VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System

October 4, 2016
15-04672-342

ACRONYMS

BISL	Business Intelligence Service Line
FY	Fiscal Year
HAS	Health Administration Service
MSA	Medical Support Assistant
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
PSA	Program Support Assistant
PVAHCS	Phoenix VA Health Care System
QSI	Quality, Safety, and Improvement
SOP	Standard Operating Procedure
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

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Executive Summary

Why We Did This Review

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) initiated this review of alleged consult management issues at the Phoenix VA Health Care System (PVAHCS) in response to allegations reported to the OIG by the House Committee on Veterans' Affairs in July 2015. These allegations, communicated by a confidential complainant, were received about one year after the OIG published a report confirming allegations of patient care delays, wait times, and problematic scheduling practices at PVAHCS. We reviewed these more-recent allegations that PVAHCS staff inappropriately discontinued and canceled consults, management provided staff inappropriate direction, patients died waiting for consultative appointments, more than 35,000 patients were waiting for consults, and other allegations received during our review, to assess the adequacy of managing patient consults at PVAHCS. Specific allegations included:

- PVAHCS staff inappropriately discontinued consults. This included providers that erroneously discontinued consults because PVAHCS staff uploaded patients' information for community care and non-clinicians who discontinued consults for vascular patients.

- PVAHCS management provided inappropriate directions to its staff. Specifically, the Acting Chief of Health Administration Service (HAS) requested HAS staff to discontinue consults that providers should review and PVAHCS leadership approved the discontinuation of consults by administrative staff. In addition, PVAHCS managers advised clinic directors and lead schedulers to improperly discontinue and cancel pending clinical consults, and the Acting Chief of HAS instructed administrative staff to discontinue consults of patients who had died.

- A scheduler was assigned to a surgical service to help schedule patients, reported problems, and then was removed from the position.

- The PVAHCS Chiropractic Service maintained an unofficial paper wait list.

- PVAHCS patients died waiting for consultative appointments. The complainant provided a copy of a report that listed 87 deceased patients and 116 open consults.

- PVAHCS had non-providers discontinue consults for vascular patients, potentially to hide the fact that a patient died while waiting for care.

- PVAHCS had more than 35,000 patients waiting for consults.

- PVAHCS patients were waiting in excess of 300 days for vascular care.

In August 2014, the OIG reported on a myriad of allegations regarding patient deaths, patient wait times, and scheduling practices at PVAHCS. The report recommended, among other things,

that the VA Secretary ensure PVAHCS follow VA consult guidance and appropriately review consults prior to closing them to ensure veterans receive necessary medical care. In addition, in December 2014, the OIG published a report on the evaluation of the Veterans Health Administration's (VHA) system-wide review of "unresolved" consults. The OIG recommended that VHA conduct a systematic assessment of the processes each VA medical facility used to address unresolved consults during that review, and ensure that, should a medical facility's processes be found to have been inconsistent with VHA guidance on addressing unresolved consults, action be taken to confirm that patients have received appropriate care.

What We Found

We substantiated that in 2015, PVAHCS staff inappropriately discontinued consults. We determined that staff inappropriately discontinued 74 of the 309 specialty care consults (24 percent) we reviewed. This occurred because staff were generally unclear about specific consult management procedures, and services varied in their procedures and consult management responsibilities. As a result, patients did not receive the requested care or they encountered delays in care. Of the 74 inappropriately discontinued consults, 53 patients had not received the requested care at PVAHCS.

We did not substantiate that the Acting Chief of HAS instructed administrative staff to discontinue inappropriately the consults of patients before a provider reviewed the consult. We determined that some staff believed the guidance was not clear, and that leadership, clinicians, and schedulers had a different understanding of the various consult management responsibilities. We interviewed 58 PVAHCS schedulers, clinicians, and other administrative staff, including the complainant. The complainant told us that discontinuing consults required a medical decision and did not agree that administrative staff should be involved in this action. VHA's *National Guidance for Discontinuing or Cancelling Consults* (June 2015) stated that non-clinicians can discontinue consults under certain circumstances, including instances when the patient has died, the consult was a duplicate request, the patient refused care, or the patient opted for non-VA care. Although some of the remaining 57 interviewees also stated that only clinicians should discontinue consults, none of them told us PVAHCS management instructed them to discontinue or cancel consults improperly. Two interviewees told us they received unclear guidance, which we determined resulted in inappropriate consult management. Two providers stated that facility leadership applied pressure to services to ensure consults did not exceed 90 days, and further stated that services had to provide justification for those consults that exceeded 90 days.

We did not substantiate that PVAHCS management removed a scheduler from Vascular Service because the scheduler identified and reported problems. In an effort to reduce a scheduling backlog, HAS temporarily reassigned two medical support assistants (MSAs) from Cardiology Service to schedule consults in the Vascular Lab. Based on interviews with staff, we determined that differences in consult management responsibilities between the services may have led the incoming staff to believe that the program support assistant (PSA) in the Vascular Lab was inappropriately discontinuing consults since the Cardiology Service section chief did not allow MSAs to discontinue consults. We found that because of poor cooperation among staff, Vascular Service and HAS decided to assign a different scheduler to assist Vascular Service with scheduling.

We did not substantiate that a paper list of patients waiting for chiropractic care, reported to us by the complainant and PVAHCS leadership, was an unofficial wait list. PVAHCS staff printed the list from the Veterans Health Information Systems and Technology Architecture (VistA) and used the list to record their attempts to contact the patients. We determined that the consults were electronically tracked in VHA's consult package. However, we also determined that the PVAHCS Chiropractic Service inappropriately canceled consults. We analyzed 30 consults canceled from January through March 2015, and found that the Chiropractic Service staff responsible for scheduling inappropriately canceled all 30 consults. This occurred because the Chiropractic Service did not make adequate attempts to contact patients to schedule appointments and did not maintain sufficient resources to manage and schedule consults. Canceled consults resulted in patients not receiving a scheduled appointment and, therefore, not receiving the requested chiropractic care. Within the 30 canceled consults we reviewed, 28 patients had not received the requested chiropractic care at PVAHCS.

The OIG's Office of Healthcare Inspections (OHI) reviewed a total of 294 facility consults for 215 individual patients who had open consult requests at the time of their deaths, or had consults discontinued after the date of their deaths. This included 87 deceased patients with 116 open consults from a report that identified patients who had open consults and a date of death associated with their medical record. The review also included 119 deceased patients with 169 open consults who had an active or pending consult on September 30, 2015, but died before that date, and/or had at least one consult that was ordered from May 1 through September 30, 2015, and was discontinued after the date of death. In addition, OHI reviewed nine deceased patients' records with nine discontinued consults from a list of discontinued vascular consults provided by the complainant.

Of the 215 individual patients' records reviewed, OHI determined that untimely care from PVAHCS may have contributed to the death of 1 patient. OHI found that this patient never received an appointment for a cardiology exam that could have prompted further definitive testing and interventions that could have forestalled his death. OHI determined that the remaining patients' records reviewed did not die because they did not receive the requested consult in a timely fashion before they died. We did not substantiate that the facility was having non-clinical staff discontinue consults for vascular patients to hide the fact that a patient died while waiting for care. In regard to the consults reviewed of patients who died while they had open consults, we found that PVAHCS closed these consults because VHA and PVAHCS business rules and policy both required that a consult be discontinued if the patient is deceased. However, facility staff did not consistently comply with this policy and some consults remained open long after patients' deaths.

We determined that, as of August 12, 2015, more than 22,000 individual patients had 34,769 open consults at PVAHCS. The total open consults included all categories, statuses, and ages of consults.[1] Of all the open consults at that time, about 4,800 patients had nearly 5,500 consults for appointments within PVAHCS that exceeded 30 days from their clinically

[1] We identified open consults with a status of pending, active, scheduled, and partial results. Open consults included traditional clinical consults within the facility, community care consults, such as non-VA care and Choice, prosthetics consults, and administrative consults.

indicated appointment date. In addition, more than 10,000 patients had nearly 12,000 community care consults exceeding 30 days. Consults for care in the community included traditional non-VA care and Choice.[2] The remaining approximately 17,000 open consults were for prosthetics, administrative purposes, and/or did not exceed 30 days. VHA does not require staff to complete prosthetics consults immediately.

By March 2016, PVAHCS had just over 32,500 total open consults. As of July 2016, according to PVAHCS, the facility had nearly 38,000 total open consults. PVAHCS continues to have a high number of open consults because providers are not always receiving and reviewing consults to their clinics timely, staff had not scheduled patients' appointments in a timely manner (or had not rescheduled canceled appointments), a clinic could not find lab results, and staff did not properly link completed appointment notes to the corresponding consults. As a result, patients attempting to get care at PVAHCS continued to encounter delays in obtaining such care.

We substantiated that one patient waited in excess of 300 days for vascular care. A patient received vascular care in October 2015 following a consult request from a clinician in Vascular Surgery in June 2013. The requesting provider's clinically indicated date for care was June 19, 2014. Vascular Lab staff scheduled an appointment to which the patient did not go and the consult remained open. Staff did not act on the consult again until July 2015. Facility staff then made multiple attempts to contact the patient and provided care to the patient in October 2015. As of August 12, 2015, we identified 13 open consults of patients waiting for Vascular Lab more than 30 days beyond the clinically indicated date of the provider, ranging from 32 to 157 days. We also found that the PVAHCS Vascular Service staff did not properly link clinicians' notes for the completed appointments to the corresponding consults, which meant consults remained open even though the patient received the care.

This occurred, in part, because they could not find printed lab results of completed appointments associated with open consults to input completed appointment results into the electronic health records. The Vascular Service electronically sent, received, and scheduled consults in VHA's consult package. However, PVAHCS's Vascular Lab machines were not connected to the VA network, which meant the lab results of completed appointments had to be printed and scanned into VistA after the provider dictated the results. We found 29 consults in which clinicians had not reviewed and dictated the consult results because they could not find the lab results. Since 2008, the Chief of Vascular Service has been voicing concerns about delays in scanning reports and lost appointment documents, and attempting to improve Vascular Lab procedures by requesting that the Veterans Integrated Service Network (VISN) and PVAHCS replace the Vascular Lab software. The Chief of Vascular Service reported lost documents again in July and October 2013. During the course of this review, PVAHCS took action to move appointment results for Vascular Labs to an electronic process. However, the Vascular Service still printed results for some studies.

[2] In response to the Veterans Access, Choice, and Accountability Act of 2014, VHA initiated the Veterans Choice Program (Choice). The Choice program allowed eligible veterans to use providers outside the VA system.

What We Recommended

During the past two years, the OIG has reviewed a myriad of allegations at PVAHCS and issued six reports involving policy, access to care, scheduling and canceling of appointments, staffing, and consult management. Although VHA has made efforts to improve the care provided at PVAHCS, these issues remain. This report contains 14 recommendations, including that the Under Secretary for Health update VHA's consult policy. The remaining 13 recommendations were issued to the VISN 22 Director to ensure the PVAHCS Director improves consult management and to follow up with patients who may not have received the requested care. This included recommendations to ensure PVAHCS management develops a routine review of closed consults to ensure staff are appropriately discontinuing and documenting consults in accordance with national and local policy, and communicates consult policies and procedures to all facility staff to ensure consistent procedures and responsibilities to manage consults effectively.

Management Comments

The Under Secretary for Health concurred with the recommendation to update VHA's consult policy, and VHA published a new directive on August 23, 2016.[3] The VISN 22 Director concurred with the remaining 13 recommendations to improve consult management at PVAHCS and submitted acceptable corrective action plans. Based on actions already implemented, we consider Recommendations 1, 2, 7, and 12 closed. We will follow up on the remaining recommendations to ensure full implementation of all corrective actions.

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[3] VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016.

