Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04681-228

Healthcare Inspection

Consult Management Concerns
VA Greater Los Angeles Healthcare System
Los Angeles, California

May 4, 2017

Washington, DC 20420

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various Federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
Web site: www.va.gov/oig

Table of Contents

Executive Summary

The VA Office of Inspector General conducted a healthcare inspection at the request of former Chairman Jeff Miller, Committee on Veterans' Affairs, US House of Representatives, to determine the validity of an allegation that 74 deceased patients had open consults at the VA Greater Los Angeles Healthcare System (facility), Los Angeles, CA.

For the period October 1, 2014 through August 9, 2015, we identified 225 deceased patients who had 371 open or pending consults at the time of their deaths or had discontinued consults after their deaths.

Of the 225 patients, we found 117 patients with 158 consults experienced delays in obtaining requested consults. We substantiated that 43 percent (158/371) of consults were not timely because providers and scheduling staff did not consistently follow consult policy or procedures.

We did not substantiate the allegation that patients experienced serious or severe impact with long-term consequences or organ dysfunctions or that patients died as a result of delayed consults. However, we identified two patients who experienced intermediate impact (Patient 1) or minor impact (Patient 2).

We found that providers entered incorrect inpatient/outpatient setting and/or urgency for 14 percent (52/371) of the reviewed consults. Providers entered incorrect consult service settings for 9 percent (34/371) of consults and incorrect consult urgency for 5 percent (18/371) of consults.

While not an allegation, we observed deficiencies in consult management practices which contributed to the delays. Of the 158 delayed consults identified, we noted that facility staff did not: (a) timely act on clinical consult requests, (b) close completed consults or discontinue duplicate requests or consults no longer indicated, or (c) monitor the electronic wait list for Homemaker/Home Health Aide services. Additionally, scheduling staff encountered challenges scheduling appointments due to patient unavailability or patients not attending scheduled appointments for various reasons.

We determined that had the facility implemented consistent and timely review of open and pending consults, facility consult data would have reflected a more accurate number of delayed consults that had potential clinical impact.

We recommended that the Facility Director ensure that:

- Providers assign the proper consult setting and urgency.
- Staff take action within 7 days of a consult request or sooner if clinically indicated.
- Staff timely close or discontinue consults.

- Staff review the quality and timeliness of the cardiology care for Patient 1 and take action if appropriate.
- Staff monitor and address the care needs of patients on the Homemaker/Home Health Aide services electronic wait list.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 22–26, for the Directors' comments.)

The Facility Director requested closure of recommendations 2 and 4. Based on information provided, we consider recommendation 4 closed. We will follow up on the planned actions for all other recommendations until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of former Chairman Jeff Miller, Committee on Veterans' Affairs, US House of Representatives, to determine the validity of an allegation that 74 deceased patients had open consults at the VA Greater Los Angeles Healthcare System (facility), Los Angeles, CA.

Background

The facility consists of a medical center, two ambulatory care centers, and eight community-based outpatient clinics. The facility provides primary, specialty, outpatient, medical, surgical, psychiatric, rehabilitative, and long-term care services, and serves a veteran population of approximately 88,000 in a primary service area that includes Los Angeles, Santa Barbara, San Luis Obispo, Ventura, and Kern counties in California. The facility has a total of 1,049 operating beds—316 hospital, 296 domiciliary, 372 community living center, and 65 compensated work therapy transitional residence program operating beds. The facility is part of Veterans Integrated Service Network (VISN) 22.

Consult Management

The consult process is a method of coordinating patient care among different services. Veterans Health Administration (VHA) updated its consult management directive in August 2016.[1] A previous directive was in effect at the time of the events discussed in this report. The 2008 directive stated "a consult is a specific document, most often electronic, which facilitates and communicates consultative and non-consultative service requests and subsequent activities."[2] The 2008 directive also required that "all requests for clinical consultation be clinically completed with results consistent with VHA timeliness standards and resolved efficiently taking into account individual health needs."[3] Both the 2008 and 2016 directives require that action be taken by the receiving service within 7 days of the request.

On May 23, 2013, VHA issued a memorandum to all VISN Directors and VA Central Office Program Offices to announce the standardization of certain aspects of the

[1] VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016.
[2] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive was in effect during the time of the events discussed in this report but has been rescinded and replaced with VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016. The 2016 Directive has the same or similar language regarding the definition of a consult.
[3] VHA Directive 2008-056. VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016 states: "It is VHA policy to ensure timely and clinically appropriate care to all Veterans by standardizing and managing consultation processes."

electronic consultation process and establish timelines for business rule implementation by May 2014.[4]

Consults are requested with different types of urgency. In 2014, VHA issued business rules requiring each facility to take action on STAT consults within 6 hours and emergency consults within 4 hours for inpatient and outpatient consults.[5] For routine consults, each facility was to determine the timeframe for action. For inpatients, the facility required clinicians to take action within 24 hours or at the end of the next calendar day. For outpatients, the facility policy did not define timeliness;[6] however, 30 days has been commonly used.[7,8] We considered consults that exceeded the timeliness standards as delayed consults.[9]

The business rules made the use of the consult package mandatory for clinical, non-VA Care Coordination (NVCC), and clinical procedures with vendor interface. For administrative consults, use of the consult package was optional. Below are the business rules for the following consult request types:[10]

- Clinical consults are consults for clinical services to be delivered in outpatient settings either face-to-face or electronically (e-consult), or completed during an inpatient stay, or requests for service between VA facilities. This type of consult requires two-way communication. Requesting staff receive clinical information in response to the consult request.

