visit him in the CLC before his death at the end of June. On day 22 after the patient's readmission to CLC from his last hospitalization, a markedly low blood sugar was recorded. The patient's insulin regimen was adjusted. On day 36 post CLC re-admission, the endocrinology team reviewed the patient's blood sugar levels and recommended no changes to his insulin regimen. That night, the patient's blood sugar was low but responded well to a snack. At the time of the next visit, on day 39 post CLC re-admission, the endocrinology team reviewed the patient's record and recommended no changes in the patient's insulin regimen. On day 40 post CLC re-admission, the patient's finger stick blood sugar was again low.

Early the next morning, the CLC nursing staff noted the patient was having difficulty breathing and checked a fingerstick blood sugar, which was found to be 24 mg/dL (normal 65–110 mg/dL). The patient stopped breathing before nursing staff could render treatment. A "Code Blue"¹⁴ was called, but pursuant to the patient's previously identified wishes, resuscitation was not attempted when the Code Blue team arrived at the patient's bedside.

At the time of our review, the facility had already identified and conducted an internal review of this case.

Patient B. This patient was a man in his late twenties who had a history of substance abuse and post-traumatic stress disorder. In the summer of 2014, he agreed to admission into the facility's substance use disorder (SUD) program. Shortly after admission, the patient was involved in an incident, which led to the patient being transferred to the emergency department (ED) for assessment. He was cleared both medically and psychiatrically for return to the SUD program. However, upon return to the SUD program building, the patient developed difficulty breathing and collapsed. He was immediately returned to the ED, re-evaluated, diagnosed with a panic attack and psychotic episode, and admitted to the facility's inpatient mental health unit.

The patient recovered from the psychotic episode, was discharged from the inpatient unit 9 days later, admitted to the SUD program, and successfully completed the SUD program with discharge to home about a month later.

¹⁴At this institution, a "code blue" activates a medical team that will respond quickly, come to the patient's bedside as soon as possible, and provide emergency life support measures.

Increased Quality of Care Deficiencies Post Reorganization

We did not substantiate the allegations that increases in falls, pressure ulcers, urinary tract infections, elopements, diversions, and wrong site procedures have occurred as a result of senior leaders' mismanagement after a reorganization in spring 2014.

Since its inception, the facility's leadership and governance model has varied from the common "quadrad" structure used at most VA medical centers.¹⁵ In accordance with the EA, top leadership has generally been provided by a VA Director and a Navy Deputy Director. To accommodate its unique mission, a leadership structure more complex than the usual quadrad one was originally created to include a Command Master Chief (a Navy position) and six Associate Directors who reported to the Director and/or Deputy Director.¹⁶

At the end of March 2014, the previous Director (a VA senior executive) unexpectedly resigned. In April, the then Deputy Director, who was a Navy Captain, was named Acting Director, and a VA manager from another VISN 12 facility was named Acting Deputy Director. In October 2014, a new Director from VA was appointed, and a Navy Captain was named Deputy Director thereby restoring the order of leadership as required by the EA.

At the same time that the previous VA Director retired and the Navy Captain was named Acting Director, a new Associate Director organizational plan was implemented, as recommended by the facility's Advisory Board.¹⁷ The 6 Associate Directors were increased initially to 10 and, a few months later (in June), to 11 Associates. While some of the new Associate Directors were permanently designated either VA or Navy personnel, three of the Associate Director positions will rotate between VA and Navy personnel.

We reviewed available facility data from April (time of reorganization) through the beginning of August (time of complaint) for significant increases in the rates of falls, pressure ulcers, urinary tract infections, elopements, diversions, and wrong site procedures. We did not see an increase in these numbers that could be attributed to changes in senior leadership and management during this fairly short period of time. The facility identified and addressed an increase in elopements and ICU and ED diversions that began prior to the April reorganization through August. The facility had also appropriately addressed two wrong site procedures that occurred in April.

¹⁵ The quadrad leadership model includes a Director, Associate Director, a Chief of Staff who oversees medical care, and a Nurse Executive who oversees patient care services.

¹⁶ The six Associate Director Departments were: Patient Care, Patient Services, Facility Support, Dental Services Fleet Medicine, and Resources. Generally, the first three offices were staffed with VA personnel, and the others were staffed with Navy personnel.

