



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Review of Delays in Clinical  
Consult Processing at  
VA Boston Healthcare  
System

Massachusetts



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review delays in clinical consult processing at the VA Boston Healthcare System (facility), Massachusetts.<sup>1</sup>

On April 23, 2015, the OIG received a complaint regarding discontinuation of consults without patients receiving an initial medical review. On May 21, 2015, the OIG team completed a review of a sample of the discontinued consults and determined that none of the consults reviewed had been discontinued inappropriately. The OIG recommended referral of the case to the Veterans Integrated Service Network (VISN) for monitoring of consult management and improvement plans. Internal OIG procedures related to protecting the privacy and confidentiality of this complainant resulted in a more than two-year process delay in obtaining information.

On August 29, 2017, the OIG requested a response from the VISN to address specific questions related to the facility's consult management, policies regarding discontinuation of consults, and monitoring and improvement plans. The information received from the VISN identified consults at the facility not meeting the Veterans Health Administration's (VHA) timeliness goal of an appointment within 30 days of the provider's clinically indicated date (CID).<sup>2</sup> Specifically, as of October 2017, over 4,000 consults remained open for greater than 30 days, 948 consults remained open greater than 90 days, 457 consults remained open greater than 180 days, and 42 consults remained open greater than one year.

In April 2018, the OIG initiated a review to evaluate specific aspects of consult processing at the facility:

1. Consult processing issues resulted in patient care delays.
2. Clinical issues caused delays in processing consults.
3. Administrative issues caused delays in processing consults.
4. Facility staff utilized non-VA care to ensure timely appointments.
5. Facility leaders monitored consult timeliness and implemented action plans in response to consult delays.<sup>3</sup>

Although the OIG identified deficiencies in timeliness for some consults, facility leaders had consult policies and processes in place prior to the OIG review. Analysis of clinical consult data determined that 90 percent of the facility's routine clinical consults were scheduled within

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<sup>1</sup> A consult is a request for services on behalf of a patient.

<sup>2</sup> The CID is the date an appointment is deemed clinically appropriate. VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

<sup>3</sup> OIG Hotline Contact 2015-21237, received April 19, 2018.

30 days of the CID. Further, 71 percent of primary care consults were timely scheduled. The average wait time for a primary care consult at the facility was 25 days.

Based on interviews, a review of consult data, other information sources, and facility action plans for improvement, the OIG team determined that facility leaders were knowledgeable about how the facility was meeting VA consult standards, and were monitoring consult timeliness, identifying challenges related to access to care, implementing informed plans in response to identified problems, and assessing the results of those actions. Facility leaders were aware of issues that impacted consult processing and implemented performance improvement plans. The facility ranked within the top 20 percent of VHA facilities on access to care in the fiscal year (FY) 2018 second quarter Strategic Analytics for Improvement and Learning (SAIL) Report.<sup>4</sup> The facility's Access Domain score ranking improved from the FY 2015 third quarter to the FY 2018 second quarter.

Although the OIG did not issue any recommendations, its findings in this report describe the types of issues that should be considered by facilities assessing their consult management processes and the range of actions that this particular facility has taken to reduce delays in patients' accessing care.

The team reviewed electronic health records (EHRs) for 339 patients with consult wait times greater than 60 days in four specialty services. The review did not identify occurrences of adverse clinical outcomes related to delays in care caused by consult wait times.

The team's review of the facility's consult management processes determined that consults remained open for a variety of reasons, both clinical and administrative.<sup>5</sup>

The OIG determined that clinical issues contributed to delays in consult processing. These included: (a) staffing vacancies and the need for additional full-time employee equivalents to support clinical services, (b) clinic space constraints, (c) competing demands and coordination of shared clinical resources (such as anesthesiologists), and (d) patient cancellations and "no shows."<sup>6</sup>

Administrative issues contributed to delays in consult processing as well. Consult processing was impacted by the following administrative issues: (a) difficulties contacting patients for scheduling that delayed making patient appointments; (b) patient scheduling preferences, which

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<sup>4</sup> The SAIL Value Model is a tool VHA uses to help define performance expectations. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency.

<sup>5</sup> A consult remains "open" until completed. A consult is considered completed when the patient has been seen by the responding provider and the consultation or evaluation has been documented in the EHR, which closes the consult.

<sup>6</sup> Full-time employee equivalent (FTE) is one employee working full time. <http://www.businessdictionary.com/definition/full-time-equivalent-FTE.html>. (The website was accessed on August 7, 2018.)

could delay care; (c) inconsistent use of future care consults<sup>7</sup> that made timely consults appear delayed on monitoring reports; and (d) consult CID defaults to date of entry that artificially shortened the window for timely scheduling. While difficulties contacting patients for scheduling and patient scheduling preferences contributed to subsequent delays in care, inconsistent use of future care consults and CID defaults to the date of entry delayed processing but did not cause delays in care.

At the time of the inspection, the team determined that facility leaders implemented action plans to mitigate the identified clinical and administrative issues. Clinical process improvements for consult management and timeliness, according to facility staff, included (a) using nurse clinics to assist specialty services, (b) employing consults for a primary care common pathway, (c) implementing Advanced Access Clinics to assist with primary care workload, and (d) better managing inter-facility consults.<sup>8</sup> Facility leaders also reported implementing administrative process improvements, which included direct scheduling of specialty clinic referrals, better hiring and onboarding processes for medical support assistants, and updating clinic profiles.

Non-VA care was offered when services at the facility were not available within 30 days of the CID. VHA policy sets timeliness standards for consults and provides for referral of patients to non-VA care when VA facilities cannot provide care in a timely manner.<sup>9</sup> The OIG team's review of consult data from October 2016 through December 2017 showed that two percent of the facility's clinical consults were referred to non-VA care. The Chief of Staff estimated that six percent of the facility's care was referred to non-VA care, but reported some patients preferred VHA services rather than referrals to non-VA care regardless of delays.

The OIG verified that facility leaders and managers monitored and analyzed consult data and communicated with service leaders about identified concerns; they also implemented clinical and administrative processes for performance improvement and monitored the results.

The OIG team determined, from an interview with the VISN Quality Management Officer, that the VISN provided oversight for tracking access, managing consults, and other performance measures for the facility. VISN leaders conducted monthly management meetings to review access and consult processing concerns, as well as performance data with facility leaders. Facility Group Practice Managers provided monthly reports on access and consult processing to the VISN-level Group Practice Manager, who tracked facility action plans related to access to care.

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<sup>7</sup> VHA defines future care consults as requests for care in which the CID is more than 90 days from the consult initiation. VHA Directive 1232(1).

<sup>8</sup> Common pathway refers to a single route by which referrals are made to primary care; Advanced Access Clinics provide patients with certain problem-specific evaluations without requiring a primary care appointment.

<sup>9</sup> VHA Directive 1230; VHA Directive 1232(1).

The VISN Quality Management Officer identified provider recruitment and retention as challenges across the VISN and identified timeframes for consult management and access as national priorities. The VISN Quality Management Officer informed the OIG team that, based on the number of consults the facility processes, the facility is performing well with consult processing.