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INTRODUCTION

Allegations

In July 2015, the Department of Veterans Affairs (VA) Office of Inspector General (OIG) received allegations that Phoenix VA Health Care System (PVAHCS) employees were mismanaging consults. These allegations were reported to the OIG by the House Committee on Veterans' Affairs. We expanded our work to include additional, related issues presented to us during the course of the review. Specific allegations included:

- PVAHCS staff inappropriately discontinued consults. This included providers that erroneously discontinued consults because PVAHCS staff uploaded the patients' information for community care and non-clinicians who discontinued consults for vascular patients.
- PVAHCS management provided inappropriate directions to its staff. Specifically, the Acting Chief of Health Administration Service (HAS) requested HAS staff to discontinue consults that providers should review and PVAHCS leadership approved the discontinuation of consults by administrative staff. In addition, PVAHCS managers advised clinic directors and lead schedulers to improperly discontinue and cancel pending clinical consults, and the Acting Chief of HAS instructed administrative staff to discontinue consults of patients who had died.
- A scheduler was assigned to a surgical service to help schedule patients, reported problems, and then was removed from the position.
- The PVAHCS Chiropractic Service maintained an unofficial paper wait list.
- PVAHCS patients died waiting for consultative appointments. The complainant provided a copy of a report that listed 87 deceased patients and 116 open consults.
- PVAHCS had non-providers discontinue consults for vascular patients, potentially to hide the fact that a patient died while waiting for care.
- PVAHCS had more than 35,000 patients waiting for consults.
- PVAHCS patients were waiting in excess of 300 days for vascular care.

These allegations were received about one year after the OIG published a report confirming allegations of patient care delays, wait times, and problematic scheduling practices at PVAHCS. We reviewed these recent allegations to assess the adequacy of managing patient consults at PVAHCS.

Consult Management

A clinical consultation is provided by a physician or other health care provider in response to a request seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem. A clinical consultation request is initiated by a physician or appropriate source with the clear expectation that a reply will be provided in a timely fashion.

Consult timeliness is not synonymous with appointment timeliness, in part, because not all consults are completed with an outpatient appointment.

Consult Policy

The Veterans Health Administration's (VHA) *VHA Consult Policy*, Directive 2008-056, provided policy to VHA staff on appropriate consult management. This directive expired in September 2013, but VHA had not superseded it with a new policy until August 2016. VHA's *Consult Management Business Rules* (May 2014) provides guidance on when staff can discontinue or cancel a consult. However, neither the 2008 VHA Directive nor the *Consult Management Business Rules* specified when a clinician was responsible for discontinuing or canceling consults. Detailed information about VHA's consult policies can be found in Appendix A.

Prior Reviews

During the past two years, the OIG has reviewed a myriad of allegations concerning PVAHCS, conducted a national consult evaluation, and issued six reports.

- *Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System – Interim Report* (Report No. 14-02603-178, May 28, 2014)
- *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (Report No. 14-02603-267, August 26, 2014)
- *Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet* (Report No. 14-04705-62, December 15, 2014)
- *Review of Phoenix VA Health Care System's Urology Department, Phoenix, AZ – Interim Report* (Report No. 14-00875-112, January 28, 2015)
- *Radiology Scheduling and Other Administrative Issues, Phoenix VA Health Care System, Phoenix, Arizona* (Report No. 14-00875-133, February 26, 2015)
- *Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona* (Report No. 14-00875-03, October 15, 2015)

In the OIG's *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (August 2014), the OIG recommended, among other things, that the VA Secretary ensure PVAHCS follow VA consult guidance and appropriately review consults prior to closing them to ensure veterans receive necessary medical care.

In the OIG's *Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet* (December 2014), the OIG concluded that, because VHA did not implement appropriate control activities, it lacked reasonable assurance that consults were appropriately

reviewed and resolved; that consults were closed only after ensuring veterans had received the requested services, when appropriate, and, to the extent that consult delays contributed to harm to patients, those patients were notified as required by VHA policy. The OIG recommended that VHA conduct a systematic assessment of the processes each VA medical facility used to address unresolved consults during VHA's system-wide consult review, and ensure that if a medical facility's processes are found to have been inconsistent with VHA guidance on addressing unresolved consults, action is taken to confirm patients received appropriate care.

Other Information

- Appendix A provides pertinent background information.
- Appendix B provides details on our scope and methodology.
- Appendix C and D provide management comments.

RESULTS AND RECOMMENDATIONS

Finding 1 PVAHCS Staff Inappropriately Discontinued Consults

We substantiated that PVAHCS staff inappropriately discontinued consults during calendar year 2015. This included providers who inappropriately discontinued consults when PVAHCS staff uploaded the patients' information for community care and non-clinicians who inappropriately discontinued consults for vascular patients in instances that required a clinical review. PVAHCS mismanaged patients' consults to specialty care services because staff were generally unclear about specific consult management procedures, and services varied in their procedures and consult management responsibilities. As a result, patients encountered delays in care or, in some instances, had not received the requested care at PVAHCS.

We did not substantiate that the Acting Chief of HAS instructed administrative staff to discontinue inappropriately the consults of patients before a provider reviewed the consult. The Acting Chief of HAS instructed administrative staff to work with the clinicians collaboratively to ensure adherence to HAS's part of the consult process.

We did not substantiate that PVAHCS management removed a scheduler from Vascular Service because the scheduler identified and reported problems. We found that PVAHCS management reassigned two medical support assistants (MSAs) who were temporarily assigned to schedule in Vascular Lab services back to Cardiology Service because of poor cooperation between the Vascular and Cardiology staff.

Criteria

VHA Consult Policy (VHA Directive 2008-056, dated September 2008) provided policy for the management of clinical consults, but did not provide direction on discontinuing consults. This directive expired in September 2013, but VHA had not superseded it with a new policy until August 2016. VHA's *Consult Management Business Rules* (May 2014) stated that VA staff should discontinue a consult when the:

- Consult is received by the wrong service
- Patient has met the threshold for the number of no-shows allowed by the facility
- Service is no longer needed or the patient refuses service
- Patient is deceased or is already an established patient
- Consult is a duplicate request

Neither the *VHA Consult Policy* nor the *Consult Management Business Rules* stated what actions required a clinical review prior to discontinuing a consult.

PVAHCS's *Consult Clean-Up Business Rules* (March 2014) provided guidance to staff to discontinue consults, if supported by a clinical review, when a patient did not show up two times for their appointment, or canceled appointments twice.

Staff Inappropriately Discontinued Consults

We substantiated that PVAHCS staff inappropriately discontinued consults. This included providers who inappropriately discontinued consults when PVAHCS staff uploaded the patients' information for community care and non-clinicians who inappropriately discontinued consults for vascular patients. We analyzed 265 randomly selected consults from 10 specialty care services that facility staff discontinued from January 1 through August 15, 2015, after the consults were older than 90 days. During the review, the complainant gave us a list of Vascular Lab consults; we analyzed 44 consults discontinued from January 1 through June 2, 2015. In total, we reviewed 309 discontinued consults.

We determined that staff inappropriately discontinued 74 of the 309 specialty care consults (24 percent) we reviewed for the reasons described here.

Staff Discontinued Consults With Inadequate or No Documented Reasons

Staff inappropriately discontinued 32 of the 309 consults we reviewed without an adequate or documented reason. Specifically:

- Staff discontinued 23 consults and documented in the medical record that the consult "expired," was "outdated," or "greater than 90 days." However, these were not acceptable reasons in VHA or PVAHCS policy or business rules.
- Staff discontinued nine consults and did not document a reason for discontinuing the consult.

Staff Discontinued Consults Without Contacting Patients

Staff inappropriately discontinued 20 consults following a single patient cancellation or no-show or lack of adequate attempts to contact the patient. PVAHCS's *Consult Clean-Up Business Rules* stated that staff should not discontinue consults until two patient no-shows or cancellations or three documented attempts to contact the patient to schedule an appointment.

Non-Clinicians Discontinued Consults When Clinical Decision Was Needed

Non-clinicians inappropriately discontinued 11 consults when the patients canceled or did not show for their appointment multiple times. PVAHCS's *Consult Clean-Up Business Rules* required a clinical review or concurrence in these instances. The medical records contained no documentation showing that a clinician was involved in the decision to discontinue the consult.

Providers Discontinued Consults When Patient Was Referred to Choice

Providers inappropriately discontinued four consults when PVAHCS staff uploaded the patients' information for community care to TriWest (the contractor PVAHCS uses to coordinate veterans' Choice[4] appointments). In these four instances, providers improperly discontinued consults in two specialty care services when the patient was eligible for a Choice appointment. The providers annotated on the medical record that they discontinued the consult because the patient was seeking care through TriWest. However, TriWest had not scheduled the patient's Choice appointment. Therefore, it was inappropriate to discontinue the consult for a patient who was still seeking and expecting specialty care services at PVAHCS or through Choice. The section chief in one of those services acknowledged the cases may have been errors on his part.

Other Reasons

Staff inappropriately discontinued three consults for these reasons:

- Staff discontinued the consult when the appointment was scheduled—the consult should have remained open in a scheduled status
- Staff inadvertently discontinued a consult and then requested a new consult
- A new patient in the service was inadvertently considered an established patient

Vascular Lab

In addition, we identified four inappropriately discontinued vascular lab consults. The complainant gave us a list of Vascular Lab consults that a program support assistant (PSA) discontinued. A PSA is a non-clinician who works for a specific service and provides administrative support for that service. We determined that the PSA appropriately discontinued 40 of the 44 consults we reviewed because they were duplicates, the patient refused care, or the patient was deceased. However, we determined that the remaining four consults following patient cancellations or no-shows were inappropriately discontinued. PVAHCS's *Consult Clean-Up Business Rules* required a clinical review or concurrence in these instances. Vascular clinicians stated that they believed the PSA usually checked with clinicians when she discontinued consults for scheduling issues. However, in these instances, the PSA did not document in the patients' records that she consulted with clinicians.

[4] In response to the Veterans Access, Choice, and Accountability Act of 2014, VHA initiated the Veterans Choice Program (Choice). The Choice program allowed eligible veterans to use providers outside the VA system.

Staff Were Unclear About Consult Procedures

PVAHCS mismanaged patients' consults to specialty care services because staff were generally unclear about specific consult management procedures, and services varied in their procedures and consult management responsibilities. Staff, who discontinued consults because the consult expired, was outdated, or was greater than 90 days, said that it was because they were unclear about the specific rules regarding when to discontinue consults. One scheduler stated that their process was to close consults after two attempts of any means to contact a patient to schedule an appointment. A nurse in one specialty care service told us that before May 2015, their protocol was to discontinue consults after one no-show. However, PVAHCS's *Consult Clean-Up Business Rules* (March 2014) provided guidance to staff to discontinue consults, if supported by a clinical review, when a patient did not show up two times for their appointment.

VHA had not updated or superseded its 2008 national consult policy for management of clinical consults since it expired in September 2013. The consult policy did not provide direction on discontinuing consults and did not state what actions required a clinical review before discontinuing a consult. Recommendation 1 addresses the need for VHA's Under Secretary for Health to update the *VHA Consult Policy*.

Different Procedures and Consult Management Responsibilities

We determined that leadership, clinicians, and schedulers had a different understanding of the various consult management responsibilities. Schedulers were composed predominantly of HAS MSAs and PSAs. HAS MSAs scheduled appointments for several clinical services, but primarily worked under HAS and not the service for which they scheduled appointments. PSAs scheduled and performed administrative duties for a specific clinic.

HAS staff told us they did not discontinue consults and stated that was always a medical decision and required a clinical review. However, the then-Chief of Staff and Chief of Medicine provided guidance from VHA that non-clinicians could discontinue consults under certain circumstances. The same Chief of Staff told us that his guidance to staff was for providers to discontinue consults, but that MSAs can discontinue consults in specific instances—such as for deceased patients and duplicate entries. He stated that new guidance from VHA in June 2015 (VHA's June 2015 *National Guidance for Discontinuing or Cancelling Consults*) reinforced this practice. Examples of different consult management responsibilities are described here.