- Administrative consults are consults that may include a clinical request, such as transfer of care between providers; requests to a specialty clinic to re-schedule appointments and to order tests, such as electrocardiograms; or for purchase of a prosthetic item, such as a lens implant for cataract surgery. This type of

[4] Under Secretary for Health, "Consult Business Rule Implementation" memorandum, May 23, 2013.
[5] These business rules were in effect and provided consult completion timeliness requirements to VHA facilities during the time frame of the events discussed in this report. VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016 mandates the use of 2 urgency categories only: Routine and STAT. For a routine consult, the patient should be seen in accordance with the clinically indicated date. STAT consults are used for patients with an immediate need and must be completed within 24 hours.
[6] VA Greater Los Angeles Healthcare System, Standard Operating Procedure, *11-161 Outpatient Consult Management*, April 2014.
[7] VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006. This Directive expired June 30, 2011 and has not yet been updated.
[8] Veterans Access, Choice, and Accountability Act of 2014. The 30 day requirement for routine care was articulated in the VHA Choice Act enacted August 7, 2014, that defined VHA wait time goals as "…not more than 30 days from the date on which a veteran requests an appointment for hospital care or medical services from the Department." This definition was further refined by VA in its October 2014 proposed interim rule that states wait-time goals of VHA would mean" not more than 30 days from either the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination has been made, the date a veteran prefers to be seen for hospital care or medical services."
[9] VHA Directive 2006-041.
[10] VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016 incorporated the business rules into Appendix A.

consult was meant for one-way communication. It is considered completed by entry of a progress note for a clinical procedure or administratively completed by entry of an appropriate comment when the need is addressed. Facilities were required to establish a policy that outlined timeframes for closing administratively completed consults.

- NVCC consults are consults for medical care provided to eligible veterans outside of VA (in the community) when VA facilities and services are not reasonably available. Requesting providers submit an NVCC consult, which NVCC staff review to determine administrative eligibility. The NVCC consult is reviewed for clinical appropriateness and confirmation that any prerequisite testing has been completed. The Chief of Staff or a designated clinical leader approves the consult, and NVCC staff generate an "authorization" for non-VA care. Then NVCC staff send the consult, authorization, and supporting documents to a community-based provider or a medical practice for completion of the consultation and/or evaluation. NVCC case managers and schedulers coordinate the scheduling and follow-up process.

- Clinical procedures with vendor interface consults are consults for clinical services (such as dialysis) when an interface with a vendor is necessary.

National efforts are underway to help ensure that patients' appointments are within 30 days of the clinically indicated[11] or preferred date[12] for services.[13]

Allegation

On July 21, 2015, we received a letter from former Chairman Jeff Miller stating that "74 veterans died while waiting for a consult in Greater Los Angeles." The letter contained a copy of the facility's open consults report by service line and the number of deceased patients (no specific patient identifiers provided) as of May 6, 2015. See Figure 1.

[11] The clinically indicated date is the date an appointment is deemed clinically appropriate by a medical provider and documented in the EHR.
[12] The preferred date is the date the patient prefers to be seen for care or services.
[13] http://www.va.gov/HEALTH/docs/VA_Report_Section101-PL_113-146-Final.pdf. Report to Congress on the Veterans Choice Program Authorized by Section 101 of the Veterans Access, Choice, and Accountability Act of 2014, October 3,2014. Accessed June 8, 2016.

Figure 1: Facility Open Consult Report as of May 6, 2015

BISL

SAT - Open Consult Dashboard

VA HEALTH CARE Defining EXCELLENCE in the 21st Century

(691) Greater Los Angeles HCS (Los Angeles CA)

Feedback

Click here for all closed open details

Data Current Through: 5/6/2015

Service Line	To Request Service Name	Avg. Elapsed Days Open	Open 0 - 30 Days	Open 31 - 60 Days	Open 61 - 90 Days	Open 91- 120 Days	Open 121- 360 Days	Open > 360 Days	Total Open Consults	Deceased Total
ANESTHESIA		5.75	11	0	0	0	0	0	11	0
AUDIO/SPEECH		17.29	89	29	3	1	1	0	123	0
DENTAL		11.55	82	4	3	3	0	0	92	0
IFC		52.67	74	14	9	4	9	5	115	0
MEDICINE		62.28	1,355	290	205	207	775	114	2,946	4
MENTAL HEALTH		35.65	397	57	12	9	5	3	483	0
MULTIPLE		42.80	9	5	0	1	1	0	16	0
NEUROLOGY		51.47	86	8	5	2	2	2	105	1
NON-VA CARE		115.15	1,442	544	545	206	436	32	3,205	9
NURSING/PCS		157.12	1,329	1,254	541	343	1,955	467	5,889	51
NUTRITION		5.43	68	1	0	0	0	0	69	0
PALLIATIVE CARE		135.00	6	0	0	0	0	1	7	0
PALMS		178.00	13	3	3	0	6	5	30	0
PHARMACY		6.00	64	0	0	0	0	0	64	0
PMRS		31.83	686	80	52	14	7	2	841	0
PRIMARY CARE		30.09	206	30	6	3	45	31	321	0
PROSTHETICS		140.90	3,186	1,484	100	38	65	21	4,894	9
RADIOLOGY		149.57	57	11	9	11	44	0	132	0
SOCIAL WORK		126.64	38	4	1	0	2	2	47	0
SPINAL CORD		7.13	94	10	2	0	0	0	106	0
SURGERY		47.53	679	89	30	17	24	27	866	0
Total		65.30	9,971	3,917	1,526	859	3,377	712	20,362	74

Page Number: Page 1 of 1 page(s)

Report executed by VHA22\VHA[redacted] on 5/7/2015 12:58:00 PM

Source: VA Open Consult report provided by former Chairman Jeff Miller

The report had 20,362 open consults and identified 74 total deceased patients from 5 service lines. See table 1 (extracted from Figure 1) listing the 5 service lines.

