



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

Office of Healthcare Inspections

Report No. 14-03824-155

Healthcare Inspection

Lapses in Access and Quality of Care VA Maryland Health Care System Baltimore, Maryland

April 14, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the request of Senator Barbara Mikulski to assess the merit of allegations regarding lapses in access and quality of care issues at the VA Maryland Health Care System (system).

We reviewed allegations of delays in access to care for: (1) patient A's urgent care clinic and Patient Aligned Care Team (PACT) appointments, (2) patient B's PACT and mental health clinic appointments prior to committing suicide, and (3) patient C's hip-replacement surgery. We also reviewed allegations that the system failed to: (1) diagnose patient A's lung cancer and endorse chemotherapy and radiation, (2) manage patient B's diabetes and diabetic neuropathy pain, and (3) help patient D with tube-feeding nutrition following surgery for mouth cancer. Because we did not have personal identifiers for patients C and D, we instead reviewed the availability of system-wide orthopedic surgery and policies for tube-feeding nutrition.

We substantiated that delays in access did occur for patient B at the Perry Point VA Medical Center (VAMC) and that the Baltimore VAMC experienced challenges in providing timely access to orthopedic surgical services for the system as a whole. We identified PACT provider staffing and clinic cancellation rates, as well as mental health scheduling and consult discontinuation practices, as potential factors contributing to the access issues at the Perry Point VAMC. Further, we found that the system was aware of the delays in orthopedic care at the Baltimore VAMC and had developed an action plan to address these issues prior to our visit. We did not substantiate that patient A experienced a delay in receiving urgent care services from the Perry Point VAMC.

In our review of the allegations concerning quality of care, we did not substantiate that patient A experienced a delay in diagnosis of his cancer at the Perry Point VAMC. We did not substantiate that patient B almost died as a result of a blood sugar of 440; patient B's diabetes was not well controlled, in part, because of poor coordination between the facility and community providers. Further, Patient B's electronic health record (EHR) did not contain the required community care and medications information due to lapses in provider documentation and, possibly, the backlog of documents waiting to be scanned into EHRs by Health Information Management staff.

We further found that the system's policy for tube-feeding nutrition did not comply with all Veterans Health Administration requirements.

We recommended that the System Director ensure that:

- PACT provider staffing is adequate to provide patients with timely access to care.
- PACT cancellations and other data are monitored to determine when there is a need to activate a contingency plan.
- A contingency plan for PACT provider shortages is developed.

- Staff comply with local and national policies on contacting patients when scheduling mental health services.
- Policy requirements for discontinuation of mental health consultations are clear and that staff comply with those requirements.
- The *Access Action Plan* for Orthopedic Surgery Services is carried out in an effort to improve access to orthopedic surgical services.
- Providers comply with their responsibilities of EHR documentation of the community care of co-managed patients.
- Compliance with local policy requiring that community health care records be scanned into the EHRs of co-managed patients.
- The local outpatient tube-feeding policy and practice comply with Veterans Health Administration requirements.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 19–24 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Barbara Mikulski to assess the merit of allegations regarding lapses in access and quality of care issues at the VA Maryland Health Care System (system).

Background

The system consists of three campuses—the Baltimore VA Medical Center (VAMC), the Perry Point VAMC, and the Loch Raven VA Community Living and Rehabilitation Center—and six community based outpatient clinics. The system has 667 total operating beds and provides a range of acute medical, surgical, specialty, and outpatient services. The system has affiliations with the University of Maryland School of Medicine and other local colleges and universities and is part of Veterans Integrated Service Network (VISN) 5.

Urgent Care Clinics (UCCs) provide medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health (MH) illness or minor injuries. UCCs can exist in facilities with or without an emergency department, and facility needs and policy determine the hours of operation. Upon arrival to UCCs or emergency departments, staff assess patients' symptoms by a process called "triage" and prioritize the medical care needed as level 1 (higher priority) to level 5 (lower priority).

Patient Aligned Care Teams (PACTs) provide patients with primary care (PC) and team-based care, which is oriented toward wellness and disease prevention. According to Veterans Health Administration (VHA) policy, each PACT is composed of a medical provider, registered nurse (RN), clinical associate (licensed practical nurse, licensed vocational nurse, or medical or health technician), and a medical support assistant. Other health care professionals, such as pharmacists, registered dietitians, social workers, and psychologists, further support the team.¹

Co-managed care, also called dual care, refers to patients who are enrolled with VHA PACTs but also see community providers. Patients may choose co-managed care for reasons such as the desire to use VA comprehensive pharmacy benefits and distance to VA acute and specialty services.² Except in certain circumstances, VA has no responsibility to pay for testing, medications, or treatment recommended by the community provider.

Clinic Access (ability of patients to schedule appointments) is managed by staff who schedule outpatient clinic appointments using the Veterans Health Information Systems

¹ [VHA Handbook 1101.01](#), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

² [VHA Directive 2009-038](#), *VHA National Dual Care Policy*, August 25, 2009.

and Technology Architecture (VistA) Appointment Management system.³ VHA requires that each clinic reserve some appointments for same-day access, which allows appointment scheduling within 1 business day of when the patient contacts the system.⁴

VHA has also implemented performance measures regarding access and wait times. VHA is currently restructuring its standard for measuring wait times. Historically, when measuring access to care, VHA used a 14-day standard for new patients and a 30-day standard for established patients. VHA recently conducted a national access audit of wait time practices and published the results on June 9, 2014, and did not identify the system as one of the facilities flagged for further review and investigation.⁵

Orthopedics is a field of medical practice that involves conditions of the musculoskeletal system and is one of several specialty care services available at the system. Orthopedic specialists use both surgical and non-surgical interventions to treat musculoskeletal trauma, sports injuries, and degenerative diseases. Typical orthopedic surgeries include knee and shoulder arthroscopy, knee and hip replacement, and ankle fractures. PACTs arrange orthopedic services through consultations.

Allegations. In late June and early July 2014, at the request of Senator Barbara Mikulski, OIG reviewed three complaints regarding lapses in access and quality of care at the system.⁶ These three complaints concerned four patients and contained the following allegations.

Delays in Access:

- Patient A, who in late May, waited 1-1/2 hours for a UCC appointment at the Perry Point VAMC while experiencing chest pain and shortness of breath, was told in early June that there were no PC appointments available until August. Patient A died in late June.
- Patient B had two Perry Point VAMC PC clinic appointments in 2014 cancelled by staff and rescheduled for 2 months later. This patient also experienced a delay in receiving a MH appointment for post-traumatic stress disorder (PTSD). Patient B committed suicide in early May.
- Patient C needed a hip replacement and experienced at least a 4-month scheduling delay for surgery, as well as delays on the day of surgery at the Baltimore VAMC.

