Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00621-175

Healthcare Inspection

Consult Delays and Management Concerns VA Montana Healthcare System Fort Harrison, Montana

March 10, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senators Jon Tester and Steve Daines to assess the extent that patients experienced delays in obtaining consults, and the impact of any delays on patient outcomes, at the VA Montana Health Care System (system), Fort Harrison, MT. We also evaluated the adequacy of internal feedback mechanisms related to consults at the system.

VHA policy states that consults are a mechanism for physicians and other health care providers to create templated notes to request an opinion, advice, or expertise regarding evaluation or management of specific problems in the care of individual patients.[1] Consults may be completed in various settings, including during inpatient stays, and outpatient or telehealth encounters. In cases when consulted services are not available timely through the system, the system may refer patients for care through other VA medical centers, other non-VA facilities as part of sharing agreements, or community providers. VHA has several mechanisms for purchasing care from community providers, including the Veterans Choice Program (Choice) and traditional non-VA care.[2]

For system consults ordered in fiscal year (FY) 2015, we found apparent delays[3] for

- 11,073 of 26,293 patients (42 percent) with at least one in-house consult;
- 11,863 of 21,221 patients (56 percent) with at least one non-VA care consult; and,
- 2,683 of 4,427 patients (61 percent) with at least one Choice consult.

Among the VA facilities reviewed for comparison, including those within the same Veterans Integrated Service Network (VISN), the system had the lowest or among the lowest percentage of patients with delayed in-house and Choice consults, and the highest percentage of patients with delayed non-VA care consults. We found that

[1] 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 This Directive was in effect during the time of the events discussed in this report but has been rescinded and replaced with VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016.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 contains similar language regarding the definition of a consult.

[2] The Veterans Choice Program was established by the Veterans Access, Choice, and Accountability Act of 2014. Under this program, VA contracts with third-party administrators to purchase care from certain community providers. Veterans are eligible to receive care through Choice if, for example, they live more than 40 miles from a VA facility or would wait greater than 30 days to receive services through VA. Traditional non-VA care refers to the process through which VA purchases care from community providers without the involvement of third-party administrators

[3] We considered delayed consults to be those that were not completed, canceled or discontinued within the expected timeframe.

delays among consults ordered in FY 2015 may have harmed four patients. In 2016, system leadership provided an institutional disclosure for one of these patients.

Beginning in July 2015, system leadership initiated a focused effort to identify and resolve factors that contributed to consult delays and reduced outstanding consults. Between late June 2014 and July 2015, the backlog of system consults increased as providers began systematically referring patients to community providers when VA appointments were not available within 30 days, as required under the Accelerating Care Initiative.[4] According to system leaders, they initiated their focused effort because they determined that their prior actions to manage the backlog were not working.

Despite this effort, we found evidence of persistent issues with completing consults timely in FY 2016 (through late August 2016). VISN and system leadership and staff we interviewed explained reasons for these ongoing delays that included providers ordering an increased volume of consults. Efforts are ongoing to address those factors within the system's control that contribute to consult delays, including hiring additional staff to process non-VA care and Choice consults and reducing the number of unnecessary consults. We independently verified that the reported factors contributed to delays for the patients we reviewed.

We also noted that system leadership initiated ongoing reviews to determine if patient harm occurred due to delays in care. System leadership coordinated with primary and specialty care teams to clinically review all outstanding consults that had been open for more than 90 days. These clinical reviews included identifying if services had been rendered, determining the status of each consult, and whether care was clinically indicated.

We found that, consistent with federal standards for internal control for information and communication, the system had several mechanisms in place for staff to communicate concerns about consult delays to system leadership. Despite available mechanisms, staff expressed concerns about communication with system leadership. Some staff we interviewed indicated that they were frustrated when feedback from management was limited.

We recommended that the System Director:

- Ensure that the care of the potentially harmed patients be reviewed by an external (non-system) source.

[4] In May 2014, VA implemented the Accelerating Care Initiative in an effort to increase timely access to care, decrease the number of patients on the electronic wait list, and reduce the number of patients waiting greater than 30 days for services. See *U.S. Department of Veterans Affairs Accelerating Access to Care Initiative Fact Sheet*, May 27, 2014. http://www.va.gov/health/docs/052714AcceleratingAccessFactSheet. Accessed November 29, 2016.

- Confer with the Office of Chief Counsel as necessary regarding the potentially harmed patients for possible institutional disclosure and take action as appropriate.

- Continue efforts to improve consult timeliness and address factors that contribute to delays.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes C and D, pages 30–33 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) conducted a healthcare inspection at the request of Senators Jon Tester and Steve Daines to assess the extent that patients experienced delays in obtaining consults, and the impact of any delays on patient outcomes, at the VA Montana Health Care System (system), Fort Harrison, MT. We also evaluated the adequacy of internal feedback mechanisms related to consults at the system.

Background

The system is part of Veterans Integrated Service Network (VISN) 19 and provides services to about 40,000 patients per year in the primarily rural state of Montana. Montana is the fourth largest state based on square miles, but ranks 44th in population size, according to 2015 U.S. Census Bureau data. The system comprises a 50-bed medical center located in Fort Harrison, a 30-bed Nursing Home Care Unit in Miles City, and 11 community based outpatient clinics (CBOCs) dispersed throughout Montana.

The system provides a range of inpatient and outpatient medical, surgical, and behavioral health services, although some services are not available at all locations. Veterans typically seen at the Miles City CBOC, for example, may travel about 6 hours (354 miles) for VA services that are only available at the medical center in Fort Harrison.

Consults

In 1999, the Veterans Health Administration (VHA) implemented a consult package in its Computerized Patient Records System (CPRS).[5] The consult package was originally intended to assist physicians and other health care providers to create templated notes to request an opinion, advice, or expertise regarding evaluation or management of specific problems in the care of individual patients. However, use of the consult package for other purposes became common practice. These other purposes included administrative uses, such as requests to a specialty clinic to re-schedule appointments, and for ordering tests, such as electrocardiograms.

Once a clinician orders a consult using the consult package, it remains unresolved until a specific action is taken to close it. A consult can be closed administratively (for example discontinued or cancelled) which is generally accomplished by non-clinical staff. Alternatively, the consult may be closed by a clinician when he/she properly enters a note into the consult package indicating that the consult has been completed.

[5] 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 contains similar language regarding the consult process.

If the clinician enters a note outside of the consult package, the consult remains open even though the care has been rendered.

Consults may be completed in various settings, including during inpatient stays, and outpatient or telehealth encounters. Consults that were intended to be rendered at the system are referred to, in this report, as "in-house" consults. In cases when consult services are not available or not available timely in the system, system staff may refer patients for care through other VA medical centers, other facilities as part of sharing agreements, or community providers. VHA has several mechanisms for purchasing care from community providers, including the Veterans Choice Program (Choice) and traditional non-VA care.[6]

The system's 2015 consult policy, which was consistent with VHA policy,[7] included timeliness standards.[8] Specifically, consults that necessitate outpatient appointments should have:

1. Actions taken to schedule an appointment within 7 days.
2. Appointments completed timely, consistent with the consult urgency. For example:
    - For routine consults, the appointment should occur within 30 days of the clinically indicated date (the date specified by the provider that the patient should be seen).
    - For STAT[9] consults, the appointment should occur within 6 hours.

[6] The Veterans Choice Program was established by the Veterans Access, Choice, and Accountability Act of 2014. Under this program, VA contracts with third-party administrators to purchase care from certain community providers. Veterans are eligible to receive care through Choice if, for example, they live more than 40 miles from a VA facility or would wait greater than 30 days to receive services through VA. Traditional non-VA care refers to the process through which VA purchases care from community providers without the involvement of third-party administrators.