- The Cardiology Section Chief told us, in November 2015, that MSAs working in Cardiology did not discontinue any consults to Cardiology Services. Instead, if the Cardiology Service needed to discontinue a consult, his guidance to staff was for them to send it to a clinician.

- A staff member stated, in August 2015, that her section chief provided her guidance based on VHA's June 2015 guidance, which specified instances when a non-clinician could discontinue a consult.
- The Acting Chief of HAS's direction to staff was to work with providers collaboratively and ensure the HAS staff were adhering to their part of the consult process. In addition, she told us, in November 2015, that providers were to discontinue consults and that HAS staff did not do so.

Although the Acting Chief of HAS instructed administrative staff to work with the clinicians collaboratively to ensure adherence to HAS's part of the consult process, we found a lack of collaboration between HAS staff and clinicians at the time of our review. During interviews conducted in November 2015, February 2016, and March 2016, three section chiefs and one staff member told us there was a lack of communication and coordination between clinical staff and HAS staff. One of the section chiefs interviewed in November 2015, said that he/she believed that clinicians and HAS staff worked in silos and did not work as a team.

In April 2015, VHA sent a team of scheduling and consult personnel to PVAHCS to conduct a training session for all scheduling staff. The training focused on providing guidance on appropriate consult management with training material outlining when it was appropriate for a clinician and non-clinician to discontinue consults. The training material was consistent with VHA's June 2015 guidance. PVAHCS training records showed that 325 staff completed the training during April 2015, out of roughly 550 schedulers, according to a HAS staff member.

Despite VHA providing facility-wide scheduling and consult management training in April 2015, staff were not managing or scheduling consults according to that training. Of the 74 inappropriately discontinued consults we identified, 34 occurred after the April 2015 training.

Recommendation 2 addresses the need for PVAHCS to communicate consult policies and procedures to all staff involved in consult management to ensure consistent procedures and responsibilities for managing and scheduling consults.

In addition, Recommendation 3 addresses the need for PVAHCS to develop a routine review of closed consults and ensure staff are appropriately discontinuing and documenting consults in accordance with national and local policy.

Pressure To Ensure Consults Were Less Than 90 Days Old

We determined there was a different understanding of consult management responsibilities between HAS staff and clinical staff. The complainant alleged that PVAHCS leadership approved administrative staff to discontinue consults, and that managers advised clinic directors and lead schedulers to improperly discontinue and cancel pending clinical consults.

We determined that the Chief of Medicine provided staff VHA's *National Guidance for Discontinuing or Cancelling Consults* (June 2015) that specified when clinicians and non-clinicians can appropriately discontinue consults. This guidance was also included in the facility-wide scheduling and consult management training at PVAHCS in April 2015.

We interviewed 58 PVAHCS staff, including the complainant, schedulers, clinicians, and other administrative staff. The complainant told us that discontinuing consults required a medical decision and did not agree that administrative staff should be involved in this action. VHA's June 2015 guidance stated that non-clinicians can discontinue consults under certain circumstances, including when the patient has died, the consult was a duplicate request, the patient refused care, or the patient opted for non-VA care. Although some of the remaining 57 interviewees also stated that only clinicians should discontinue consults, none of them told us PVAHCS management instructed them to discontinue or cancel consults improperly. Two interviewees told us they received unclear guidance, which we determined resulted in inappropriate consult management.

- One scheduler for a service said she received guidance to discontinue consults that had been open greater than 90 days. However, she said that she realized later that her supervisor had not intended for her to discontinue consults solely because they were older than 90 days. We identified 17 consults in our sample review in which this individual discontinued consults and documented the reason as the "consult has expired" or "over 90 days old."
- One staff member told us that, until recently, there had been no guidance regarding when and why to discontinue consults. He stated that his service discontinued some consults because they were old. We identified six instances in our sample review that staff discontinued consults and documented the reason as "greater than 90 days."

Two providers stated that facility leadership applied pressure to services to ensure consults were no more than 90 days old, and added that services had to provide justification for those consults that were greater than 90 days old. For example, the Chief of Medicine would send the section chiefs weekly reports of open consults, which identified consults open greater than 30, 60, and 90 days. The Chief of Medicine stated that PVAHCS's ultimate goal is to have consults less than 30 days old. PVAHCS's local consult policy (June 1, 2015) also states that all consults must be completed within 30 days. According to the Chief of Medicine, the purpose of the 30-day goal is to ensure services do not neglect consults or leave them open longer than necessary.

Delays in Care

As a result of PVAHCS staff inappropriately discontinuing consults, patients had not received the requested care or encountered delays in care. Of the

74 inappropriately discontinued consults, 53 patients had not received the requested care at PVAHCS. Specifically:

- Nineteen patients had not received the requested care and their medical records show no evidence they received care at PVAHCS since staff discontinued the consult to the time of this review. For example, a Primary Care provider referred a patient to Cardiology in March 2015, and documented an urgency of "within 72 hours" on the consult. Cardiology staff discontinued the consult in June 2015 and documented in the patient's record, "consult older than 90 days." According to documentation available in the patient's record, the patient had not received care at PVAHCS since the consult was discontinued. PVAHCS acknowledged that staff should not have discontinued the consult, and the service submitted a new consult for Cardiology in November 2015. According to the patient's medical records, staff discontinued that consult a week later and annotated in the consult that the veteran refused the service from VA and was pursing the test through the private sector.
- Thirty-four patients also had not received the requested care. However, the patients' records indicated that the referring provider had since seen or talked to the patient.

We provided PVAHCS the consults of the patients we determined had not received the requested care.

Recommendation 4 addresses the need for PVAHCS to ensure services follow-up with the patients identified in this review for appropriate action.

Of the remaining 21 inappropriately discontinued consults, 11 patients encountered delays in care because staff discontinued their consults. After the service discontinued those consults, staff requested new consults and the patients eventually completed their appointment. The other 10 patients received care as requested by the consults, but staff improperly recorded the consult as discontinued instead of completed. Policy stated that staff should make appropriate documentation available in the patients' medical records and link the documentation to the consult.

Scheduler Was Not Removed From Clinic for Reporting Problems

We did not substantiate that a scheduler was removed from a service for identifying and reporting problems. In an effort to reduce a scheduling backlog, two MSAs were temporarily reassigned from Cardiology to schedule in the Vascular Lab around May 2015. Based on interviews with staff, we determined that differences in consult management responsibilities between the services may have led the incoming staff to believe that the PSA in Vascular Lab was inappropriately discontinuing consults since the Cardiology Service section chief did not allow MSAs to discontinue consults. Although the MSAs stated that they believed that only clinicians were allowed to discontinue consults, we determined that the consults the PSA discontinued were generally in accordance with VHA guidance. We

found that, because of poor cooperation among staff, Vascular Service and HAS decided to assign a different scheduler to assist with scheduling.

Conclusion

PVAHCS inappropriately discontinued consults during calendar year 2015. This occurred because staff were generally unclear about specific consult management procedures, and services varied in their procedures and consult management responsibilities. As a result of staff inappropriately discontinuing consults, patients had not received the requested care (53 patients) or encountered delays in care (11 patients). Complying with consult procedures is critical to ensure patients are seen in a timely manner.

Recommendations

1. We recommended the Under Secretary for Health update the Veterans Health Administration Consult Policy.

2. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System communicate consult policies and procedures to all facility staff and providers to ensure consistent procedures and responsibilities to effectively manage and schedule consults.

3. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System develop a routine review of closed consults to ensure staff are appropriately discontinuing and documenting consults in accordance with national and local policy.

4. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System make sure respective services follow up with the patients identified in this review for appropriate action.

Management Comments

The Under Secretary for Health concurred with Recommendation 1. VHA published Directive 1232, *Consult Processes and Procedures*, on August 23, 2016. The Under Secretary for Health's response can be found in Appendix C.

The VISN 22 Director concurred with the recommendations and stated that they already implemented Recommendation 2, and that they would implement Recommendations 3 and 4 by January 2017. The VISN 22 Director's response can be found in Appendix C.

OIG Response

The VISN 22 Director's planned corrective actions are acceptable. We consider Recommendations 1 and 2 closed based on VHA's and PVAHCS's actions. We will monitor PVAHCS's progress and follow up on the implementation of Recommendations 3 and 4 until all proposed actions are completed.

Finding 2 PVAHCS Staff Inappropriately Canceled Chiropractic Care Consults

We did not substantiate that a paper list of patients waiting for Chiropractic Care, reported to us by the complainant and PVAHCS leadership, was an unofficial wait list. PVAHCS staff printed the list from the Veterans Health Information Systems and Technology Architecture (VistA) and used the list to annotate their attempts to contact the patients. We determined that the consults were electronically tracked in VHA's consult package.

However, we reviewed 30 Chiropractic Service consults canceled from January through March 2015 and determined that the PVAHCS Chiropractic Service inappropriately canceled consults. The service staff did not make adequate attempts to contact patients to schedule appointments and did not maintain sufficient resources to manage and schedule consults. Canceled consults resulted in patients not receiving a scheduled appointment and, therefore, not receiving the requested Chiropractic Care.

Alleged Unofficial Wait List

We reviewed the alleged unofficial paper wait list for chiropractic care and determined that PVAHCS staff printed the list from VHA's electronic scheduling system, VistA. We interviewed an MSA responsible for scheduling consults and found that staff used the list to annotate and document the date of attempts made to contact patients to schedule their appointments. The list included patients referred to Chiropractic Care from Primary Care and was maintained in VHA's electronic records at all times. We analyzed the medical records of 10 patients from the list and found that the data on the paper list were consistent with the consult requests in VistA for all 10 patients. We concluded that these consults were electronically tracked in VHA's consult package.

Improperly Canceled Chiropractic Care Consults

We determined that the Chiropractic Service inappropriately canceled consults. According to VHA's *Consult Management Business Rules*, the facility should only cancel a consult when the consult prerequisite work is inadequate or when the service is not available and the facility will provide the patient a community care consult.

We analyzed 30 consults canceled from January through March 2015 and found that the staff responsible for scheduling inappropriately canceled all 30 consults. A staff member did not make three attempts to contact the patient to schedule appointments, which was contrary to PVAHCS policy. PVAHCS's local scheduling policy (March 2014) stated that schedulers should make three documented attempts to contact a patient for scheduling the appointment.

Furthermore, PVAHCS's *Consult Clean-Up Business Rules* (March 2014) stated that staff should only cancel a consult if the patient does not have the prerequisite studies completed.

We interviewed the Chiropractic Service staff responsible for scheduling and other administrative and clinic staff involved with Chiropractic Services at PVAHCS. According to a staff member, before July 2015, when the Chiropractic Service received a consult, she would send a letter to the patient and usually cancel the consult a week later if the patient did not contact the service to schedule an appointment. She stated that she would send a second letter to inform the patient she was canceling the consult and requesting the patient to call if he or she still desired the care. Based on our review of canceled consults, we found that the staff member sent the first letter the same day the consult was received and sent the second letter an average of 17 days later (ranging from 1 to 63 days later). She canceled the consult the same day she sent the second letter. Within the 30 canceled consults we reviewed, 28 patients had not received the requested chiropractic care at PVAHCS.

Inadequate Attempts To Contact Patients

The staff member told us that she did not receive specific instructions on how to contact the patient, so she decided to mail letters in an effort to reach a multitude of patients in a timely manner. The staff member stated that she requested scheduling guidance from the administrative officer for Primary Care services regarding protocols on contacting patients to schedule appointments, as early as June 2013. According to the staff member, she did not receive any written guidance or policy. She stated that her supervisor verbally informed her that once she had made two contacts, she could cease making contact attempts. However, PVAHCS's scheduling policy (March 2014) stated that schedulers should make three documented attempts to contact a patient for scheduling the appointment.

Recommendation 2 addresses the need for PVAHCS to ensure staff make three documented contacts in an attempt to schedule consults by communicating consult policies and procedures to all facility staff.