³ [VHA Directive 2010-027](#), *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

⁴ VHA Handbook 1101.01, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

⁵ Department of Veterans Affairs Access Audit, System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014. <http://www.va.gov/health/access-audit.asp>. Accessed September 25, 2014.

⁶ A fourth case was received, but not considered because a legal action had been filed.

Quality of Care Concerns:

- Patient A was diagnosed with pneumonia by the Perry Point VAMC UCC in late May and when he went to a community hospital, was found to have stage 4 lung cancer in mid-June, with metastasis to the back, shoulder, and bones. He was scheduled to start chemotherapy and radiation on but was told that the VA “would not endorse⁷ it as they had no proof he had lung cancer.” Patient A died in late June.
- Patient B, who almost died as a result of an elevated blood sugar of 440, received poor care for his diabetic neuropathy pain from the Perry Point VAMC PACT. Patient B committed suicide in early May.
- Patient D had to be fed by a tube after surgery for mouth cancer. The system did not help with patient D’s nutrition.

Scope and Methodology

The scope of this review included patient and employee practices related to access, scheduling, appointment wait times, and specific patient quality of care issues raised by the cases described in the allegations during the period of fiscal year 2013 to September 1, 2014.

We conducted a site visit July 30 through August 1, 2014, and interviewed the complainants; select system leaders, managers, and other staff; and other individuals knowledgeable about the allegations. We reviewed VHA and facility documents related to access, MH consultation, orthopedic care, outpatient tube feeding, dual care, and PACTs. We also reviewed and evaluated meeting minutes, performance improvement data, VHA Support Services Center (VSSC) reports, email, and applicable patient electronic health records (EHRs) and community medical records.

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

⁷ “Endorse” was the language used in the complaint, and through document review and interviews, OIG defined this to mean approval of VA payment for community-provided services.

Case Summaries

Patient A. Patient A was in his early 60s and received care at the system for multiple health problems, including knee, ankle and foot conditions; osteoarthritis; peripheral vascular disease; cirrhosis of the liver; chronic Hepatitis C; and hypertension. He had completed treatment for Hepatitis C in 2012 and recently had a negative magnetic resonance imaging (MRI) scan of his abdomen to screen for a type of liver cancer associated with Hepatitis C.

The patient last saw his PACT provider in mid-January 2014 for high blood pressure. At that time, he weighed 205 pounds and did not complain of respiratory symptoms. The patient was scheduled for a follow-up with his PACT in 6 months. In the interim, he received physical medicine and rehabilitation (physical therapy) services for degenerative joint disease of the knee and an evaluation by Dental Service at the end of April. During an April pre-operative clearance for a possible total knee replacement, the patient had a normal chest x-ray and a weight gain of 7 pounds from 4 months earlier.

At the end of May, patient A came to the Perry Point VAMC UCC but did not stay to be seen by the provider. Patient A returned to the UCC the next day complaining of shortness of breath, cough, and chest pain. The UCC provider evaluated patient A with blood tests, chest x-ray, and an electrocardiogram (EKG or ECG). The chest x-ray report described evidence of a possible pneumonia in the middle and lower lobe of the right lung, with a small amount of fluid present around the lung (known as a pleural effusion).⁸ The radiologist, in making this diagnosis, compared the May x-ray to the previous negative chest x-ray done in August 2013. Patient A also had a previous computed tomography (CT) scan of the abdomen and pelvis in April, which included the lower chest in its views. The report indicated that the scan did not show any lung abnormalities. The radiologist also noted on the May chest x-ray report that follow-up tests should be ordered to ensure clearance of the pneumonia.

In early June, a Perry Point VAMC PACT member called patient A to check on his state of health. The PACT nurse noted in the EHR that the patient reported feeling better but still had some shortness of breath on exertion.

Seven days after the PACT nurse called the patient, he went to a community hospital's emergency department for complaints of continued shortness of breath, upper back pain, nausea and vomiting, and a 35-pound weight loss during the past month. A CT scan of the chest done in the emergency department demonstrated a large right pleural effusion and enlarged lymph nodes in the chest. Findings were suspicious for cancer, and the community hospital staff admitted the patient for further treatment.

At the community hospital, a provider drained the fluid from patient A's lung and sent it to the laboratory for analysis. On the basis of these results, the patient was diagnosed

⁸ Pleural Disorders. Medline Plus Website. <http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=+pleural+effusion>. Accessed September 8, 2014.

with non-small cell lung cancer. Additional studies demonstrated that the cancer had spread (metastasized) to the bone, and patient A began community-based radiation treatments for pain control. Because an echocardiogram (an ultrasound procedure to evaluate heart conditions)⁹ showed a blood clot in the heart, the providers prescribed medications to reduce the chance of further blood clots. Despite these efforts, patient A experienced an acute mental status change a few days later prompting further evaluation and a move to the intensive care unit. An MRI of the brain showed several mini-strokes. By this time, patient A could not speak and had developed a right sided paralysis (a weakened ability or inability to use the muscles on the right side of the body).¹⁰ A repeat chest x-ray showed that the fluid had returned and now appeared to completely fill the right lung. After discussions with family, patient A was transitioned to comfort care only and placed on a morphine (pain medicine)¹¹ drip. The patient died in the community hospital at the end of June.

Patient B. Patient B was in his early 60s with a history of PTSD, diabetes, chronic leg and back pain, high blood pressure, and hypothyroidism. This patient received PC through both the community and the system and had also been seen at the system for depression, anxiety, and PTSD. However, patient B disengaged from the system's MH services in 2010 and did not report for or cancel a scheduled MH consultation in 2011, despite multiple contact attempts made by staff.

In recent years and at different times, patient B's community providers prescribed medications for pain and MH conditions, including duloxetine, diazepam, meperidine, methadone, alprazolam, and flurazepam. The system's PACT provider prescribed other medication to manage the patient's diabetes, high blood pressure, and hypothyroidism; however, the system did not supply controlled substances (medications such as narcotics which are regulated at the federal level).¹²

In mid-June 2013, patient B came to the Perry Point VAMC for a PACT appointment. According to the nursing assessment, the patient answered negatively to screening questions about suicide but answered positively to screening questions about depression and PTSD. The PACT provider saw the patient and noted that he had a May hospitalization in the community for a narcotic and benzodiazepine overdose. The PACT provider ordered a consultation for MH Service to follow up with the patient for

⁹ Cardiology Tests. VA Pittsburgh Healthcare System VA Pittsburgh Healthcare System Website. http://www.pittsburgh.va.gov/Cardiology_Tests.asp. Accessed September 21, 2014.

