



Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02890-168

Healthcare Inspection

Improper Consult and Appointment Management Practices, False Documentation, and Document Scanning Errors Charlie Norwood VA Medical Center Augusta, Georgia

March 10, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General conducted a healthcare inspection in response to allegations involving improper completion of consults, false documentation, inappropriate scheduling practices, and Non-VA Care Coordination (NVCC) document scanning errors at the Charlie Norwood VA Medical Center (facility), Augusta, GA.

This inspection was initially conducted and submitted to facility leadership in late summer 2014. We received facility responses in October 2014 and prepared the report for publication. However, a criminal investigation had been initiated regarding an issue we discussed in the report. OIG delayed publication of the report pending completion of the criminal investigation at the request of the United States Attorney's Office. The case went to trial in late May 2016 and sentencing was in October 2016. In August 2016, we requested updated information from the facility about the 2014 proposed action plans. Based on the updated information, we consider the six recommendations closed.

The specific allegations were:

- Senior managers instructed clerks to delete consults for all clinics.
- A physician completed consults prior to seeing the patients.
- Staff completed NVCC consults by placing false statements in patients' electronic health records.
- A clinic scheduler manipulated patients' desired appointment dates.
- Managers directed a clerk not to schedule new patients if they could not be seen within 14 days of their desired appointment date. Instead, the clerk was to:
 - Maintain a manual list of patients and call those patients when the clinic was able to schedule the appointment within 14 days of their desired date.
 - Instruct patients to call within 14 days of their desired date to schedule an appointment.
- Facility leadership identified a scanning and document management deficiency involving NVCC records.

We did not substantiate that senior managers instructed clerks to delete consults for all clinics. We substantiated that a physician was completing consults prior to seeing patients. Facility managers became aware of the issue in February 2013 and educated the physician on the correct process; however, they did not conduct a review of this physician's previously completed consults to ensure that the care was actually delivered. We reviewed 119 consults completed by the subject physician in January 2013 and found that nearly 25 percent of the patients did not receive care within 90 days or did not receive care at all. We identified five patients for whom delays

in consult completion were of clinical concern. We referred these cases to the facility for appropriate clinical action. The facility identified an additional case of delayed care and completed an institutional disclosure.

We substantiated that a supervisor instructed four employees to improperly complete NVCC consults and document, "Services provided or patient refused services," even though they did not review the records or contact the patients. Facility clinical review teams subsequently evaluated all 1,514 cases and arranged for follow-up as needed. No cases of patient harm had been identified as of October 2014.

We substantiated that a clinic scheduler manipulated patients' desired appointment dates in an effort to correct scheduling errors. Primary Care leaders had instructed a clerk to identify records with scheduling errors and notify their respective supervisors; however, the clerk changed the desired dates instead of sending the information to the supervisors for action.

We substantiated that managers directed a clerk not to schedule new patients if they could not be scheduled within 14 days [of the desired date]. This condition existed for about 2 weeks while Primary Care leaders were seeking Veterans Integrated Service Network (VISN) guidance about a new performance measure.

In addition, we found that the facility identified 3,776 "errors" that prevented scanning and uploading of NVCC clinical documentation. The errors occurred because a software option had not been enabled. The 3,776 medical records have been reviewed and the appropriate documents uploaded to the Computerized Patient Record System. The facility did not identify any cases of harm.

We recommended that the Interim Under Secretary for Health ensure that all Veterans Health Administration (VHA) medical facilities using the DocManager™ system certify their use of the appropriate software settings.

We recommended that the VISN Director review the circumstances surrounding improperly completed Non-VA Care Coordination and urology consults and confer with appropriate VA offices to determine the need for administrative action, if any. We further recommended that the VISN Director review the circumstances surrounding managers' failures to promptly evaluate the scope and breadth of the improperly completed urology consults when first learning of the issue in February 2013 and confer with appropriate VA offices to determine the need for administrative action, if any.

We recommended that the Facility Director take actions to clinically evaluate the improperly completed urology consults, ensure follow-up care for those patients still requiring services, and follow VHA guidelines for disclosure of adverse events, if needed. We also recommended that the Facility Director continue to monitor the status of the improperly completed NVCC consults and assure continued care, as needed, and ensure that all clinic schedulers are trained on correct scheduling practices.

Comments

In October 2014, the then Interim Under Secretary for Health, VISN Director, and Facility Director concurred with this report. (See Appendixes A, B, and C, pages 13–21, for the then Interim Under Secretary for Health’s and Directors’ comments.) We noted that definitive completion dates were not identified for actions related to recommendations 2 and 3 (see pages 16–17 for details), as these potential administrative actions would involve due process, timeframes for completion are uncertain.

OIG 2016 UPDATE: After completion of this report and response from VHA officials, OIG subsequently learned that the four employees who had been instructed to improperly close consults for the 1,514 cases noted above had also completed 1,212 NVCC consults on February 6–7, 2014, using the statement “Services provided or patient refused services.” In support of an OIG criminal investigation into the matter, we reviewed all 2,726 consults that were completed from February 6–11, 2014. The false documentation aspect of this review was under criminal investigation for more than 18 months, and OIG delayed publication of this report pending completion of the trial in late May 2016. As of August 9, 2016, VHA had completed corrective actions in response to all six recommendations.