Based on interviews and review of facility committee minutes and action plans, the OIG team concluded that facility leaders were actively engaged and had performance improvement and consult management processes in place. Therefore, the OIG made no recommendations.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report. (See Appendixes A and B, pages 25–26 for the Directors’ comments.) No further action is required.



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## Abbreviations

Choice	Veterans Choice Program
CID	clinically indicated date
COS	Chief of Staff
EHR	electronic health record
FTE	full-time employee equivalent
FY	fiscal year
GI	gastroenterology
MSA	medical support assistant
OIG	Office of Inspector General
SAIL	Strategic Analytics for Improvement and Learning
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network





## Introduction

### Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review delays in clinical consult processing at the VA Boston Healthcare System (facility), Massachusetts.

### Background

The facility, part of Veterans Integrated Service Network (VISN) 1, encompasses three main campuses and five outpatient clinics within a 40-mile radius of the greater Boston area. “[t]he consolidated facility consists of the Jamaica Plain campus, located in the heart of Boston's Longwood Medical Community; the West Roxbury campus, located on the Dedham line; and the Brockton campus, located 20 miles south of Boston in the City of Brockton.”<sup>10</sup> The facility includes five community based outpatient clinics located in Boston, Framingham, Lowell, Plymouth, and Quincy, Massachusetts.

In fiscal year (FY) 2017, the facility served 62,982 patients and had a total of 592 operating beds, including 349 inpatient beds, 98 domiciliary beds, 112 community living center beds, and 33 Compensated Work Therapy Transitional Resident beds.

### Clinical Consults

A clinical consult is a request for services on behalf of a patient. One provider requests an opinion, advice, or expertise regarding the evaluation or management of a patient-specific problem and another provider responds to the request. The consult process provides a method of coordinating patient care among different services. VA facilities use software in the electronic health record (EHR) to enter, receive, schedule, and document information for consults.<sup>11</sup> The software generates an automatic notification (an alert) in the EHR to notify the requesting provider of updates made to the consult. Clinical consults include a clinically indicated date (CID), which is the date an appointment is deemed clinically appropriate. The CID is “based upon the needs of the patient and should be at the soonest appropriate date.”<sup>12</sup> The Veterans Health Administration’s (VHA) timeliness goal for consults specifies scheduling within 30 calendar days or less from the CID.<sup>13</sup> When a VA facility cannot provide an appointment

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<sup>10</sup> VA Boston Healthcare System Internet Reference. <https://www.boston.va.gov/about/index.asp>. (The website was accessed on June 21, 2018.)

<sup>11</sup> VA Office of Information and Technology, Consult/Request Tracking User Manual Version 3.0, March 2018.

<sup>12</sup> VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

<sup>13</sup> VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

within the 30-day time frame, clinical consults may be processed to refer patients for non-VA care.

## Non-VA Care

Non-VA care refers to community-based patient care purchased by VHA. Services are coordinated through VHA or a contracted third-party administrator. Non-VA care may be utilized by eligible veterans when VA facilities cannot provide care and services; a patient cannot safely travel due to medical reasons; care cannot be provided in a timely manner; or care cannot be provided due to geographic inaccessibility.<sup>14</sup> A consult and preauthorization are required for non-VA treatment.<sup>15</sup>

Non-VA care includes options for purchasing care outside the VA, including the Veterans Choice Program (Choice) and traditional Non-VA Coordinated Care. Choice was established by the Veterans Access, Choice, and Accountability Act of 2014.<sup>16</sup> Under this program, VA contracts with a third-party administrator to purchase care from specific non-VA providers. To receive care through Choice, a veteran must be enrolled in the VA health care system and meet certain eligibility criteria, such as a greater than 30-day wait time for services or living more than 40 miles from a VA facility.

Non-VA Coordinated Care refers to the process through which VA purchases care from non-VA providers without the involvement of a third-party administrator.<sup>17</sup>

## VHA Performance Data

The VA Office of Operational Analytics and Reporting developed the Strategic Analytics for Improvement and Learning (SAIL) Value Model to help define performance expectations within VHA.<sup>18</sup> This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data

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<sup>14</sup> Eligible veterans are those who have been approved by VHA (using military and other records) and enrolled for care at the VHA: VHA Directive 1601A.02, *Eligibility Determination*, April 3, 2015, changed from a VHA handbook to a directive on June 7, 2017 (updated July 27, 2017); VHA Directive 1232(1).

<sup>15</sup> VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013. The directive was scheduled for recertification on or before the last working date of January 2018 and has not been recertified.

<sup>16</sup> VHA Directive 1700, *Veterans Choice Program*, October 25, 2016; Public Law 113-146, Veterans Access, Choice and Accountability Act of 2014, August 7, 2014. <https://www.gpo.gov/fdsys/pkg/PLAW-113publ146/pdf/PLAW-113publ146.pdf>. (The website was accessed on February 8, 2018.)

<sup>17</sup> VHA Directive 1601.

<sup>18</sup> The model is derived from the Thomson Reuters Top Health Systems Study.

are presented as one way “to understand the similarities and differences between the top and bottom performers” within VHA.<sup>19</sup>

The SAIL model includes an Access Domain score, which is derived from a combination of measures, that includes patient responses to surveys on access to primary care, specialty care, and urgent care; analysis of wait time data for primary care, specialty care, and mental health care; as well as call center telephone pick-up speeds and abandonment rates.<sup>20</sup>

## Concerns

On April 23, 2015, the OIG received a complaint regarding discontinuation of consults without an initial medical review. On May 21, 2015, the OIG team completed a review of a sample of the discontinued consults and determined that none of the consults reviewed had been discontinued inappropriately. The OIG recommended referral of the case to the VISN for monitoring of consult management and improvement plans. However, internal OIG procedures related to protecting the privacy and confidentiality of the complainant resulted in a more than two-year process delay in requesting the VISN information.

On August 29, 2017, the OIG requested a response from the VISN regarding the facility’s consult management process, consult discontinuation policies, and monitoring and improvement plans. On November 14, 2017, the OIG received the VISN response that detailed a focused review of discontinued consults by the facility Chief of Staff (COS) office in response to the OIG’s inquiry. The response concluded that the findings from that review did not substantiate that the facility had discontinued consults inappropriately. The VISN reported that the facility followed national VHA policies for consult management. The VISN response also indicated weekly monitoring of open consults by the facility and identified tracking of open consults by the VISN, which sends daily, weekly, and monthly access reports to facility leaders. The response referenced actions for improvement of consult management including continued monitoring and review of standard operating procedures.

In December 2017, the OIG reviewed the VISN response and related consult data for the facility from FY 2017. Based on data received from the VISN, the OIG determined that as of October 2017, over 4,000 consults remained open for greater than 30 days, 948 consults remained open greater than 90 days, 457 consults remained open greater than 180 days, and

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<sup>19</sup> VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model. <http://vawww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>. (The website was accessed on August 7, 2018.) This website is not accessible to the public.