¹⁰ Stroke: Hope Through Research. National Institute of Neurological Disorders and Stroke Website. http://www.ninds.nih.gov/disorders/stroke/detail_stroke.htm. Accessed September 8, 2014.

¹¹ Up close with opioid receptors. National Institute of Neurological Disorders and Stroke Website. http://www.ninds.nih.gov/news_and_events/news_articles/opioid_receptors_up_close.htm. Accessed September 8, 2014.

¹² The Controlled Substances Act (see 21 USC §801) categorizes drugs (medications or components of a medication) according to potential for abuse, acceptable medical uses, and likelihood to lead to dependence into five schedules (see 21 USC §812 Schedules of Controlled Substances I, II, III, IV, or V). Drugs with the highest potential for abuse and no currently acceptable medical use are listed in Schedule I while those with low potential for abuse, an acceptable medical use, and limited physical or psychological dependence are listed in Schedule V.

depression, panic episodes, and PTSD. Two days later, a MH employee documented the following.

Attempted to contact Veteran via telephone; number provided in CPRS indicated, "You have reached (...) and immediately went to busy signal. No ability to leave message. Discontinuing consult. If Veteran interested in MH care, please refer to this writer at (...) to schedule intake appoint or have him contact (...).

Patient B returned for a follow-up PACT appointment in July and called the PACT staff to request medication refills in October and December. The patient came in December for laboratory testing in anticipation of an appointment with the PACT provider in February. The laboratory results showed the patient had normal values for a blood sugar test,¹³ urine protein (kidney damage marker),¹⁴ and a thyroid test.

In January 2014, the patient visited the Perry Point VAMC UCC with complaints of knee pain and swelling. The patient declined to get an ultrasound of his leg at the time and stated he would rather get this testing at a community hospital. Although patient B was scheduled for a PACT appointment in February, the clinic cancelled the appointment but provided medication refills through telephone calls in February and March. The PACT clinic also cancelled a subsequent appointment scheduled for the end of April and made a new appointment for the middle of June. In the beginning of May, patient B died from a self-inflicted gunshot wound.

Patient C. This patient allegedly experienced delays related to total joint replacement surgery at the Baltimore VAMC; however, we were unable to obtain specific patient information and could not review the case.

Patient D. This patient allegedly experienced quality of care concerns with tube feedings; however, we were unable to obtain specific patient information and could not review the case.

¹³ The A1C Test and Diabetes. National Diabetes Information Clearinghouse Website. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&uact=8&ved=0CDUQFjAA&url=http%3A%2F%2Fdiabetes.niddk.nih.gov%2Fdm%2Fpubs%2FA1CTest%2F&ei=rlgEVOOnMO8_KgwSfjoGwDQ&usg=AFQjCNHuhXUYZfJLOgIdLdCytLOvQjz1w&bvm=bv.74115972.d.aWw. Accessed August 29, 2014.

¹⁴ Protein Urine Test. Medline Plus Website. <http://www.nlm.nih.gov/medlineplus/ency/article/003580.htm>. Accessed September 8, 2014.

Inspection Results

Issue 1: Delays in Access

We did not substantiate that patient A, while having chest pain and shortness of breath, experienced a 1½-hour wait in the UCC. We could not substantiate that patient A was told there were no PACT provider appointments until August. We did substantiate the allegations that patient B experienced delays in access to primary and MH care and that the system, as a whole, experienced challenges in providing timely orthopedic surgery services.

Alleged Delay in Access at the Perry Point VAMC UCC

Access for Patient A: We did not substantiate the allegation that patient A, while experiencing chest pain and shortness of breath, waited 1½ hours unattended in the Perry Point VAMC UCC in May 2014. We could not substantiate the allegation that in June, staff told patient A that there were no PACT appointments until August.

At the end of May, patient A attended a support group in the morning and a few hours later, interacted with his PACT RN who documented the following.

Walk in stating he thinks his medicine needs adjusted. Patient states nausea, vomiting diarrhea for several days. Also noted is shortness of breath with minimal exertion noted for 2 days. Patient states tightness in his chest, noticed mostly after coughing. Nonproductive cough. Report given to (...) RN in urgent care for further evaluation.

According to the EHR, the patient signed into the UCC about the same time the PACT RN documented the note above, and 1 hour and 10 minutes later, the UCC RN documented the following.

Called vet several times to traige [sic] no answer, vet left. Called vet at home, answered "unable to wait, will return in the morning". Instructed vet if condition worsen to go to nearest hospital, verbalized understanding.

The complainant alleged that patient A's symptoms were more severe than those observed and described by system staff members who interacted with the patient on this day. The support group's EHR note described the patient as participative and made no mention of physical symptoms. In an interview with us, the PACT RN stated that patient A came to the clinic asking if the PACT provider could see him that day; however, the PACT schedule was full. The RN observed that patient A seemed to not feel well but did not appear or report to be acutely ill, coughing, or experiencing active chest pain. The RN recalled that when offering to accompany patient A to the UCC in order to be seen that day, patient A responded that transportation issues prohibited him from staying long. The RN reported that if she suspected that patient A's symptoms required immediate attention, she would have taken patient A directly to the staff in the UCC.

The 5-bed UCC is open 11-1/2 hours daily (from 7:30 a.m. to 6:00 p.m.) and typically staffed with one provider, one nurse practitioner, three nurses, and two health

technicians. On the day of patient A's visit described above, the UCC had a full complement of staff who saw 33 patients. Eleven of the 33 patients checked-in during the time that patient A's support group session was ending and his UCC check-in time. The UCC's workload varied on a daily basis, ranging from 5 to 45 patients, which VHA calculations deem to be a manageable number for staff.¹⁵ However, staff reported that many patients leave the UCC when they see several people in the waiting area. Because the patient had already left the area 1 hour and 10 minutes following his check-in at the clinic, we could not determine how long he waited before he was called to triage.

Alleged Delay in Access at the Perry Point VAMC PACT

Access for Patient A: We did not find documented evidence to confirm what staff told the patient in June regarding a next available appointment with the PACT provider. We also cannot retrospectively see the status of any clinic's schedule availability because of limitations within the VistA Appointment Management system.