Table 1: Facility Open Consults and Deceased Patients by Service Line as of May 6, 2015

Service Line	No. of Open Consults	No. of Deceased Patients
Nursing/ Patient Care Service	5,889	51
Prosthetics	4,894	9
Non-VA Care Coordination (NVCC)	3,205	9
Medicine	2,946	4
Neurology	105	1
Total	**20,362**	**74**

Source: Facility open consult report as of May 6, 2015 and print date May 7, 2015

Because the report only captured deceased patients who had open consults, on October 22, 2015, we informed former Chairman Miller that we would conduct a comprehensive review to identify patients who had open consults at the time of their death and those who had discontinued consults after their death. Additionally, we indicated we would verify the accuracy of the consult setting (inpatient /outpatient) and the urgency of the consults (STAT, emergency, or routine) and apply timeliness standards. For delayed (consults that exceeded established timeliness standards) or unresolved (not completed) consults, we would determine whether patients were harmed and the degree of harm (clinical impact). We clarified the request and provided the response below to former Chairman Miller.

> *We have initiated a review into the extent of wait times at the GLAHCS [Greater LA Healthcare System] as it pertains to deceased patients who had active, pending, or discontinued consults and whether any patients were harmed because of unresolved consults. We will provide you with the results of our review when it is completed.*
>
> *Please be aware that the list of 74 deceased patients with open consults that you provided to us has some limitations. VHA guidance allows facilities to discontinue consults after a patient's death, even if they had not received the service prior to their death. The list of 74 patients you provided would not capture those discontinued consults because they would not be considered "open" in VHA's databases. To ensure that our review is as comprehensive as possible, we will try to identify patients who had open consults at the time of their death as well as those who had consults that were discontinued after their death through August 9, 2015, at the VA GLAHCS. We will try to identify these patients by querying the Corporate Data Warehouse (CDW) and reviewing associated patient health information. Each of the consults for the deceased patients will be reviewed by OIG health system specialists to determine whether a delay occurred based on the requested urgency and consult business rules of the Veterans Health Administration and GLAHCS.*

Scope and Methodology

We conducted our review from August 2015 through June 2016.

We identified a study population that consisted of 225 patients who died from October 1, 2014 through August 9, 2015, and had at least:

- One active or pending consult as of August 13, 2015, or
- One discontinued consult after their date of death as of August 27, 2015.

We extracted eligible (active[14] or pending[15] consult as of August 13, 2015, or discontinued after death as of August 27, 2015) consults from the tables of Con.Consult and Con.ConsultActivity in VA's Corporate Data Warehouse[16] on August 13 and then on August 27, 2015. We identified 225 patients who died between October 1, 2014 and August 9, 2015 with 371 eligible consults.

For each of the eligible consults, we reviewed the patient electronic health record (EHR) to determine whether patients had delayed consults, and if a delay occurred, whether that delay had a clinical impact or harmed the patient. We considered consults that exceeded the timeliness standards as delayed consults.

EHR Review Process

We employed a two-phase process to review EHRs. The first phase was a screening process. Healthcare inspectors independently reviewed each consult to determine whether the consult was delayed based on the urgency of the requested consult. We reviewed and applied VHA and facility consult business rules to determine the timeliness of consults.[17]

During the screening phase, healthcare inspectors first verified the accuracy of the consult setting (inpatient or outpatient) and the urgency (such as routine, STAT, emergency). Inspectors then identified delayed consults based on the true setting (inpatient or outpatient) and urgency; applying VA and facility consult business rules. We determined consult timeliness by calculating the life span of the consult using the start date and the end date. We defined the start date as the consult order date or clinically indicated date, whichever was the later date. We defined the end date as the service completed date, the discontinued date, or August 13, 2015, for those that were still in active or pending status on that date, whichever was the earliest date.

[14] Facility policy defines active consults as received by the service and ready for scheduling.
[15] Facility policy defines pending consults as requested and awaiting action by the receiving service.
[16] VA's Corporate Data Warehouse is a national data set of clinical and other data collected and stored on servers maintained by the VA Office of Information and Technology in the form of relational databases.
[17] We reviewed the recently published VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016 and determined the new directive is consistent with the 2014 Consult Management Business Rules.

For consults that met the timeliness standards, inspectors did not screen for clinical impact and stopped further review.

We considered a consult completed if the service was delivered or completed within the timeframe requested by the ordering physician or the clinically indicated date of the requested urgency status regardless of the consult request setting or provider/specialty. For example:

- Alternate setting—If a patient had a routine neurology evaluation consult to be delivered in the outpatient setting, and the patient was hospitalized, we considered the consult completed if the patient saw the neurologist within the requested timeframe, even though the consult was completed in the inpatient setting.

- Alternate provider/specialty—If a patient was seen in the Emergency Department and was discharged home with a follow-up consult to obtain a speech evaluation through his or her primary care provider (PCP), we considered the consult completed if the patient did not see his PCP but received the evaluation from a speech pathologist within the requested timeframe.

For all delayed consults (those that exceeded the timeliness requirement), inspectors reviewed the relevant patient's EHR for clinical impact. We developed and defined the following six-level scale to measure clinical impact:

1 = no impact
2 = minor or self-limited
3 = intermediate: patient needed a medical intervention, but there was no long-term consequence
4 = serious: patient needed medical intervention with some long-term consequence
5 = severe: major organ dysfunction, severe long-term consequence
6 = death

Inspectors referred delayed consults that screened as a Level 2 (minor or self-limited) or above (screen positive) to an OIG physician reviewer for a second phase EHR review. In addition, inspectors referred consults to the physician when:

- they were unable to determine clinical impact
- they were uncertain if the consult was no longer indicated because of changing patient condition after consult placement
- they had any other concerns requiring further medical review

During the second phase, the OIG physician reviewed the patient's EHR, starting from the consult order date up to the last recorded entry available as of June 7, 2016, for all consults referred by inspectors. For patients who we did not have EHRs at the time of their death, we subpoenaed EHRs from three non-VA facilities for patients who died at those facilities. For patients who died in a non-medical facility, we subpoenaed death