<sup>20</sup> In the context of health care, access “refers to the ease with which an individual can obtain needed medical services.” <https://www.rand.org/topics/health-care-access.html>. (The website was accessed on August 1, 2018.); Abandonment rate refers to the percentage of inbound phone calls where the caller hangs up before being connected to a live agent at a service desk.

42 consults remained open greater than one year. The review identified consults not meeting the VHA timeliness goal of appointment within 30 days of the CID.

In April 2018, the OIG initiated a review to evaluate specific aspects of consult processing at the facility:<sup>21</sup>

1. Consult processing issues resulted in patient care delays.
2. Clinical issues caused delays in processing consults.
3. Administrative issues caused delays in processing consults.
4. Non-VA care was not consistently used to ensure timely appointments.
5. Leaders monitored consult timeliness and implemented action plans in response to consult delays.

## **Scope and Methodology**

The review was initiated on April 19, 2018, and a site visit was conducted June 12–13, 2018.

The OIG team interviewed the Facility Director, COS, Director of Primary and Ambulatory Care, Business Managers for primary care, Medical Director of the Office of Community Care, Associate Chief of Outpatient and Specialty Clinics, Group Practice Manager, service chiefs of selected specialty services, and supervisory medical support assistants (MSAs). The VISN Quality Management Officer was interviewed regarding the processes for consult oversight at the facilities.

The team reviewed VHA and facility policies, leadership reports related to consult management, committee minutes, and facility action plans related to consults and access to care. To assess the impact of common factors that can affect timely access to care, the OIG team obtained information related to staffing and physical space limitations. Additionally, service chiefs responded to written queries to provide specific details regarding factors impacting consult processing for their respective services.

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<sup>21</sup> The OIG Hotline Contact 2015-21237 was received April 19, 2018.

Data on facility consults were obtained from the VHA Corporate Data Warehouse database.<sup>22</sup> The OIG team reviewed summary data for facility consults from October 1, 2016, through December 31, 2017. The data reviewed included the number and percentage of consults meeting the 30-day timeliness expectation for scheduled appointments and average wait times for the various facility services.<sup>23</sup>

Based on analyses of the summary data and OIG medical consultants' opinions on the relative risks of delays in care associated with the various services, four specialty services were selected for an in-depth review of delayed consults:<sup>24</sup>

1. Cardiology<sup>25</sup>
2. Gastroenterology (GI)<sup>26</sup>
3. Neurosurgery<sup>27</sup>
4. Urology<sup>28</sup>

A total of 339 consults (87 Cardiology, 86 GI, 80 Neurosurgery, and 86 Urology) were identified for review due to wait times greater than 60 days. OIG registered nurses reviewed the 339 patients' EHRs to determine if death, hospitalization, an emergency department visit, or

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<sup>22</sup> VHA's Corporate Data Warehouse "is a national repository comprising data from several VHA clinical and administrative systems." The objective of maintaining this database "is to facilitate reporting and data analysis at the enterprise level by incorporating data from multiple data sets throughout the VHA into one standard database structure." Corporate Data Warehouse "provides data and tools to support management decision making, performance measurement, and research objectives."

<http://vaww.vhadatportal.med.va.gov/DataSources/CDW.aspx>. (The website was accessed on November 6, 2018.) This website is not accessible to the public.

<sup>23</sup> For consults in which the consult appointment was scheduled within 30 days of CID but were delayed due to "No Show" or cancellation by the patient, the consult was identified as meeting the timeliness standard, as the cause for the delay was due to the patient's actions. For consults in which the consult appointment was scheduled within 30 days of CID, but was delayed due to cancellation by the clinic, the consult was identified as failing to meet the timeliness standard, as the cause for the delay was due to VA's actions; Average wait time refers to the mean number of days between the CID and the appointment.

<sup>24</sup> The medical specialties selected for review are referred to as services in this report. At the facility, these medical specialties are designated as sections of larger service lines. Cardiology and GI are sections of the Medical Service and Neurosurgery and Urology are sections of the Surgical Service.

<sup>25</sup> Cardiology is a branch of medicine concerned with the heart, its action and diseases. <https://www.merriam-webster.com/dictionary/cardiology#medicalDictionary>. (The website was accessed on June 25, 2018.)

<sup>26</sup> Gastroenterology is "a branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines." <https://www.merriam-webster.com/dictionary/gastroenterology>. (The website was accessed on June 25, 2018.)

<sup>27</sup> Neurosurgery is a branch of medicine concerned with surgery of nervous structures, such as nerves, the brain or the spinal cord. <https://www.merriam-webster.com/dictionary/neurosurgery#medicalDictionary>. (The website was accessed on June 25, 2018.)

<sup>28</sup> Urology is "a branch of medicine concerned with the urinary and urogenital organs." <https://www.merriam-webster.com/medical/urology>. (The website was accessed on June 25, 2018.)

indication of clinical deterioration occurred during the interval between ordering the consult and completing the initial consult appointment.<sup>29</sup>

OIG medical consultants performed a second-level EHR review for all 51 consults where death, hospitalization, emergency department visit, or indication of clinical deterioration was identified and potentially related to the clinical condition for which the consult was ordered. OIG medical consultants conducted reviews of the 51 identified patients' EHRs to determine if the consult delays were associated with adverse clinical outcomes.<sup>30</sup> Figure 1 displays the methodology for the consult review.

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<sup>29</sup> For Cardiology consults, indicators of clinical deterioration included an electrocardiogram change (such as heart blocks, premature ventricular contractions, s or heart attacks) or decrease in ejection fraction percentage. For GI consults, indicators of clinical deterioration included an onset of vomiting blood, dark or black stool, or blood in stool. For Neurosurgery consults, indicators of clinical deterioration included motor sensory deterioration evidenced by the onset of paralysis, incontinence, or loss of bowel control. For Urology consults, indicators of clinical deterioration included sepsis, confirmed by blood or urine.

<sup>30</sup> Within the context of this report, the OIG considered an adverse clinical outcome to be potentially avoidable changes in the patient's condition including worsening symptoms, psychosocial deterioration, and death. The OIG recognizes that in addition to the potential for adverse clinical outcomes, avoidable delays associated with the deficiencies discussed in this report may impact the convenience and quality of care received by veterans, some of whom travel long distances to seek care from a VA hospital. The OIG was unable to quantify the frustration, confusion, or disturbances in a veteran's activities of daily living that may have resulted from these deficiencies and focused its evaluation of patient harm in terms of adverse clinical outcomes.