Access for Patient B: We substantiated the allegation that patient B was scheduled for two PACT appointments at the Perry Point VAMC that the staff cancelled and rescheduled within the 6 months prior to his suicide. The clinic staff cancelled PACT appointments for this patient in February and at the end of April with the rescheduling of the April appointment for mid-June. The patient committed suicide in early May.

We were told that patient B had several personal stressors and, in the past, had been reluctant to receive MH care. Given the unavailability of more information, it cannot be determined what, if any, impact the PACT appointment cancellations may have had on the outcome in this case.

Provider staffing resulted in appointment cancellations for patients receiving PC at the Perry Point VAMC during October 2013 through September 2014. At the time of our review, Perry Point VAMC had five PACTs, and each PACT had one physician provider. In 2013, one PACT provider fell ill, stopped seeing patients in the beginning of September, and resigned by the end of September. The other four Perry Point PACT providers rotated, seeing the resigned provider's patients. Three months later, patient B's PACT provider experienced unforeseen personal events and a serious illness that resulted in cancellation of 110 (more than half of the 204) full clinic days and 23 partial clinic days during October 2013 to September 2014. Patient B's PACT clinic support staff took steps to manage the provider's cancelled appointment cases by rescheduling patients within 2 weeks to 2 months, as required by local policy, or with another PACT provider.^{16,17} Because of ongoing PACT provider absences, clinic staff

¹⁵ [VHA Directive 2010-010](#), *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010.

¹⁶ [VAMHCS PM 512 101/MC-013](#), *Primary Care Program*, April 2012.

¹⁷ [VAMHCS PM 512-11/COS-051](#), *Missed Clinic Appointments Clinic Cancellation and Patient No-Show*, June 2013.

often had to reschedule patient appointments more than once, including those for patient B.

With the decreased staffing, the acting lead PC provider tried to arrange for the remaining three Perry Point VAMC PACT providers to manage the nearly 5,000 clinic patients—more than the baseline panel size of 800–1,200 patients per provider, as established by VHA.¹⁸ The impact of the short staffing was exacerbated by providers having other duties, such as training residents. Although the Perry Point VAMC PACT providers each had two daily acute care (same-day) appointments, staff confirmed that, for several months, provider staffing shortages resulted in 2-month or longer wait times for routine appointments and an access backlog for PACT clinics.

In a February 14, 2014 email, the supervising physician for primary care¹⁹ requested that the other three PACT providers receive the electronic alerts (such as laboratory results, radiology reports, and other important reminders) of the two absent PACT providers. Perry Point VAMC's acting lead PACT provider replied that the remaining PACT providers were overwhelmed with electronic alerts. By day's end, the supervising physician for primary care took responsibility for the alerts of patient B's provider.

On February 26, the acting lead Perry Point VAMC PACT provider asked system provider leaders for help in an email, as follows.

I am not able to think of any acceptable or practical way to do all that you are requesting and provide adequate patient care to the veterans we are actually seeing. We three, (...) have been covering [for two absent providers] since at least the end of September. We had very little help and the expectation that three physicians carry a load of five forever is unrealistic.(...)How long are we expected to continue like this? We need help.

In early 2014, system leadership assigned a part-time provider to see some of the PACT patients; however, the part-time provider also went out on extended sick leave at the end of August. In July, the system contracted with a provider to help with the PACT workload, but the contracted provider was instead assigned to cover for a Perry Point VAMC UCC provider who was deployed on military leave.

Physician leaders reported reviewing PC wait time information and were aware of the need to decrease wait times in clinics where wait times exceeded VHA guidelines. According to the VSSC's *30-day Prospective Wait Time for Established Patients Report* for January 1–September 1, 2014, the Perry Point VAMC PACT clinics had an average wait time of 7 days. Although this wait time met the 30-day performance measure, it did not reflect the actual PACT access backlog²⁰ because, in part, the *Prospective Wait Time Report* for PC data is averaged with wait times for other clinics, specifically,

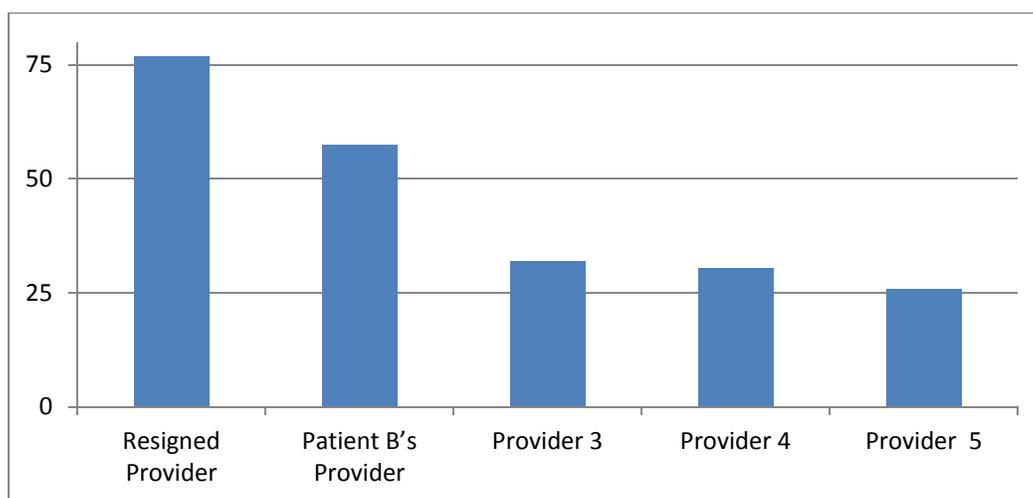
¹⁸ [VHA Handbook 1101.02](#), *Primary Care Management Module (PCMM)*, April 21, 2009.

¹⁹ The system's title for the supervising physician for primary care is Deputy Director for Managed Care Clinical Center.

²⁰ VSSC Prospective Wait Times Within 30 Days Report. VSSC Intranet Site. <https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fSystems+Redesign%2fProspective+Wait+Times+30+Days&rs:Command=Render>. Accessed September 29, 2014.

Women's and Geriatric PC clinics. VSSC had other data available to use in monitoring PACT clinic scheduling, such as cancellation reports. Graph 1 below shows that clinic cancellations of the resigned provider and the ill provider were at least twice that of the other providers.

Graph 1. Cancellation Percentage Rate (by Clinics and Patients) for Perry Point PACT Providers' Clinics October 2013 through August 2014



Source: VA OIG Analysis of VSSC Data

In addition to VSSC data, VistA reports, such as *Display Clinic Availability*, can also yield access information. For example, of three Perry Point VAMC PACT providers' clinics examined during the last week of September 2014, the average first available appointment wait time was just over 3 days for an acute (same day) visit and 40 days for routine care.