[7] 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. According to the 2016 Directive, STAT consults must be completed within 24 hours.

[8] VA Montana Health Care System Policy Memorandum 12-17-11-02-15, *Consult Process*, January 20, 2015. According to system staff, this policy replaced a local policy that was in draft form from 2013-2015 and was never published. The earlier draft policy included similar though less specific information regarding timeliness for outpatient consults. The 30 day requirement for routine care was also 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." www.govtrack.us/congress/bills/113/hr3230. Accessed July 16, 2016. This definition was further refined by VA in its October 2014 proposed interim rule that states wait-time goals of the Veterans Health Administration 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."

For inpatients, system policy stated that consults should be completed prior to the patient being discharged.

Adverse Events

According to VHA Handbook 1004.08, adverse events are untoward incidents or other occurrences of harm or potential harm directly associated with care or services to veterans.[10] Disclosure of adverse events is a forthright discussion between providers or other VHA personnel and patients or patients' representatives of clinically significant facts about the occurrence of a harmful adverse event.

Federal Internal Control Standards

Internal control is a process effected by management to provide reasonable assurance that the objectives of an entity are achieved.[11] A number of standards for internal control exist, including the standard for information and communication. According to this standard, management should create an environment for quality information to communicate up, down, across, and around reporting lines to all levels of a system.

Relevant OIG Reviews Published Within the Last 3 Years

We conducted one review of the system that identified instances in which patients did not receive ordered aftercare services timely, including consults. Specifically, as part of OIG's periodic Combined Assessment Program review of the system in early 2014, we identified noncompliance with selected VHA requirements regarding coordination of care following inpatient hospitalization. As a result, we made several recommendations, including that the System Director "…ensure patients receive ordered aftercare services and/or items within the ordered/expected timeframe." The System Director concurred with our recommendation and provided acceptable documentation to support that corrective actions were taken and sustained, so we closed this recommendation in July 2015.[12]

We also have issued additional reports involving other VA facilities that evaluated consult timeliness and the impact of consult delays on patient outcomes. See Appendix A.

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[9] STAT, from the Latin statim, means immediately, without delay.
[10] VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012.
[11] GAO. Standards for Internal Control in the Federal Government. GAO-14-704G. September 10, 2014. http://www.gao.gov/products/GAO-14-704G.
[12] VA OIG *Combined Assessment Program Review of the VA Montana Health Care System, Fort Harrison, Montana*, Report No. 14-00685-156, May 19, 2014. https://vaww.portal.oig.va.gov/directorates/54/Hotlines/2016-00621-HI-0594/Work%20Papers/VAOIG-14-00685-156%20-%20CAP.pdf.

Request for Review

On November 10, 2015, Senator Jon Tester sent a letter to the OIG requesting a review of the extent to which patients experienced consult delays at the system, the impact of any delays on patient outcomes, and the adequacy of internal feedback mechanisms related to consults. Senator Steve Daines raised similar concerns to the OIG.

Scope and Methodology

The period of our review was from November 2015 through August 2016. We reviewed data from fiscal year (FY) 2015 and 2016 (through late August 2016). In addition, we conducted a site visit from December 14, 2015 through December 16, 2015.

Issue 1: Consult Delays and Potential Impact on Patients

To respond to the concerns raised regarding consult delays, we evaluated the extent to which patients experienced delays for system consults ordered in FY 2015 and the impact of delays on patients.

Study Population. The study population comprised all patients at the system who had at least one delayed consult for clinical care during FY 2015 (study period). We identified the study population using the Corporate Data Warehouse (CDW), which is a centralized data repository that contains VHA clinical, administrative, and financial data.[13] Because we were interested in clinical care as opposed to administrative requests, we excluded those consults with an administrative flag, such as requests for transportation. Data were extracted from CDW on March 11, 2016.

Whether Patients Experienced at Least One Consult Delay. We determined that patients experienced a consult delay if at least one of the patients' consults was not completed within the expected timeframe based on the information in the consult's urgency field.[14] The start date for this timeframe was the later of the date that the consult was ordered or the clinically indicated date. The end date was the date that the patient had a clinic visit that was linked to the consult, the patient died, or the consult was discontinued or canceled. For additional information about timeliness expectations based on the documented consult urgency, see Appendix B, Table 5. We also compared the extent that patients experienced consult delays at the system with other facilities in VISN 19 and other VA facilities that we selected because they were similar in terms of rurality and size.

[13] For an overview of the CDW data referenced throughout this scope and methodology section, see Appendix B, Table 4.
[14] For additional information about timeliness expectations based on the documented consult urgency, see Appendix B, Table 5.

Whether Patients Experienced at Least One Health Event. For patients who experienced at least one consult delay, we analyzed CDW data that includes data on traditional non-VA care. We used the CDW data to classify patients who experienced at least one delay into two subpopulations. One subpopulation included those patients who experienced at least one of the seven health events listed below after the first delayed consult was requested through September 30, 2015. The other subpopulation included those who did not experience an identified health event after the delayed consult. The seven health events we included are:

- Lower extremity amputation
- Abdominal aortic aneurysm rupture
- Cancer diagnosis
- Myocardial infarction
- Cerebrovascular accident
- Hospital admission
- Death

We selected these health events because they represented those that could potentially be attributed to consult delays and have patient impact. In addition, we could readily identify these events using VHA's administrative data.

To determine whether patients had one or more of the first five health events (lower extremity amputation through cerebrovascular accident), we analyzed CDW data to obtain occurrences of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT ®) codes listed in Appendix A, Tables 6 and 7. To identify patients who were hospitalized, we analyzed CDW data to identify inpatient admissions. Where available, we used information on patients' primary discharge diagnoses. When that information was unavailable, we used information on patients' admission diagnoses. To identify patients who were deceased, we analyzed CDW data to identify those patients who had a recorded date of death. For these patients, we requested death certificates to identify cause of death. For the patients in our study population who did not experience one of the selected health events, we were unable to conclude that the consult delays had a clinical impact. Optimally, our analysis would have included outcome data through the date that our data were extracted from CDW (March 11, 2016). However, on October 1, 2015, VA transitioned to an updated disease classification system (ICD-10). These classification systems are markedly different and a comprehensive crosswalk between ICD-9-CM and ICD-10 was not available at the time of our review for the selected health events.

Impact of Consult Delays. Our team of clinical reviewers, which included at least one nurse or physician assistant, evaluated whether there could be a relationship between each consult delay and health event. We defined "relationship" to include consult delays that could have contributed to or led to the event as well as consult delays that

could have resulted in a clinically significant delay in diagnosis of and treatment for a condition. For example, we would generally conclude that a delayed audiology consult was *unlikely* to be related *to* a cerebrovascular accident. However, we would generally conclude that a delayed neurology consult *could* be related to a subsequent cerebrovascular accident. For those delayed consults that could have been related to health events, we conducted an in-depth electronic health record (EHR) review to better understand potential clinical impact. At least one physician reviewed the EHRs of patients for whom we suspected consult delays resulted in a clinical impact.

Factors That Contributed to Delays. To understand factors that contributed to delays, we interviewed leadership and other staff from the VISN and system and community providers familiar with Choice. We also requested and reviewed relevant documentation, including correspondence between system staff and leadership, internal reports, and case summaries.

Issue 2: System Efforts to Identify Patients Harmed by Consult Delays and Address Factors that Contributed to Consult Delays

To understand system efforts to identify patients harmed by consult delays and address factors that contributed to delays, we interviewed leadership and other staff from the VISN and system and community providers familiar with Choice. To supplement information gathered during those interviews, we requested and reviewed relevant documentation, particularly internal reports and case summaries.