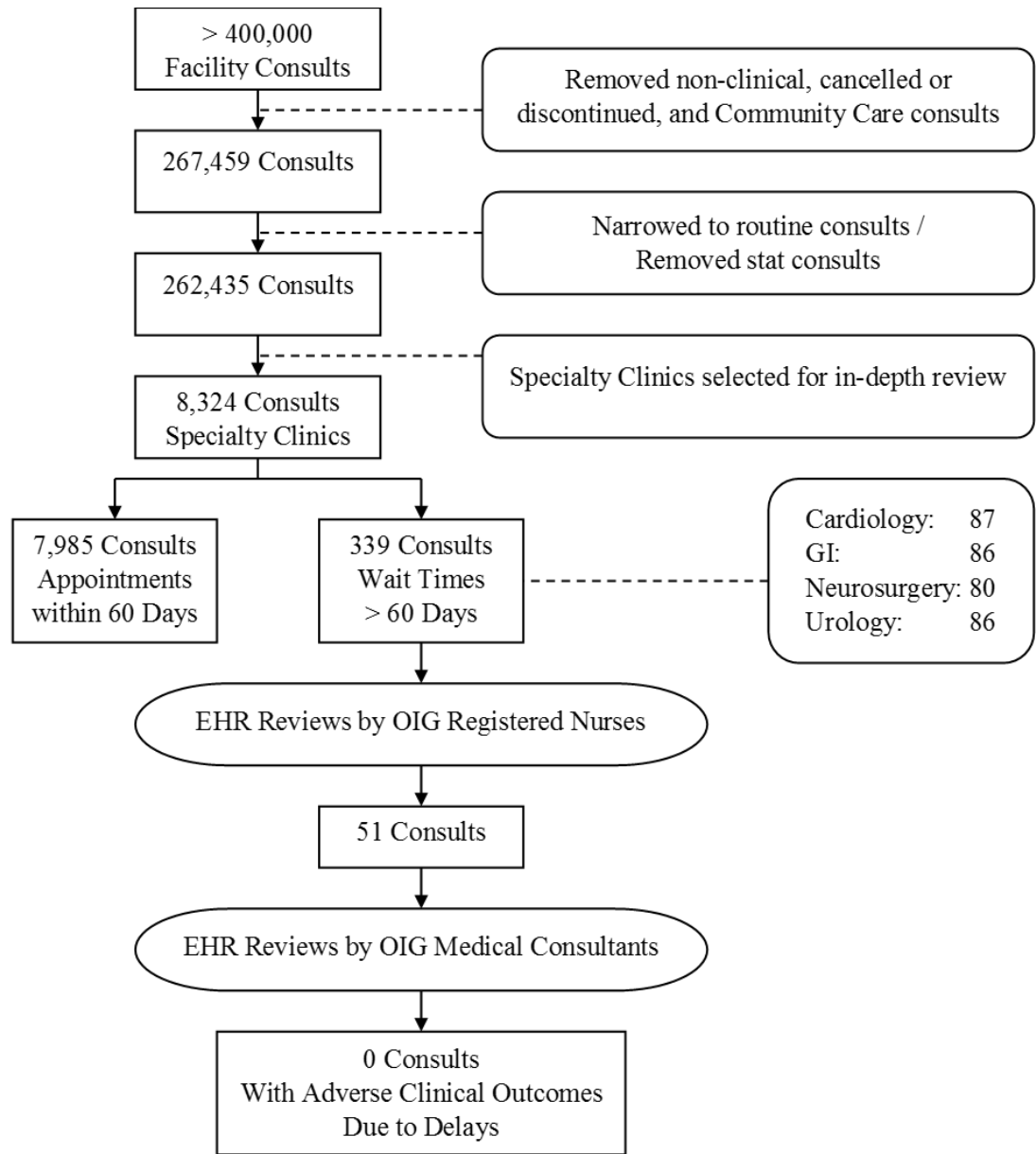


Figure 1. Consult Review Methodology<sup>31</sup>  
 Source: VA OIG analysis of VHA facility data

<sup>31</sup> The designations “routine” and “stat” specify the urgency status of a consult. “A routine consult indicates the patient should be seen in accordance with the clinically indicated date.” A stat consult is “defined as an “immediate” need[.]” “must be completed within 24 hours” and requires that the referring provider contact the intended receiver of the consult to discuss the patient’s situation. VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG 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 Processing and Patient Care Delays

The facility had consult policies and processes in place, and the OIG's analysis of clinical consult data determined that 90 percent of the facility's routine clinical consults were scheduled within 30 days of the CID. Seventy-one percent of primary care consults were scheduled timely. The average wait time for a consult at the facility was 25 days. While delays in care can increase a patient's risk, the OIG team's review of EHRs for 339 patients with consult wait times greater than 60 days in four specialty services did not find occurrences of adverse clinical outcomes related to delays in care caused by consult delays; therefore, the OIG made no recommendations.

VHA policy sets timeliness standards for consults and specifies scheduling within 30 calendar days or less from the CID for routine consults.<sup>32</sup> The OIG team's review of the facility's consult management processes determined that consults may remain open for a variety of reasons. (See Issues 2 and 3.)<sup>33</sup> Facility leaders were aware of issues that impacted consult processing and implemented performance improvement plans. The facility's Access Domain score ranking improved from FY 2015 third quarter to FY 2018 second quarter.

#### Consult Wait Times

The OIG team analyzed facility consult data from October 1, 2016, through December 31, 2017, and determined that 235,207 of 262,435 (90 percent) routine clinical consults were scheduled within 30 days of the CID. Review of consult data across the facility's services identified differences in the rate the consult timeliness goal was met. Analysis of the facility's primary care clinics data showed 71 percent of consults were scheduled for appointments within 30 days of the CID.<sup>34</sup> The average wait time for a primary care consult at the facility was 25 days. Wait times for primary care at the facility were shorter than those reported for non-VA primary care in the Boston area. In 2017, a private sector survey reported an average new patient appointment wait time of 52 days in the Boston area.<sup>35</sup>

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<sup>32</sup> VHA Directive 1230.

<sup>33</sup> A consult remains open until completed. A consult is considered completed when the patient has been seen by the responding provider and the consultation or evaluation has been documented in the EHR, which closes the consult.

<sup>34</sup> Analysis of primary care wait times included primary care clinics which provided the full range of primary care services. The analysis excluded clinics dedicated to other specific types of care which may be integrated with the primary care setting, but which do not provide a full range of primary care services. Exclusions included clinics specific to: anticoagulation follow-up, behavioral health, ear cleaning, gynecology, injections, weight management, nursing nail debridement, pharmacy, smoking cessation, sexual health, and social work.

<sup>35</sup> Merritt Hawkins, 2017 Survey of Physician Appointment Wait times.

<https://www.merrithawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf>.  
(The website was accessed on July 16, 2018.)

## EHR Reviews

The OIG team did not find occurrences of adverse clinical outcomes related to consult delays for the 339 patients with wait times greater than 60 days in the four specialty services reviewed.