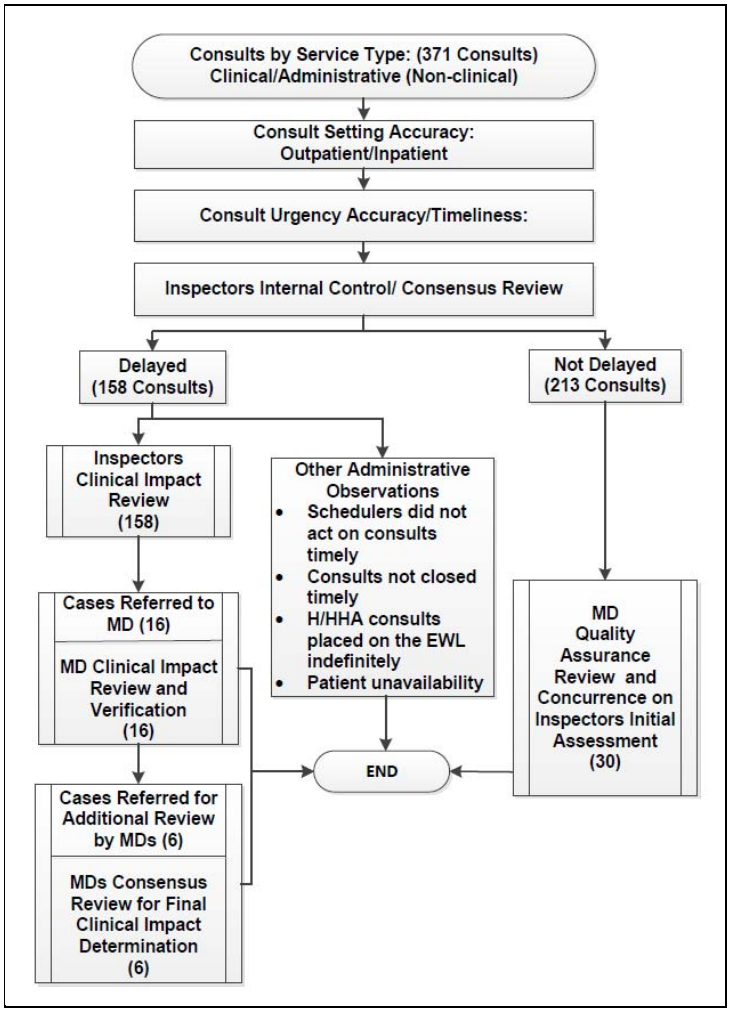
certificates. The physician determined whether clinical impact resulted from the consult delay by using the same clinical impact level scale the inspectors used during the screening phase. Finally, the physician referred all cases with a potential clinical impact to at least two additional physicians to review in order to reach a consensus on the final clinical impact levels.

After determining the timeliness of consults, we further reviewed the characteristics of all 371 consults such as consult accuracy by service type (administrative or clinical), setting (inpatient or outpatient), and urgency (STAT, emergency, or routine) and factors contributing to the delays.

EHR Internal Control and Quality Assurance

For internal control of the screening phase, two inspectors independently reviewed each consult. We compared the screened consult results and resolved all discrepancies via a consensus review performed by both inspectors. For quality assurance, the physician independently reviewed and verified a random sample of 30 (screen negative) consults that were not referred for further review and concurred with the inspectors' initial assessments. Figure 2 shows the process followed for reviewing consults.

Figure 2: Review Process



Source: VA OIG

Two VHA policies cited in this report were expired or beyond the recertification date:

1. VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006 (expired June 30, 2011).

2. VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006 (recertification due date July 31, 2011).

We considered these policies to be in effect as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[18] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a

[18] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

more recent policy or guidance."[19] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[20]

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.

[19] VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document,* June 29, 2016.
[20] Ibid.

Inspection Results

Issue 1: Clinical Impact of Delayed Consults

We confirmed that 225 deceased patients had active/pending consults at the time of their deaths or had discontinued consults after their deaths. We did not substantiate that they died as a result of the delayed or unresolved consults. However, we found two patients who experienced minor (level 2) or intermediate (level 3) clinical impact due to delayed consults.

We reviewed the EHRs of 225 patients with 371 eligible consults. We identified 117 (52 percent) patients with 158 (43 percent) delayed consults. Inspectors referred 16 delayed consults for OIG physician review. One physician reviewed all 16 referred consults and determined 6 had potential clinical impact. After further review by at least two additional OIG physicians, we reached a consensus that three of the six delayed consults had clinical impact and three did not. We did not find any patients who experienced serious or severe impact with long-term consequence or organ dysfunction or who died (Levels 4–6) as a result of delayed consults. Table 2 shows the clinical impact for all 158 delayed consults.

Table 2: Clinical Impact of Patients With Delayed Consults

Level of Clinical Impact	Number of Patients*	Number of Delayed Consults
Intermediate (Level 3)	1	1
Minor or self-limited (Level 2)	1	2
No impact (Level 1)	115	155

Source: VA OIG EHR analysis of identified patients with delayed consults

Of the 117 patients who had delayed consults, we identified 2 patients who experienced minor or intermediate clinical impact due to delayed consults.

Patient 1 experienced intermediate clinical impact (Level 3) from a delayed cardiothoracic (CT) surgery consult.

The patient was in his 70s with a history of valvular heart disease, heart failure, and an abnormal heart rhythm at the time of his death. In 2014, the patient was seen by a cardiologist who ordered a routine outpatient CT surgery consult for heart valve replacement.[21]

The patient was admitted to the facility a few weeks later to expedite the preoperative evaluation needed for heart valve surgery. During the admission, the cardiologist noted "CT surgery consulted prior. Needs [valve repair] workup." We reviewed the EHR

[21] Valve replacement is indicated when patients become symptomatic.

dating back to 1996 and did not find any CT surgery notes regarding a valve repair. As part of the preoperative evaluation, the patient underwent a heart catheterization and was found to have coronary artery disease.[22] He was discharged with a dental appointment to evaluate for infections that might adversely affect his surgical outcome.