¹⁷ Governance for the facility is as follows: DoD/VA Joint Executive Council through the DoD/VA Health Executive Council (sub-committee of the Joint Executive Council). The FHCC Advisory Board is co-chaired by the Commander, Navy Medicine East and VISN 12 Network Director; members include three DoD and three VA staff. A Stakeholders Advisory Council comprising community leaders and veteran service and retiree organizations, among others, provides guidance and input to facility leaders.

Issue 3: Unnecessary GI Procedures Requested by Facility Leaders

We did not substantiate the allegation that facility leaders requested gastroenterologists perform unnecessary procedures.

We were provided the names of two patients (Patient C and D) who allegedly underwent unnecessary procedures at the request of a facility leader. The facts of the cases are provided below.

Patient C, a Navy recruit in his early twenties, was transferred from one of the Navy clinics in spring 2014 after multiple episodes of vomiting and bleeding since arriving from the East Coast the previous day. His blood pressure and heart rate were within normal limits. The admitting clinician requested a GI consult, and a gastroenterologist arranged for an endoscopic procedure (in this case, a small tube passed through the mouth into the patient's stomach) to be performed the next day. The procedure was done as planned the next morning and revealed a tear at the gastroesophageal junction.¹⁸ The physician ordered medications, and hospital staff provided education on diet, medications, and alcohol avoidance. The patient returned to active duty within 48 hours of admission.

Patient D was a Navy recruit in his late teens who was admitted with complaints of vomiting and bleeding.¹⁹ Patient D's blood pressure and heart rate were within normal limits, but his temperature was mildly elevated. The morning after Patient D's admission, his treating provider requested a GI consult, and an endoscopic procedure was performed an hour later. The gastroenterologist reported normal findings. The patient was returned to active duty the next day with a diagnosis of a probable tear at the gastroesophageal junction. He was prescribed medications and a regular diet.

We did not find orders or notes from facility leaders in either of patient C's or D's EHR. We also reviewed email communication between facility leaders and the GI staff but did not find untoward or coercive messages. We found that the procedures performed were consistent with standard clinical practice.

Issue 4: Lack of Process for Coordination of Non-VA GI Care

We did not substantiate the allegation that the facility lacked a process for the coordination of non-VA GI care. However, we noted inconsistencies in the posting of non-VA GI care procedure results into the facility's EHR.

The facility has employed a Non VA Care Coordinator since 2011. For veterans, the preferred order for referral of specialty care when care at the facility is not feasible is the following: (1) another VA facility, (2) a facility with a sharing agreement, (3) contracted

¹⁸ The gastroesophageal junction is located at the lower end of the esophagus where it joins the stomach.

¹⁹ Patient D had very similar complaints to Patient C and was admitted approximately 24 hours within Patient C's admission, but the two cases were not related.

care,²⁰ and (4) civilian or community providers. When referred to a community provider, both the vendor and the patient receive a copy of the authorization for care and a cover letter that includes a requirement that the vendor provide the VA with written results of the test/care. The authorization does not specify a time frame for the community provider to make the results available to the facility provider. The vendor may return the required documentation via facsimile or by regular mail.

Return of the documentation of care with the claim may result in a several week time lag between the date of care and the date that the facility receives the documentation. When the documentation is received, a staff member in the Non-VA Care Coordination department scans the document into the Fee Basis Claims System.²¹ If the scanner is able to link the document to a consult, the image may be immediately available in the EHR; otherwise the image is not available until the facility's Health Information Management staff uploads the image.

We reviewed the EHRs for 20 of the 79 veteran patients who were referred to community providers for GI care in Q4 FY 2014.²² We found that 3 of the 20 patients had not undergone the recommended procedure and/or the consult had been discontinued, and the patient had not yet returned for a visit with the requesting provider by the time of our review. Of the remaining 17 referrals, 12 results were either acknowledged by the requesting provider in a note or viewable in the patients' EHRs. For the other five records, documentation of procedure results was neither viewable nor acknowledged by providers.

Conclusions

We substantiated the allegations that facility gastroenterologists had been directed by facility leaders to prioritize care in favor of active service members during times of resource constraints and that scheduled GI procedures were limited to four per day. However, we found that the facility leaders' decision to prioritize care in favor of service members was made in accordance with the EA, veterans were receiving care when necessary through the Non-VA Medical Care program, and increased capacity for GI procedures performed at the facility is expected when a new endoscopic suite is opened in early 2015.