For the 51 patients who experienced death, hospitalization, emergency department visits, or indicators of clinical deterioration potentially related to the consulted medical condition, OIG medical consultants identified documented reasons for wait times greater than 60 days. (See Table 1.)<sup>36</sup>

**Table 1. Reasons Documented for Wait Times Greater Than 60 Days**

Reasons for Delays	Number of Consults Impacted <sup>37</sup>
Scheduled beyond 60 days by the specialty service	23
Cancelled appointment and rescheduled by patient	13
“No show” for scheduled appointment <sup>38</sup>	5
Hospitalized at the time of the scheduled appointment requiring rescheduling	5
Declined referrals to non-VA care and preferred to schedule with a delay at the facility	4
Preferred to schedule the appointment to a future date despite VHA offering earlier availability	3
Cancelled and rescheduled by clinic staff prior to the initial appointment	1
Appeared delayed due to follow-up appointment documented on consult; however, consult was not delayed	2
Delayed appointment date due to a medical equipment software upgrade by the manufacturer	1
Delayed due to treatment and resolution for an acute medical condition	1

*Source: VA OIG medical consultants’ EHR analysis*

The OIG medical consultants determined that the 51 patients reviewed did not experience adverse clinical outcomes from the delays caused by reasons documented in Table 1. For the services reviewed, clinical staff were involved in reviewing and prioritizing the urgency of consults. Documentation showed that administrative staff alerted clinical staff to review consults

<sup>36</sup> Wait time refers to the number of days between the CID and the consult appointment.

<sup>37</sup> Seven of the EHRs documented more than one reason for consult delays. Patient cancellations or “no shows” accounted for at least one of the delays in each of those consults. Two of the consults showed delays due to both patient cancellations and “no shows.”

<sup>38</sup> “No show” refers to failure to attend a scheduled medical appointment without calling to cancel the appointment in advance.

prior to scheduling appointments. OIG medical consultant EHR reviews confirmed clinical staff were triaging consults as a standard practice.<sup>39</sup> Triaging consults provided a level of patient safety in assessing clinical needs before offering appointments.

In addition to clinical staff triaging consults, requesting providers received alerts regarding actions taken on consults, including scheduling of appointments. When patients selected dates beyond the CID, requesting providers can communicate concerns to the patient and consult service about the delays or accept patients' preferences.

## **Patient Advocate Data**

The OIG team reviewed 720 entries from the Patient Advocate Tracking System to gain patients' perspectives regarding consult scheduling timeliness. The OIG determined that 10 patient complaints documented in the Patient Advocate Tracking System were directly related to consult scheduling timeliness. The OIG identified an additional 11 complaints related to scheduling timeliness but was unable to determine if those complaints were related to consult scheduling or follow-up appointments for established patients due to insufficient documentation.<sup>40</sup>

Documentation indicates that facility staff addressed 19 of the 21 complaints by scheduling an appointment or providing a referral to non-VA care. Documentation for two of the 21 complaints was insufficient to identify the patients and determine how the complaints were resolved.

## **Access to Care Performance Data**

The facility's FY 2018 second quarter score on the SAIL Access Domain placed the facility's performance in the top 20 percent of VHA facilities for this measure. The facility's scores on primary care and Specialty Care Access ranked in the top 10 percent of VA facilities. The facility's scores on wait times for new patients in Specialty Care and Mental Health also ranked in the top 10 percent of VA facilities. The score on wait times for new patients in primary care was above the 50th percentile.

## **Issue 2: Consult Processing Delays Related to Clinical Factors**

The OIG identified four specific clinical factors that contributed to delays in consult processing. Timely processing of consults and care was delayed by (a) staffing vacancies and need for additional full-time employee equivalents (FTE) to support clinical services, (b) clinic space

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<sup>39</sup> Triage refers to "the sorting of patients... according to the urgency of their need for care." <https://www.merriam-webster.com/dictionary/triage>. (The website was accessed on August 7, 2018.)

<sup>40</sup> The Patient Advocate Tracking System "is a centralized, web-based application that records and tracks instances of patient compliments and complaints concerning their care at VA health care facilities." <https://www.data.va.gov/dataset/patient-advocate-tracking-system-pats>. (The website was accessed on July 30, 2018.)

constraints, (c) competing demands and coordination for shared clinical resources, and (d) patient cancellations and “no shows.”<sup>41</sup> VHA policy specifies scheduling patients’ appointments within 30 calendar days or less from the CID for routine consults.<sup>42</sup> It is the responsibility of the facility director to allocate “sufficient resources to enable management of consultations and timely delivery of care.”<sup>43</sup> Service and department clinical leaders are responsible for identifying, requesting, and managing resources needed to comply with consult performance measures. OIG staff verified that facility and service leaders implemented action plans to mitigate the impact of identified causes for delays and reported plans for continuing improvement efforts. Action plans included recruitment and hiring efforts, as well as renovations and clinic relocations.

## Staffing

The OIG team determined that staffing impacted consult management and timeliness; however, facility leaders implemented action plans to support recruitment efforts.

Review of five services’ staffing data showed vacancy rates ranging from 1.00 to 9.85 FTEs. Table 2 shows staffing and vacancies for primary care and the four selected specialty services.

**Table 2. Primary Care and Specialty Service Staffing and Vacancies**

Service	Total Approved Clinical FTEs	Total Clinical FTE Vacancies
Primary Care	146.20	4.75
Cardiology	58.03	7.13
GI (including Endoscopy) <sup>44</sup>	39.78	9.85
Neurosurgery	4.00	2.00
Urology	9.15	1.00

Source: August 2018 facility data on primary care and specialty service staffing and vacancies

The COS and service chiefs identified challenges across the reviewed services with turnover, attrition, and recruitment. Action plans to address identified vacancies included recruitment and hiring of additional staff.

The Director of Primary and Ambulatory Care identified provider turn-over as affecting access and stated the primary care sites with stable staffing maintained timely access more easily than

<sup>41</sup> One FTE is equal to one employee working full time. <http://www.businessdictionary.com/definition/full-time-equivalent-FTE.html>. (The website was accessed on August 7, 2018.)

<sup>42</sup> VHA Directive 1230.

<sup>43</sup> VHA Directive 1232(1).

<sup>44</sup> “[E]ndoscopy is a procedure used to visually examine [the] upper digestive system with tiny camera on the end of a long, flexible tube.” Endoscopy is used to diagnose and sometimes treat conditions that affect the esophagus, stomach and small intestine. <https://www.mayoclinic.org/tests-procedures/endoscopy/about/pac-20395197>. (The website was accessed on August 2, 2018.)

sites with higher rates of provider attrition. Due to providers' lack of interest in covering clinics spread across a large geographical area, the Director of Primary and Ambulatory Care reported difficulty with recruiting "float" providers to supplement primary care. Recruitment efforts for float primary care providers were bolstered by dividing the one large coverage area into two smaller areas.

The COS and Chief of Neurosurgery reported difficulties with recruiting medical instrument technicians for GI service and providers for Neurosurgery Service. VA salaries for medical instrument technicians and neurosurgery providers were described as non-competitive in the local market. The COS stated that Office of Personnel Management regulations do not allow the facility to hire medical instrument technicians at a salary that would be competitive in the Boston area, thus hiring efforts for these positions were unsuccessful.<sup>45</sup> The COS also reported replacing chronically vacant GI medical instrument technician positions with nursing personnel, but indicated this was insufficient.