Issue 3: Adequacy of the System's Internal Feedback Mechanisms

We evaluated the adequacy of the system's internal feedback mechanisms regarding consult concerns in the context of the Federal internal control standard for information and communication. According to this standard, management should create an environment for quality information to be communicated up, down, across, and around reporting lines to all levels of the system. As part of our evaluation, we interviewed leadership and staff from the system. We also reviewed relevant correspondence between system leadership and staff.

All Issues

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

Inspection Results

Issue 1: Consult Delays and Potential Impact on Patients

For system consults ordered in FY 2015, we found apparent delays for

- 11,073 of 26,293 patients (42 percent) with at least 1 in-house consult,
- 11,863 of 21,221 patients (56 percent) with at least 1 non-VA care consult, and
- 2,683 of 4,427 patients (61 percent) with at least 1 Choice consult.[15]

Among the VA facilities included for comparison, the system had the lowest or among the lowest percentage of patients with delayed in-house and Choice consults and the highest percentage of patients with delayed non-VA care consults. (See Table 1 on next page.)

[15] For additional information about consult timeliness expectations based on the documented consult urgency, see Appendix B, Table 5.

Table 1. Patients Who Appeared to Have Experienced Delays for Consults Ordered in FY 2015, by Selected Facility

Facility / System	Type of Consult		
	In-House	Non-VA Care	Choice
VA Montana Healthcare System	11,073 / 26,293 (42.1 percent)	11,863 / 21,221 (55.9 percent)	2,683 / 4,427 (60.6 percent)
Sioux Falls VA Medical Center	9,900 / 16,559 (59.8 percent)	2,668 / 6,856 (38.9 percent)	1,025 / 1,469 (69.8 percent)
Cheyenne VA Medical Center	8,609 / 13,958 (61.7 percent)	2,085 / 4,911 (42.5 percent)	562 / 657 (85.5 percent)
Boise VA Medical Center	11,545 / 21,061 (54.8 percent)	2,674 / 7,545 (35.4 percent)	611 / 904 (67.6 percent)
Eastern Colorado VA Health Care System	38,142 / 57,504 (66.3 percent)	9,215 / 17,906 (51.5 percent)	4,917 / 5,636 (87.2 percent)
Black Hills VA Health Care System	5,789 / 11,682 (49.6 percent)	3,226 / 6,706 (48.1 percent)	1,859 / 2,259 (82.3 percent)
Grand Junction VA Medical Center	5,782 / 9,196 (62.9 percent)	3,756 / 7,461 (50.3 percent)	981 / 1,008 (97.3 percent)
Eastern Oklahoma VA Health Care System	14,741 / 27,298 (54.0 percent)	3,558 / 6,847 (52.0 percent)	3,682 / 3,959 (93.0 percent)
Oklahoma City VA Health Care System	20,526 / 35,457 (57.9 percent)	2,908 / 10,831 (26.8 percent)	1,412 / 1,831 (77.1 percent)
Salt Lake City VA Health Care System	20,955 / 41,136 (50.9 percent)	2,778 / 14,891 (18.7 percent)	156 / 275 (56.7 percent)
Sheridan VA Medical Center	3,847 / 8,183 (47.0 percent)	2,005 / 5,166 (38.8 percent)	993 / 1,452 (68.4 percent)

Source: OIG analysis of CDW data.

According to system leadership and staff we interviewed and system documents we reviewed, factors that contributed to consult delays or the appearance of delays included the following:

All Types of Consults

- **Mismatch between consult urgencies and clinical needs**. Some consults were considered delayed, at least in part, because consults for care that were arguably routine in nature were inappropriately ordered as STAT consults.

Subsequently, those services were not rendered within the required timeframe of six hours.[16] Interviewees told us that some providers entered STAT consults for routine services because they were frustrated by consult delays, in general, and wanted to help ensure that consults would be noticed and addressed. Another interviewee told us that some providers inappropriately entered STAT consults for routine services to avoid having consults reviewed and triaged by the individual identified under Delegation of Authority, who could discontinue consults if, for example, he or she needed additional information regarding prerequisite tests or treatments. By "skipping" the Delegation of Authority review process, consults were automatically approved and a clinic scheduler could take action to schedule an appointment for the patient. However, even those consults were often delayed since the system did not have a robust process in place for quickly triaging and taking action on STAT consults.

- **Consult appropriateness**. Several interviewees told us that some providers ordered too many consults and that the resulting consult volume contributed to delays. In particular, several interviewees told us that some providers ordered consults because they do not feel confident or competent to care for certain types of patients. For example, some PCPs may refer relatively uncomplicated patients to mental health for treatment of depression whereas other PCPs would address those patients' needs in the primary care setting.

In-House Consults

- **Clinic access**. Access to certain services, particularly specialty services, is limited at the system. At the time of our site visit in December 2015, the system did not have certain types of specialists, such as an optometrist, and only had part-time providers in other specialties, including ear, nose, and throat. As a result, system staff had to refer patients to community providers for those services.

- **Missed opportunities**. Some issues with access to appointments in the system were compounded by missed opportunities (patients did not come and did not cancel the appointment). Specifically, consistent with VA policy at the time, patients who were referred to Choice for appointments for services that were not available within 30 days were also scheduled for appointments for the same services with VA providers.[17] That was considered advantageous by system staff

[16] VA Montana Health Care System Policy Memorandum 12-17-11-02-15. As noted earlier in this report, the preceding local policy was never published and included similar though less specific information regarding timeliness for outpatient consults.
[17] VHA Directive 2010-027, *Outpatient Scheduling Processes and Procedures*, June 9, 2010. This VHA Directive was in effect at the time of the events discussion in this report; it was rescinded and replaced by VHA Directive1230, *Outpatient Scheduling Processes and Procedures,* which no longer requires system staff to create a VA appointment for patients who are referred to Choice because services are not available timely.

because the patient would still have the VA appointment in the event that the third-party administrator was unable to schedule the patient timely with a community provider. Unfortunately, the system did not have an efficient way to determine whether patients were scheduled through the third-party administrator. As a result, unbeknownst to system staff, some patients were seen by Choice providers. This made the system appointment unnecessary, and patients frequently no-showed for the appointments.

Non-VA Care Consults

- **Timeliness of Delegation of Authority**. When a provider ordered a specialty consult, the consult generally needed to be reviewed and approved by an individual identified under Delegation of Authority. System staff determined that between mid-August 2015 and mid-December 2015, a number of non-VA care consults that required Delegation of Authority approval were not approved timely because CPRS did not send electronic alerts to appropriate staff, notifying them of consults in need of approval.

- **Efficiency and timeliness of fee department operations**. System leadership determined that the adequacy of fee department staffing and the approach used to process non-VA care consults contributed to consult delays.[18] For example, they determined that consult processing would be enhanced by the involvement of clinical staff, since those staff could help to ensure that patients with more urgent clinical needs would be prioritized.

- **Availability of services in the community**. Interviewees explained that, since system staff began referring an increasing number of patients for services in the community, those resources had become saturated as well. As a result, patients were not necessarily able to obtain more timely care from community providers than they would from VA providers.

- **Delays in scanning outside medical records**. System staff explained that non-VA care consults were left open until outside medical records were received, scanned, and saved in patients' VA EHRs. Because of delays in scanning and saving those records, some patients appeared to have delayed consults even though the requested services were already provided.