After the patient failed to show for his dental appointment, dental staff made three unsuccessful attempts to reschedule his appointment. A week after the scheduled dental appointment, the patient presented to a non-VA hospital with "massive leg swelling" and was admitted for myocardial infarction (heart attack) with kidney and heart failure. Less than 12 hours after admission, he died of cardiogenic shock[23] presumed to be related to a massive myocardial infarction. Facility staff did not take action on the CT surgery consult for more than 4 months, when they discontinued the consult because the patient had died.

We determined that the patient experienced an intermediate clinical impact (Level 3) from not receiving a CT surgery evaluation. The patient's advanced age and comorbidities (coronary artery disease and an abnormal heart rhythm), increased his risk for heart failure, a known complication of valvular disease. While the EHR did not have documentation from a CT surgeon, the cardiologist had been coordinating the patient's preoperative evaluation in preparation for a heart valve replacement. Timely consultation by a CT surgeon would not likely have prevented his death because he was receiving appropriate care from the cardiologist.

Patient 2 experienced minor or self-limited impact (Level 2) due to delayed nephrology and cardiomyopathy consults.

Nephrology Consult

The patient was in his late 60s with a history of diabetes, hypertension, heart failure, and chronic kidney disease requiring several months of dialysis in 2014 (month 1), which he received at a non-VA facility. After completion of dialysis treatments, he was seen by the VA nephrology (kidney) clinic, with a plan to follow up in 4–6 weeks. In month 10, the patient was admitted to the facility for heart failure with worsening kidney disease. In month 11, his PCP ordered laboratory tests and a routine outpatient nephrology consult to help determine the cause of the chronic kidney disease. Clinic staff approved the consult for an appointment in 3–4 weeks noting that the patient had not been followed up by nephrology clinic since a month 4 appointment. The scheduler made an appointment for month 13 after multiple scheduling attempts.

[22] Coronary artery disease is characterized by fatty deposits in the arteries that supply blood to the heart muscles and predisposes patients to heart attacks.
[23] Cardiogenic shock is a condition when the heart cannot pump enough blood to meet the body's needs, often causing multi-organ failure.

Cardiomyopathy Consult

Prior to the patient's discharge home from his month 10 hospitalization, the hospitalist requested a routine outpatient cardiomyopathy (heart failure) clinic[24] consult. The patient did not attend a scheduled month 11 appointment, so the scheduler made another appointment for the next month (month 12).[25]

Before the scheduled appointment in month 12, a physician's assistant in the cardiology clinic saw the patient for worsening heart failure and sent him to the ED. The ED physician treated the patient for heart failure and discharged him home with instructions to follow up with cardiology the following week. The patient did not attend the cardiomyopathy appointment but presented to a non-VA facility 2 days after the missed appointment with massive leg swelling and shortness of breath. His kidney function had worsened but was without signs of kidney failure as indicated by normal electrolytes.[26] He was diagnosed with heart failure and underwent dialysis to remove fluid but not electrolytes. On hospital day 3, he developed worsening shortness of breath that progressed to cardiac arrest, and died of presumed myocardial infarction. An autopsy was not performed.

We determined that the patient experienced minor clinical impact (Level 2) as a result of the delayed nephrology and cardiomyopathy consults. The patient had severe multi-organ disease. However, had the patient received the nephrology consult timely, physicians would not likely have performed any interventions as he had no signs of kidney failure.[27] The goal of the cardiomyopathy clinic was to encourage treatment adherence, and the patient had a history of poor attendance at his cardiology appointments, including "no show" to a heart failure consultation in month 9.

Issue 2: Characteristics of Reviewed Consults

Of the 371 consults reviewed, we substantiated that 43 percent (158/371) were not provided timely. Of the 158 delayed consults, 39 percent (61/158) were administrative (non-clinical) in nature. We also found that providers entered the incorrect inpatient/outpatient setting and/or urgency for 14 percent (52/371) of consults.

[24] Patients are enrolled in Cardiomyopathy clinic to educate and encourage them to adhere to their treatment regimen by helping them monitor their daily weights and salt intake.
[25] Although the patient was scheduled within 30 days for his routine urgency consult, we determined the consult was delayed because the appointment was not completed within the required 30-day timeframe. See issue 3 for more information on delayed consults.
[26] Electrolytes are salts and minerals that conduct electrical impulses and control fluid balance in the body.
[27] Symptoms of kidney failure include high potassium levels, massive swelling, and shortness of breath. At the time of the consult review and the PCP visit in November, the patient did not have any of these symptoms.

Consults by Service Type (Administrative and Clinical)

We reviewed all 371 consults to determine timeliness and the type of consult service requested. Table 3 on the next page shows the consults by service type. Of the 245 clinical consults, about half (133/245) were for medical and rehabilitation services. Of the 126 administrative (non-clinical) consults, 14 were requested for NVCC services.

Thirty-four percent (126/371) of the reviewed consults were administrative (non-clinical) in nature; almost half (61/126) of them were delayed. We noted that the majority of delayed administrative (non-clinical) consults were for homemaker/home health aide (H/HHA) (19/61), tissue examinations (13/61), and preoperative implant purchase for cataract procedures (9/61). These administrative consult delays had no clinical impact but resulted in the appearance of delay.

Of the clinical consults, 40 percent (97/245) were delayed. We noted that 59 percent of rehabilitation (27/46), 60 percent of surgery (18/30), and 39 percent (34/87) of medicine consults were delayed. See Table 3.