The COS and Chief of Surgical Service also described plans to increase the availability of subspecialty care within neurosurgery and reduce fluctuations in staffing within the Neurosurgery Service by adding two 0.5 FTE neurosurgeons and neurosurgery residents through affiliation with a private-sector residency program.

Cardiology and GI service chiefs reported the submission of clinical staffing proposals to increase approved FTEs due to the demand for services greater than the current provider staffing levels.

## **Clinic Space Constraints**

The OIG team was informed that space constraints negatively impacted the efficiency for Cardiology, GI, and Urology services. This lack of efficiency translated into an impediment to processing and accepting consults for care. In February 2016, damage from a flood at the Jamaica Plain campus reduced available space by 40,000 square-feet. Renovations to rehabilitate the affected areas were continuing.

The Chief of GI indicated that the space allotted for GI clinical, administrative, and research activities was reduced by approximately 40 percent at the Jamaica Plain campus. Also, availability of patient examination rooms was impacted due to sharing allotted space with other services, and since the flood, several providers remained without dedicated office space. At the West Roxbury campus, where the Chief of GI estimated that 40 percent of GI procedures were completed, space constraints reduced the efficiency for completing procedures.

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<sup>45</sup> "The U.S. Office of Personnel Management serves as the chief human resources agency and personnel policy manager for the Federal Government." <https://www.opm.gov/>. (The website was accessed on August 28, 2018.)

According to the Chief of Urology, the service's allotted space at the Jamaica Plain campus was divided into two separate areas located on the third and sixth floors within the building. The separation required assigning staff between the two separate areas. Additionally, uroflowmetry testing occurred in a separate location on the fifth floor, reportedly for infection control precautions related to urine exposure that required additional time and staff resources to complete uroflowmetry tests for patients.<sup>46</sup>

The Chief of Urology informed the OIG that the third-floor procedure area was fairly public and privacy complaints were reported by patients regarding the space used for patient consent procedures. The Chief of Urology reported that patient flow was modified to remediate the privacy concerns.<sup>47</sup> The Chief of Urology estimated current plans to unify the Urology service space would take two to three years at the Jamaica Plain campus due to the completion of renovations in progress and relocation of two services from the space to be allocated to Urology. Previous efforts to consolidate Urology services into one location were reportedly unsuccessful.

The Chief of Cardiology discussed the approval and progress of two new patient examination rooms. Space to accommodate rotating providers and dedicated space for research were also identified as concerns.

The COS reported progress on the renovation and relocation of certain clinics and projected that space constraints for affected services would improve within three months to one year. Projected timelines for renovations and clinic relocations provided from the facility's Deputy Director of Engineering Service and Strategic Planner indicated that Urology service would gain additional space on the sixth floor in FY 2019, following relocations by two services that have been housed there since the flood. The projected timeline indicated that GI service would gain additional space at the Jamaica Plain campus in FY 2019 following relocations by two services. GI service was also included on a list of specialty services to benefit from expansion of designated specialty clinic space at the West Roxbury campus in late 2018. Additional renovation and expansion of the Urology service space after FY 2019 was identified as dependent on anticipated funding.

## **Competing Demands and Coordination**

Competing demands for shared clinical resources resulted in consult delays. Some procedures required coordination of multiple clinical resources across services. The OIG team was advised, for example, that GI endoscopy procedures requiring support from Anesthesia service experienced delays due to competing demands for anesthesia personnel at the facility.

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<sup>46</sup> "Uroflowmetry is a test that measures the volume of urine released from the body, the speed with which it is released, and how long the release takes." MedlinePlus, <https://medlineplus.gov/ency/article/003325.htm>. (The website was accessed on August 14, 2018.)

<sup>47</sup> Patient flow refers to patients' movements through the hospital setting during episodes of care and the processes which guide those movements.

Despite Anesthesia service allocating additional timeslots for GI procedures, as of April 2018, the next available appointments for GI consults requiring anesthesia were in August 2018. The Medical Director for the Office of Community Care reported that the facility had processes in place to provide timely care for services and procedures with access issues through non-VA care, such as colonoscopy procedures requiring anesthesia services.

## **Cancellations and No-Shows**

The OIG team found that consults were delayed and remained open because of patient cancellations and “no shows” for scheduled appointments. Of the 51 patients’ EHRs reviewed by OIG medical consultants, 16 indicated consult delays due to patient cancellations or “no shows” with two consult delays due to both. (See Table 1.) VHA policy states that a minimum of two contact attempts, usually one telephone call and a letter, are made in attempting to reschedule patients who “no show” for scheduled appointments.<sup>48</sup> If no response is received within 14 days of mailing the letter, the provider decides if further rescheduling efforts are necessary.<sup>49</sup> The OIG team was informed during interviews that consults may remain open for extended time periods while trying to reengage patients or awaiting determinations to discontinue consults. The facility’s Group Practice Manager stated that 85 percent of consults open for greater than one year were GI endoscopy consults where patients canceled, or “no shows” for scheduled appointments awaiting provider determination to discontinue the consults. The Group Practice Manager stated that the facility had a process in place for reviewing aging consults and alerting services on consults that needed to be addressed.

## **Issue 3: Consult Processing Delays Related to Administrative Factors**

The OIG determined that four specific administrative factors contributed to delays in consult processing. VHA policy sets timeliness standards for consults, specifying that receiving services take action on consults within seven days of receipt and scheduling of an appointment within 30 calendar days or less from the CID for routine consults.<sup>50</sup> VHA policy also requires monitoring of facility consult performance and results.<sup>51</sup>

Consult processing was impacted by the following administrative issues: (a) difficulties contacting patients for scheduling, which delayed making patient appointments; (b) patient scheduling preferences, which could delay care; (c) inconsistent use of future care consults,

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<sup>48</sup> VHA Directive 1232(1); Deputy Under Secretary for Health for Operations and Management Memorandum, *Guidance on Patients Failure to Attend Appointments (No Shows)*, June 25, 2013, established an alternative minimum requirement of three attempted contacts when missed appointments are for mental health and substance use disorders.

<sup>49</sup> VHA Directive 1232(1).

<sup>50</sup> VHA Directive 1230.

<sup>51</sup> VHA Directive 1232(1).

which made timely consults appear delayed on monitoring reports; and (d) consult CID defaults to date of entry, which artificially shortened the window for timely scheduling. While difficulties contacting patients for scheduling and patient scheduling preferences contributed to subsequent delays in care, inconsistent use of future care consults and CID defaults to the date of entry did not cause delays in care. At the time of the inspection, the OIG team confirmed that facility leaders implemented action plans to mitigate the identified administrative issues.

### **Difficulties Contacting Patients for Scheduling**

The OIG team was informed that facility staff encountered “phone tag,” as well as incorrect and inoperable telephone numbers when attempting to contact patients to schedule appointments that caused delays in care.<sup>52</sup> VHA policy prohibits the practice of scheduling appointments without negotiating the date and time with patients. VHA policy also establishes rules for minimum scheduling efforts, which must be made prior to consults being discontinued for nonresponsive patients.<sup>53</sup> VHA Directive 1232(1) specifies that clinical services may decide that additional scheduling efforts are warranted before discontinuation of a consult, and the Group Practice Manager reported that facility policy allows discretion when making further efforts to contact patients before discontinuing consults when patients do not respond to scheduling efforts.