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

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations involving improper completion of consults, false documentation, inappropriate scheduling practices, and Non-VA Care Coordination (NVCC) document scanning errors at the Charlie Norwood VA Medical Center (facility), Augusta, GA. The purpose of the review was to determine whether the allegations had merit.

This inspection was initially conducted and submitted to facility leadership in late summer 2014. We received facility responses in October 2014 and prepared the report for publication. However, a criminal investigation had been initiated regarding an issue we discussed in the report. OIG delayed publication of the report pending completion of the criminal investigation at the request of the United States Attorney's Office. The case went to trial in late May 2016 and sentencing was in October 2016. In August 2016, we requested updated information from the facility about the 2014 proposed action plans. Based on the updated information, we consider the six recommendations closed.

Background

The facility is a two-division healthcare system located in Augusta, GA, and is part of Veterans Integrated Service Network (VISN) 7. It provides medicine, surgery, neurology, rehabilitation medicine, and spinal cord injury services at a downtown campus and mental health and long-term care at an uptown campus.

NVCC

NVCC is medical care provided to eligible veterans outside of VA when VA facilities and services are not reasonably available.¹ VA-based nurses provide case management and coordination to assure that patients receive the requested care and that consult results are available to clinicians in the computerized patient record system (CPRS). A consult and pre-authorization for treatment in the community is required. NVCC is organizationally aligned under Health Administration Service (HAS); guidance for managing NVCC consults is found in VHA Directive 1601, *Non-VA Medical Care Program*.²

The facility implemented its NVCC program in January 2014. Prior to that, patients could receive medical care in the community through the Non-VA Care (FEE) program. We use the term NVCC in the remainder of this report to refer to both NVCC and Non-VA Care (FEE).

In 2013, the Veterans Health Administration (VHA) undertook a series of activities to decrease the number of "unresolved" consults nationwide. Unresolved consults are consults that are still open or active in the electronic health record (EHR).

¹ <http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/>, accessed July 5, 2016.

² VHA Directive, 1601, *Non-VA Medical Care Program*, January 23, 2013.

On May 23, 2013, the Under Secretary for Health (USH) issued a memorandum nationwide that defined four specific tasks to address unresolved consults and the timelines by which those tasks should be completed. Tasks 1–3 were largely administrative and were to be completed by October 1, 2013. Task 4 consisted of five “waves” to close unresolved consults older than 90 days. Waves 1–4 focused on medicine, mental health, surgery, and rehabilitation/extended care consults, with completion dates ranging from October 1, 2013, through April 1, 2014. Wave 5 focused on “All Other” consults, including NVCC consults, and had a completion date of May 1, 2014. For more information about this nationwide process, please see the OIG Report “Evaluation of the VHA’s National Consult Delay Review and Associated Fact Sheet.”³

VHA’s guidance to the VISNs and facilities for resolving open consults was largely found in a series of PowerPoint presentations and on VHA’s Consult Switchboard website.⁴

Allegations

On May 23, 2014, OIG received an anonymous complaint alleging that senior managers instructed clerks to delete consults for all clinics. While we were onsite, several employees we interviewed reported additional allegations that:

- A physician completed consults prior to seeing the patients.
- Staff completed NVCC consults by placing false statements in patients’ EHRs.
- A clinic scheduler manipulated patients’ desired appointment dates.
- Managers directed a clerk not to schedule new patients if they could not be seen within 14 days of their desired appointment date. Instead, the clerk was to:
 - Maintain a manual list of patients and call those patients when the clinic was able to schedule the appointment within 14 days of their desired date.
 - Instruct patients to call within 14 days of their desired date to schedule an appointment.

During the course of our review, facility leadership identified a scanning and document management deficiency involving NVCC records that is also addressed within this report.

³ *Healthcare Inspection - Evaluation of the Veterans Health Administration’s National Consult Delay Review and Associated Fact Sheet* (Report No. 14-04705-62, December 15, 2014).

⁴ VHA’s Consult Switchboard is a central location for new consult business rule information and where users may access documentation, tasks, reporting, and training information.

Scope and Methodology

We conducted site visits to the facility June 18–19, July 1–2, July 8–9, July 30, and August 12, 2014. We reviewed relevant VHA and facility policies and procedures related to NVCC, consult management, and outpatient scheduling procedures; emails related to consult closures and appointment scheduling practices; and facility data on efforts to clinically review and complete inappropriately closed consults. We also reviewed selected patients' EHRs.

We interviewed the Facility Director, Associate Director, Chief Nurse Executive (CNE), Deputy CNE, and the executive assistant to the Chief of Staff; the Chief of HAS (now retired), Assistant Chief of HAS, the prior Chief of Fee Basis, and the Chief of Health Information Management (HIM); the VISN 7 Chief Information Officer (CIO); representatives from VHA's Office of Information and Analytics and the National Center for Patient Safety, NVCC staff, several schedulers, clerks detailed during the Consult Clean-up process, the Data Processing Applications Coordinator, the Primary Care Business Manager, several physicians, and others with knowledge about the issues.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

Inspection Results

Issue 1: Improper Consult Management Practices

Allegation 1. Managers instructed clerks to delete consults for all clinics.