VHA requires that local service-level officials plan for, establish, and implement contingency plans for ensuring patients receive continuity of and access to appropriate PC during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events. Contingency plans must include systems that identify a cadre of qualified, credentialed, and privileged staff willing to assume coverage responsibilities on short notice. Such a contingency plan may use temporary staff such as those from academic affiliates, the National Primary Care Locum Tenens Program, or permanent replacement staff (for example, "float" PCP).^{21,22}

The system did not have a contingency plan for PACT provider shortages as required. System leadership also described hiring challenges for Perry Point VAMC because, in part, the area had a high demand for providers and less-than-competitive salaries.

Delay in a MH Appointment at the Perry Point VAMC

²¹ [VHA Handbook 1101.10](#), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

²² [VHA Directive 2010-027](#), *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

We substantiated that patient B experienced a delay in obtaining a MH appointment from the Perry Point VAMC. Patient B's EHR shows that the patient reported a suicide attempt in 2000, and he was engaged in some MH care until 2010. At a September 2011 PC appointment, the patient denied suicide risk factors. In May 2013, the patient was hospitalized in the community. Although staff documented a negative suicide screening the following month, the patient's PACT provider ordered a MH consultation. The consult was cancelled after one failed attempt to call patient B using what appears to have been an incorrect phone number. The patient again saw his PACT provider in January 2014 and had a negative suicide screening at that time. He committed suicide 4 months later.

System policy requires that MH staff members "...ensure that at least three documented attempts by telephone or letter have been made to contact the patient before the consult has been cancelled or discontinued."²³ Responding to the 2013 consultation, the MH provider believed that patient B's phone number was not correct and, after making one phone call, did not send a letter or attempt other contact with the patient. After learning of this case, the Site Manager for MH took action to review the policy requirements with MH staff in a June email and the July staff meeting.

The local policy also states, "The receiving provider may also discontinue the consult if the patient has been a no-show three or more times for the same consult or when the consult has been duplicated or when the patient has received requested services."²⁴ This section of the policy could cause confusion for staff since, over time, MH consultations are often resubmitted, and many patients cancel or fail to report for appointments.

Orthopedic Surgery Service Access at the Baltimore VAMC

Access for Patient C: Complaint 3 alleged that patient C needed a hip replacement and experienced at least a 4-month delay with scheduling the surgery, as well as delays on the day of surgery. We could not review patient C's case because the complainant did not provide specific patient information.

The system's orthopedic surgery access has been limited for several years and for several reasons. The system offers many types of surgeries; however, a fixed number of operating rooms and inpatient beds affect the total number and types of surgeries that can be performed. At the time of our visit, a university surgeon performed joint replacement surgeries on Tuesdays and, depending upon complexity, could generally perform two or three surgeries per day.

Joint replacement surgery is often elective, but can have serious health risks, including bone infections, heart attacks, blood clots, and bleeding.²⁵ To reduce these risks, the

²³ [VAMHCS PM 512-116/MH-003](#), *Mental Health Clinical Center Consultation/Referral Services*, February 2010.

²⁴ [VAMHCS PM 512-116/MH-003](#), *Mental Health Clinical Center Consultation/Referral Services*, February 2010.

²⁵ Risks of hip and knee replacement. Medline Plus Website.

<http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000375.htm>. Accessed August 31, 2014.

system established a multi-stage process for the flow of patients with joint replacement conditions. This process typically begins with a PC consultation using the EHR's consult system and initial patient evaluation by surgical residents. From this evaluation and before surgery, many patients must first try physical therapy, corticosteroid (a medication to relieve pain and swelling) injection, medication, or weight management treatments.

Before undergoing joint replacement surgery, the system's Orthopedic Surgery Service requires that patients have a series of pre-operative appointments, including medical, dental, and anesthesia evaluations. Pre-operative appointment availability is dependent upon access to each clinic and determined by the patient "passing" each evaluation. For example, a patient with a tooth infection would not be scheduled for the next pre-operative evaluation until the infection is eliminated with antibiotics. Resolution of an infection varies and can take from several days to weeks. The next step in the pre-operative process may also require more than one appointment. Although the goal of this pre-operative process is patient safety, this multiple appointment process contributes to real and perceived surgical delays.

VHA requires that staff complete consults within 90 days and document the consultation results or reasons why they were unable to complete the consult.²⁶ As of late August 2014, the system reported having 56 patients on the joint (hip and knee) replacement surgery list, and the average wait time for joint replacement surgery was 137 days.

Patient complaints regarding Orthopedic Service delays are tracked on the *Patient Advocate Reports* for Orthopedic Surgery Service. For the period of FY 2012 through September 4, 2014, 22 or more patients complained annually of delayed surgery. (See Table 1.) Comparatively, there were few complaints regarding the wait time for scheduled appointments.

Table 1. Orthopedic Surgery Service *Patient Advocate Report* Summary

Number and Topic of Patient Complaints	FY 2012	FY 2013	FY 2014*
Delay/Postponement in Scheduled Test/Procedures or Surgery	22	74	26
Excessive Wait at Facility for a Scheduled Appointment	1	2	5

Source: *OIG analysis of VHA data*

*2014 through September 4, 2014

VHA requires that the system director utilize patient complaint data to identify trends indicating a need for change in system processes and ensuring that those changes occur.²⁷ The system has a process for communicating the *Patient Advocate Report* complaint data to the service and leadership level. Having previously identified some of the complaints and issues, the system recently developed an *Access Action Plan* for

²⁶ [VHA Directive 2008-056](#), *VHA Consult Policy*, September 16, 2008.

²⁷ [VHA Handbook 1003.4](#), *VHA Patient Advocacy Program*, September 2, 2005.

Orthopedic Surgery Services. This document proposed several plans to address patient needs through, for example, increasing orthopedic staff, Non-VA Care referrals, and coordination with Neurology Service and Physical Medicine and Rehabilitation Service.

Issue 2: Quality of Care Concerns

Case of Patient A: We did not substantiate the allegation that system providers delayed or missed patient A's lung cancer diagnosis. We also did not substantiate that system staff would not endorse patient A's chemotherapy and radiation in the community.