The staff member stated that she started requesting assistance in January 2014 because she was falling behind scheduling appointments. A month later, the Primary Care nurse manager replied that they did not have the staff to assist Chiropractic Services at that time. In July 2014, the staff member made a similar request to the team leader because she was having an "extremely difficult time keeping up" with her workload. In August 2014, she sent an email to her supervisor and the Chief of Primary Care informing them that consults and scheduling requests for chiropractic care were arriving faster than she could keep up with and patients were waiting. According to the staff member and one other staff member, she did not receive assistance at that time.

In July 2015, the staff member received new guidance to make at least three attempts to contact a patient for scheduling appointments. This was consistent with updated Outpatient Scheduling Standard Operating Procedures that VHA issued in June 2015, which stated that if a patient cannot be reached after three documented attempts, the scheduler must ask the receiving provider for disposition of the consult and these steps must be documented in the patient's record. Later, in August 2015, Chiropractic Services started using HAS staff to schedule patients. HAS assigned four MSAs to schedule appointments in Chiropractic Services. In addition, PVAHCS activated the Electronic Wait List for Chiropractic Service on August 5, 2015, so staff could add patients waiting more than 90 days for an appointment to the Electronic Wait List.

PVAHCS addressed the action needed to ensure Chiropractic Services maintain sufficient resources to manage and schedule consults by assigning additional MSAs to Chiropractic Services.

Patients Did Not Receive Requested Care

Within the 30 canceled consults we reviewed, 28 patients had not received the requested chiropractic care. PVAHCS had not made adequate attempts to contact those patients to schedule their consults. Of the 28 patients, 10 had not received the requested care and their medical records showed no evidence they received care at PVAHCS from the referring provider since staff canceled the consult. The medical records of 18 patients who had not received the requested chiropractic care indicated that the referring provider had seen or talked to the patient since the canceled consult. The referring provider subsequently requested new consults for two of those patients. However, staff discontinued those consults because either the patient refused the care or Chiropractic Services could not reach the patient for scheduling after making two phone calls and sending two letters. We provided PVAHCS the consults of the 30 patients we reviewed.

Recommendation 5 addresses the need for PVAHCS to ensure Chiropractic Services follow-up with the patients whose consults were canceled by the service, for appropriate action.

Conclusion

PVAHCS's Chiropractic Service inappropriately canceled consults. This occurred because the service did not make adequate attempts to contact patients to schedule appointments, and did not maintain sufficient resources to manage and schedule consults. Of the 30 consults we reviewed, 28 patients had not received the requested chiropractic care at PVAHCS at the time of our review.

Recommendation

5. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System make sure

Chiropractic Services review all consults canceled by the service since January 1, 2015, for appropriate action.

Management Comments

The VISN 22 Director concurred with the recommendation and stated they already implemented Recommendation 5. The VISN 22 Director's response can be found in Appendix C.

OIG Response

The VISN 22 Director stated that PVAHCS reviewed the chiropractic consults identified by the OIG in this review to ensure appropriate action occurred, and that PVAHCS now has an established process to ensure appropriate consult cancellation. We will close Recommendation 5 when VISN 22 provides us with documentation supporting PVAHCS's review of all consults canceled by Chiropractic Services since January 1, 2015.

Finding 3 PVAHCS Had Open Consults for Veterans Who Had Died

OIG's Office of Healthcare Inspections (OHI) reviewed a total of 294 facility consults for 215 individual patients who had open consult requests at the times of their deaths, or had consults discontinued after the dates of their deaths. OHI evaluated whether each patient actually received the requested service and if they received the service, OHI determined whether it was within the expected time frame based on the consult urgency (stat, urgent, routine). In some instances when the documented urgency of the consult was inconsistent with the clinical indication for the consult, OHI reclassified the urgency level for the purposes of this review. For example, if a consult was ordered as a stat consult, but the clinical indication was actually routine in nature, OHI considered the consult to be a routine consult.

OHI concluded that in 62 of the 294 consults (21 percent), care was delayed. OHI then completed a review of these consults to determine whether the patients' deaths may have been related to a delay (as measured by the clinically indicated date) in obtaining the requested services. In some instances when the cause of death was not available within the electronic health record, OHI assessed the impact based on the information within other clinical encounters, the patients' medical histories, and the most recent treatment plans.

OHI concluded that in one case, a delay in receiving a requested consult may have caused patient harm. This case is summarized below. OHI determined that the remaining 61 patients did not die as a result of a delay in receiving the requested care.[5] For example, one patient's cause of death was determined to be liver failure. However, the consult for which care was delayed was to podiatry for unrelated foot care.

Case Summary

At the time of his death, this patient was a 58-year-old male with a past medical history of previous moderate tobacco use. He presented as a new patient to the facility in May 2015, complaining of dull chest pain that was exacerbated by strenuous activity. The provider ordered an exercise treadmill test to further evaluate the patient's chest pain. A consult was submitted to Cardiology Outpatient Treadmill Consult. Within the consult, the ordering provider requested that the test be completed within 1 week.

[5] Many of the consults we reviewed to evaluate the impact of delay were to non-clinical services or for preventative or non-acute care. For example, delays to services such as in-home respite for caregivers, physical therapy, rehab medicine, routine eye exams, and podiatry orthotics would not be considered significant in terms of being "causal" to the patient's death. Overall, we determined that 135 of the 294 consults (46 percent) we reviewed were not related to a patient's death simply because of the nature of the requested service.

Minutes later, a staff physician approved the consult. In June 2015, the patient was found deceased in his home by a family member. According to the death certificate, an autopsy was performed confirming the cause of death as atherosclerotic cardiovascular disease. At the time of his death, the treadmill test was not scheduled. The consult was closed when the facility was informed of the patient's death. A Primary Care provider evaluated this patient and appropriately referred the patient for further cardiac testing based on his symptoms. In addition, the Primary Care provider appropriately requested the test be completed within a week, as his symptoms were concerning and suggestive of heart disease. Timely testing may have indicated that the patient had significant disease and could have prompted further definitive testing and interventions that could have forestalled his death.

Recommendation 6 addresses the need for PVAHCS to ensure that the care of this patient is reviewed and that appropriate action is taken.

Patients Reviewed

OHI reviewed a total of 294 facility consults for 215 individual patients who had open consult requests at the times of their deaths, or had consults discontinued after the dates of their deaths. This included the following.

In July 2015, the complainant provided a report of 87 deceased patients with 116 open consults. The report provided by the complainant, as well as the additional data we collected, identified patients who died with open consults. This report was available through VHA's Business Intelligence Service Line (BISL) and was updated daily. Therefore, the numbers of patients and consults change daily. The data captures patients who have open consults and a date of death associated with their medical record. OHI reviewed the medical records of the 87 patients submitted by the complainant to determine if the patients received care in a timely fashion, based on the urgency of the consult, before they died.

In addition, OHI reviewed the medical records of 119 deceased patients with 169 open consults who:

- Had an active or pending consult on September 30, 2015, but died before that date, and/or
- Had at least one consult that was ordered from May 1 through September 30, 2015, and was discontinued after the date of death.

OHI also reviewed the medical records of nine deceased patients who had nine vascular consults discontinued because they died. We identified nine deceased patients from a list of discontinued vascular consults provided by the complainant. OHI determined that these patients did not die because they did not receive the associated consult timely. We determined that the Vascular Lab PSA discontinued the nine consults because the patients were

deceased. VHA's June 2015 guidance states that non-clinicians can discontinue consults if the patient is deceased.

PVAHCS Did Not Discontinue Consults Timely

For the consults we reviewed, we found that PVAHCS closed the consults because VHA and PVAHCS business rules and policy prescribed that a consult be discontinued if the patient is deceased. However, facility staff did not consistently comply with this policy and some consults remained open long after patients' deaths.

VHA's Consult Steering Committee and VHA's *National Guidance for Discontinuing or Cancelling Consults* allow non-clinicians to discontinue an open consult if the circumstances can be defined by a rule such that no independent medical decision-making is required—including if the patient is deceased. The then-Chief of Quality, Safety, and Improvement (QSI) at PVAHCS stated that all patients who die with an open consult go through a screening process to determine if an additional review is necessary. If further review is required, VA may perform a protected peer review, institutional disclosure, or a root cause analysis. We reviewed the records of 26 outpatients who died with an open consult to determine if they were included in QSI's outpatient screening process and verified that all 26 patients were included in the list of patients PVAHCS screened.

VHA's *Consult Management Business Rules* (May 2014) stated that VHA staff should discontinue a consult when the patient is deceased. Specifically, PVAHCS's consult policy stated that, for any patient who is confirmed as deceased, staff must discontinue the consult and send the patient's name, last four digits of their Social Security number, and consult title to the Chief of QSI for review. Therefore, if a patient dies waiting for a consult, facility staff should discontinue the consult. We determined that this policy was to ensure consults do not remain unnecessarily open for an extended period and schedulers do not attempt to contact the patient to schedule an appointment.

Because facility staff did not consistently comply with this policy, some consults remained open long after the patients' deaths. According to the Decedent Affairs clerk, consults were generally not discontinued until the referring provider noticed the alert, or when the specialty care service assessed the patient's record and determined the patient was deceased. The clerk stated that this resulted in a period of time during which the providers are not aware that the patient is deceased.

Recommendation 7 addresses the need for PVAHCS to develop a mechanism to ensure that QSI services appropriately screen deceased patients records with an open consult, and staff timely and appropriately close the consult upon verification of death by Decedent Affairs.

Conclusion

OHI determined that untimely care from PVAHCS may have contributed to the death of one patient. OHI found that this patient had a delayed

cardiology outpatient treadmill consult (outpatient stress test) and that timely testing may have indicated that the patient had significant cardiac disease and could have prompted further definitive testing and interventions that could have forestalled his death. OHI determined that, for the remaining patients' records reviewed, consult delays did not contribute to the patients' deaths. We found that PVAHCS discontinued consults of patients who died waiting for care because policy prescribed that a consult be discontinued if the patient is deceased. However, facility staff did not consistently comply with this policy and some consults remained open long after the patients' deaths.

Recommendations

6. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System ensure that the care of the patient identified in the reported case summary is evaluated, takes action, if appropriate, and confers with Regional Counsel regarding the appropriateness of disclosures to patients and families.

7. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System develop a mechanism to ensure that Quality, Safety, and Improvement services appropriately review deceased patients' records with an open consult, and staff timely and appropriately close the consult upon verification of death by Decedent Affairs.

Management Comments

The VISN 22 Director concurred with the recommendations and stated they already implemented Recommendations 6 and 7. The VISN 22 Director's response can be found in Appendix C.

OIG Response

The VISN 22 Director's corrective actions are acceptable. We will close Recommendation 6 once VISN 22 provides documentation supporting the decision regarding Institutional Disclosure. We consider Recommendation 7 closed based on PVAHCS's actions.

Finding 4 Nearly 4,800 Patients Had Open Consults for PVAHCS Care for More Than 30 Days, and 10,000 Patients Had Open Consults for Community Care Exceeding 30 Days

We determined that, as of August 12, 2015, more than 22,000 individual patients had 34,769 open consults at PVAHCS. This included all categories, statuses, and ages of consults. Of all the open consults at that time, about 4,800 patients had nearly 5,500 consults for appointments within PVAHCS that exceeded 30 days from their clinically indicated appointment date. These included consults in a status of pending, active, scheduled, and partial results. In addition, more than 10,000 patients had nearly 12,000 community care consults that exceeded 30 days. Consults for care in the community included traditional non-VA care and Choice.

The remaining approximately 17,000 open consults were for prosthetics, administrative purposes, and/or did not exceed 30 days from their clinically indicated appointment date. VHA does not require staff to complete prosthetics consults immediately.

Consults for care within PVAHCS accounted for about 56 percent of the open consults. Consults for care in the community, which included the traditional non-VA care and Choice, accounted for more than 44 percent of the open consults. By March 2016, PVAHCS had just over 32,500 total open consults. As of July 2016, according to PVAHCS, the facility had nearly 38,000 total open consults.