We did not substantiate the allegation. The anonymous complainant used the term “delete” in describing the alleged actions. Medical records are legal documents, and any alteration must meet strict VHA guidelines. Electronically signed documents can be administratively retracted (hidden from view) under certain limited circumstances and only by the Privacy Officer or designated HIM professional. The text integration utility DELETE action maintains the original document; therefore, documents are not really deleted.

The anonymous complainant did not provide specific details to support the allegation. The proximate timing of the complaint, however, coincides with VHA’s Consult Clean-up initiative. From January 2013 to April 2014, the facility closed about 15,000 consults that had been unresolved for more than 90 days. The intensity of the effort, often involving teams of people working late, may have appeared unusual and improper to the complainant.

Allegation 2. A physician was completing consults prior to seeing the patients.

We substantiated the allegation. In February 2013, a scheduling clerk sent an email to several administrative supervisors reporting that the subject physician was completing consults prior to seeing patients. The scheduling clerk reported that he/she was unable to schedule appointments, and then link those appointments to the consults as required, because the consults had already been completed. Facility managers educated the physician on the correct process, and the physician promptly ceased the practice of completing consults before seeing the patients. However, facility managers did not conduct a review of this physician’s previously completed consults to ensure that the care was actually delivered and to resubmit consults where care had not been delivered and was still needed.

Physician’s Actions. The subject physician confirmed the practice of completing consults before patients were seen but stated that this was done “out of ignorance” of the policy and was not “a high-level conspiracy” [to hide unresolved consults]. The physician told us that she reviewed every consult and documented the next step (for example, clinic appointment, lab test, or procedure) in the ‘added comment’ section, then completed the consult. The physician told us that this had been her practice for many years, dating back to when she would review medical records and make recommendations for patients receiving care at smaller VHA facilities that did not offer urology services. While the physician could not say with certainty how long she had completed consults in this manner, it may have dated back to 2002.

Preliminary EHR Review. Because the physician reviewed and triaged each consult, the potential for patient harm was limited as long as the patient attended the future

scheduled appointment. However, if the patient (or clinic) cancelled the appointment and did not immediately reschedule, or the patient did not show up for the appointment, the patient could be lost to follow-up. We reviewed 119 consults completed in January 2013 by the subject physician and found that in more than 75 percent of cases, patients were seen (clinic visit or procedure) within 90 days of the date the physician completed the consult. However, nearly 25 percent of the patients did not receive care within 90 days or did not receive care at all. Specifically:

- 7 patients were seen between 91–180 days after consult completion
- 9 patients were seen more than 181 days after consult completion
- 12 patients were never seen

Of the 12 patients never seen, we identified five for whom we had clinical concerns; we referred them back to the facility for review and action. For example, in one case, a patient in his early 50s was referred for urology consultation. In addition to microscopic hematuria (red blood cells in his urine), the patient had other risk factors for bladder cancer. The physician completed the consult with a note saying that the appointment would be scheduled in 4–6 weeks. There is no evidence that an appointment was scheduled or that the patient was evaluated by urology for his microscopic hematuria. We noted that subsequent tests did not show any red blood cells, and that the consultation request was for a different urologic condition, not blood in the urine. However, because of this patient's risk factors, and the presence of blood in his urine on that urinalysis, the failure to schedule an appointment for urology as ordered unnecessarily exposed the patient to the risk of an undiagnosed malignancy.

Since beginning this review, the facility identified an additional case involving an improperly completed consult. A patient in his mid-70s received an abdominal computed tomography (CT) scan as part of a pre-operative work-up. The CT report described a lesion as concerning for renal cell carcinoma. The surgeon consulted urology for evaluation of the kidney lesion. The physician reviewed and completed the consult, and the patient was scheduled to be seen in Urology Clinic. Records indicate the patient was a “no-show” for the scheduled appointment. The patient was seen for follow-up five times in general surgery during a 6-month span between 2009 and 2010. None of the surgery progress notes mentions the kidney lesion or need for follow-up. The patient was not seen again at the facility until he visited the emergency room with hip pain. At that time, a CT scan of the pelvis showed findings consistent with metastatic kidney cancer. The facility conducted an institutional disclosure in the fall of 2014.⁵

⁵ Institutional disclosure of adverse events is a formal process required in cases resulting in serious injury or death, or those involving reasonably expected serious injury. During an institutional disclosure, facility leaders discuss the clinically significant facts of the case with the patient or representative, and explain how they can file a claim if they choose.

Facility Follow-Up Actions. Because this physician may have been improperly completing consults for more than 10 years, facility leaders are developing a plan to identify, through an electronic cross-reference system and individual clinical review, those patients with urologic conditions who may still require attention and/or who may have suffered harm as a result of not receiving appropriate urology evaluation and follow-up. As of September 25, 2014, the extent of this problem, and its effect on patients, is unknown.