One month before the Perry Point VAMC UCC visit, the patient had been active to the point that providers were planning to do an elective surgery for total knee replacement. Patient A participated in physical rehabilitation therapy for his knee until immediately before going to the UCC. He had a recent negative chest x-ray, and we found no documentation in the EHR before the end of May that the patient had complained of respiratory symptoms or that he experienced weight loss or worsening pain. As such, patient A's EHR did not include signs and symptoms that would have triggered additional evaluations of his lungs at the time of the UCC visit.

The community hospital's medical records demonstrated that the patient developed a rapidly progressive lung cancer, which resulted in bone metastasis, blood clots, strokes, and re-accumulating fluid in his lungs. In mid-June, the patient contacted the system and a PACT nurse documented the following.

Telephone call from patient stating he is currently an inpatient at (...) [community] hospital. Admitted for possible pneumonia, further diagnostic testing with diagnosis of lung cancer. Treatment plan being formulated at this time. Patient will continue to update us on care.

Five days later, a community hospital case manager contacted the system, and a PACT RN requested that when the community hospital discharged patient A, they send a discharge summary and prescriptions to the system's PACT provider for review. The system's EHR and community hospital records did not include other evidence of discussion between the community providers and system staff regarding the system sponsoring or denying chemotherapy or radiation.

The next day, patient A contacted a system patient advocate and reported that he was denied authorization by the system to receive chemotherapy. The patient advocate advised the patient on steps needed to request system-sponsored cancer treatment, including involving his PACT provider, and provided applicable contact information to the patient. However, patient A died from the lung cancer-related complications before discharge from the community hospital.

As of the end of August 2014, the system received five claims for payment of community medical care with no associated medical documentation. Without accompanying medical documentation, system staff could not determine if the care was related to his service connection disability and, therefore, payable under Title 38 U.S.C.

1728, as required by VHA policy.²⁸ Reportedly, when system staff requested medical records from the community hospital, the community hospital staff refused because the system was not the first party payer and advised that, if desired, the system would need to subpoena the records.

Based on the documentation, we concluded that the system provided appropriate quality of care. Through communications with the patient and requests for records from the community hospital, several system staff members made efforts to obtain information needed to endorse patient A's treatment, including chemotherapy or radiation for cancer. However, system staff were unable—in the absence of community medical records—to provide payment for community-provided treatment.

Case of Patient B. We did not substantiate that the patient almost died as a result of a blood sugar of 440 but noted that the patient was admitted to a community hospital in May 2013 as a result of both an elevated blood glucose level and pneumonia.

Prior to the May 2013 admission, the patient's blood glucose level was not well controlled. The American Diabetes Association sets a goal for the A1C laboratory test (a measure of blood glucose control over the prior 2 to 3 months) of 7.0% or lower, which corresponds to a blood glucose of 154 mg/dl or less.²⁹ In March 2013, patient B's A1C was 12.0%, which corresponds to a blood sugar of 298 mg/dl.³⁰ This was due, in part, to poor coordination between the facility and community providers in managing the patient's diabetes and the patient not attending appointments and diabetes education classes. Community providers subsequently placed patient B on insulin with improvement of his A1C to 7.0% by December of 2013. We were unable to assess the adequacy of management of the patient's diabetic neuropathy, because the patient obtained PC for this condition on his own (and not paid for by VA) in the community.

During 2014, patient B came to the Perry Point VAMC PACT clinic periodically to have blood work done and often called for prescription refills. The system's PACT provider reviewed the laboratory results and continued to prescribe diabetes and thyroid medications.

VHA and the system require that the care of patients receiving co-managed (system and community) care is well coordinated, safe, documented, and appropriate and that the professional autonomy and responsibility of system providers are respected.^{31,32} Specifically, system providers must, at least:

- Document the list of non-VA providers and medications in the patient's EHR.

²⁸ [VHA Directive 1601](#), *Non-VA Medical Care Program*, January 23, 2014.

²⁹ The A1C Test and Diabetes. National Diabetes Information Clearinghouse Website. <http://diabetes.niddk.nih.gov/dm/pubs/A1CTest/>. Accessed September 8, 2014.

³⁰ What does an A1C (Hemoglobin A1C) Test Measure. Scottsdale Healthcare website. <http://www.shc.org/medical-services/diabetes-management/what-does-an-a1c-hemoglobin-a1c-test-measure>. Accessed November 24, 2014.

³¹ [VHA Directive 2009-038](#), *VHA National Dual Care Policy*, August 25, 2009.

³² [VAMHCS Policy Memorandum 512-101/MC-003](#), *Co-Managed Care Policy*, January 2011.

- Coordinate care to ensure that medications or diagnostic tests are not ordered for any condition that the system provider is not managing.
- Ensure that a treatment or medication plan recommended by community providers is not followed if the system provider believes the plan is not medically appropriate.

Local policy states that the veteran or surrogate and the community provider are responsible for providing relevant information to the system staff. The policy also requires that within the EHRs of patients receiving co-managed care, staff document the community provider(s) name(s) and contact information and summarize other pertinent information.³³ System policy also requires that staff send “documents that cannot be readily summarized to the Scanning Unit in Health Information Management for scanning into the EHR.”³⁴

We were informed that patient B gave his PACT documentation from community providers. Based on this report, patient B’s EHR did not contain the expected number of notes from the community provider who prescribed controlled substances for the patient’s neuropathic pain and chronic back pain. Patient B’s EHR does not contain lists of community providers or evidence that the system’s providers actively considered or had available, the medication and treatment plans recommended by the community providers. In addition, patient B’s EHR did not contain pertinent records from his community hospitalizations and follow-up appointments. In order for a VA provider to coordinate community-based care appropriately, that provider would need to know what care the patient was receiving, from whom, and to know that the patient was being appropriately monitored.

Perry Point VAMC PACT providers correctly described the required local policy regarding community medical records, including receiving, reviewing, summarizing in EHR, documenting selected information, and forwarding records for scanning. However, there were, in this case, lapses in compliance by the provider(s). Some documents may also have been sitting in the queue of documents awaiting scanning by Health Information Management staff. The Health Information Management staff responsible for scanning reported that they are short-staffed by two positions (one for more than a year), and the paper backlog for documents to be scanned into the patients’ EHRs measured 37.75 inches deep in August 2014.

Case of Patient D: Complaint 3 alleged that patient D had surgery for mouth cancer that resulted in him needing to be fed by a tube, and the system did not help with his nutrition. We cannot determine if the system did not help patient D with nutrition by tube feeding because the complainant did not provide specific patient information. However, we found that the system did not fully comply with VHA’s guidelines regarding provision of home tube feeding.