PVAHCS had a high number of open consults because providers did not always act upon (receive and review) consults to their clinics timely. We identified 499 consults that were pending more than 7 days, which means the clinic had not yet received and reviewed the consults for appropriateness and scheduling. In addition, staff had not scheduled patients' appointments in a timely manner (or had not rescheduled canceled appointments), a clinic could not find lab results, and staff did not properly link completed appointment notes to the corresponding consults. PVAHCS had a high number of open consults for care in the community primarily because patients were still awaiting care, and also because PVAHCS had not received documentation supporting completed care from the contractor TriWest or community care providers. As a result, patients attempting to get care at PVAHCS continued to encounter delays in obtaining such care.

Criteria

VHA's *Consult Management Business Rules* (May 2014) and VHA's *Interim Consult Standard Operating Procedures* (SOPs) (March 2015) stated that consults should remain pending for no more than 7 days. Procedures stated that if a consult is not scheduled within 7 days, the consult must be "received," which, according to local policy, means to screen and review consults for appropriateness and scheduling. When a consult is received, the

status becomes "active" while the service is attempting to schedule or reschedule an appointment.

PVAHCS's local consult policy (June 2015) requires each service to designate clinical staff to screen and review consults for appropriateness and scheduling. This local policy also requires pending outpatient consults to be acted on within 7 calendar days and care completed within 30 days.

Patients Waiting for Consults

We analyzed open consults at PVAHCS as of August 12, 2015, and determined that more than 22,000 patients had 34,769 open consults at PVAHCS. This included all categories, statuses, and ages of consults. Of all the open consults at that time, about 4,800 patients had consults for appointments within PVAHCS that exceeded 30 days from their clinically indicated appointment date. During fiscal year (FY) 2015, VHA established goals to reduce the number of aging consults and began weekly performance improvement calls with facilities to monitor consults exceeding 90 days. In addition, PVAHCS established in its local consult policy, dated June 1, 2015, that all consults for outpatient care must be completed within 30 days.

As shown in Table 1, of the nearly 35,000 open consults, 13,531 were for consults for care within PVAHCS and 15,459 were consults for community care.

Table 1. Open Consults at PVAHCS

Consult Type	Total Open Consults	Average Days Open	Consults Greater Than 30 Days From Consult Release Date	Percent of Consults Greater Than 30 days
PVAHCS Care	13,531	36	5,708	42
Community Care	15,459	91	11,984	78

Source: VA OIG analysis of VHA's Business Intelligence Service Line data as of August 12, 2015

The remaining 5,779 open consults were for future care, prosthetics, or administrative purposes within PVAHCS. Future care consults are requests for care that are medically appropriate more than 90 days after requested. VHA does not require staff to schedule future consults immediately. Prosthetics consults may also remain pending for longer than 7 days, according to VHA's Interim SOPs. For the purposes of this review, we separated future care, prosthetics, and administrative consults since VHA did not apply the same timeliness standards to those consults.

Patients Waiting for Vascular Care

We substantiated that one vascular patient waited in excess of 300 days for vascular care. A patient received vascular care in October 2015 following a consult request from a clinician in Vascular Surgery in June 2013. The requesting provider's clinically indicated date for care was June 19, 2014. Vascular Lab staff scheduled an appointment, but the patient did not go to the appointment and the consult remained open. Staff did not act upon the consult again until July 2015. Facility staff then made multiple attempts to contact the patient, and provided care to the patient in October 2015.

As of August 12, 2015, we identified 13 open consults of patients waiting for Vascular Lab more than 30 days beyond the clinically indicated date of the provider, ranging from 32 to 157 days. We determined that staff had yet to schedule four of these consults.

Vascular Service did have 130 consults that appeared to be open for more than 300 days. However, 126 were future care consults in which the requesting provider requested care for a date more than 90 days in the future. For example, on June 19, 2015, Vascular Surgery submitted a consult to Vascular Lab in which the clinician requested the patient return on or after July 19, 2016. The remaining four consults that appeared to be more than 300 days old were not future care consults. However, the status of the consult indicated that the patient had already received care and staff did not appropriately complete the consult. For example, Vascular Lab received a routine consult request on February 18, 2014. The clinic provided care on April 8, 2014, but a provider had not linked the results of the appointment as of August 2015.

Why This Occurred

Several factors contributed to the delays in completing consults at PVAHCS. Of the 13,531 open consults within PVAHCS (not including prosthetics, future care, or administrative consults), we found that providers did not always act upon consults to their clinics timely (pending), and staff had not scheduled or rescheduled patients' appointments in a timely manner (active). In addition, a clinic could not find lab results, and clinics did not properly link completed appointment notes to the corresponding consults (scheduled). In a small number of consults, staff properly linked the completed appointment notes to the corresponding consults but did not sign the clinical note (partial results).

Our analysis is outlined in Table 2.

Table 2. Status of Open Consults for Care at PVAHCS

Consult Status	Total	Greater Than 30 Days From Consult Release Date
Pending (Unscheduled)	1,274*	128
Active (Unscheduled)	4,095	1,490
Scheduled	7,907	3,992
Partial Results	255	98
Total PVAHCS Care Consults	**13,531**	5,708

Source: VA OIG analysis of VHA's Business Intelligence Service Line data, as of August 12, 2015

*We identified 499 of 1,274 pending PVAHCS consults that were greater than 7 days.

Clinicians Did Not Timely Review Pending Consults

Clinicians did not always act upon consults timely, leaving some consults in a pending status for more than 7 days. This means the consults are not available for schedulers to contact the patients and schedule an appointment. Policy required pending outpatient consults to be acted on within 7 calendar days. We identified 499 of 1,274 PVAHCS consults pending more than 7 days, which means the clinic had not yet received and reviewed the consults for appropriateness and scheduling. Furthermore, 15 of those consults were pending for more than 90 days.

During the review, we determined that non-clinicians inappropriately screened 48 of the 265 consults (18 percent) we reviewed. Policy required clinicians to screen and review consults for appropriateness and scheduling, with the exception of direct schedule consults, when the administrative staff of the ordering provider directly schedule the consult. Facility staff stated that this occurred when one service relied on fee-basis providers instead of having an onboard full-time provider, and when a section chief provided specific guidance to administrative staff detailing when procedures do not require a clinical review.

PVAHCS staff, including clinical section chiefs, stated that clinicians should receive consults to ensure medical necessity and that the consult is labeled with the appropriate urgency. Recommendation 8 addresses the need for PVAHCS to ensure all services maintain appropriate and sufficient clinical staff to receive and review consults within target time frames.

Staff Did Not Timely Schedule Appointments

Staff had not scheduled patients' appointments or had not rescheduled a canceled appointment, leaving nearly 4,100 consults in an active status. Of those, nearly 1,500 were older than 30 days. Specialty care services at PVAHCS lacked sufficient personnel to schedule appointments in their clinics, which resulted in services not timely contacting patients to schedule appointments.

A shortage of MSAs in services can lead to a backlog of active consults in which the service needs to contact and schedule the patients for their appointment. PVAHCS had yet to fill several MSA scheduler vacancies. Based on our analysis of data used by Human Resources staffing specialists at PVAHCS, we identified 93 HAS MSA vacancies, as of November 2015. The 93 HAS MSA vacancies were for a combination of specialty care and Primary Care services, and were not advertised for specific clinics. According to a Human Resources specialist, the hiring process to fill a vacancy for MSAs at PVAHCS can take more than 3 months. In addition, she stated that, because of poor communication, an incorrect job announcement was being used when officials wanted to hire GS-6 MSAs, which also hindered efforts in filling the MSA vacancies.

Recommendation 9 addresses the need for PVAHCS to ensure Human Resources and specialty care services fill vacant MSA positions responsible for scheduling consults in specialty care services to ensure sufficient resources to manage and schedule consults. The OIG is conducting an ongoing audit of MSA management at PVAHCS.

Clinic Could Not Find Printed Lab Results

PVAHCS Vascular Service did not properly link clinicians' notes for the completed appointments to the corresponding consults. This caused these completed consults to remain open in a "scheduled" status. We identified more than 170 open Vascular Lab consults in which the appointment already occurred and the consult documentation was not appropriately completed. To complete a Vascular Lab consult, a clinician must review and dictate the patients' appointment results, including the results of any ordered tests. The Chief of Vascular Service stated that, in recent months, on multiple occasions, she had received paper documents of older studies without evidence of review or dictation.

Since 2008, the Chief of Vascular Service voiced concerns about delays in scanning reports and lost appointment documents, and attempted to improve Vascular Lab procedures by requesting that the VISN and PVAHCS replace the Vascular Lab software. She stated that none of the Vascular Lab machines were connected to the VA network, which meant every image had to be printed and scanned into VistA after the provider dictated the results. Over the following years, information technology and budget constraints hindered the facility's ability to obtain and implement new software. In 2011, she followed up with Information Technology staff regarding the status of getting Vascular Lab equipment connected to the facility's network

system, citing lost photo images of Vascular Lab appointment results because of the current paper process. The Chief of Vascular Service reported lost documents again in July 2013 and in October 2013.

Vascular Service staff did not properly link clinicians' notes to the corresponding consults, in part, because they could not find printed lab results of completed appointments associated with open consults in order to input completed appointment results into the electronic health records. Therefore, Vascular clinicians could not dictate the appointment results and link the note to the consult. We reviewed 60 incomplete Vascular Lab consults and found that many of these consults were not closed because:

- Clinicians had not reviewed and dictated 29 consults because they could not find the lab results.
- Clinicians incorrectly linked 25 appointment results to the wrong consults.
- Clinicians completed six consults during our review, but did not immediately complete them because they had a backlog of consults to review and dictate.

Of the 29 consults for which staff could not find the lab results, patients had an appointment with a Vascular Surgery clinician on the same day in 13 instances. In these instances, we found evidence that the clinician reviewed the studies during the appointment. Some clinic notes mentioned the lab studies in detail, while others simply referred to the studies. However, clinicians had yet to review and dictate the lab results to complete the consult.

PVAHCS staff gave the lab studies of two consults to a patient who had an appointment with the Vascular Surgery Clinic on the same day. According to the note on the clinic appointment, the patient checked in, but then left with her/his Vascular Lab studies. According to staff and supervisors in Vascular Service, if a patient has a Vascular Clinic appointment on the same day as a Vascular Lab appointment, the patient is given the study to walk between the clinics. According to the Vascular Lab PSA, some patients have left PVAHCS with their studies while waiting in the clinic for their Vascular Clinic appointment.

The remaining 14 consults had neither a lab note nor a comment in a clinic note to document care. Therefore, it was unknown whether Vascular Service appropriately reviewed the results of these labs or if the patients were still awaiting the results. We provided PVAHCS with the 29 incomplete consults for which staff could not find the lab results.

Vascular Service electronically sent, received, and scheduled consults in VHA's consult package. However, PVAHCS's Vascular Lab machines were not connected to the VA network, which meant the lab results of completed

appointments had to be printed and scanned into VistA after the provider dictated the results. During the course of this review, PVAHCS took action to move Vascular Labs to an electronic process. However, the service still printed consults and labs for some studies.

Recommendation 10 addresses the need for PVAHCS to ensure it pursues an automated process to ensure Vascular Lab results are entered in the electronic medical records to eliminate reliance on printed appointment results.

Recommendation 11 addresses the need for PVAHCS to ensure it reviews all incomplete Vascular Lab consults to identify and address all potential lost lab results.

Staff Did Not Complete Consults After the Patient Received Care

PVAHCS staff had not appropriately completed consults after the patient received care. Of the nearly 8,000 consults that staff already scheduled, we determined that about 8 percent had an appointment status of "checked-out," which indicated the patient already received care but staff did not properly link the providers' notes of the completed appointments to the corresponding consults.

Recommendation 12 addresses the need for PVAHCS to ensure clinics and clinic informatics services develop a mechanism to routinely identify and address open consults in which the corresponding appointment was already completed.