Issue 2: False Documentation

We substantiated the allegation that, at the direction of a supervisor, facility staff improperly completed NVCC consults by placing potentially false statements in patients' EHRs.

Per VHA Handbook 1907.01, when clinical documentation from the non-VA provider is secured, it should be scanned into the patient's EHR and be available for care providers. The process of attaching, or "linking," the scanned clinical document to the consult completes and closes the episode of care. Facility policy states that when a consult is marked as complete, the service has been performed and no further action is required.⁶

As part of the Consult Clean-Up effort, in February 2014 the facility began intensifying efforts to close approximately 5,000 unresolved NVCC consults that were greater than 90 days old. The Chief of HAS tasked several supervisors to assign staff to review patients' EHRs, link scanned clinical documentation when available, and mark the consults as complete. If scanned documentation was not available, no action was to be taken on the consult at that time.

A supervisor instructed four of his/her employees to complete NVCC open consults⁷ and add the comment, "Services provided or patient refused services." During our interview, the supervisor acknowledged that the four employees assigned did not have experience with consult management and that he/she did instruct them to complete the consults without reviewing the records or contacting the patients. Three⁸ of the employees confirmed that they completed consults without reviewing the records or contacting the patients. These employees reported that they voiced their concerns to their supervisor about this instruction but were assured that it was acceptable. The supervisor told us he/she felt pressure from the Chief of HAS to complete the unresolved NVCC consults.

In June 2014, the Chief of HAS received an email that expressed concerns about NVCC consults being improperly completed with the statement, "Services provided or patient refused services" with no evidence to support it. The Chief of HAS addressed other

⁶ Charlie Norwood VAMC Memorandum 116-14-17, *Consultation and Consults Scheduling Processes*, January 29, 2014.

⁷ A list of NVCC open consults was provided to the employees.

⁸ One employee died prior to this evaluation.

issues regarding the consult closure process but did not address the apparent falsification of medical record documentation. She told us that while she was aware of improper NVCC consult completion, she did not recall taking any action to review the consults completed under the direction of the supervisor.

We determined that on February 10–11, 2014, the four employees completed 1,514 NVCC consults with the unconfirmed statement, “Services provided or patient refused services.” We provided the list of the 1,514 NVCC consults to the facility for clinical review.

Facility Follow-Up Actions. Clinical review teams, consisting of physicians and nurses, completed evaluations of the affected consults, and as of September 22, 2014:

- 1,257 patients have received the care or service requested
- 118 patients no longer required the previously requested care or service
- 33 consults have been re-initiated
- 40 patients have been scheduled for care or services
- 60 consults have been cancelled (patients declined)
- 5 patients did not show for scheduled appointments
- 1 consult was a duplicate

While no cases of patient harm had been identified as of September 29, 2014, the facility is tracking two mammogram consults to ensure that the patients receive the screening exams and, in the event of positive findings, that appropriate care planning is promptly initiated.

OIG 2016 UPDATE: OIG subsequently learned that the four employees had also completed 1,212 NVCC consults on February 6–7, 2014, using the same unconfirmed statements. In support of an OIG criminal investigation, we reviewed all 2,726 (1,212 + 1,514) consults that were completed from February 6–11, 2014. We provided facility leaders with the results of our review for follow-up, as needed.

Issue 3: Inappropriate Appointment Management Practices

Guidance for appointment scheduling is found in VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, which requires patient appointments to be scheduled on or as close to the patient's desired date as possible.⁹ Schedulers are responsible for recording the desired appointment date accurately, and once the desired date is established, "it must not be altered for lack of appointment availability on the desired date."¹⁰

Allegation 1. A clinic scheduler manipulated patients' desired appointment dates.

We substantiated the allegation. The Primary Care Clinic identified scheduling errors in May and June 2013 for several established patients returning for clinic appointments. Several schedulers were entering "T" for today as the desired date rather than entering the patient's actual future desired date. If an appointment creation date and a desired date for a future appointment are the same, a scheduling error occurs.¹¹

In an effort to correct the errors, a Primary Care supervisor and the Chief of Primary Care instructed a clerk to review the Wait Time Monitor report, identify records with scheduling errors, conduct chart reviews to identify the agreed upon date by the provider and patient, and inform the respective supervisors that their schedulers were not scheduling patients correctly. The Primary Care supervisor told us that despite the instructions, the clerk changed the desired dates to reflect the return to clinic date instead of sending the information to the supervisors for action. Primary Care, HAS, and facility leadership were made aware in July 2013 that the clerk had corrected the scheduling errors by changing the desired dates.

To improve compliance with scheduling policies, the facility implemented monitoring for scheduling errors and initiated staff training focusing on appointment management and accurate documentation of desired appointment dates.

Allegation 2. Managers directed a clerk not to schedule new patients if they could not be scheduled within 14 days [of the desired date].