³³ [VAMHCS Policy Memorandum 512-101/MC-003](#), *Co-Managed Care Policy*, January 2011.

³⁴ [SOP No. 136/MAS-003](#), *Document Scanning*, June 5, 2013.

VHA has published guidance for managing outpatients who require tube-feeding nutrition due to problems of chewing/swallowing, complication with gastrointestinal function, or as a result of a disease process.³⁵ The guideline directs that through consultation, assessment, and review, interdisciplinary staff must ensure that tube-feedings are ordered and compatible with prescribed medications and that outpatients and family members receive tube-feeding supplies, education, and regular physical assessment. VHA also states that, "Each VHA facility is responsible to establish local policy that incorporates these guidelines as a minimum to ensure continuity of care for home tube-feeding."³⁶

The system's policy requires the system's pharmacy to provide tube-feeding products to outpatients with feeding tubes or those undergoing active treatment for head and neck cancer. However, the system's policy does not address the elements of interdisciplinary outpatient tube-feeding care and management, such as patient education and physical assessment, as directed by VHA.

Conclusions

We did not substantiate the allegation that patient A, while experiencing chest pain and shortness of breath, waited 1-½ hours unattended in the Perry Point VAMC UCC. The UCC was fully staffed and able to manage the 33 patients who sought care the day of patient A's visit. Staff observed patient A's symptoms to be less severe than those described by the complainant and noted that he was gone from the UCC waiting area after 1 hour and 10 minutes. We could not substantiate the allegation that patient A was told in June that he could not get a PACT appointment until August because there is no documented evidence, and the VistA Appointment Management system cannot show schedules retrospectively.

We substantiated the allegation that patient B had two PACT appointments that were cancelled and rescheduled within 6-months prior to his suicide. We cannot determine what, if any, impact this PC appointment cancellation may have had on the patient's suicide. However, staffing issues related to provider shortages resulted in appointment cancellations for PACT patients at Perry Point VAMC. Although required, the system did not have a contingency plan for PACT provider shortages.

We also substantiated that patient B experienced a delay in obtaining a MH appointment from the Perry Point VAMC. In addressing the 2013 consultation, the MH provider believed that patient B's phone number was not correct and, after making one phone call, did not make the additional two requisite attempts to contact the patient. We also found that staff could be confused regarding a section of the local policy related to closure of duplicate consultations.

³⁵ [VHA Guidelines for Outpatient Enteral Nutrition Therapy](#), [VHA's Nutrition and Food Service Intranet Site](#).

³⁶ [VHA Guidelines for Outpatient Enteral Nutrition Therapy](#), [VHA's Nutrition and Food Service Intranet Site](#).

We could not determine if patient C experienced a 4-month delay in hip replacement surgery scheduling, as well as delays on the day of surgery, because the complainant did not provide specific patient information. However, we found that Orthopedic Service requires that patients progress through a multi-stage process that promotes patient safety but contributes to real and perceived surgical delays. The system had previously identified issues and patient complaints related to Orthopedic Surgery Services and developed an *Access Action Plan* to address several concerns.

We did not substantiate the allegation that the system providers delayed or missed patient A's lung cancer diagnosis or that system staff would not endorse chemotherapy and radiation. Although the community hospital's records demonstrated that patient A developed a rapidly progressive lung cancer, patient A's EHR did not include signs and symptoms that would have triggered additional evaluations of his lungs at the time of the UCC visit. As of late August 2014, the system received five professional claims for payment from community providers with no associated medical documentation. System staff were unsuccessful in obtaining medical records from the community providers and, without them, could not determine if the care was payable by VHA policy.

We did not substantiate that patient B almost died as a result of a blood sugar of 440. Patient B's diabetes was not well controlled, in part, because of poor coordination between the facility and community providers in managing the patient's care and the patient's non-attendance to appointments and diabetes education classes. We were unable to assess the adequacy of management of the patient's diabetic neuropathy, because the patient obtained care for his chronic pain in the community. Patient B's EHR did not contain the required information regarding community care and medications due to lapses in provider documentation. Some community-provided documents may also have been in a queue of documents waiting to be scanned by Health Information Management staff.

We could not determine if the system did not help patient D with nutrition by tube feeding, because the complainant did not provide specific patient information. The system's policy requires that the system's pharmacy provide tube-feeding products to outpatients with feeding tubes or those undergoing active treatment for head and neck cancer. However, the policy does not address elements of interdisciplinary outpatient tube-feeding care and management, such as patient education and physical assessment, as directed by VHA.

Recommendations

1. We recommended that the System Director ensure that patient aligned care team provider staffing is adequate to provide patients with timely access to care.
2. We recommended that the System Director ensure that a contingency plan for patient aligned care team provider shortages is developed.

3. We recommended that the System Director ensure that patient aligned care team cancellations and other data are monitored to determine when there is a need to activate a contingency plan.
4. We recommended that the System Director ensure that staff comply with local and national policies on contacting patients when scheduling mental health services.
5. We recommended that the System Director ensure that policy requirements for discontinuation of mental health consultation are clear and that staff comply with those requirements.
6. We recommended that the System Director ensure that the *Access Action Plan* for Orthopedic Surgery Services is carried out in an effort to improve access to orthopedic surgical services.
7. We recommended that the System Director ensure that providers comply with their responsibilities of electronic health record documentation of the community care of co-managed patients.
8. We recommended that the System Director ensure compliance with local policy requiring that community health care records be scanned into the electronic health records of co-managed patients.
9. We recommended that the System Director ensure that the local outpatient tube-feeding policy and practice comply with Veterans Health Administration requirements.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 13, 2015
From: Director, VA Capitol Health Care Network (10N5)
Subj: Healthcare Inspection—Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland
To: Director, Baltimore Regional Office of Healthcare Inspections (54BA)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. We appreciate the opportunity to review and provide comments to the draft report of the Office of Inspector General's Healthcare Inspection – Lapses in Access and Quality of Care at the VA Maryland Health Care System (VAMHCS) Baltimore, Maryland, on July 30, 2014 to August 1, 2014. The findings and recommendations have been reviewed with the senior leadership at the VISN and VAMHCS.
2. We concur with the recommendations in this report. The VAMHCS staff have initiated improvement actions.
3. If you have any questions, please contact my office at (410) 691-1131.


