Department of Veterans Affairs
Office of Inspector General

ADMINISTRATIVE SUMMARY
Non-VA Care Consult Program Concerns
Charles George VA Medical Center
Asheville, North Carolina
August 3, 2017

1. Why the Inspection was Initiated

The VA Office of Inspector General (OIG) conducted a healthcare inspection in 2016 to assess concerns made regarding the clinical and administrative systems and practices within the non-VA care program at the Charles George VA Medical Center (facility), Asheville, NC. In 2015, we conducted a survey in advance of a Combined Assessment Program review and multiple respondents raised concerns about the non-VA care program.[1] These concerns included the following:

- Inappropriately cancelled or discontinued consults
- Lack of clinical oversight
- Unanswered telephone calls
- Delays in obtaining non-VA care

We started the healthcare inspection in early 2016 and then coordinated the review with OIG's Office of Audit and Evaluation staff because of similarities with their work regarding non-VA care patient wait time data, Choice access, and consult management in Veterans Integrated Service Network (VISN) 6, which included the facility. In March 2017, we issued *VHA Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6* (Report No. 16-02618-424, March 2, 2017) that addressed the concerns that prompted our healthcare inspection. In the audit report, OIG made four recommendations to the Under Secretary for Health and six recommendations to the VISN 6 Director. The VISN 6 recommendations included strengthening controls over access to health care and consult management within the VISN, including the facility.

[1] The OIG conducted a Combined Assessment Program review at the facility during the week of September 14, 2015. The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care. Prior to the review, we electronically surveyed employees regarding patient safety and quality of care at the facility.

2. How the Inspection was Conducted

- **Interviews Conducted:** We interviewed 19 VA employees, including facility senior leaders and a VISN 6 manager.

- **Records Reviewed:**

  - We reviewed a random sample of 147 non-VA care consults from fiscal year (FY) 2015 to evaluate whether staff inappropriately cancelled or discontinued consults, and whether the approving official documented clinical oversight.

  - We reviewed facility data from April 2015 through April 2016 on telephone abandonment rates,[2] and the average speed in answering telephone calls for non-VA care.[3]

  - We reviewed data extracted from VA's Corporate Data Warehouse and the 863 electronic health records (EHR) of patients that experienced a hospital admission or death to evaluate the extent of non-VA care consult delays in FY 2016, and whether the delay clinically impacted the patients.

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.

3. Summary of Our Findings

Inappropriately Cancelled or Discontinued Consults

We did not find that non-VA care consult staff inappropriately discontinued or cancelled consults. Based on our random sample of 147 non-VA care consults, we found that staff discontinued or cancelled 33 consults. Of the 33 consults, we found 32 (97 percent) had appropriate reasoning documented within the consult.[4]

[2] Abandonment rate of calls is the rate in which people calling in will hang up.
[3] The average speed of answer is the average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a telephone service system before answer by a staff person. VHA Directive 2007-033, *Telephone Service For Clinical Care*, October 11, 2007. This VHA Directive expired October 31, 2012, and has not yet been updated.
[4] Documentation for discontinued or cancelled consults included: nine - other treatment was indicated, nine – patient declined/no showed, six – care provided at facility, four - duplicate consults entered, two – patient was hospitalized, two - other. One consult contained no information regarding the discontinuation.

Clinical Oversight

We did not find that the facility's non-VA care program lacked clinical oversight. Further, we found that approving officials[5] reviewed and documented approval for the 147 randomly sampled consults.

Because we did not have findings for the above two concerns in FY 2015, we decided further review of inappropriately discontinued or cancelled consults and lack of clinical oversight was not indicated.