We substantiated the allegation. On March 15, 2013, the Deputy USH for Administrative Operations issued a memorandum nationwide to "standardize use of the VHA's Electronic Wait List (EWL) and convey changes in timeliness measurement methods." Per the memorandum, new patient wait times would be measured using the

⁹ The desired date is the date the patient and/or the provider want the patient to be seen. VHA Directive 2010-027 was current at the time of the events discussed in this report; it has been rescinded and replaced by VHA Directive 1230, *VHA Outpatient Scheduling Processes and Procedures*, July 15, 2016. Per the 2016 Directive: "Desired date has been replaced with Preferred Date(PD) to indicate when the patient wants to be seen and clinically indicated date to indicate the date the provider wants the patient to be seen."

¹⁰ Ibid.

¹¹ This type of scheduling error would have made the clinic's wait times look worse. By defaulting to a desired appointment date for "today," but scheduling an appointment for 1 month in the future, it appeared that the facility was not able to schedule the patient when the patient requested "T" for today.

date the appointments are created.¹² Effective April 8, 2013, Primary Care added a new performance measure that would report the number of patients seen within 14 days of their appointment creation date.

Primary Care leaders expressed concern that if they scheduled new patients requesting appointments greater than 14 days in the future, they would not meet the new performance measure. The Primary Care leaders sought guidance from the VISN on how to schedule patients requesting future appointments. For approximately 2 weeks, while seeking guidance from the VISN, a clerk was instructed not to schedule new patients who requested appointments greater than 14 days in the future. Once the VISN provided guidance, the facility complied with the requirement to schedule all new patients requesting future appointments.

Issue 4: NVCC Document Scanning Errors

During the course of the facility's clinical review of the improperly completed NVCC consults discussed in Issue 2, the facility identified 3,776 "errors" preventing NVCC scanned clinical documentation from being imported into the computerized patient record system (CPRS) from DocManager™.¹³

Clinical documentation was scanned into the DocManager™ system (an electronic repository for the old Non-VA Care [FEE] documents where they are stored before upload to CPRS), but some of the documents were never validated and uploaded to CPRS. Poor scan images, incomplete/unreadable patient identifiers, or improper indexing can result in "errors" that must be individually reviewed and corrected before documents can be moved to CPRS.

The facility reviewed and validated 100 percent of the affected medical records. A team reviewed the clinical documentation to assure that consultants' recommendations were addressed and that patients received appropriate follow-up care and then printed and manually scanned the documents into the correct patients' medical records.¹⁴ The clinical review teams did not identify any cases of patient harm that may have resulted from delays in follow-up care.

To better understand how the errors occurred, the facility consulted with the VISN 7 CIO, who in turn consulted with the DocManager™ vendor. It appears that the errors occurred because a software option that would have assured the assignment of VISN-wide unique identifier numbers had not been enabled. The assignment of

¹² A new patient is any patient not seen by a qualifying provider type or stop code group at the facility within the past 24 months.

¹³ These errors occurred between 2010–2013 when the Non-VA Care (FEE) program was still the method by which patients could receive care in the community.

¹⁴ During the course of clinically reviewing the 3,776 DocManager™ "errors," the review teams found 4 records that contained other patients' medical information (error rate of .001). These documents were removed per VHA Handbook guidance and uploaded to the correct medical records. The facility suspects this was human error related to manual scanning, not to the DocManager™ issue under review.

VISN-wide unique identifier numbers would have ensured that the scanned documents were added to the correct patient's medical record.

To identify any potential mismatches resulting from this error or other system weaknesses, the vendor created a Patient Verification software utility to identify mismatched records. When run against the facility's database, the software utility identified an additional 9,600 mismatches between the facility's and the vendor's databases. These mismatches are not NVCC specific but could come from a variety of sources including human error. The utility identified similar errors at other VISN 7 facilities. The Office of Information and Technology (OI&T) ran a second utility to update and correct the mismatches. Facility teams reviewed about 3,000 of the 9,600 records and validated that the utility did correct all of the errors. No further evaluation of these records was planned.

All VISN O&IT Help Desks were notified of the VISN 7 issue and provided with instructions for assuring appropriate software settings and running the Patient Verification utility for any potential mismatched records residing on the DocManager™ system.

Conclusions

We did not substantiate that senior managers instructed clerks to delete consults for all clinics. Medical records are legal documents and any alteration must meet strict VHA guidelines. The proximate timing of the complaint coincides with VHA's Consult Clean-up initiative, and from January 2013 to April 2014, the facility closed about 15,000 consults that had been unresolved for more than 90 days. The intensity of the effort may have appeared unusual or improper to the complainant.

We substantiated that a physician was completing consults prior to seeing patients, a practice that may date back to 2002. Facility managers became aware of the issue in February 2013 and educated the physician on the correct process; the physician promptly ceased the practice. However, facility managers did not conduct a review of this physician's previously completed consults to ensure that the care was actually delivered. We reviewed 119 consults completed in January 2013 by the subject physician and found that nearly 25 percent of the patients did not receive care within 90 days or did not receive care at all. One case of delayed care resulting in patient harm has been identified to date; the facility conducted an institutional disclosure in the fall of 2014. The facility is currently devising a plan to identify patients with urologic conditions who may still require attention and/or who may have suffered harm as a result of not receiving appropriate urology evaluation and follow-up.