Table 3: Reviewed and Delayed Consults by Service Type

Service Type	Number of Consults Reviewed: 371	Number (Percentage) of Delayed Consults: 158 (43 percent)
Administrative	**126**	**61 (48)**
Dialysis Interface	12	6 (50)
H/HHA	23	19 (83)
NVCC	14	5 (36)
Preoperative Implants	14	9 (64
Tissue Examination	41	13 (32)
Prosthetics	10	5 (50)
Miscellaneous*	12	4 (33)
Clinical	**245**	**97 (40)**
Dental	4	1 (25)
Event Capture (Hospice)	3	1 (33)
Extended Care	19	2 (11)
Home Based Care	12	2 (17)
Medicine	87	34 (39)
Mental Health	12	3 (25)
Nursing	19	7 (37)
Nutrition	7	0
Pharmacy	2	0
Primary Care	2	1 (50)
Radiation Oncology	2	1 (50)
Rehabilitation	46	27 (59)
Surgery	30	18 (60)

Source: VA OIG analysis of October 1, 2014 through August 9, 2015 facility consult data

**Miscellaneous administrative consults include Dental Radiograph (3), Ethics (2), Fisher House (2), Primary Care/Emergency Department Follow-Up (2), Transfer Coordinator (1), Social Work (1), and Telephone Care (1)*

Consults by Setting and Urgency

We first verified the accuracy of the (inpatient/outpatient) setting and urgency requested for all 371 consults. We found that providers entered the incorrect consult service setting for 9 percent (34/371) of consults. For instance, a provider may enter an inpatient consult for an outpatient follow-up appointment at discharge when the appropriate consult setting would be outpatient.

Additionally, we found, providers incorrectly entered the consult urgency for 5 percent (18/371) of consults. Future care consults, which should be acted upon 90 days or later, were incorrectly requested as routine. For example, surveillance colonoscopy,

which would be due in 1 year, was ordered as a "routine future care" consult. This request would be considered delayed if not completed within 30 days.

Of the 371 eligible consults, 33 percent (123/371) were inpatient consults. For both settings, the majority (111/123 inpatient and 225/248 outpatient) were requested as routine.

We identified 158 (43 percent) delayed consults. The distribution of the delay was similar across inpatient and outpatient settings. Table 4 shows reviewed and delayed consults by verified setting and urgency.

Table 4: Reviewed and Delayed Consults by Verified Setting and Urgency

Setting/Urgency	Number of Consults Reviewed: 371	Number (Percentage) of Delayed Consults: 158 (43 percent)
Inpatient	**123**	**57 (46)**
Emergency (4 hours)	8	5 (63)
Within 48 hours	3	2 (67)
Routine (24 hours)	111	50 (45)
Future care	1	0
Outpatient	**248**	**101 (41)**
Emergency/STAT (6 hours)	8	2 (25)
Within 24/48 hours	1	1 (100)
Future care	7	0
Other	7	4 (57)
Routine (30 days)	225	94 (42)

Source: VA OIG analysis of October 1, 2014 through August 9, 2015 facility consult data

Issue 3: Factors Contributing to Delayed Consults

While not an allegation, we observed deficiencies in consult management practices contributing to the appearance of delays. Of the 158 delayed consults identified, we further reviewed each stage of the consult's management.

We focused on the following factors contributing to delays:

- Schedulers not acting on consults timely
- Consults not closed timely
- Consult requests indefinitely placed on the electronic wait list (EWL)
- Patient unavailability

Schedulers Did Not Act on Consults Timely

The 2008 directive required facilities to establish procedures to track and process outpatient clinical consultation requests that are without action within 7 days of the request.[28] After excluding 98 delayed inpatient or administrative (non-clinical) consults that did not require scheduling, we reviewed all remaining 60 delayed outpatient clinical consults that required scheduling to assess the timeliness of action. We considered any action taken (such as scheduled or discontinued) in response to the consult request as a scheduling attempt. Of the 60 consults reviewed, 37 percent (22/60) did not meet the requirement of action within 7 days, ranging from 8 to 169 days (Table 5). The consult with the longest delay of 169 days was discontinued without an attempt to schedule. See Table 5.

Table 5: Time From Consult Order to the Date of the First Attempt to Schedule

Days from Order to Scheduling Attempt	Number of Consults (percent)
0–7	38 (63)
8–14	7 (12)
15–21	4 (7)
22–28	2 (3)
29–35	3 (5)
Greater than 36 days	6 (10)

Source: VA OIG analysis of October 1, 2014 through August 9, 2015 facility consult data

Consults Not Timely Closed

Staff did not consistently close consults when the services were completed or the consults were no longer indicated, and did not consistently discontinue duplicate consults. This had no clinical impact but resulted in the appearance of delay although staff completed requested consults or determined that consults were no longer clinically indicated. We determined that had the facility implemented consistent and timely review of open and pending consults, facility consult data would have reflected a more accurate number of delayed consults that had potential clinical impact.

We found that 27 percent (43/158) of delayed consults were completed but not closed. Examples included:

- Tissue examination consults for a pathologist to review tissue or fluid samples.
- Prosthetics consults to purchase implants (such as a cataract lens for cataract surgery or artificial joints for joint replacement surgery).

[28] VHA Directive 2008-056. VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016 contains same or similar language regarding the requirement for action within 7 days of request.

- Prosthetics consult to replenish clinic supply (such as EpiFix® human tissue for wound care).
- Dialysis interface.[29]
- Dental radiographs for uploading images to the EHR.

We found that 18 percent (29/158) of delayed consults were no longer indicated or were duplicate requests, but staff did not discontinue them. Examples included:

- Patient's condition changed quickly, and providers did not discontinue the consult when it was no longer indicated.

> The patient was in his 70s with a history of multiple chronic medical conditions including metastatic renal cell carcinoma (kidney cancer that has spread beyond the organ) and, leukemia. He was admitted to the facility in 2015 (day 1), for weakness and bloody urine. The hospitalist had ordered a routine inpatient hematology/oncology consult for treatment and prognosis even though, 11 days prior, the oncologist determined that the risk of chemotherapy outweighed the benefits. During this hospitalization, the palliative care team, primary team, and social worker had daily conversations with the patient regarding enrollment in hospice. The patient agreed to a Do Not Resuscitate order on post admission day 6 and died 4 days later, after transferring to inpatient hospice. Staff did not take action on the hematology/oncology consult for approximately 5 months when they discontinued it.

- Two different providers or members of the treatment team requested the same consult service or placed a consult within days of the initial request for the same service.