Unanswered Telephone Calls

We found that telephone calls to the non-VA care program went unanswered. The telephone abandonment rate increased from 10.5 percent in April 2015 to a high of 70.5 percent in January 2016. The average time to answer telephone calls increased from 24 seconds in April 2015 to 112 seconds in February 2016. The facility reported that beginning in October 2015, non-VA care leadership changed and then implemented a reorganization. In addition, the non-VA care program increased the number of phone lines, implemented teams, clarified roles and responsibilities, and increased staffing. With these efforts, the facility's telephone metrics improved by the end of March 2016.[6]

Delays in Obtaining Non-VA Care

We found apparent delays in processing non-VA care consults in FY 2015 and FY 2016. Due to the coordination of efforts with OIG's Office of Audit and Evaluation staff, we focused our findings on the results from our review of the non-VA care consults ordered in FY 2016. We found apparent delays[7] for:

- 3,294 of 6,800 patients (48.4 percent) with at least one non-VA care consult.[8]
    - 1,562 of 4,948 patients (31.6 percent) with at least one traditional non-VA care consult.[9]
    - 1,896 of 2,538 patients (74.7 percent) with at least one Choice consult.[10][11]

[5] The approving official is either the Chief of Staff or designee.
[6] The abandonment rate decreased from 70.5 to 52 percent and time to answer telephone calls decreased from 112 seconds to 58 seconds.
[7] We considered delayed consults to be those that were not completed, canceled, or discontinued within the expected timeframe.
[8] Non-VA care is a combination of traditional non-VA care and Choice consults.
[9] NVCC, formerly known as Fee Basis, is non-VA (community-based) medical care provided to eligible veterans when VA facilities and services are not reasonably available.
[10] Veterans Choice is an alternate form of non-VA care using a third-party administrator.
[11] The subset numbers do not add up to equal the primary numbers because a patient may have had both a traditional non-VA care consult and a Choice consult.

We reviewed the 863 EHRs of patients who experienced either a hospital admission or death following an apparent delay. We did not identify that the delays in care clinically impacted the patients reviewed.

4. Conclusion

We did not find that consults were inappropriately cancelled or discontinued, or lacked clinical oversight. Although we found non-VA care telephone calls went unanswered, and delays in answering telephone calls, the facility took steps to address these concerns and the telephone metrics improved. We found apparent delays in obtaining non-VA care; however, we did not find evidence of clinical impact on patients reviewed.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our findings. (See Appendixes B and C, pages 9–10). No follow-up actions are required.

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

Appendix A

Prior OIG Reports

Facility Reports

Healthcare Inspection - Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina
9/29/2016 | *15-01982-113* | *Summary* | *Report*

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Charles George VA Medical Center, Asheville, North Carolina
12/7/2015 | *15-00175-50* | *Summary* | *Report*

Combined Assessment Program Review of the Charles George VA Medical Center, Asheville, North Carolina
11/10/2015 | *15-00621-23* | *Summary* | *Report*

Reports on Consult Delays

Healthcare Inspection – Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana
3/10/2017 | *16-00621-175* | *Summary* | *Report*

Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System, Phoenix, Arizona
10/4/2016 | *15-04672-342* | *Summary* | *Report*

Combined Assessment Program Summary Report – Evaluation of Coordination of Inpatient Consults in Veterans Health Administration Facilities
5/23/2016 | *16-01489-311* | *Summary* | *Report*

Alleged Improper Management of Dermatology Requests, Fayetteville VAMC, Fayetteville, North Carolina
5/3/2016 | *14-02890-286* | *Summary* | *Report*

Healthcare Inspection – Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California
3/30/2016 | *14-04897-221* | *Summary* | *Report*

Healthcare Inspection – Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, SC
1/6/2016 | *15-00992-71* | *Summary* | *Report*

Appendix A

Prior OIG Reports

Healthcare Inspection – Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, ME
6/17/2015 | 14-05158-377 | Summary | Report

Review of the Implementation of the Veterans Choice Program
1/30/2017 | 15-04673-333 | Summary | Report

Healthcare Inspection – Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, Kansas
12/22/2015 | 15-00268-66 | Summary | Report