Choice Consults

- **Efficiency and timeliness of fee department operations**. Knowledgeable staff indicated that system staff did not expeditiously take action on some Choice consults, because of staffing constraints and issues with workflow efficiency. As

[18] The fee department is responsible for processing non-VA care and Choice consults, among other things.

a result, the Choice third-party administrator did not have the information needed to timely schedule appointments for patients. Since the fee department also has responsibilities for processing Choice consults, the fee department operations-related factors described earlier also apply to Choice consults.

- **Size of the Choice provider network in Montana**. System leadership explained that a key challenge associated with obtaining patients care through Choice in Montana is the limited availability of providers in that network. Community providers we interviewed told us that, although they initially provided care to veterans through Choice, they discontinued participating in the program due to considerable challenges associated with meeting Choice requirements and obtaining timely payment for services provided. For example, Choice providers must transmit documentation of medical care to the Choice third-party administrator, which is not an expectation from many other payers, such as private health insurance.[19]

- **Delays in retrieval of outside medical records**. Similar to non-VA consults, Choice consults are generally left open until outside medical records are received and saved in patients' VA EHRs. Because of delays in records retrieval and the time it takes to scan those records and save them to patients' VA EHRs, some patients appeared to have delayed consults even though the requested services had been provided.

We independently verified that many of these factors contributed to delays for the patients we reviewed. We also found that delays among consults ordered in FY 2015 that we reviewed may have adversely impacted four patients, as described below.[20]

Patient 1

The patient was a male in his early 30s who had a history of post-traumatic stress disorder. The patient had a job that involved working at an out-of-state location for several weeks at a time. In 2014, as part of the process for establishing care at the system, he saw a counselor for an initial mental health assessment. The patient did not report taking any mental health-related medications, such as antidepressants, at that time. The counselor noted a plan to refer the patient for counseling at a Vet Center[21] and psychiatric medication management. The counselor documented calling the Vet

[19] To assist these community providers in obtaining resolution to their specific questions and concerns, we connected the community providers to VA staff responsible for overseeing administration of Choice.
[20] We provided the names of the patients who may have been adversely impacted to facility and VISN leadership.
[21] The Vet Center Program, launched in 1979, established community based Vet Centers as part of the U.S. Department of Veterans Affairs with the goal of providing a broad range of counseling, outreach, and referral services to eligible veterans and family members in order to help them make a satisfying post-war readjustment to civilian life. http://www.vetcenter.va.gov/About_US.asp. Accessed October 20, 2016.

Center, and the patient was scheduled for an appointment with a psychiatrist for approximately 8 weeks later.

The patient did not come and did not call to cancel the appointment with the psychiatrist. Three days after the scheduled appointment that the patient missed, he contacted the Veterans Crisis Line and reported experiencing suicidal thoughts. With agreement from the patient, the Veterans Crisis Line staff referred the patient to the system's suicide prevention coordinator. The coordinator documented that she made an unsuccessful attempt to contact the patient the following day and left a voicemail. The EHR does not contain documentation that the patient returned the coordinator's call.

In 2015, the patient saw a system mental health nurse as a walk-in after an appointment with a Vet Center therapist. That therapist referred the patient to the mental health clinic because the patient informed the therapist that he had made a suicide attempt within the last week. The patient denied suicidal thoughts, plans, or intent to the nurse. The nurse documented reviewing her plan. As part of that plan, she encouraged the patient to reschedule his appointment with a psychiatrist, consider a referral for evaluation of substance use disorder, and go to the Emergency Department (ED) if he experienced a crisis. The nurse also indicated that the patient had limited availability for a psychiatry appointment since he would be out-of-state for work for several weeks and would then return to Montana for one week the following month. The patient did not reschedule his psychiatry appointment.

Five days later, the Vet Center therapist contacted the mental health clinic to notify them that she had received two calls from the patient the previous day. During those calls, the patient told the therapist that he was out-of-state and was having suicidal thoughts. The therapist advised the patient to go to the ED, but noted that the patient seemed reluctant to follow that advice because he was working out-of-state at the time and was unable to easily travel to an ED. The same day, the primary care provider (PCP) ordered an in-house, routine telemental health consult for the patient to be seen by a psychiatrist. Over the following week, staff documented multiple attempts to contact the patient to schedule an appointment. An appointment was scheduled for the patient to see a psychiatrist in about 7 weeks. The patient's PCP subsequently noted in the patient's EHR that the patient needed to be seen by either a VA or non-VA psychiatrist within a week. Three days later, the PCP received a reply that non-VA provider wait time was the same as VA wait time.

Before the date of the scheduled outpatient psychiatry appointment, the patient was transferred from a community hospital to another VA hospital. The patient was admitted to the inpatient psychiatry unit for suicidal ideation. At the time of admission to the VA hospital, the patient noted that he had been admitted to a community hospital the prior month for suicidal ideation.

In conclusion, the patient had delayed psychiatric care due to several factors, including the challenges of trying to schedule an appointment for a patient who worked out-of-state for several weeks at a time as well as documented limited access to

outpatient psychiatric care at the system and in the community. It is noteworthy that the patient's PCP did not initiate a medication, such as antidepressant, while the patient was waiting for an appointment in mental health. That provider did not document the rationale for ordering a consult rather than attempting to treat the patient in the primary care setting, so it is unclear whether this decision was a reflection of the PCP's confidence to provide that care. Further, system staff did not refer the patient to a community provider because of observed limited access in the community. Nonetheless, the patient had multiple indications for urgent scheduling an appointment at the time of submission of the outpatient psychiatry consult. More timely care could have helped to avert the mental health decline that contributed to his suicidal thoughts and need for inpatient admission.

Patient 2

The patient was a male in his late 70s who had a history of smoking. In 2014, the patient called a primary care clinic nurse and reported that he had been experiencing nausea and vomiting for several weeks. As a result, clinic staff scheduled an appointment for 3 days later for this patient to see his PCP. During that appointment, the provider documented the patient's ongoing complaints of nausea and difficulty swallowing, a diagnosis of gastroenteritis (inflammation of the lining of the stomach), and concerns that the patient could aspirate or have a narrowing of his esophagus.

A week later, the patient had a diagnostic study of his upper gastrointestinal tract as ordered by his PCP. The study showed a significant lesion in the esophagus that was suspicious for a malignancy. Evaluation by endoscopy was recommended. One day after this procedure, a letter was mailed to the patient describing the procedure results and recommending further evaluation. The letter to the patient did not indicate urgency for a follow-up procedure.

Approximately 6-7 weeks later, the patient had a follow-up appointment with his PCP. The provider did not document a discussion with the patient of the possibility of esophageal malignancy as suggested by the diagnostic study, but did document a plan for an esophagogastroduodenoscopy (EGD).[22] The next day, the provider submitted a routine non-VA care consult for the patient to see a gastrointestinal specialist. This consult was approved more than 45 days later. The EGD was scheduled and completed more than 30 days after the consult should have been completed.

Clinical notes from the 2015 non-VA care appointment reflected that previous imaging results (the diagnostic study of the upper gastrointestinal tract) were unavailable for review and that the patient would need to have an endoscopy.[23] The patient underwent

[22] An EGD is a test to examine the lining of the esophagus, stomach and part of the small intestine.
[23] An endoscopy is a procedure to examine the lining of upper gastrointestinal tract using a long, flexible tube with a camera.

an endoscopy, which identified an esophageal tumor from which multiple biopsies were obtained.

Several days later, the patient discussed treatment options with his PCP for his recently diagnosed esophageal cancer. The provider ordered non-VA care consults for oncology, thoracic surgery, and radiation therapy.