According to the facility’s Group Practice Manager, unscheduled consults remained open until a provider reviewed the clinical request for services and approved discontinuation of unscheduled consults. The Group Practice Manager reported that open consults were reviewed, administrative issues were identified, and reminders were sent to the specialty services regarding closure for open consults.

To facilitate accuracy in VHA databases, facility MSAs review and update patient contact information during appointment check-ins. When patients opt to check-in using an automated kiosk, the user is automatically prompted to review and update contact information.<sup>54</sup> Returned scheduling postcards marked as undeliverable are sent to the facility’s business office, where attempts are made to contact patients by telephone. Facility staff reported these processes for updating contact information reduced difficulties with reaching patients.

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<sup>52</sup> “Phone tag” refers to “telephoning back and forth by parties trying to reach each other without success.” Meriam-Webster, <https://www.merriam-webster.com/dictionary/telephone%20tag>. (The website was accessed on August 9, 2018.)

<sup>53</sup> VHA Directive 1230; VHA Directive 1232(1); Minimum scheduling efforts require two attempted contacts, usually one phone call and one letter, with a minimum of 14 calendar days allowed to receive a response after the letter is mailed.

<sup>54</sup> Kiosks are self-service, touch screen devices that allow veterans to complete certain activities, such as check in for a scheduled appointment, view future appointments, and update personal information. Kiosks are located in VA facilities across the United States.



## Patient Scheduling Preferences

Patient scheduling preferences were one of the reasons consults remained open for extended timeframes. Patients' requests for appointment dates beyond the 30-day timeframe were identified as the reason for consult delays in 3 of the 51 patient EHRs reviewed by OIG medical consultants. While VHA's timeliness standards specify appointments should be scheduled within 30 days of the CID, patients' scheduling preferences are taken into consideration. Patients may prefer to schedule appointments beyond 30 days despite earlier available options. For example, the facility's COS and Group Practice Manager referred to seasonal patients who chose to delay care until returning to the Boston area, resulting in consults that remained open for months.<sup>55</sup> Providers who request consults receive alerts when the subsequent appointment is scheduled. When a patient indicates a preferred date that is significantly different than the CID identified by the provider, scheduling staff alert the provider for clinical review before scheduling an appointment. Requesting providers can communicate concerns about the delays or accept patients' preferences. The Facility Group Practice Manager said this process allowed for clinical review when patients preferred delayed scheduling, which gave consideration to patient preferences. VHA policy also establishes guidance on coordination of care for veterans who require services while traveling outside their VHA facility's geographical area.<sup>56</sup>

## Inconsistent Use of Future Care Consults

The OIG determined that facility staff failed to consistently designate future care consults when the requested CID was greater than 90 days. This failure caused undesignated future care consults to appear delayed on monitoring reports. VHA policy describes future care consults as requests for care in which the CID is more than 90 days from consult initiation.<sup>57</sup> VHA policy also specifies that consults should remain in "pending" status for no more than seven calendar days from the consult creation date.<sup>58</sup> Future care consults are exempt from this requirement, and staff may delay scheduling of a future care consult until closer to the date when the appointment is needed. The OIG team was informed that some services scheduled consults for dates beyond 90 days without the future care consult designation. The failure to assign future care designations for applicable consults across clinical services caused outliers on timeliness reports but did not cause delays in care. Such consults remained open for up to one year. Facility leaders developed an action plan to implement use of future care consults as appropriate for services not already using this designation to improve consistency of future care consults across services. As a

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<sup>55</sup> Seasonal patients are veterans who live in the facility's geographic area for only part of the year.

<sup>56</sup> VHA Handbook 1101.11(3), *Coordinated Care for Traveling Veterans*, April 22, 2015.

<sup>57</sup> VHA Directive 1232(1).

<sup>58</sup> "Pending" status designates consults which have been sent but not yet acted on by the receiving service; VHA Directive 1232(1).

performance improvement measure, the Chief of GI reported that elective screening and surveillance GI procedures were transitioned to future care consults.

### **Consult CID Defaults to Date of Entry**

The OIG team determined that if requesting providers do not manually specify CIDs when ordering consults, the software selects the date the consults are ordered as the default CID. For consults in which the CID defaults to the date of consult entry, the clock starts immediately on measures of timeliness and wait times. The requesting provider is responsible for completing the consult order, including manual entry of the CID.<sup>59</sup>

During interviews with the OIG team, supervisory MSAs reported receipt of consults in which the CID had defaulted to the date the consult was ordered as a common occurrence. Providers' scheduling education was provided via email distributions on multiple dates from June 2015 through August 2017. Supervisory MSAs noted that provider education was an ongoing improvement effort.

### **Issue 4: Non-VA Care**

Patients were referred to non-VA care when services at the facility were not available within 30 days of the CID. Consult data reviewed from October 2016 through December 2017 showed that two percent of the facility's clinical consults were referred to non-VA care. The COS reported that patients' preferences were for VHA services regardless of delays.

VHA policy sets timeliness standards for consults and provides for referral of patients to non-VA care when VA facilities cannot provide care in a timely manner.<sup>60</sup> The facility director is responsible for ensuring non-VA care is utilized in accordance with VHA Directive 1232(1). The Medical Director for Office of Community Care told the OIG that services not offered at the facility, such as chiropractic care and acupuncture, are referred directly to non-VA care.

### **Issue 5: Facility Leaders' Responses to Consult Processing Delays**

The OIG verified that facility leaders monitored consult timeliness and implemented action plans in response to consult delays. The OIG determined that facility leaders and managers

- Monitored and analyzed consult data and communicated with service leaders about identified concerns,
- Implemented clinical processes for performance improvement and monitored the results, and

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<sup>59</sup> VHA Directive 1232(1).

<sup>60</sup> VHA Directive 1230; VHA Directive 1232(1).

- Implemented administrative processes for performance improvement and monitored the results.

Based on facility leaders and staff interviews, a review of consult data and committee meeting minutes, and action plans implemented for performance improvement, the OIG team determined that facility leaders were knowledgeable about the facility's performance in meeting VA consult standards, monitoring consult timeliness, identifying challenges related to access, implementing informed action plans in response to identified problems, and assessing the results of actions implemented. Monitoring and quality improvement processes contributed to the facility's performance in the top 20 percent of VA facilities on SAIL model access measures.

VHA policy specifies the facility director is responsible for “[o]versight of the facility consult policy, processes and outcomes[,]” including “[r]egular monitoring and improvement of facility consult performance” and “[a]llocating sufficient resources to enable management of consults and timely delivery of care.”<sup>61</sup> VHA policy specifies the facility COS is responsible for “[r]egularly reviewing and improving facility consult performance” and “application of corrective measures as needed to address consult quality outcomes.”<sup>62</sup>

## **Monitoring, Communication, and Action Plans**

The OIG team determined that the facility has processes in place for monitoring consult data, communicating access and consult management issues, and developing action plans to address concerns.