We substantiated the allegation that, at the direction of a supervisor, facility staff improperly completed NVCC consults by placing unconfirmed statements in patients' EHRs. We determined that on February 10–11, 2014, four employees completed 1,514 NVCC consults with the statement "Services provided or patient refused services" without reviewing the records or contacting the patients. Clinical review teams evaluated all 1,514 cases and arranged for follow-up as needed. While no cases of

patient harm have been identified to date, the facility is still tracking two screening mammogram consults to ensure that the patients receive the screening exams and, in the event of positive findings, that appropriate care planning is promptly initiated.

We substantiated that a clinic scheduler manipulated patients' desired appointment dates in an effort to correct scheduling errors. Several Primary Care schedulers were entering "T" for today as the desired date rather than entering the patient's actual future desired date, which created a scheduling "error." Primary Care leaders instructed a clerk to identify records with scheduling errors, determine the correct desired date, and inform the respective supervisors that their schedulers were not scheduling patients correctly. However, the clerk changed the desired dates instead of sending the information to the supervisors for action. The facility implemented daily monitoring for scheduling errors and trained staff on appointment management and accurate documentation of desired appointment dates.

We substantiated that managers directed a clerk not to schedule new patients if they could not be scheduled within 14 days [of the desired date]. In April 2013, Primary Care added a new performance measure that would report the number of new patients seen within 14 days of their appointment creation date. Primary Care leaders were concerned about the measure and sought guidance from the VISN. For approximately 2 weeks, a clerk was instructed not to schedule new patients who requested appointments greater than 14 days in the future. Once the VISN provided guidance, the facility complied with the requirement to schedule all new patients requesting future appointments.

Although not an allegation, we found that during the course of the facility's clinical review of the improperly completed NVCC consults, the facility identified 3,776 "errors" that prevented scanning and uploading of NVCC clinical documentation. The errors occurred because a software option that would have assured the assignment of VISN-wide unique identifier numbers had not been enabled. All VISN OI&T Help Desks were provided instructions for assuring appropriate DocManager™ software settings.

A facility-based clinical team reviewed and validated all 3,776 medical records and uploaded the appropriate documents to CPRS. No cases of patient harm were identified.

OIG 2016 UPDATE: OIG subsequently learned that more than 2,700 NVCC consults were completed using unconfirmed statements. We reviewed those records and provided facility leaders with the results of our review for follow-up as needed.

Recommendations

1. We recommended that the Interim Under Secretary for Health ensure that all Veterans Health Administration medical facilities using the DocManager™ system certify their use of the appropriate software settings.

- 2.** We recommended that the Veterans Integrated Service Network Director review the circumstances surrounding improperly completed Non-VA Care Coordination and urology consults and confer with appropriate VA offices to determine the need for administrative action, if any.
- 3.** We recommended that the Veterans Integrated Service Network Director review the circumstances surrounding managers' failures to promptly evaluate the scope and breadth of the improperly completed urology consults when first learning of the issue in February 2013 and confer with appropriate VA offices to determine the need for administrative action, if any.
- 4.** We recommended that the Facility Director take actions to clinically evaluate the improperly completed urology consults, ensure follow-up care for those patients still requiring services, and follow Veterans Health Administration guidelines for disclosure of adverse events, if needed.
- 5.** We recommended that the Facility Director continue to monitor the status of the improperly completed Non-VA Care Coordination consults and assure continued care, as needed.
- 6.** We recommended that the Facility Director ensure that all clinic schedulers are trained on correct scheduling practices.

Interim Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

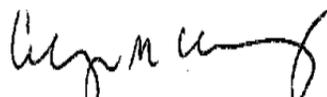
Date: October 29, 2014

From: Interim Under Secretary for Health (10N)

Subj: Healthcare Inspection— Improper Consult and Appointment Management Practices, False Documentation, and Document Scanning Errors, Charlie Norwood VA Medical Center, Augusta, Georgia

To: Assistant Inspector General for Healthcare Inspections (54)
Director, Atlanta Regional Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Thank you for the opportunity to review the draft report, Healthcare Inspection- Improper Consult and Appointment Management Practices, False Documentation, and Document Scanning Errors, Charlie Norwood VAMC, Augusta Georgia.
2. I have reviewed the draft report and concur with the report's recommendations. Attached is the Veterans Health Administration's corrective action plan for recommendations 1 through 6.
3. If you have any questions, please contact [REDACTED], M.D., Director, Management Review Service (10AR) at email [REDACTED].



Carolyn M Clancy, MD
Interim Under Secretary of Health

Comments to OIG's Report

The following Interim Under Secretary for Health comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Interim Under Secretary for Health ensure that all VHA medical facilities using the DocManager™ system certify their use of the appropriate software settings.

Concur

Target date for completion: Completed

Facility response: VHA Chief Business Office (CBO) ensured all VHA medical facilities using the DocManager™ system certify their use of the appropriate software settings. In August 2014, CBO confirmed with all of the medical IT Regions that their DocManager configurations were correct. As a follow-up, CBO reached out to all IT Regions, rather than only medical IT Regions, to verify that VHA facilities were using the proper configuration. In October 2014, all regional IT points of contact confirmed use of proper configuration.