During the non-VA surgical consult, the patient was told that he was not a candidate for surgical removal of the esophageal cancer because he had significant shortness of breath on exertion, continued to regularly smoke cigarettes, and reported feeling poorly. After multiple evaluations by a non-VA cancer treatment specialist, the patient decided not to have further cancer treatments. At the time of this review in December 2015, the patient was receiving palliative care.[24]

In conclusion, serial consult delays contributed to a delay in diagnosis and treatment for this patient. Nearly 45 days elapsed from the time that a radiologist noted the lesion that was suspicious for malignancy and recommended further evaluation by endoscopy, to the time that the non-VA care consult for endoscopy was ordered. In addition, approximately 30 days elapsed from when the non-VA care consult should have been completed and the actual date of that procedure. The patient subsequently received a diagnosis of esophageal cancer. These delays could have adversely impacted this patient's treatment options and long-term prognosis.

Patient 3

The patient was a male in his late 60s with a history of chest pain, high blood pressure, high cholesterol, and coronary artery disease. He lived in rural Montana, 3 hours from the system medical center, though a VA CBOC was located where he routinely obtained primary care and a non-VA hospital was in his community.

In 2015, the patient told his PCP that he went to an ED in May for evaluation of chest pain and complained of ongoing intermittent chest pain. The provider subsequently ordered a consult for a non-VA care cardiology evaluation because the service was not available timely at the system.

The patient was evaluated by a non-VA cardiologist approximately one month later. The cardiologist noted that the patient's history included a normal cardiac stress test in 2013 and normal heart function. The specialist discussed options with the patient, including monitoring and medical treatment, non-invasive cardiac stress testing, and/or cardiac catheterization. The patient elected to proceed with cardiac catheterization in 2 weeks at the community hospital.

[24] Palliative care, commonly referred to as comfort care and symptom management, is care given to improve the quality of life of patients who have a serious or life-threatening disease, such as cancer. This type of care is not intended to be curative.

Slightly less than 1 week after the patient saw the non-VA cardiologist, the patient's PCP ordered a consult for the patient to undergo cardiac catheterization within a week at another VA facility that was located over 600 miles from his home because the service was not available through the system. An appointment for the procedure was initially scheduled, but was later cancelled because the patient did not want to travel for the procedure. The patient was advised that since VA could perform the procedure and provide transportation, the patient would be responsible for the cost of the procedure if he chose to have it done at the community hospital. While awaiting the patient's decision on where to have his cardiac catheterization, the procedure was rescheduled, as the earlier appointment was no longer available.

Three days prior to his scheduled appointment for the procedure at the other VA facility, the patient presented to a community ED with chest pain and shortness of breath. Diagnostic tests showed that he had suffered a myocardial infarction and he was admitted to the community hospital. A cardiac catheterization was done during this admission and a stent was placed.[25] At the time of our review, the patient continued to follow up with his VA PCP and his non-VA cardiologist.

In conclusion, this patient experienced a delay in obtaining cardiac catheterization that was due, in part, to his desire to obtain care locally and avoid travel to another VA facility that was more than 600 miles from his home. Had the patient undergone cardiac catheterization and interventions as originally scheduled, he may not have had a myocardial infarction. The patient's EHR does not contain documentation that he was referred for cardiology through Choice. He may have been eligible to receive care through that mechanism since the veteran arguably faced an "unusual or excessive burden" in traveling to the other VA medical facility. However, VA Montana leadership and staff expressed that limited information was available regarding which patients met criteria to receive care under that authority until VHA finalized and disseminated guidance in November 2015. The system could have paid to have the patient undergo the procedure locally at a community hospital. However, VA Montana leadership and staff expressed that sending the patient to the other VA hospital was consistent with VHA guidance. Further, many facilities feared or experienced a budget shortfall for traditional non-VA care near the end of FY 2015.

Patient 4

The patient was a male in his late 60's with a diagnosis of chronic obstructive pulmonary disease and a history of chronic tobacco use and exposure to industrial pollutants without using airway protection. In 2015, the patient's PCP ordered a chest x-ray to follow up on a presumed pneumonia experienced a few months prior. The chest x-ray results were essentially the same as the results of a chest x-ray done two months earlier. The radiologist recommended further evaluation, including a computed

[25] A stent is a small, mesh tube that expands inside a heart vessel to keep the artery from closing up again.

tomography (CT) scan. The patient received a CT scan of the thorax about 1 week later, which was suspicious for malignancy. A week later, the PCP contacted the patient by phone with the results of the CT scan and ordered a non-VA care pulmonology consult because the service was not available timely at the system and specified that the patient should be seen within 1 week. However, system staff did not review, approve, and authorize the consult for nearly 3 months. A non-VA care pulmonologist saw the patient nearly 3½ months after the consult was ordered.

Shortly after the initial visit with the non-VA care pulmonologist, the patient had a bronchoscopy and was subsequently diagnosed with lung cancer without metastasis.[26] The patient had a partial lobectomy followed by chemotherapy.[27]

A non-VA care oncologist saw the patient in 2016 approximately one year after the follow-up chest x-ray, and a CT scan completed just prior to the visit did not show evidence of cancer.

In conclusion, the patient experienced a nearly 3½ month delay in obtaining a non-VA care pulmonology consult due to, at least in part, delays in administrative processing of the consult. The delay that the patient experienced could have negatively impacted his cancer treatment options and long-term prognosis.

Issue 2: System Efforts to Identify Patients Who Were Harmed and Address Factors that Contributed to Consult Delays

Beginning in July 2015, system leadership initiated a focused effort to identify and resolve factors that contributed to consult delays and reduce outstanding consults. Between late June 2014 and July 2015, the backlog of system consults increased as providers began systematically referring patients to community providers when VA appointments were not available within 30 days, as required under the Accelerating Care Initiative.[28] According to system leaders, they initiated their focused effort because they determined that their existing efforts to manage the backlog were not working.

Despite this effort, we found evidence of persistent issues with completing consults timely in FY 2016 (through late August 2016). We also noted that system leadership initiated ongoing reviews to determine if any patient harm occurred due to potential delays in care. Beginning in July 2015, system leadership coordinated with primary and

[26] A bronchoscopy is a procedure to examine a patient's windpipe and airways using a long, flexible tube with a camera.
[27] A partial lobectomy is a surgical procedure to remove a portion of the lung.
[28] In May 2014, VA implemented the Accelerating Care Initiative in an effort to increase timely access to care, decrease the number of patients on the electronic wait list, and reduce the number of patients waiting greater than 30 days for services. See *U.S. Department of Veterans Affairs Accelerating Access to Care Initiative Fact Sheet*, May 27, 2014. http://www.va.gov/health/docs/052714AcceleratingAccessFactSheet.PDF. Accessed November 29, 2016.

specialty care teams to clinically review all outstanding consults that had been open for more than 90 days. These clinical reviews included determining if services had been rendered, the status of the consult and whether care was clinically indicated.

System Efforts to Address Factors that Contributed to Delays

System leadership and staff had taken numerous steps intended to address factors that contributed to consult delays, including factors highlighted earlier in this report. The steps taken by the system are summarized in Table 2 on the next page. Those steps were augmented by recommendations and associated corrective actions from VA Central Office and VISN 19 reviews.