H/HHA Consults Placed on the EWL Indefinitely

H/HHA services are an alternative to nursing home care and provide in-home assistance with patients' activities of daily living, such as bathing, eating, and toileting. To determine eligibility for H/HHA services, an interdisciplinary VHA team assesses the patient's clinical condition to identify qualifying conditions, such as three or more activities of daily living dependencies or significant cognitive impairment.[30]

We found that 19 H/HHA consults were delayed while on the EWL. Because VHA allows the use of the consult package for administrative service such as H/HHA, the

[29] Dialysis interface refers to electronic recording of hemodialysis data from the machine into the patient's EHR.

[30] VHA Handbook 1140.6, *Purchased Home Health Care Services Procedures*, July 21, 2006. This VHA Handbook was scheduled for re-certification on or before the last working day of July 2011 but has not yet been recertified.

overall elapsed time or wait time for patients waiting for this service gave the appearance of delay. The H/HHA program is a service provided at the discretion of the facility based on funding availability. When the program reached its maximum patient enrollment, staff placed patients on the EWL.

The EWL is the official VHA wait list for outpatient clinical care and is primarily used to list patients waiting to be scheduled.[31] According to VHA, EWLs are used (among other things) for:

> *…veterans in need of and seeking home health care services when budget resources are not sufficient to meet all identified home health care needs of veterans. For eligible veterans who are determined to be in need of H/HHA, VA gives priority to veterans who are in receipt of, or are in need of, nursing home care primarily for the treatment of a service-connected disability, or who have a service-connected disability rated at 50 percent or more. A waiting list process for hospice care services is not to be utilized, as VA must provide or purchase needed hospice services without delay.*[32]

A facility leader told the review team that patients can potentially wait indefinitely on the EWL for H/HHA depending on program capacity, local budget situations, and priority needs (clinical or related to service-connection).

Patient Unavailability

Scheduling staff encountered challenges related to patients' availability. We noted that staff made multiple attempts to reach patients, sent out notification letters, and waited for patients to respond to the schedulers.

Sometimes patients were not available to attend their scheduled appointments for various reasons. For example:

- Patients hospitalized during their scheduled appointment. They were rescheduled for a different date but may again have been hospitalized.
- A patient was in an isolation room in the community living center (VA nursing home) and could not be released to attend his appointment.
- Patients no-showed to their appointments.

[31] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010. This Directive was in effect during the time frame of the events discussed in this report; it was rescinded and replaced by Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016 that contains the same or similar language regarding the EWL: "The Electronic Wait List (EWL) is VHA's official list to track patients who have been waiting for more than 90 calendar days for an appointment."
[32] VHA Handbook 1140.6.

- Patients cancelled scheduled appointments because of conflicts or relocation and did not reschedule.
- Patients died before their scheduled appointments.

Conclusions

For the period October 1, 2014 through August 9, 2015, we identified 225 deceased patients who had 371 open or pending consults at the time of their death or had discontinued consults after their death.

We found 117 patients with 158 consults who experienced a delay in obtaining requested consults. We substantiated that 43 percent (158/371) of consults were not timely. We did not substantiate the allegation that patients experienced serious or severe impact with long-term consequence or organ dysfunction or that patients died as a result of the delayed consults. However, we identified one patient who experienced minor and one patient with intermediate clinical impact.

We found that providers entered incorrect inpatient/outpatient setting and/or urgency for 14 percent (52/371) of the reviewed consults. Providers entered the incorrect consult service setting for 9 percent (34/371) of consults and incorrect consult urgency for 5 percent (18/371) of consults.

In the course of our review, we observed deficiencies in consult management practices. Of the 158 delayed consults identified, we noted that facility staff did not: (a) timely act on clinical consult requests, (b) close completed consults or discontinue duplicate requests or consults no longer indicated, or (c) monitor the EWL for H/HHA services. Additionally, staff encountered challenges scheduling appointments due to patient unavailability.

We determined that had the facility implemented consistent and timely review of open and pending consults, facility consult data would have reflected a more accurate number of delayed consults that had potential clinical impact.

Recommendations

1. We recommended that the Facility Director ensure that providers assign the proper inpatient/outpatient setting and urgency of consults in the electronic health record.

2. We recommended that the Facility Director ensure that staff take action within 7 days of a consult request or sooner if clinically indicated.

3. We recommended that the Facility Director ensure that staff timely close or discontinue consults.

4. We recommended that the Facility Director ensure that staff conduct a review on the quality and timeliness of the cardiology care for Patient 1 as discussed in the report, and take action if appropriate.

5. We recommended that the Facility Director ensure that staff monitor and address the care needs of patients on the Homemaker/Home Health Aide services electronic wait list.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 9, 2017

From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Consult Management Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California

To: Director, Los Angeles Office of Healthcare Inspections (54LA)
Director, Management Review Service (VHA 10E1D MRS OIG Hotline)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, "Consult Management Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California.

2. If you have any questions or need further information, please contact VISN 22 at (562) 826 5963.

(original signed by:)

Marie L. Weldon, FACHE
Network Director, VISN 22

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 9, 2017

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subj: Healthcare Inspection—Consult Management Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California

To: Director, Desert Pacific Healthcare Network (10N22)

1. Attached you will find the facility response to Recommendations 1-5 for OIG report entitled, "Consult Management Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California."
2. If you have any questions or need further information, please contact (310) 478-3711.

(original signed by:)

Ann Brown, 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 1. We recommended that the Facility Director ensure that providers assign the proper inpatient/outpatient setting and urgency of consults in the electronic health record.

Concur

Target date for completion: June 30, 2017

Facility response:

GLA ensures that all consults are labeled as inpatient/outpatient in adherence to VHA Directive 1232, Consult Rules and Procedures. These are clear labels with OUTPT designated for Outpatient and INPT designated for Inpatient. Scheduling staff are instructed to only schedule for Outpatient consults. Clinical services are required to monitor and disposition inpatient consults and forward the consult to an outpatient consult as appropriate. If any new consults are created, the consult name includes OUTPT for outpatient consults and INPT for inpatient consults.