Healthcare Inspection – Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California
10/28/2015 | 14-02890-497 | Summary | Report

Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ
10/15/2015 | 14-00875-03 | Summary | Report

Healthcare Inspection – Quality of Care Concerns in a Diagnostic Evaluation, Jesse Brown VA Medical Center, Chicago, Illinois
9/29/2015 | 14-02952-498 | Summary | Report

Review of VHA's Alleged Mishandling of Ophthalmology Consults at the Oklahoma City VAMC
8/31/2015 | 15-02397-494 | Summary | Report

Healthcare Inspection - Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama
7/29/2015 | 14-04530-452 | Summary | Report

Healthcare Inspection – Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado

7/7/2015 | 14-04049-379 | Summary | Report

Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues
7/1/2015 | 14-04116-408 | Summary | Report

Appendix A

Prior OIG Reports

Healthcare Inspection - Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama
7/29/2015 | 14-04530-452 | Summary | Report

Healthcare Inspection – Quality of Care and Access to Care Concerns, Jack C. Montgomery VA Medical Center, Muskogee, OK
6/16/2015 | 14-04573-378 | Summary | Report

Healthcare Inspection – Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland
4/14/2015 | 14-03824-155 | Summary | Report

Healthcare Inspection — Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
3/3/2015 | 14-04473-132 | Summary | Report

Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
2/18/2015 | 14-04194-118 | Summary | Report

Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, AZ
1/28/2015 | 14-00875-112 | Summary | Report

Healthcare Inspection – Alleged Delay in Gastroenterology Care, Durham VA Medical Center, Durham, NC
11/6/2014 | 14-03298-20 | Summary | Report

Healthcare Inspection - Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, GA
8/12/2014 | 14-03010-251 | Summary | Report

Healthcare Inspection – Podiatry Clinic Staffing Issues and Delays in Care, Central Alabama Veterans Health Care System, Montgomery, Alabama
5/19/2014 | 13-04474-157 | Summary | Report

Review of Alleged Improper Non-VA Community Care Consult Practices at Ralph H. Johnson VA Medical Center, Charleston, South Carolina

12/20/2016 | 14-02890-352 | Summary | Report

Appendix A

Prior OIG Reports

Healthcare Inspection – Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii
9/22/2016 | *15-04655-347* | *Summary* | *Report*

Review of the Implementation of the Veterans Choice Program
1/30/2017 | *15-04673-333* | *Summary* | *Report*

Review of VA's Award of the PC3 Contracts
9/22/2016 | *15-01396-525* | *Summary* | *Report*

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: Date: May 25, 2017

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subj: Administrative Summary: Non-VA Care Consult Program Concerns, Charles George VA Medical Center, Asheville, North Carolina

To: Director, Atlanta Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10E1D MRS Action)

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the Charles George VAMC, Asheville, North Carolina and concur with the facility's recommendations.

2. If you have further questions, please contact Lisa Shear, Quality Management Officer at (919) 956-5541.

MARK E. SHELHORSE, MD

Appendix C

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: Date: May 23, 2017

From: Director, Charles George VA Medical Center (637/00)

Subj: Administrative Summary: Non-VA Care Consult Program Concerns, Charles George VA Medical Center, Asheville, North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. I would like to express my appreciation to the Office of Inspector General (OIG) Healthcare Inspection Team for their professional and comprehensive review of the Charles George VA Medical Center's Non-VA Care Consult Program.

2. I have reviewed the draft report for the Charles George VA Medical Center, Asheville, NC, and concur with the report and conclusions rendered.

3. Please express my thanks to the Team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our Veterans.

4. If you have any questions or need further information, please contact Robin James, Chief, Quality Management Service, at (828) 298-7911, extension 5596.

Cynthia Breyfogle

CYNTHIA BREYFOGLE, FACHE
Medical Center Director

Appendix D

OIG Contact and Staff Acknowledgments

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Appendix E

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