Table 2. Steps Taken by the System in an Effort to Address Consult Delays

Consult Type	Factor	Steps Taken by the System Staff
All Types	Consult appropriateness	Educated providers on the clinical indications for STAT versus routine consults
	Timeliness of Delegation of Authority	The list of individuals responsible for Delegation of Authority was updated
In-house	Missed opportunities	Fee department staff now track if patients obtain appointments through Choice and cancel redundant in-house consults/appointments
Non-VA Care	Efficiency and timeliness of fee department operations	Hired additional utilization review nurses to assist with non-VA care consult processing in November 2014 Hired additional fee clerks Began regularly reviewing incoming STAT consults to help ensure services are scheduled and addressed appropriately to resolution Re-engineered fee department consult processing, from a process wherein staff had assigned clinical areas to a "production line" process
	Delays in scanning outside medical records	Instituted voluntary overtime for fee department staff Purchased an electronic fax that is expected to improve efficiency by automatically scanning and saving outside medical records Filled relevant staff vacancies in late 2015
Choice	Efficiency and timeliness of fee department operations	(See corresponding steps taken by the system staff under non-VA care consults)
	Size of the Choice provider network in Montana	System leadership spoke with the American Medical Association at healthcare conferences and Chief Executive Officers across the state in an effort to recruit providers to participate in Choice
	Delays in retrieval of outside medical records	Instituted voluntary overtime for fee department staff Filled relevant staff vacancies in late 2015

Source: OIG analysis of interview data and system documents

Persistence of System Consult Delays, FY 2016 Through August 25, 2016

For consults ordered in FY 2016 through August 25, 2016, we found the following apparent delays:

- 10,984 of 22,546 patients (49 percent) with at least one in-house consult,
- 3,284 of 10,481 patients (31 percent) with at least one non-VA care consult,
- 7,291 of 10,263 patients (71 percent) with at least one Choice consult.

This represented an increase in the percentage of patients who experienced in-house and Choice consult delays, but a reduction in those who experienced non-VA care consult delays. (See Table 3.)

VISN and system leadership and staff we interviewed explained that increased delays for in-house consults were due to efforts to provide more care within the system in light of the barriers faced when accessing non-VA care and Choice. They explained that ongoing delays associated with consults to Choice were primarily a function of the limited provider network in Montana and ongoing issues in obtaining outside medical records timely. Efforts are ongoing to address those factors within the system leadership's control that contribute to consult delays, including hiring additional staff to process non-VA care and Choice consults and reducing the number of consults for services that could reasonably be provided in primary care.

Table 3. Patients Who Appeared to Have Experienced Consult Delays by FY

Consult Type	FY 2015	FY 2016 (through August 25, 2016)
In-House	11,073 / 26,293 (42.1 percent)	10,984 / 22,546 (48.7 percent)
Non-VA Care	11,863 / 21,221 (55.9 percent)	3,284 / 10,481 (31.3 percent)
Choice	2,683 / 4,427 (60.6 percent)	7,291 / 10,263 (71.0 percent)

Source: OIG analysis of CDW data.

System Efforts to Identify Patients Who Were Harmed by Consult Delays

The system leadership and staff had two primary mechanisms for identifying patients who may have been harmed by consult delays—incident reporting and mortality reviews. Through November 2014, staff primarily used a general incident reporting system to report concerns about consult delays. System leadership subsequently developed a consult-specific incident reporting system that staff used to facilitate more detailed communication of consult-related concerns after November 2014.

Under this reporting system, staff shared their consult-related concerns by completing a consult incident template and submitting it via email to the patient safety group. Nurses designated to review consults stratified outstanding consults by risk and urgency. If the nurses determined there was a possibility that a delay in care could cause harm, they forwarded the information to an interdisciplinary team for additional review. A physician review panel reviewed the subset of cases flagged as concerning by the interdisciplinary team, and leadership at the system requested an outside subject matter expert to review cases of potential harm. System staff maintained a database that synthesizes information from consult-related incident reports, decisions regarding the extent of patient harm, and other data. Mortality reviews began in January 2015, and the system reviewed all patient deaths to determine whether those patients had open consults and, if so, whether any consult delays could have contributed to the patients' deaths. System leadership and staff also conducted a retrospective review of mortalities with open consults from 2012 through the time of our review.

Through mid-May 2016, system staff identified 21 patients who may have been harmed by consult delays. Initially, a panel of physicians from the system reviewed some of those patients, and a panel of specialists from another VA facility reviewed the remaining patients. Due to, in part, the complexities associated with evaluating the relationship between timeliness of care and clinical outcomes, the system leadership

forwarded all 21 cases for review by a clinical review board at VA Central Office. In the interim, the system leadership provided an institutional disclosure to 1 of the 21 patients whose lung cancer diagnosis was delayed by 4 months.[29]

Issue 3: Adequacy of Internal Feedback Mechanisms

We found that, consistent with federal standards for internal control for information and communication, the system had several mechanisms in place for staff to communicate concerns about consult delays to system leadership. Despite available mechanisms, staff expressed concerns to us about communication with system leadership.

We found that the system had the following mechanisms in place for staff to communicate concerns about consult delays to system leadership:

- Incident Reporting System: As described earlier in this report, the system leadership and staff developed a consult specific incident reporting system that staff used to facilitate the communication of consult-related concerns.

- Stop the Line Program: "Stop the Line" is a VA-wide initiative launched in 2013 that empowers VA staff to speak up if they have concerns about risks to patient safety. Staff used "stop the line" to notify leaders of concerns about consult delays that might place veterans at risk. For example, a staff member informed leadership of a consult concern by email, with "stop the line" in the subject line. This email described the staff member's concern and desired course of action.

- Other Communication Efforts: System staff reported that leadership facilitated some ongoing communication regarding consults through monthly meetings, town hall meetings, and other open forum opportunities to share concerns and discuss solutions.

Some staff reported that they feared reprisal for raising concerns about consult delays. However, no one that we interviewed provided us with specific examples, such as examples of adverse personnel actions. Therefore, we provided concerned individuals with information on whistleblower protection laws and how to file a complaint of reprisal, in case such action was indicated at a later time. In addition, some staff we interviewed indicated that they were frustrated when feedback from management was limited. For example, some staff reported they did not receive timely feedback from management in response to concerns they raised and perceived that their communication was unwelcomed. System leadership recognized that, "…to date, progress has been focused and deliberate which at times can slow progress…"

[29] Institutional disclosure is a formal process by which facility leadership and staff inform the patient or a representative for the patient that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.

Conclusions

For patients with consults ordered in FY 2015, we found that a large percentage (between 42 and 61 percent) experienced a delay in obtaining a clinical in-house consult, non-VA care consult, and/or Choice consult. Of note, among the VA facilities included for comparison, the system had the lowest or among the lowest percentage of patients with delayed in-house and Choice consults and the highest percentage patients with delayed non-VA care consults. We found that delays among consults ordered in FY 2015 may have harmed four patients, whose names we provided to facility and VISN leadership. At the time of our review, system leadership had already provided an institutional disclosure for one of these patients.

Beginning in July 2015, the system initiated a focused effort to identify and resolve factors that contributed to consult delays and reduce outstanding consults. Despite this effort, we found evidence of persistent issues with completing consults timely in FY 2016 (through late August 2016). VISN and system leadership, and staff we interviewed, explained reasons for these ongoing delays. Further, efforts are ongoing to address those factors within the system's control that contribute to consult delays, including hiring additional staff to process non-VA care and Choice consults and reducing the number of unnecessary consults.

We also noted that the system initiated ongoing reviews to determine if any patient harm occurred due to potential delays in care. System leadership coordinated with primary and specialty care teams to clinically review all outstanding consults that had been open for more than 90 days. These clinical reviews included determining if services had been rendered, the status of the consult, and whether care was clinically indicated.

We found that, consistent with federal standards for internal control for information and communication, the system had several mechanisms in place for staff to communicate concerns about consult delays to system leadership. Despite available mechanisms, staff expressed concerns about communication with system leadership. For example, some staff we interviewed indicated that they were frustrated when feedback from management was limited.

Recommendations

1. We recommended that the System Director ensure that the care of the potentially harmed patients be reviewed by an external (non-system) source.