Incomplete Non-VA Care and Choice Consults

As of August 2015, about 15,500 of PVAHCS's nearly 35,000 open consults were for non-VA care or Choice appointments. Non-VA care and Choice consults indicate that the facility is requesting care from a provider in the community. Based on the status of the open community care consults, nearly 10,100 of the nearly 15,500 consults (65 percent) indicated that a patient was still waiting for care. On average, those patients' consults had been open for about 78 days.

The more than 5,400 remaining open community care consults (35 percent) had a status that indicated the patient received care. According to PVAHCS staff, this generally occurred because PVAHCS had not received notification from the contractor or non-VA care provider, or had not documented whether patients completed their non-VA care or Choice appointments. Community care consults are completed after medical documents have been received from the outside provider and indexed through document management. A non-VA care nurse said they check the contractor's portal for patients' medical records on a daily basis.

PVAHCS expressed challenges with the Choice program, such as engagement with the contractor and hiring sufficient non-VA care staff to manage the Choice appointments for the facility. According to PVAHCS, as

of February 2016, 17 clinical full-time equivalents and 34 administrative full-time equivalents managed community care consults and appointments. In addition to these onboard staff, PVAHCS had 16 vacancies in non-VA care—2 clinical FTEs and 14 administrative FTEs. In addition, more than 3,700 community care consults were older than 120 days.

Recommendation 13 addresses the need for PVAHCS to assign sufficient staff to manage community care consults, as they represented nearly half of PVAHCS's open consults.

Recommendation 14 addresses the need for PVAHCS to ensure non-VA care staff follow up with those patients with open community care consults exceeding 120 days to determine if they received the requested care.

Delays in Care

Patients attempting to address new care needs at PVAHCS continued to encounter delays in obtaining such care. As of August 2015, about 4,800 patients were waiting more than 30 days from their clinically indicated appointment date for consultative appointments within PVAHCS. Those patients were waiting an average of 66 days. More than 10,000 patients had community care consults exceeding 30 days.

Furthermore, according to the Chief of Vascular Service, lost Vascular Lab results present a risk that the patient may need to return to the clinic to redo the test or procedure. In addition, consults that a clinician has not reviewed present a risk that the service did not identify an issue in the patients' lab results.

PVAHCS and VISN Efforts To Improve Access

PVAHCS leaders stated that they continue to make efforts to improve consult management and access to specialty care services at the facility. Specifically, in June 2015, PVAHCS implemented a local consult management policy to align facility processes with national VHA guidance. PVAHCS also created a consult management committee, which provides oversight of all aspects of the consult process and works with the facility to adapt to consult policy changes. PVAHCS leadership established "Morning Reports" that occur every day and include representatives from HAS and the respective specialty care service. The then-Chief of Staff stated that their focus has been on reducing the number of consults exceeding 90 days. In addition, they are focusing on reducing pending consults older than 7 days.

The then-Chief of Staff stated that VHA selected PVAHCS as one of six Group Practice Manager pilot sites nationally to optimize clinic access. He also stated that PVAHCS had discussed plans to build a consult scheduling group within HAS to oversee and assist with the scheduling of consults.

A VISN official stated that he/she had worked with PVAHCS to add staff over the past two years to improve access. PVAHCS increased staff from more than 2,460 full-time equivalent employees in December 2013 to over

3,000 in November 2015. Moreover, PVAHCS added additional clinical space at the main facility and three outpatient clinics in an effort to improve access.

Conclusion

More than 22,000 individual patients had 34,769 open specialty care consults at PVAHCS, as of August 2015. Nearly 4,800 patients were waiting more than 30 days from their clinically indicated appointment date for consultative appointments within PVAHCS, and more than 10,000 patients had community care consults exceeding 30 days.

PVAHCS did not timely complete consults primarily because providers did not always act upon consults to their clinics timely, staff had not scheduled patients' appointments in a timely manner (or had not rescheduled canceled appointments), a clinic could not find lab results, and staff did not properly link completed appointments to the corresponding consults. PVAHCS had a high number of open consults for care in the community primarily because patients were still awaiting care, and also because PVAHCS had not received or documented completed care from the contractor TriWest or community care providers. As a result, patients attempting to get care at PVAHCS continued to encounter delays in obtaining such care.

Recommendations

8. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System make sure services assign and maintain appropriate and sufficient clinical staff to receive and review consults within target time frames.

9. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System make sure Human Resources and specialty care services fill vacant medical support assistant positions responsible for scheduling consults in specialty care services to ensure sufficient resources to manage and schedule consults.

10. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System pursue an automated process to ensure Vascular Lab results are entered in the electronic medical records in order to eliminate reliance on printed lab results.

11. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System make sure Vascular Service review all incomplete Vascular Lab consults to identify and address all potential lost lab results.

12. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System make sure clinics

coordinate with clinic informatics services to develop a mechanism to routinely identify and address open consults in which the corresponding appointment was already completed.

13. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System assign sufficient staff to manage non-VA care and Choice consults and appointments.

14. We recommended the Veterans Integrated Service Network 22 Director ensure the director of Phoenix VA Health Care System make sure non-VA care develop a process to routinely follow up with those patients with open community care consults older than 120 days to determine if they received the requested care.

Management Comments

The VISN 22 Director concurred with the recommendations and stated they would implement Recommendations 9, 10, 11, and 14 by November 2016, and that VISN 22 already implemented Recommendations 8, 12, and 13. The VISN 22 Director's response can be found in Appendix C.

OIG Response

The VISN 22 Director's planned corrective actions are acceptable. We will close Recommendation 8 once VISN 22 provides documentation supporting PVAHCS's assessment of staffing needs for each service and their action to designate a clinician who performs consult management duties for each service. We will monitor VA's progress and follow up on the implementation of Recommendations 9, 10, 11, and 14 until all proposed actions are completed. We consider Recommendation 12 closed based on PVAHCS's actions. We will close Recommendation 13 once VISN 22 provides documentation supporting PVAHCS's ongoing process to review personnel needs to meet the demand for non-VA care and Choice consults.

Appendix A Background

Phoenix VA Health Care System

PVAHCS comprises the Carl T. Hayden Veterans Affairs Medical Center and seven clinics and is now part of VISN 22. PVAHCS serves more than 80,000 patients in central Arizona, including the Phoenix area. The medical center provides acute medical, surgical, and psychiatric inpatient care, as well as rehabilitation medicine and neurological care.

Consult Policy

VHA Consult Policy, Directive 2008-056, provided policy to VHA staff on appropriate consult management. This directive expired in September 2013, but VHA had not superseded it with a new policy until August 2016. VHA's *Consult Management Business Rules* (May 2014) provides guidance on when staff can discontinue or cancel a consult. However, neither the 2008 VHA Directive nor the *Consult Management Business Rules* specified when a clinician was responsible for discontinuing or canceling consults.

Starting in 2014, VHA began drafting a new consult management directive, handbook, and SOPs. In 2015, VHA began providing facilities updated consult management guidance based on these draft policies and distributed an Interim Consult SOPs. On June 1, 2015, PVAHCS published a local consult policy based on VHA's Draft Directive and VHA's Draft Handbook. VHA also developed guidance called *National Guidance for Discontinuing or Cancelling Consults* (June 2015), which stated that clinicians and non-clinicians can discontinue consults under certain circumstances, and that facilities are required to document the reason for discontinuing a consult. The guidance specifies that a clinician should discontinue the consult or electronically document concurrence for administrative staff to discontinue the consult when the patient canceled multiple times, did not respond to the minimum scheduling efforts, or did not show up for a scheduled appointment multiple times. The guidance also specifies that non-clinicians can discontinue consults if the patient is deceased, the consult is a duplicate request, the patient refuses care, or the patient opts for non-VA care.

VHA's *National Guidance for Discontinuing or Cancelling Consults* also states that consults may only be canceled if the ordering provider did not include sufficient information in the consult request or to correct an error in the Earliest Appropriate Date or Clinically Indicated Date entry.

On June 8, 2015, VHA issued a memo titled, *CORRECTION: Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance*. This included Outpatient Scheduling SOPs, which stated that when scheduling in response to a consult, if a patient cannot be reached after three documented attempts, the scheduler must ask the receiving provider for disposition of the consult and these steps must be documented in the patient's record.

Appendix B Scope and Methodology

Scope

We conducted our review from August 2015 through June 2016. To assess the merits of the allegations, we focused on PVAHCS's consult management practices during FY 2015 and part of FY 2016, and conducted site visits at PVAHCS during August, September, November, and December 2015. Specifically, we reviewed consults that were discontinued or canceled from January 1 through August 15, 2015. We analyzed consults at PVAHCS that were open as of August 12, 2015. We conducted interviews at PVAHCS from August through December 2015, and conducted additional interviews over the phone through March 2016.

Methodology

We conducted 84 interviews with 58 facility staff, including the complainant, schedulers, administrative officers, clinicians, clinical chiefs of service, the Chief of Medicine, the then-Chief of Staff, and other management responsible for providing consult management guidance and oversight.

We obtained and reviewed a myriad of consult data. To assess discontinued consults and if patients received the requested care, we reviewed a statistically random sample of 265 discontinued consults from 10 specialty care services. The 10 specialty care services were Cardiology, Chiropractic, Gastroenterology, General Surgery, Hand and Plastics, Orthopedics, Podiatry, Renal, Vascular Lab, and Vascular Surgery. We derived the random sample from a population of consults that were greater than 90 days old and discontinued from January 1 through August 15, 2015. We also obtained a list of discontinued Vascular Lab consults by a non-clinician, from the complainant, and reviewed 44 consults discontinued January 1 through June 2, 2015.

To assess canceled consults, we obtained and reviewed summary data from VistA of canceled consults in 10 specialty care services. Based on these summary data, we identified Chiropractic Service as an outlier, and selected 30 canceled consults to determine why staff canceled the consults and if patients received the requested care.

In August 2015, we obtained a list of 397 patients referred for chiropractic care between March 21 and July 21, 2015, from the complainant and the director's office. We reviewed 10 patients in VistA to determine if the list was an unofficial list of patients waiting for chiropractic care.

To assess patients who died with open consults at PVAHCS, OHI reviewed 87 patients' medical records to determine if the patients received care in a timely fashion, based on the urgency of the consult, before they died. OHI conducted this review because of a report provided by the complainant. In addition to these 87 patients, OHI reviewed the records of 119 deceased patients who had an active or pending consult on September 30, 2015, but had died before that date, and/or had at least one consult that was ordered

from May 1 through September 30, 2015, and was discontinued after the date of death. The complainant also provided us a list of discontinued consults of patients who were waiting for vascular care. We identified nine patients from the list of patients whose consults were discontinued from July 31, 2014, through June 2, 2015, because they died, which OHI also reviewed. In total, OHI reviewed 294 consults involving 215 individual patients.

To assess whether PVAHCS had more than 35,000 patients waiting for consults and vascular patients waiting in excess of 300 days for care, we obtained and analyzed all open consults at PVAHCS, as of August 12, 2015, to determine the age of consults in various statuses and specialty care services.

Fraud Assessment

In order to obtain reasonable assurance of detecting fraud that may have occurred within the context of our review, we assessed risks applicable to fraud, illegal acts, and abuse. We considered risk factors such as the prior review of scheduling practices at PVAHCS and the lack of SOPs or outdated policies when developing our review steps.

We interviewed numerous staff with knowledge of PVAHCS's consult practices. We consulted with OIG's OHI to review whether patients identified by the complainant received care in a timely fashion, based on urgency within the consult, before they died. We did not find any standards to support that staff closed consults illegally.