Joseph A. Williams, Jr. RN, BSN, MPM

System Director Comments

Department of Veterans Affairs

Memorandum

Date: January 9, 2015
From: Acting Director, VA Maryland Health Care System, Baltimore, MD (512)
Subj: Healthcare Inspection—Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland
To: Director, VA Capitol Health Care Network (10N5)

1. We appreciate the opportunity to review and provide comments to the draft report of the Office of Inspector General's Healthcare Inspection – Lapses in Access and Quality of Care at the VA Maryland Health Care System (VAMHCS) Baltimore, Maryland, on July 30, 2014 to August 1, 2014. The findings and recommendations have been reviewed with the senior leadership at the VAMHCS and VISN.
2. We concur with the recommendations in this report. The VAMHCS staff have initiated improvement actions.
3. If you have any questions, please contact my office at (410) 605-7016.


ADAM M. ROBINSON, JR., M.D.
Acting Director, VA Maryland Health Care System

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the System Director ensure that patient aligned care team provider staffing is adequate to provide patients with timely access to care.

Concur

Target date for completion: July 2015

System response: These specific incidents and the renewed VA-wide emphasis on access issues have afforded Primary Care leadership at the VAMHCS an opportunity to examine, in detail, the structure, configuration and delivery of efficient, timely care to Veterans especially in context of provider staffing shortages. As specified below, despite difficulty recruiting and processing time constraints, additional providers to enhance access and maintain continuity of care have been hired; and proactive efforts are in place for additional recruitment.

We are in active processes of hiring several Primary Care providers to replace providers who have left or will be leaving soon. Twelve providers have been added to PACT in Calendar Year 2014. An additional seven providers are in the recruitment process. Interviewing of additional providers continues. Monitoring of access to include third next available (TNA) times for New and Established patients, and Missed Opportunity rates is ongoing.

Recommendation 2. We recommended that the System Director ensure that a contingency plan for patient aligned care team provider shortages is developed.

Concur

Target date for completion: July 2015

System response: We are planning to hire a contingency pool of providers who will be available in any contingency to bridge any unexpected provider absences. These providers will not carry full panel sizes thus allowing them flexibility to respond to provider shortages as needed. These providers will assist in maintaining continuity and uninterrupted care.

Recommendation 3. We recommended that the System Director ensure that patient aligned care team cancellations and other data are monitored to determine when there is a need to activate a contingency plan.

Concur

Target date for completion: April 2015

System response: A Chief of Staff memo regarding Clinical Cancellations was sent on November 06, 2014, to all Clinical Center Directors and Medical Staff outlining patient centered clinic operations. Additionally, the VAMHCS Clinic Cancellation Policy has been distributed to all Primary Care Clinic staff and is enforced daily. The Deputy Director of Managed Care will proactively review data and trends to identify opportunities for improvement. Enforcing the local VAMHCS Policy, minimizing clinic cancellations, and hiring additional providers, as specified under Recommendations (1) and (2), will improve clinic access and coverage.

Recommendation 4. We recommended that the System Director ensure that staff comply with local and national policies on contacting patients when scheduling mental health services.

Concur

Target date for completion: April 2015

System response: All VAMHCS Mental Health (MH) staff have been made aware of the local and national policies that dictate procedure for contacting patients when scheduling appointments. Further, all MH staff are expected to fully comply with such policies. Index clinicians involved in the care of Patient B have been specifically counseled regarding the events surrounding the contact and scheduling of this Veteran's MH consult appointment. The Mental Health Clinical Director will ensure compliance with this policy by adding it as a line item at each monthly all staff meeting and tracking attendance. A random sampling of mental health patients will be done monthly for the next three months to ensure staff comply with local and national policies on contacting patients when scheduling mental health services. The benchmark for compliance will be 90%.

Recommendation 5. We recommended that the System Director ensure that policy requirements for discontinuation of mental health consultation are clear and that staff comply with those requirements.

Concur

Target date for completion: April 2015

System response: All VAMHCS MH staff have been educated regarding the local and national policies that outline procedures for the discontinuation of MH consults. A revised VAMHCS policy to strengthen our local processes related to the discontinuation of MH consults is in progress. Once this local policy is completed, all MH staff will be educated on this policy. In addition, this local policy will be discussed at each of the monthly MH "All Staff" meetings. Specific to the index case, policy was reviewed with all staff regarding the process for consult discontinuation in the setting of duplicate consultation requests.

Recommendation 6. We recommended that the System Director ensure that the *Access Action Plan* for Orthopedic Surgery Services is carried out in an effort to improve access to orthopedic surgical services.

Concur

Target date for completion: April 2015

System response: Surgical Care Clinical Center Leadership is working proactively to improve access and efficiency. This is being accomplished by hiring additional mid-level providers, enforcing Care Coordination Agreements, stressing Consult Management Business Rules, and monitoring Missed Opportunity rates. The VAMHCS has increased the use of Non-VA Care when the internal capacity is unable to meet the clinical needs of the Veteran(s).

Recommendation 7. We recommended that the System Director ensure that providers comply with their responsibilities of electronic health record documentation of the community care of co-managed patients.

Concur

Target date for completion: April 2015

System response: This issue will be discussed with all Primary Care providers at monthly Managed Care All Staff Meetings. Follow up education will be provided. The Director of the Managed Care Clinical Center will ensure that 100% of the Primary Care Providers are educated by April 2015.

A random sampling of co-managed patients will be done monthly for the next three months to ensure providers comply with the responsibility of electronic health record documentation of the community care of co-managed patients. The benchmark for compliance will be 90%.

Recommendation 8. We recommended that the System Director ensure compliance with local policy requiring that community health care records be scanned into the electronic health records of co-managed patients.

Concur

Target date for completion: April 2015

System response: The VAMHCS does not have a local policy for scanning medical records. In discussion with the Chief of Medical Administration Service and the Deputy Director of Managed Care, the present scanning protocol and practice is efficient and timely. We will continue to educate and monitor the compliance of all Primary Care Providers to submit all appropriate non-VA records for scanning into the electronic medical record. This has been discussed with the Health Information Management Service to ensure timely scanning of paper medical documentation. The VAMHCS will

develop a local policy to ensure consistent compliance with the inclusion of community health records into the Veteran's medical record.

A random sampling of co-managed patients that have been seen by their outside provider and have documentation for the VA that requires scanning will be done monthly for the next three months to ensure compliance with local policy. The benchmark for compliance will be 90%.

Recommendation 9. We recommended that the System Director ensure that the local outpatient tube-feeding policy and practice comply with Veterans Health Administration requirements.

Concur

Target date for completion: April 2015

System response: The current VAMHCS Enteral Nutrition Policy will be revised to strengthen our processes to ensure full compliance with VHA requirements.

Office of Inspector General Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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