2. We recommended that the System Director confer with the Office of Chief Counsel as necessary regarding the potentially harmed patients for possible institutional disclosure, and take action as appropriate.

3. We recommended that the System Director continue efforts to improve consult timeliness and address factors that contribute to delays.

Appendix A

Prior OIG Reviews of Consult Delays November 2013 Through November 2016

The following is a chronological list of OIG oversight reports that addressed alleged consult delays and the impact of delays on patient outcomes.

- Healthcare Inspection: Alleged Improper Management of Dermatology Requests Fayetteville VA Medical Center Fayetteville, North Carolina (5/3/2016)
- Healthcare Inspection: Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California (3/30/2016)
- Healthcare Inspection: Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina (1/6/2016)
- Healthcare Inspection: Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, Kansas (12/22/2015)
- 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)
- Healthcare Inspection: Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona (10/15/2015)
- Healthcare Inspection: Quality of Care Concerns in a Diagnostic Evaluation, Jesse Brown VA Medical Center, Chicago, Illinois (9/29/2015)
- Healthcare Inspection: Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama (7/29/2015)
- Healthcare Inspection: Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado (7/7/2015)
- Healthcare Inspection: Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine (6/17/2015)
- Healthcare Inspection: Quality of Care and Access to Care Concerns, Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma (6/16/2015)
- Healthcare Inspection: Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland (4/14/2015)
- 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)
- Healthcare Inspection: Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina (2/18/2015)
- Interim Report: Review of Phoenix VA Health Care System's Urology Department, Phoenix, Arizona (1/28/2015)
- Healthcare Inspection: Alleged Delay in Gastroenterology Care, Durham VA Medical Center, Durham, North Carolina (11/6/2014)

- Healthcare Inspection: Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, Georgia (8/12/2014)
- Healthcare Inspection: Podiatry Clinic Staffing Issues and Delays in Care, Central Alabama Veterans Health Care System, Montgomery, Alabama (5/19/2014)
- Healthcare Inspection: Audiology Staffing, Consult Management, and Access to Care, Sheridan VA Healthcare System, Sheridan, Wyoming (11/5/2013)

Appendix B

Additional Scope and Methodology Information

This appendix provides supplemental scope and methodology information for how we evaluated the timeliness of system consults ordered from October 1, 2014 through September 30, 2015 and the impact of delays on patients. See tables 4–7 below.

Table 4. CDW Data That were Extracted and Analyzed by OIG

CDW Location (database.schema.table)	How Extracted Data Were Used
CDWWORK.DIM.STA3N	Obtained station numbers for study population
CDWWORK.DIM.LOCATION	Decoded VA station physical location (for reference only)
CDWWORK.DIM.REQUESTSERVICE	Distinguished between administrative from clinical consults
CDWWORK.DIM.CLINICALTERM	Decoded clinical terminology (for reference only)
CDWWORK.DIM.PROVIDERNARRATIVE	Decoded provider narrative (for reference only)
CDWWORK.DIM.CPT	Obtained CPT codes and descriptions
CDWWORK.DIM.ICD9	Obtained ICD-9-CM codes
CDWWORK.DIM.ICD9DESCRIPTIONVERSION	Obtained ICD-9-CM descriptions
CDWWORK.CON.CONSULT	Obtained all consults for selected stations
CDWWORK.CON.CONSULTACTIVITY	Identified consult activities for cancellation or closure without patient encounters
CDWWORK.SPATIENT.SCONSULTREASON	Obtained text identifying the reason for the consult
CDWWORK.SPATIENT.SPATIENT	Obtained patient identifiable information, including date of death
CDWWORK.APPT.APPOINTMENT	Identified appointments created from consults; if applicable
CDWWORK.OUTPAT.VISIT	Identified if patient physically visited station during timeframe for an outpatient encounter
CDWWORK.OUTPAT.VDIAGNOSIS	Identified if patient had a diagnosis of any type at outpatient encounter
CDWWORK.OUTPAT.VPROCEDURE	Obtained full record of patient visit containing adverse event outpatient procedure
CDWWORK.INPAT.INPATIENT	Identified if patient had an inpatient stay during timeframe at VA station

CDW Location (database.schema.table)	How Extracted Data Were Used
CDWWORK.INPAT.INPATIENTDISCHARGEDIAGNOSIS	Identified if patient had a discharge diagnosis of any type during inpatient stay
CDWWORK.INPAT.INPATIENTFEEDIAGNOSIS	Obtained FEE inpatient records showing hospitalization and obtaining either discharge or admit diagnosis
CDWWORK.FBCS.DSS_AUTHSUPPDATA	Provided a link between FEE encounters and ordered consult by authorization
CDWWORK.FEE.FEEAUTHORIZATION	Obtained FEE authorizations linked to consults by ID
CDWWORK.FEE.FEEINITIALTREATMENT	Obtained FEE visits linking the authorization to the type of treatment
CDWWORK.FEE.FEESERVICEPROVIDED	Obtained FEE outpatient records for patients
CDWWORK.FEE.FEEINPATINVOICE	Obtained FEE inpatient records showing hospitalization
CDWWORK.FEE.FEEINPATINVOICEICDDIAGNOSIS	Obtained diagnosis for FEE inpatient visits
CDWWORK.SSTAFF.SSTAFF	Obtained provider information if required (for reference only)

Source: CDW Data and OIG.

Table 5. Consult Urgencies and Associated Timeframes Used to Identify Delays

Consult Urgency	Expected Timeframe
Routine	Within 30 days
Next available	Within 30 days
Within 1 month	Within 30 days
Within 1 week	Within 7 days
Within 72 hours	Within 3 days
Within 48 hours	Within 2 days
Within 24 hours	Within 1 day
Today	Same day
STAT	Within 1 day
Emergency	Within 1 day

Source: OIG and OIG analysis of VA documents.

Note: According to VHA's consult business rules, STAT and emergency consults should be addressed within 6 and 4 hours, respectively. However, for the purposes of our analysis, we considered those consults to be timely if they were completed within 1 day to account for lags in entering documentation that can occur in urgent or emergent situations.