Data Reliability

We relied on computer-processed data from VHA's BISL. To assess the reliability of BISL data, we compared details of the consult data reported in BISL with consult data of individual patient records in VHA's Computerized Patient Record System. We concluded that the data we obtained and relied upon were sufficiently reliable for the purposes of this review.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix C Management Comments – Under Secretary for Health

Department of Veterans Affairs

Memorandum

Date: August 5, 2016

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Review of Alleged Consult Management Issues at the Phoenix VA Health Care System (Project No. 2015-04672-R5-0284) (VAIQ 7711383)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on the draft report, Alleged Consult Management Issues at the Phoenix VA Health Care System. I concur with the recommendations and provide the response for recommendation 1. The Veteran Integrated Service Network (VISN) Director provides responses to recommendations 2-14.

2. VHA has taken many actions during the past 3 years to improve how we handle consultations for clinical care. Our efforts have effectively decreased the number of consults for clinical care open more than 90 days by 64 percent. In December 2013, VHA had 270,740 consults open for more than 90 days; as of August 2016, VHA has 98,757. Only 30 of these open consults were originally entered as stat or urgent. In many cases, the patient has received the requested care, however, the electronic health record lists the status of the consult as "open" until VHA receives documentation from the providing physician. Currently, 36,877 open clinical consults still need final documentation.

3. One of our most effective strategies was to hold a National Access Stand Down where VA medical centers (VAMCs) across the country participated in a large-scale review of consults that the requesting clinician felt were urgent. Facilities nation-wide reviewed 50,116 urgent open consults. Within 2 weeks, facilities scheduled 17,258 appointments for care and closed 32,858 consults that had been completed but not closed out appropriately in the health record.

4. VHA updated and published a standard operating procedure that clarifies procedures on how providers need to request and complete consults using the electronic health record. It clarifies consult procedures for managing consult cancellation, patient no-show, and consult discontinuation. As the final step to formalizing the procedures that staff have been taught through national training on the standard operating procedure, VHA developed a national Directive on consult management. This new Directive underwent robust review by stakeholders in the organization and is undergoing final leadership approval.

5. Throughout fiscal year 2015, VHA provided national training to VISN and facility employees on consult management procedures. Employees could use many different options to undergo training: webinar, VA eHealth University (VeHU), and VA's on-line Talent Management System (TMS). As of August 2015, 97 percent of Licensed Independent Practitioners assigned the TMS training had completed it.

An additional 12,740 staff who were not assigned the TMS training module voluntarily completed it and VHA provided separate consult management training for resident physicians-in-training.

6. In response to GAO's report "VA Health Care: Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care" (GAO-14-808), VHA's Office of Compliance and Business Integrity (CBI) developed a comprehensive compliance audit protocol and collaborated with the VHA Support Service Center to develop the Consult Management Compliance Audit Tool (CM-CAT) web application and database to collect, store, and report on audit outcomes at each level of the VHA organization. The audit protocol and web application underwent testing and quality assurance reviews. Pilot audits were completed in October 2015. In March 2016 Compliance and Business Integrity Officers and staff at each VISN and VHA facility were provided training on the audit protocol and received access to the CM-CAT web application. The audit will be conducted on a quarterly basis. Field work began at VAMCs on April 1, 2016.

7. As of July 7, 2016, CBI Officers submitted audit records for 8,428 outpatient consults. Of these, VISNs certified 2,591 outpatient consult audit records; 141 VHA health care facilities (100 percent) have each submitted at least 18 outpatient consult audit records; and 19 VISNs (100 percent) have each submitted at least 257 outpatient consult audit records.

8. As a result of VHA's assessment of various strategies VAMC's used to manage future care consults, VHA decided to standardize procedures by authorizing future care consults (rather than recall reminders or non-count EWL's) as the only approved method for managing consult requests for care intended to take place beyond 90 days from the date the consult is created. Standardized processes improved the consistency and reliability of future care consult data allowing better oversight.

9. VHA established a system-wide process for identifying and sharing best practices among colleagues that promotes nation-wide communication. VHA first identified a list of about 475 VISN and facility consult points of contact (POCs) and developed a mail group to facilitate communication with the POCs. VAMCs established local consult steering committees and are represented on weekly national consult performance improvement calls. Each week, close to 400 attendees participate in these calls which include training on consult policies and processes, review of consult performance data and presentations on best practices.

10. VHA has developed multiple technological tools to improve local and national consult management. VHA developed a web-based switchboard that houses consult resources and consult reports. VHA created a Consult Cube with many different Pyramid views that enable easy access to consult data. VHA used Sharepoint to establish a repository for all consult policy documents, training materials, Frequently Asked Questions, and contact information for VISN and facility consult experts and steering members.

11. The recommendations in this report apply to GAO high risk area 1. VHA's actions will serve to address ambiguous policies, inconsistent processes, and inadequate training for VA staff.

12. VHA is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the Department of Veterans Affairs (VA) health care system. VHA is using the input from VA's Office of Inspector General, and other advisory groups to identify root causes and to develop critical actions. As VHA implements corrective measures, we will ensure our actions are meeting the intent of the recommendations.

13. If you have any questions, please email Karen M. Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(original signed by:)

DAVID J. SHULKIN, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Review of Alleged Consult Management Issues at the Phoenix VA Health Care System

Date of Draft Report: June 17, 2016

Recommendations/ Actions	Status	Target Completion Date

OIG Recommendations

Recommendation 1. We recommended the Under Secretary for Health update the Veterans Health Administration Consult Policy.

VHA Comments: Concur

VHA has updated and published national Consult Business Rules and has trained staff on the content of the business rules. The business rules were developed iteratively by a rich combination of end users, clinical leaders, and consult subject matter experts. At the point the business rules were stable, system-wide training was developed and deployed by webinar, VA eHealth University, and VA's on-line Talent Management System (TMS). As of August 2015, 97 percent of Licensed Independent Practitioners assigned the TMS training had completed it. An additional 12,740 staff who were not assigned the TMS training module voluntarily completed it and VHA provided separate consult management training for resident physicians-in-training. VA's published business rules and associated standard operating procedures establish clear procedures for VHA consult management. The national training ensures employees who manage consults are adequately trained on those business rules. Using the business rules as a basis, VHA then drafted an updated Consult policy. The draft policy received additional end user and stakeholder feedback before the comments were reconciled and the policy entered the final approval phase at the end of June, 2016. Labor and Management Relations completed a review of the policy and on August 2, 2016 stated the intention to concur with the policy.

VHA expects the updated business rules already published and contained in the policy, in combination with the standard operating procedure, and robust training to enable employees to manage consults consistently in all clinical settings. This three pronged approach establishes and implements standards for performance and results in a common experience for Veterans seeking care through the consult process.

VHA has also established a system-wide process for identifying and sharing best practices among colleagues to promote improved nation-wide communication. Approximately 475 VISN and facility consult points of contact (POCs) were identified as the primary audience for communication and feedback. Each week, close to 400 attendees participate in these calls which include training on consult policies and processes, review of consult performance data and presentations on best practices. Facilities also organized consult steering committees to manage and improve local consult performance. They are also represented on weekly national consult performance improvement calls. These essential communications are critical to continuous improvement of consult management practices that help ensure that employees implement the policy consistently, and promote a learning environment toward excellence.

The Access and Clinic Administration Program Office has completed updating the national Directive on consult management. Labor and Management Relations completed a review of the policy and on August 2, 2016 stated the intention to concur with the policy. VHA anticipates publication by September 2016.

Status:	Target Completion Date:
In Process	September 2016

Appendix D Management Comments – Director, Phoenix VA Health Care System

Department of Veterans Affairs

Memorandum

Date: June 23, 2016

From: Medical Center Director, Phoenix VA Health Care System (644/00)

Subj: Response to OIG Draft Report – Review of Alleged Consult Management Issues at the Phoenix VA Health Care System

To: Assistant Inspector General for Audits and Evaluations (52)

1. Attached you will find the facility's Action Plan in response to Recommendations 2-14 of the Draft OIG Report, Review of Alleged Consult Management Issues at the Phoenix VA Health Care System.
2. If you have any questions regarding this matter, please contact Jill Friend, Interim Chief of Quality, Safety, and Improvement Service, at (602) 277-5551, extension 6362.

(original signed for:)

DEBORAH AMDUR, MSW

Concur / ~~Do Not Concur~~

(original signed by:)

MARIE L. WELDON
Network Director, VISN 22

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Review of Alleged Consult Management Issues at the Phoenix VA Health Care System

Date of Draft Report: June 17, 2016

Recommendations/ Actions	Status	Target Completion Date

OIG Recommendations

Recommendation 2. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System communicates consult policies and procedures to all facility staff and providers to ensure consistent procedures and responsibilities to effectively manage and schedule consults.

VHA Comments: Concur

In June 2015, PVAHCS signed Policy Memorandum 11E-05, *Consult Management*. This policy is available to all staff on the facility's Intranet page. Formal consult management training is provided at every New Provider Orientation training session by Clinical Applications Coordinators who are actively involved in the consult management process. The PVAHCS Chief of Informatics expanded the campaign to educate staff regarding the consult management process by coordinating with the Public Affairs Officer to place a statement in the *Hayden Hotline*, a locally produced e-bulletin for all staff, with a reminder of where to find the consult management policy and provide an overview of the consult process intended for all staff.

On March 2, 2016, the Chief of Informatics gave a consult management presentation to providers at the facility's Grand Rounds. The Chief of Education emailed the presentation to all service chiefs to distribute to appropriate staff. The presentation provided detailed explanations about the business rules that surround the consult management process. The presentation outlined a standardized approach to consult management from a service line's receipt of the consult through consult completion, detailed explanations regarding consult management business rules.

This mass distribution strategy ensures appropriate staff receives consistent messaging regarding standard consult management and scheduling procedures and responsibilities.

PVAHCS requests OIG consider closing this recommendation because PVAHCS has widely communicated consult policies to facility staff and providers thereby ensuring consistent procedures and responsibilities to effectively manage and schedule consults. These policies are permanently available for reference when questions arise.

To demonstrate completion of action on this recommendation, PVAHCS will provide the following documentation:

1. The Grand Rounds presentation from the Chief of Informatics that was also distributed to all staff
2. New Provider Orientation Agenda

Status:	Completion Date:
Completed	March 2016

Recommendation 3. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System develops a routine review of closed consults to ensure staff are appropriately discontinuing and documenting consults in accordance with national and local policy.

VHA Comments: Concur

On June 14, 2016, the PVAHCS Consult Management Committee (CMC) developed an auditing process to routinely review 40 closed consults per month per service to ensure staff are appropriately discontinuing and documenting closure of consults. Administrative Officers from each clinical service forward consults that do not meet the consult discontinuation/closure rules to a clinician (e.g., Licensed Independent Practitioner - physician, physician assistant, or nurse practitioner) for review and recommendations. Noticeable patterns are communicated to the service chief for appropriate review and action. Criteria for cancelling consults can be found in sections 4. k and l in the PVAHCS *Consult Management* policy.

To demonstrate completion of action on this recommendation, PVAHCS will provide the following documentation:

1. Minutes from the CMC meetings
2. The auditing tool
3. The PVAHCS Consult Management Policy, specifically sections 4. k and l.
4. The results of the initial audit

Status:	Target Completion Date:
In Process	January 2017

Recommendation 4. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System makes sure respective services follow up with the patients identified in this review for appropriate action.

VHA Comments: Concur

PVAHCS Quality, Safety, and Improvement (QSI) Service reviewed the list of Veterans OIG identified in this review to ensure respective services follow up with appropriate actions. Identified services were notified for appropriate clinical and administrative review to perpetuate any necessary follow up actions. Data will be collected regarding follow up review findings from each service to ensure that all concerned Veterans have received necessary follow up actions and those findings will be reported to the Chief of Staff for validation that they have been completed.

To demonstrate completion of action on this recommendation, PVAHCS will provide the following documentation:

1. Data from the follow up review findings from each service reported to the Chief of Staff.

Status:	Target Completion Date:
In Process	October 2016

Recommendation 5. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System makes sure chiropractic services review all consults cancelled by the service since January 1, 2015, for appropriate action.