OIG 2016 UPDATE: We accepted this action as complete based on the Interim Under Secretary's response.

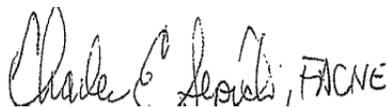
VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 16, 2014
From: Director, VA Southeast Network (10N7)
Subj: Healthcare Inspection—Improper Consult and Appointment Management Practices, False Documentation, and Document Scanning Errors, Charlie Norwood VA Medical Center, Augusta, Georgia
To: Interim Under Secretary for Health (10N)

1. Thank you for the opportunity to review the Draft Report for the Charlie Norwood VA Medical Center, Augusta, GA.
2. I concur with the review and resultant findings and submit the following corrective action plans.



Charles E. Sepich, FACHE
Network Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 2. We recommended that the Veterans Integrated Service Network Director review the circumstances surrounding improperly completed Non-VA Care Coordination and urology consults and confer with appropriate VA offices to determine the need for administrative action, if any.

Concur

Target date for completion: In Process (Per **OIG 2016 Update**: Completed.)

Facility response: VISN 7 is in process to review the activities that lead to the two improper consult closure opportunities and will determine the individuals involved in the events in both occurrences and take appropriate disciplinary action as the level of involvement requires. These actions will be initiated immediately and will be finalized as due process allows.

Additionally, training on proper consult closure for all consults, whether NVCC or facility based, will be provided to staff involved in Consult Management.

OIG 2016 UPDATE: On June 14, 2016, Veterans Integrated Service Network 7 provided the status of corrective actions.

Target date for completion: Completed

VISN 7 reviewed the activities that led to the two improper consult closure opportunities and determined the individuals involved in the events in both occurrences and took appropriate action as the level of involvement required. These actions were initiated immediately and finalized as due process allowed.

Additionally, training on proper consult closure for all consults, whether NVCC or facility-based, was provided to staff involved in Consult Management in November 2014.

Recommendation 3. We recommended that the Veterans Integrated Service Network Director review the circumstances surrounding managers' failures to promptly evaluate the scope and breadth of the improperly completed urology consults when first learning of the issue in February 2013 and confer with appropriate VA offices to determine the need for administrative action, if any.

Concur

Target date for completion: In Process (Per **OIG 2016 Update**: Completed.)

Facility response: VISN 7 is developing a chronology of events surrounding the initial notification between February 2013 and the delay in evaluation of the scope of the improper consult closure. Administrative actions will be addressed with individuals who failed to ensure a timely evaluation of Veteran care and follow-up once the question of improper consult closure was identified. These actions will be initiated immediately and finalized as due process allows.

Additionally, a look-back of Veteran care is being managed by the Charlie Norwood VAMC Risk Manager, to determine the current clinical status of each Veteran who did not have proper documentation of follow-up after the consult closure. The purpose of this look-back is to ensure no Veteran has care requirements still pending. In keeping with consult Clean-up business rules, a 100% review of all urology consults from FY 2009-2012 will be completed. Consults > 5 years will not be reviewed unless significant clinical issues are identified with the look back.

OIG 2016 UPDATE: On June 14, 2016, Veterans Integrated Service Network 7 provided the status of corrective actions.

Target date for completion: Completed

VISN 7 developed a chronology of events surrounding the initial notification between February 2013 and the delay in evaluation of the scope of the improper consult closure. Administrative actions were addressed with individuals who failed to ensure a timely evaluation of Veteran care and follow-up once the question of improper consult closure was identified. These actions were initiated immediately and finalized as due process allowed.

Additionally, a look-back of Veteran care was managed by the Charlie Norwood VAMC Risk Manager, to determine the current clinical status of each Veteran who did not have proper documentation of follow-up after the consult closure. The purpose of this look-back was to ensure no Veteran had care requirements still pending. In keeping with consult clean-up business rules, VACO instructed the facility to complete a 100% review of all urology consults from FY 2009—2012. Consults >5 years will not be reviewed (in keeping with the business rules used in prior consult cleanup process) unless significant clinical issues are identified with the look back. A sample of consults from 2002—2008, addressed by the involved provider, was also reviewed, based on information provided by the involved provider.

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 10, 2014
From: Director, Charlie Norwood VA Medical Center (509/00)
Subj: Healthcare Inspection—Improper Consult and Appointment Scheduling Practices, False Documentation, and Document Scanning Errors, Charlie Norwood VA Medical Center, Augusta, Georgia
To: Director, VA Southeast Network (10N7)

1. We concur with the findings in the report and will continue monitoring all open items until closed.
2. We sincerely appreciate the OIG's assistance in identifying areas requiring improvement so that we can provide more timely care to the Veterans we're privileged to serve.



Robert U Hamilton, MHA, FACHE
Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 4. We recommended that the Facility Director take actions to clinically evaluate the improperly completed urology consults, ensure follow-up care for those patients still requiring services, and follow Veterans Health Administration guidelines for disclosure of adverse events, if needed.