Table 6. ICD-9-CM Diagnostic Codes Used to Identify Health Events

Health Event	Diagnostic Codes
Lower Extremity Amputation	V49.70-V49.77
Abdominal Aortic Aneurysm Rupture	441.0, 441.00-441.03, 441.1, 441.3, 441.5
Cancer Diagnosis	140.0, 140.1, 140.3-140.6, 140.8, 140.9, 141.0-141.9, 142.0-142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0-145.9, 146.0-146.9, 147.0-147.3, 147.8, 147.9, 148.0-148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0-150.5, 150.8, 150.9, 151.0-151.6, 151.8, 151.9, 152.0-152.3, 152.8, 152.9, 153.0-153.9, 154.0-154.3, 154.8, 155.0-155.2, 156.0-156.2, 156.8, 156.9, 157.0-157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0-160.5, 160.8, 160.9,161.0-161.3,161.8, 161.9, 162.0, 162.2-162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0-164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0-170.9, 171.0, 171.2-171.9, 172.0-172.9, 173.0-173.9, 173.00-173.02, 173.09, 173.10-173.12, 173.19, 173.20-173.22, 173.29, 173.30-173.32, 173.39, 173.40- 173.42, 173.49, 173.50-173.52, 173.59, 173.60-173.62, 173.69, 173.70-173.72, 173.79, 173.80-173.82, 173.89, 173.90-173.92,173.99, 174.0-174.9, 175.0,175.9, 176.0-176.9, 179., 180.0, 180.1, 180.8, 180.9, 181., 182.0, 182.1, 182.8, 183.0, 183.2-183.5, 183.8, 183.9, 184.0-184.4, 184.8, 184.9, 185., 186.0, 186.9, 187.1-187.9, 188.0-188.9, 189.0-189.4, 189.8, 189.9,190.0-190.9, 191.0-191.9, 192.0-192.3, 192.8, 192.9, 193., 194.0, 194.1, 194.3-194.6, 194.8, 194.9, 195.0-195.5, 195.8, 196.0-196.3, 196.5, 196.6, 196.8, 196.9, 197.0-197.8,198.0-198.7, 198.81, 198.82, 198.89, 199.0-199.2, 200.00-200.08, 200.10-200.18, 200.20-200.28, 200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 200.80-200.88, 201.00-201.08, 201.10-201.18, 201.20-201.28, 201.40-201.48, 201.50-201.58, 201.60-201.68, 201.70-201.78, 201.90-201.98, 202.00-202.08, 202.10-202.18, 202.20-202.28, 202.30-202.38, 202.40-202.48, 202.50-202.58, 202.60-202.68, 202.70-202.78, 202.80-202.88, 202.90-202.98, 203.0, 203.1, 203.8,203.00, 203.02, 203.10, 203.12, 203.80, 203.82, 204.0, 204.00, 204.02, 204.1, 204.2, 204.10, 204.12, 204.20, 204.22, 204.8, 204.80, 204.82, 204.9, 204.90, 204.92, 205.0-205.2, 205.00, 205.02, 205.10, 205.12, 205.20, 205.22, 205.3, 205.30, 205.32, 205.8, 205.80, 205.82, 205.9, 205.90, 205.92, 206.0-206.2, 206.00, 206.02, 206.10, 206.12, 206.20, 206.22, 206.8, 206.80, 206.82, 206.9, 206.90, 206.92, 207.0-207.2, 207.00, 207.02, 207.10, 207.12, 207.20, 207.22, 207.8, 207.80, 207.82,208.0-208.2, 208.00, 208.02, 208.10, 208.12, 208.20, 208.22, 208.8, 208.80, 208.82, 208.9, 208.90, 208.92, 441.6
Myocardial Infarction	410.0-410.9, 410.00-410.02, 410.10-410.12, 410.20-410.22, 410.30-410.32, 410.40-410.42, 410.50-410.52, 410.60-410.62, 410.70-410.72, 410.80-410.82, 410.90-410.92, 411.0, 412.
Cerebrovascular Accident or Embolism	433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.10, 434.11, 434.91, 997.02, 415.0, 415.1, 415.12, 415.13, 415.19

Source: ICD-9-CM and OIG.

Table 7. CPT Codes Used to Identify a Health Event

Health event	Diagnostic codes
Lower Extremity Amputation	27882, 27592, 27888, 27881, 28825, 27591, 27590, 28800, 28810, 28820, 28805, 27290, 27880

Source: CPT Codes and OIG.

Appendix C

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 30, 2017

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana

To: Director, Hotline Coordination, Office of Healthcare Inspections (54HL)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the response from VA Montana Health Care System pertaining to this Healthcare Inspection report on Consult Delays and Management Concerns.

2. If you have any questions please contact Ms. [redacted], VISN 19 Quality Management Specialist at [redacted].

Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

Appendix D

System Director Comments

Department of Veterans Affairs

Memorandum

Date: January 25, 2017

From: Director, VA Montana Health Care System (436/00)

Subj: Healthcare Inspection—Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana

To: Director, Rocky Mountain Network (10N19)

1. Thank you for the opportunity to review the Office of Inspector General draft report: Healthcare Inspection—Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana. I concur with the findings in the draft report and provide the attached action plan to address recommendations 1 through 3.
2. VA Montana Health Care System (VAMTHCS) has a long-standing commitment to make certain timely care is provided to our Veterans. VAMTHCS is ensuring ongoing efforts are being rendered to address consult timeliness and factors contributing to delays. VAMTHCS will work with outside reviews and Regional Counsel to determine potential harm and need for institutional disclosures on the four patients identified in the OIG's extensive review.
3. I appreciate your recognition of our ongoing efforts, since July of 2015, to identify and resolve factors that contributed to consult delays and reduce outstanding consults. In addition to this, I also appreciate you recognizing our efforts to initiate ongoing reviews to determine if any patient harm occurred due to delays in care, and that VAMTHCS has put several mechanisms in place for staff to communicate concerns about consult delays to system leadership.
4. Again, thank you for the thorough review of our consult process. If you have any questions please do not hesitate to contact me.

Kathy W. Berger
Director, VA Montana 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 the care of the potentially harmed patients be reviewed by an external (non-system) source.

Concur

Target date for completion: March 31, 2017

Facility response: A review, of the care of the potentially harmed patients, was conducted in September 2016 by in-house sources. Prior to this review, VAMTHCS had completed an institutional disclosure for patient #4. An external (non-VAMTHCS) review of the remaining three potentially harmed patients was submitted on January 13, 2017.

Recommendation 2. We recommended that the System Director confer with the Office of Chief Counsel as necessary regarding the potentially harmed patients for possible institutional disclosure, and take action as appropriate.

Concur

Target date for completion: May 31, 2017

Facility response: For patient #4, Regional Counsel was contacted prior to the institutional disclosure. For patients #1, #2, and #3, Regional Counsel will be consulted if institutional disclosure is warranted.

Recommendation 3. We recommended that the System Director continue efforts to improve consult timeliness and address factors that contribute to delays.

Concur

Target date for completion: January 30, 2018

Facility response: Multiple actions have been implemented to improve consult timeliness. Actions include: VAMTHCS secured VISN approval to fund an in-house centralized Consult Scheduling Call Center (CSCC) that included 18 MSA's and 2 UR nurses. Ten MSA's and 1 RN have been hired and hiring and on boarding of the remaining FTEE's is in progress. Additional hiring includes a full-time Orthopedic Surgeon and a Neurology Nurse Practitioner. As of January 13, 2017, the recruitment announcements for the Chief of HAS and the Deputy Chief of HAS positions were posted and interviews for a non-VA Care Manger are in progress. Aggressive

recruitment continues for Audiology and an Endoscopist. Two HealthNet TPA contractors were embedded at VAMTHCS in June 2016.

VISN 19 conducted a site visit in September 2016 to review VAMTHCS's consult processes and an action plan was developed to reduce consult backlog and improve consult timeliness. VAMTHCS was selected as one of six sites for early adoption of Provider Agreements under the Veterans Choice Program (VCP) in March of 2016 and have continued our aggressive outreach efforts to date. When outreach began, VAMTHCS had zero provider agreements; as of January 9, 2017, they have 244 signed and active provider agreements. The USH Dashboard and Health Administration Services (HAS) consult reports are reviewed and discussed daily by VAMTHCS leadership. The consult department has implemented daily huddles, and the Consult Management Committee has expanded its scope to include oversight of internal controls to monitor scanning delays related to medical records. A streamlined process has been implemented to address STAT consults in a timely manner. Consult templates have been revised to align with Choice documentation requirements. Eight Consult Stand Downs have been completed. The UR nurses are responsible for the clinical tracking of in-house consults and the Electronic Wait List (EWL). A teamlet approach has been established, with the MSAs and UR nurses, within the non-VA Care Department resulting in improved daily operations. A digital fax system has been secured to assist in streamlining the records retrieval process. Leadership in the clinical services have made changes to create a culture of accountability to address practice issues related to consult management, to improve consult timeliness, and address any factors that could contribute to delays. Ongoing efforts will continue to enhance the efficiency of the consult process.

Appendix E

OIG Contact and Staff Acknowledgments

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

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