We substantiated that a significant lapse occurred in the management of a patient with low blood sugars but found that the facility had reviewed the care of the patient and taken appropriate action.

We did not substantiate the allegations that an increase in falls, pressure ulcers, urinary tract infections, elopements, diversions, and wrong site procedures occurred as a result

²⁰ The facility recently entered into an agreement with a Patient Care Centered Contract (also known as PC3) organization, but the organization's network of providers is not yet well developed.

²¹ Non-VA Medical Care was previously known as Fee Basis, hence, the name of the claims system.

²² Dates of the requesting consults ranged from July 1 through August 28, 2014. We made our final review for results in the EHR on November 9, 2014.

of senior leaders' mismanagement after a reorganization in spring 2014 or that facility leaders requested that GI staff perform unnecessary procedures. We also did not substantiate that the facility lacked a process for coordinating non-VA GI care. However, we did find inconsistencies in the posting of non-VA GI procedure results into the VA EHR.

Recommendation

1. We recommended that the Facility Director ensure that documentation of procedure results from non-VA GI care providers is obtained and available in the electronic health record for review in a timely and consistent manner.

VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: January 7, 2015

From: Acting Director, VA Great Lakes Health Care System (10N12)

Subj: **Draft Report**—Healthcare Inspection-Alleged Mismanagement of the Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, IL

To: Director, Clinical Review Management (54D)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Attached please find the response to the Draft Report of the Captain James A. Lovell Federal Health Care Center (FHCC) Review.
2. I have reviewed the completed response.
3. I appreciate the Office of Inspector General's efforts to ensure high quality of care to veterans at James A. Lovell FHCC.



Renee Oshinski

Acting Network Director, 10N12

Facility Director Comments

Department of
Veterans Affairs

Memorandum

Date: January 7, 2015

From: Director, Captain James A. Lovell Federal Health Care Center (556/00)

Subj: **Draft Report**—Healthcare Inspection-Alleged Mismanagement of the Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, IL

To: Director, VA Great Lakes Health Care System (10N12)

We would like to thank the VA OIG team for their thorough investigation into this matter. Attached you will find our response to your finding in which the FHCC concurs.



Stephen R. Holt, MD, MPH, MSNRS

Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendation in the OIG report:

OIG Recommendation

Recommendation 1. We recommended that the Facility Director ensure that documentation of procedure results from non-VA GI care providers is obtained and available in the electronic health record for review in a timely and consistent manner.

Concur

Target date for completion: 01 May 2015

Facility response: The James A. Lovell Federal Health Care Center (FHCC) has increased capacity for GI patients which allows for timely procedures therefore limiting the need for referral for Non-VA care. Due to this improvement, the GI clinic has opened access to retirees in addition to the veteran and active duty population already being seen.

FHCC will implement the following additional actions to improve the process of timely receipt of medical documentation for patients receiving care from previously authorized Non-VA Care providers.

1. FHCC NVCC supervisor will create a Non-VA Care Consult SOP to ensure that documentation received in clinics from Non-VA Care vendors is submitted to the FHCC Non-VA Care office to be scanned into the electronic medical record. Training for providers and clinic staff on the SOP and this specific procedure will be completed by February 15, 2015. The FHCC NVCC supervisor will document training with providers and clinic staff and monitor to assure current provider and clinic staff compliance. Training will also continue on an ongoing basis, and training will be provided to new providers and staff.

2. Per VHA Chief Business Office guidance, NVCC consults are to be closed within 90 days. Beginning January 12, 2015 FHCC NVCC staff will monitor pending consults on a bi-weekly basis and contact Non-VA providers to request immediate submission of medical documentation at day 75 of the consult process. NVCC staff will now receive a list of pending consults (at the 75 day mark) on a bi-weekly basis. Compliance with medical documentation receipt from vendors will be tracked and reported monthly to the Facility Support Directorate. In the event that medical documentation is not received at 90 days, the consult will be administratively closed and NVCC staff will document their attempts to obtain medical documentation from the Non-VA Care provider, in accordance with the standards prescribed by VHA's Health Information Management (HIM).

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Kathy Gudgell, RN, JD, Team Leader Jerome Herbers, MD

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