Concur

Target date for completion: December 15, 2014

Facility response: Facility senior management was not aware of a urology provider's past (prior to Feb 2013) practice of closing consults before evaluating or treating patients until informed by the OIG. The OIG investigation revealed the provider's consult management practice, while not designed to delay care intentionally, resulted in 12 patients not being properly scheduled for care during Jan 2013. Because the urology provider indicated this erroneous practice had occurred since joining the organization, VACO will instruct the facility to do a 100% review of all urology consults from FY 2009-2012. Consults > 5years will not be reviewed (in keeping with the business rules used in prior consult cleanup process) unless significant clinical issues are identified with the look back. The facility will:

- Electronically download 100% of the indicated provider consults and sort those patients without an appointment.
- Consults will be quality reviewed for follow-up care to determine any harm due to delays in care.
- Risk Management will review all follow-up care to determine any potential adverse events.
- All adverse event cases identified will be managed in accordance with the VHA Disclosure of Adverse Events to Patients Handbook 1004.08.

Any case identified for a follow-up care appointment will be post reviewed by Risk Management for potential adverse event disclosure.

OIG 2016 UPDATE: On July 5, 2016, facility leaders provided the status of corrective actions.

Target date for completion: Completed

There were no findings of adverse events and therefore, no clinical or institutional disclosures warranted. The involved provider indicated that she had employed a similar practice since joining the facility in 2002. Therefore, a 10% sample review was completed all urology consults associated with this provider from 2002-2008. There were no adverse findings with the additional look-back.

Recommendation 5. We recommended that the Facility Director continue to monitor the status of the improperly completed Non-VA Care Coordination consults and assure continued care, as needed.

Concur

Target date for completion: December 15, 2014

Facility response: Upon notification by the OIG of inappropriately closed NVCC consults, the facility immediately began reviewing 1,514 separate consult records to determine if the requested service was provided, no longer needed, cancelled due to the Veteran's preference, or still required. The comprehensive review found that 944 consults had been completed and services received. A new consult was placed into CPRS for all Veterans still requiring services and the case was reviewed by Risk Management to ensure that any delays in service did not result in harm. Regular progress reports have been submitted to the OIG since their initial notification.

As of October 9, 2014, 1,264 of the 1,514 Veterans have received the services. There are 32 new consults awaiting scheduling; 61 consults cancelled due to Veteran's preference; 119 cases where the care was no longer needed; 32 consults which have been scheduled; and 5 instances where the Veteran "No Showed" for the original consult. There was also one duplicate consult. Further monitoring will occur until all consults are completed. In addition, changes in leadership within NVCC and HAS have occurred to improve program oversight.

OIG 2016 UPDATE: On July 5, 2016, facility leaders provided the status of corrective actions.

Target date for completion: Completed

As of March 2, 2015, 1,304 of the 1,514 Veterans have received the requested services; 77 consults cancelled due to Veteran's preference; 127 cases in which the care was no longer needed; and 5 instances where the Veteran "No Showed" for the scheduled appointment. There was also one duplicate consult.

[OIG subsequently learned that an additional 1,212 NVCC consults were completed on February 6–7, 2014, using the same unconfirmed statements. In support of a criminal investigation into the matter, we reviewed all 2,700+ consults that were completed from February 6–11, 2014. We provided facility leaders with the results of our review. OIG reviewed a sample of EHRs and found documentation that facility leaders or clinicians followed up, or attempted to follow up, on appropriate cases.]

Recommendation 6. We recommended that the Facility Director ensure that all clinic schedulers are trained on correct scheduling practices.

Concur

Target date for completion: Nov 30, 2014

Facility response: VHA Directive 2010-027 requires completion of VHA Scheduling Training for Business Rules, Recall Reminders, and Make Appointment modules in TMS prior to assignment of VHA Scheduling Keys. Although this will remain an ongoing requirement, all current clinic schedulers have completed the required training. The Health Administration Service ADPAC maintains and monitors the master list of staff with access to scheduling and revises it as changes are required.

In addition, realizing the variability in the organization's scheduling processes, CNVAMC contacted VA Central Office in May 2014, to request assistance from an ISO-9001 technical team. This group came to Augusta to review our scheduling processes and assist with the development of new scheduling SOPs, which will ensure compliance and alignment with VHA Directives. The newly developed SOPs are being reviewed by leadership from several Services prior to implementation. Upon approval, each scheduler will be provided training on the new process in order to further standardize scheduling across the organization.

OIG 2016 UPDATE: On July 5, 2016, facility leaders provided the status of corrective actions.

Target date for completion: Completed

This [above mentioned] group reviewed the scheduling processes and assisted with the development of new scheduling SOPs. The newly developed SOPs were instrumental in bringing front line scheduling staff into greater understanding of scheduling compliance and VHA business rules. In July 2015, all staff assigned the scheduling keys attended the mandatory VHA training "Stepping Through the Scheduling Process" and the Scheduling Memo Training. In late 2015, the facility scheduling audit program was implemented and the results of the audit are continually used to provide targeted training to groups and individuals to address specific scheduling errors.

OIG Contact and Staff Acknowledgments

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