Inpatient consults are monitored by clinical services for disposition and closure. Regular education is provided by clinical services to trainees on appropriate usage of consults with the correct inpatient/outpatient setting. The Consult Management Oversight Committee will provide continual guidance to ensure appropriate monitoring of inpatient consults for disposition.

GLA also ensures that providers assign the proper urgency of consults in the electronic health record. STAT consults are reviewed and presented daily at morning leadership report. STAT consults > 2 days are monitored to ensure that the appropriate urgency is indicated. The definition of a STAT consult requires a warm hand-off to the service and indicates the need for the patient to be seen the same day. The clinical services review their STAT consults and if it does not meet the definition of STAT urgency, the urgency status is appropriately changed.

To ensure compliance with VHA policy, GLA will monitor clinical consults for accuracy of setting and urgency. The urgency of consult status will continue to be reviewed and discussed daily during daily morning leadership report/meeting. The assignment of consult setting and urgency status will also be reviewed monthly at the Consult Management Oversight Committee.

Recommendation 2. We recommended that the Facility Director ensure that staff take action within 7 days of a consult request or sooner if clinically indicated.

Concur

Target date for completion: Completed, February, 2017

Facility response:

GLA is committed to ensure that staff take action within 7 days of a consult request or sooner if clinically indicated. In clinical sections that screen consults, GLA policy requires that the screening be completed within 7 days. The consult is 'Received' and taken out of pending status within 7 days. From February 2015, to February, 2017, GLA continues to performs within guidelines and metrics of pending consults > 7 days (adjusted for size), as per national metrics (Consult Trigger Tool and Network Director Performance measures). The national reports are reviewed monthly by the Consult Management Oversight Committee. Clinical services are required to monitor pending consults to ensure consults are reviewed timely. Consults that are direct scheduled are monitored by the scheduling service. Consult action status will also continue to be reviewed monthly at the Consult Management Oversight Committee.

We request closure of this recommendation.

Recommendation 3. We recommended that the Facility Director ensure that staff timely close or discontinue consults.

Concur

Target date for completion: June 30, 2017

Facility response:

GLA ensures that staff timely close or discontinue consults. GLA utilizes the Region 1 Consult Management Dashboard to review consults that should be completed or discontinued. The dashboard identifies consults in a scheduled status with a past appointment date. These requests are to be completed by the clinical services.

As per the Consult Trigger Tool, in the Scheduled with Past Appointment metrics, GLA continues to display improvements since 2015. GLA continues to provide educational cards to new trainees to outline processes for appropriate closure or discontinuation of consults.

Additionally, consults meeting the minimum number of scheduling attempts (usually 1 call, 1 letter, and 14 calendar days) are reviewed by the Health Administration Services (HAS) and with guidance from the requesting provider or an LIP are then discontinued

HAS will develop a process to ensure that consults are appropriately closed and discontinued per VHA policy. Monitoring the timeliness of consult closure/

discontinuation will be reported monthly to the Consult Management Oversight Committee.

Recommendation 4. We recommended that the Facility Director ensure that staff conduct a review on the quality and timeliness of the cardiology care for Patient 1 as discussed in the report, and take action if appropriate.

Concur

Target date for completion: Completed, February 2017

Facility response:

GLA reviewed the care of Patient 1, who had advanced age, coronary artery disease and [redacted pursuant to 38 U.S.C §5701] to determine the quality and timeliness of the Cardiology care. The care was found to be both timely and appropriate. It was identified that the patient and family did not reach out to either his primary care provider or Cardiology staff in the several days after he fell ill at home, which was several days before his death. The patient and his family were urged repeatedly to seek medical attention. It appears the patient may have had advanced cardiogenic shock when he presented to the community hospital. The quality and timeliness of the cardiology care provided was appropriate for this patient.

GLA will continue to ensure that the outpatient cardiology case manager continues to assist in the appropriate tracking and follow-up of Cardiology outpatients requiring cardiac surgery to ensure handoff is made to the Cardiac Surgery team for optimal care coordination.

We request closure of this recommendation.

Recommendation 5. We recommended that the Facility Director ensure that staff monitor and address the care needs of patients on the Homemaker/ Home Health Aid Services electronic wait list.

Concur

Target date for completion: June 30, 2017

Facility response:

GLA is committed to ensure that staff regularly monitors and address the care needs of each patient on the H/ HHA electronic wait list (EWL). GLA ensures compliance with VHA Handbook 1140.06, to identify the patients most in need of H/HHA services as an alternative to nursing home care.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Review Team	Simonette Reyes, BSN, Team Leader Daisy Arugay-Rittenberg, MT Lin Clegg, PhD Amy Zheng, MD
Other Contributors	John Bertolino, MD Julie Kroviak, MD Patrice Marcarelli, MD Robin Moyer, MD Larry Ross, Jr., MS Jackelinne Melendez, MPA, Management and Program Analyst

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Desert Pacific Healthcare Network (10N22)
Director, VA Greater Los Angeles Healthcare System (691/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Dianne Feinstein, Kamala Harris
U.S. House of Representatives: Pete Aguilar, Nanette Barragan, Karen Bass, Julia Brownley, Ken Calvert, Salud Carbajal, Tony Cardenas, Judy Chu, Lou Correa, Paul J. Cook, Duncan D. Hunter, Darrell Issa, Stephen Knight, Ted Lieu, Alan Lowenthal, Grace Flores Napolitano, Kevin McCarthy, Scott Peters, Dana Rohrabacher, Lucille Roybal-Allard, Ed Royce, Paul Ruiz, Linda Sánchez, Adam Schiff, Brad Sherman, Mark Takano, Norma Torres, David G. Valadao, Mimi Walters, Maxine Waters

This report is available on our web site at **www.va.gov/oig**.