VHA Comments: Concur

PVAHCS reviewed chiropractic consults identified by OIG in this review to ensure appropriate action occurred. PVAHCS now has an established process to ensure appropriate consult cancellation.

E-consults are being utilized by the Chiropractic Service. E-consults are consults entered into the electronic health record that may not require a face-to-face visit with a chiropractor. E-consults provide the chiropractor with an efficient way to ensure patients have completed the needed studies before scheduling them for an appointment; this practice decreases unnecessary repeat appointments and increases access to care.

PVAHCS requests OIG consider closing this recommendation because PVAHCS has completed the review of all consults cancelled by chiropractic services since January 1, 2015, and has taken appropriate action.

To demonstrate completion of action on this recommendation, PVAHCS will provide the following documentation:

1. Data from the follow up review findings from the Chiropractic service.

Status:	Completion Date:
Complete	March 2016

Recommendation 6. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System ensures that the care of the patient identified in the reported case summary is evaluated, take action, if appropriate, and confer with Regional Counsel regarding the appropriateness of disclosures to patients and families.

VHA Comments: Concur

PVAHCS providers from Medicine and Cardiology Departments performed an internal clinical review of the reported case summary. The facility requested and received a clinical external review from a Cardiology provider to ensure impartiality. PVAHCS staff conferred with VA General Counsel staff on June 30, 2016 regarding the appropriateness of Institutional Disclosures to patients and families, in accordance with VHA policy (VHA Handbook 1004.08). PVAHCS will perform an Institutional Disclosure based on the delay of scheduling consult. The Office of General Counsel concurs with this action.

To demonstrate completion of action on this recommendation, PVAHCS will provide the following documentation:

1. Decision regarding Institutional Disclosure.

Status:	Target Completion Date:
Complete	August 2016

Recommendation 7. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System develops a mechanism to ensure that Quality, Safety, and Improvement services appropriately reviews deceased patients with an open consult, and staff timely and appropriately close the consult upon verification of death by Decedent Affairs.

VHA Comments: Concur

PVAHCS Quality, Safety, and Improvement (QSI) Service has an established mechanism to review Veteran deaths when the Veteran had open consults. QSI Service obtains the names of Veterans from the VHA Support Service Center (VSSC) report "*Open Consults for Potentially Deceased Patients"* and transfers them to a spreadsheet. Quality Managers conduct chart reviews of identified Veterans' status

and any relation to open consults at the time of death. Any identified concern is returned to the consulted service for review and the Chief of Staff for dual level oversight. Any Veteran identified as deceased without an updated posting to the chart is reported to Decedent Affairs to validate and record the death in the electronic health record in accordance with VHA policy. Upon posting of a death to the electronic health record, any open consults are discontinued in accordance with consult closure guidelines for a deceased patient.

PVAHCS requests OIG consider closure of this recommendation because PVAHCS has developed and implemented a robust mechanism to ensure that Quality, Safety, and Improvement services appropriately reviews deceased patients with an open consult, and staff timely and appropriately close the consult upon verification of death by Decedent Affairs.

Status:	Completion Date:
Complete	April 2016

Recommendation 8. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System makes sure services assign and maintain appropriate and sufficient clinical staff to receive and review consults within target timeframes.

VHA Comments: Concur

PVAHCS has an established process to ensure services assign and maintain appropriate and sufficient clinical staff to receive and review consults within target timeframes. PVAHCS assessed the staffing needs for each service to manage the volume and subject matter of their consults and found that each service needed one designated clinical staff person. Each clinical service has a designated clinician who performs consult management duties within target timeframes; these duties include, but are not limited to, review, acceptance, cancellation, and discontinuation of consults.

As of July 27, 2016, the number of consults greater than 90 days are:

- All Consults = 7,285 in all statuses – active, pending, and scheduled
- Clinical Consults = 933 in all statuses – active, pending, and scheduled

As of July 27, 2016, the number of consults awaiting clinical documentation—in-house and Non-VA (versus awaiting an appointment for all consults):

- Scheduled Linked and Checked out = 444
- Active Cancelled by Clinic = 11
- Active Cancelled by Patient = 54
- Active = 8,312
- Incomplete = 297
- Pending = 12,040

Non-VA consults may be in either an active or scheduled status when the facility is awaiting documentation from a past appointment. They may also be in those statuses when the Veteran is awaiting an appointment (if the appointment is scheduled into the future or is in the process of being scheduled). It can take up to 75 days for documentation to be returned from the community vendor.

As of July 27, 2016, there are 37,910 open consults in all statuses–pending, active, scheduled, and partial results.

A trend analysis chart of all areas in the consult process for Phoenix will be provided. PVAHCS does not have an active list for March 2016 to do a comparison. PVAHCS will begin maintaining a monthly total of consult trends as of July 27, 2016. The following data represent consult activity that occurred in March 2016:

- Number of Consult Referrals = 26,622
- Number of Consults Cancelled = 913
- Number of Consults Discontinued = 4,078
- Number of Consults Scheduled = 858
- Number of Consults Completed = 20,083

As of July 27, 2016, the number of consults greater than 90 days in the community are:

- Non-VA = 3,161 in all statuses – active, pending, and scheduled
- Choice = 3,191 in all statuses – active, pending, and scheduled

PVAHCS requests OIG consider closure because PVAHCS services assign and maintain appropriate and sufficient clinical staff to receive and review consults within target timeframes.

To demonstrate completion of action on this recommendation, PVAHCS will provide the following documentation:

1. PVAHCS Consult Rates SPC Charts

Status:	Completion Date:
Complete	April 2016

Recommendation 9. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System makes sure Human Resources and specialty care services fill vacant Medical Support Assistant positions responsible for scheduling consults in specialty care services to ensure sufficient resources to manage and schedule consults.

VHA Comments: Concur

At the time of this response, PVAHCS specialty clinics have 39 vacancies (or 30 percent) of 129 authorized positions. The following chart demonstrates the number of filled specialty clinic Medical Support Assistant (MSA) positions and the number vacant, which provides the total number of authorized MSA Full Time Employee Equivalents in the specialty clinics. Sixteen contract MSAs are being utilized in the specialty clinics, (although not reflected in the chart below) reducing the effective vacancy rate to 16 percent. Six additional applicants have been offered positions, which will decrease the specialty clinic vacancy rate to 12 percent including contract MSAs and potential new hires.

Section	Filled	Vacant	Grand Total
Specialty Clinics	90	39	129
Advanced MSA	**82**	**26**	**108**
Lead MSA	**4**	**5**	**9**
Manager	**1**	**0**	**1**
Supervisor	**3**	**8**	**11**

Because of the turnover of these entry level positions, there is an ongoing need for recruitment. The Specialty Clinics have a 30 percent vacancy rate. PVAHCS anticipates a recurring 20 percent vacancy rate, and has set a goal of 15 percent vacancy rate, excluding contract MSAs and potential new hires. The PVAHCS Human Resources Department has established a process to address the ongoing need to fill MSA vacancies. Due to the substantial number of applicants, Human Resources opens external job announcements for three days or until they receive 50 applications, whichever occurs first. This allows Human Resources to submit applicant lists to HAS quickly to expedite the hiring process.

Status:	Target Completion Date:
In Process	September 2016

Recommendation 10. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System pursue an automated process to ensure vascular lab results are entered in the electronic medical records in order to eliminate reliance on printed lab results.

VHA Comments: Concur

On April 20, 2016, the PVAHCS successfully tested and substantiated the integration of the VascuPro software with VHA's electronic health record that allows for automated electronic data entry of vascular lab results into patient records, eliminating the dependence on printed lab results. VascuPro software is in the procurement process and expected to be purchased in the next 30-60 days. PVAHCS is developing clinical procedures for diagnostic testing to ensure timely software implementation.

Status:	Target Completion Date:
In Process	October 2016

Recommendation 11. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System makes sure vascular services review all incomplete vascular lab consults to identify and address all potential lost lab results.

VHA Comments: Concur

PVAHCS Vascular Service has implemented a process to ensure review of all incomplete vascular lab consults to identify and address all potential lost lab results. Two vascular surgeons are reading all incoming vascular labs on a daily basis. Each day, a designated vascular surgeon collects, reads, and interprets vascular lab studies.

The Chief of Vascular Surgery is managing incomplete vascular lab consults that have been identified. The Chief of Vascular Surgery calls each Veteran whose vascular lab images were not available, read, or reported with result in the patient record. Patient education is provided regarding the ongoing need for

studies; the Veteran is requested to return for repeat studies. All Veterans who have been contacted have agreed to repeat the vascular studies. The Chief of Vascular Surgery is prepared to discuss results with them at the time of the repeat study to avoid further delays for the Veteran.

To address potential lost lab results and reduce future delays, the Chief of Vascular Surgery implemented the practice of preliminary reports for inpatient, Emergency Department, and critical labs being input into the patient record. Implementation of the VascuPro software will provide an additional level of quality assurance in the vascular lab consult completion process.

Status:	Target Completion Date:
In Process	October 2016

Recommendation 12. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System makes sure clinics coordinate with clinic informatics services to develop a mechanism to routinely identify and address open consults in which the corresponding appointment was already completed.

VHA Comments: Concur

PVAHCS now has an established process to ensure clinics coordinate with clinic informatics services to develop a mechanism to routinely identify and address open consults in which the corresponding appointment was already completed.

Each PVAHCS clinical service has a designated clinician who performs consult management duties within target timeframes; these duties include, but are not limited to, review, acceptance, cancellation, and discontinuation of consults.

PVAHCS Clinical Informatics staff meets with Administrative Officers from each clinical service weekly to identify open consults for which an appointment has already occurred and identifies those consults requiring closure in the electronic health record. Each Administrative Officer then submits this list to the designated clinician for appropriate action. Monthly audits on the consult closure process are completed for quality assurance.

PVAHCS requests OIG consider closure because it has developed a mechanism to routinely identify and address open consults in which the corresponding appointment was already completed and clinics coordinate with Clinical Informatics Service weekly to support compliance.

Status:	Completion Date:
Completed	April 2016

Recommendation 13. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System assigns sufficient staff to manage Non-VA Care and Choice consults and appointments.

VHA Comments: Concur

Currently, Purchased Care Service has 94 percent (31/33) of its assigned Registered Nurse staff, 100 percent (4/4) of it assigned Licensed Practical Nurse staff, and 77 percent (37/48) of it assigned administrative staff. Purchased Care has an ongoing process to review personnel needs and recruitment through Human Resources to ensure it can meet the demand of Non-VA Care and Choice consultation.

PVAHCS requests OIG consider closure based on completion of assigning sufficient staff to manage Non-VA Care and Choice consults and appointments.

Status:	Completion Date:
Completed	June 2016

Recommendation 14. We recommended the Veterans Integrated Service Network 22 Director ensure the Director of Phoenix VA Health Care System makes sure Non-VA Care develops a process to routinely follow up with those patients with open community care consults older than 120 days to determine if they received the requested care.

VHA Comments: Concur

PVAHCS has an established process to routinely follow up with those patients with open community care consults older than 120 days to determine if they received the requested care. PVAHCS Purchased Care Service currently implements the PVAHCS Consult Closure Business Rules and routinely monitors its implementation strategy. Community Care staff are involved in weekly routine calls with regional leadership to incorporate any new changes or revisions to the PVAHCS Consult Closure Business Rules.

Purchased Care is implementing the following strategies to ensure that all consults, including those over 120 days, have received the requested care:

- Purchase Care supervisors review this report on a weekly basis.
- Re-train staff on the Choice-First process to ensure consults are forwarded to Choice-First upon upload of consult to Tri West, the Choice vendor.
- Develop an automated monitor to identify consults that have been processed Choice-First but stay in a Non VA Care Status.
- Continue to work on quality improvement measures to improve efficiency and closer monitoring of consult processes.

Status:	Target Completion Date:
In process	November 2016

For accessibility, the format of the original documents in Appendix C and D has been modified to fit in this document.

Appendix E OIG Contact and Staff Acknowledgments

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