Facility leaders reviewed reports regarding open consults weekly and provided feedback to service leaders. The Group Practice Manager reported that services provided monthly reports regarding patient appointments scheduled greater than 30 days from the CID, which were shared with the VISN. The COS reported the facility also implemented “secret shopper” calls to primary care and mental health services to monitor availability and provision of same-day access when needed.

The COS advised that the facility authorized FTEs for a Group Practice Manager and three associate Group Practice Managers, who were organizationally aligned under the COS office. Based on interviews, the OIG team learned that the Group Practice Manager spearheaded monitoring of consult and access data across the facility's sites, communicated with facility leaders and services about access and consult management issues weekly, and served as a resource for service leaders and staff in identifying problems, analyzing data, and formulating performance improvement plans.

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<sup>61</sup> VHA Directive 1232(1).

<sup>62</sup> VHA Directive 1232(1).

Facility leaders used data to identify timeliness concerns in scheduling appointments and examined contributing factors to develop performance improvement plans that were implemented prior to the OIG review. The Group Practice Manager generated reports for services with access to care issues. The COS and the Group Practice Manager assisted service chiefs in identifying factors negatively impacting timelines and assisted service chiefs in developing action plans. Service chiefs monitored results and developed reports showing the results of the implemented plans. When warranted, action plans were revised to achieve the desired results.

## **Clinical Process Improvements**

Facility leaders implemented clinical process improvements for consult processing and timeliness. OIG interviews with facility staff identified clinical process improvements including (a) implementation of nurse clinics to assist specialty services, (b) use of consults for a primary care common pathway, (c) implementation of Advanced Access Clinics to assist with primary care workload, and (d) management of inter-facility consults.<sup>63</sup>

### *Nurse Clinics Assisting Specialty Care*

Facility leaders implemented nurse clinics in specialty services to improve efficiency by providing patient care services that did not require specialty providers. Implementation began in May 2017 with Podiatry service. Nurse clinics assisted with toenail debridement or cutting, which preserved Podiatry provider appointments for patients who required specialty care. Nurse clinics were also implemented to provide dressing changes for Vascular, suture removal for Dermatology, and catheter changes for Urology services. Nurse clinics also provided testosterone and estrogen injections for the Endocrine service, and managed infusions for Rheumatology, GI, Endocrine, and Hematology/Oncology services. Provision of these aspects of care by the nurses allowed specialty providers' appointment times to be reserved for those aspects of patient care that required a specialty provider. The Associate Chief Nurse for Specialty and Outpatient Clinics reported the facility recently added a nursing assistant for support in GI service and plans to expand nurse clinics to support the Cardiology service.

### *Consults for Primary Care Common Pathway*

In 2016, primary care service implemented an improvement process to streamline referrals and tracking of access timeliness by using consults as a common pathway for initiating primary care services. Under this process, primary care consults may be placed from any point of contact at the facility, such as the eligibility office when a patient is enrolling for VA services. The primary care business manager or lead MSA assigns patients to primary care providers and contacts

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<sup>63</sup> Common pathway refers to a single route by which referrals are made to primary care; Advanced Access Clinics provide patients with certain problem-specific evaluations without requiring a primary care appointment.

patients to schedule appointments. When urgent needs are identified in a consult, referrals are triaged by nursing support staff. Referral to primary care through one common pathway reduced variability and handoffs in the process of routing new patients to establish care and ensured that all new primary care referrals are monitored for timeliness via established consult processes.

### *Advanced Access Clinics to Assist with Workload*

The facility's Medical Director for Accelerated Access reported implementation of Advanced Access Clinics to augment primary care access, which began in August 2013. These clinics were designed to evaluate patients for problem-specific issues without requiring patients to be seen in primary care. Services handled through Advanced Access Clinics included initial prerequisite physical examinations for patients seeking specialty consults, physicals requested to meet school or work requirements, and vaccinations. Management of these aspects of care through the Advanced Access Clinics reduced demand on primary care provider appointments for such services, which in turn supported primary care access.

### *Management of Inter-Facility Consults*

The facility receives inter-facility consults to provide specialty care services for patients from other facilities in VISN 1.<sup>64</sup> The OIG team learned from facility and VISN interviews that the facility developed a dashboard, which was accessible to all facilities in the VISN, to help provide updated information on access to care. The dashboard allowed referring sites to view average wait times for clinical services at the facility and advise patients of anticipated wait times if referred. The dashboard was updated daily and presented a rolling average from the previous 30 days.

The COS and Group Practice Manager reported inter-facility consults were put on hold when access challenges were identified for a service. Temporary suspension of inter-facility consults preserved available appointments for patients in the facility's local catchment area. Patients who would have been referred through inter-facility consults were routed to non-VA care. The facility's Office of Community Care implemented a process improvement to avoid delays or disruptions for affected patients by having facility staff coordinate directly with referring sites to facilitate the transfer of consults to non-VA care. The facility's Medical Director for the Office of Community Care identified plans to further smooth this process by developing financial agreements with referring facilities that allowed the facility to manage coordination of non-VA care referrals for inter-facility consults.

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<sup>64</sup> An inter-facility consult is a request for services made on behalf of a patient between different VHA facilities.

## **Administrative Process Improvements**

The OIG team was informed through interviews that facility leaders implemented administrative process improvements for consult management and timeliness that included (a) direct scheduling of specialty clinic referrals, (b) hiring and onboarding processes for MSAs, and (c) updating clinic profiles.

### *Direct Scheduling of Specialty Clinic Referrals*

The Director of Primary and Ambulatory Care informed the OIG team that implementation of direct scheduling from primary care to specialty services began in 2016. The Director of Primary and Ambulatory Care reported primary care had processes for direct scheduling with Audiology, Geriatric, Nutrition, Optometry, Pharmacy, and Podiatry services. These processes allowed primary care to schedule specialty care appointments for patients at the time of the referral, eliminating additional steps to contact patients for scheduling. Direct scheduling also reduced delays caused by difficulties contacting patients for scheduling. The facility's Director of Primary and Ambulatory Care reported plans to expand direct scheduling from primary care to the Cardiology and Rheumatology services.

### *Hiring and Onboarding Processes for MSAs*

Facility leaders implemented VHA's *Hire Right, Hire Fast* initiative in 2016 to improve the speed of onboarding MSAs who managed scheduling for services across the facility.<sup>65</sup> The COS described reviewing the steps of the hiring process and identifying inefficiencies that contributed to delays in onboarding of new MSAs. Process changes targeting identified inefficiencies included screening resumes for qualifications to narrow interview lists and completing reference checks prior to candidate selections. Despite process improvements, continuing challenges with maintaining MSA staffing were reported including turnover due to MSAs seeking higher paying positions or better suited geographic locations and recruitment of well-qualified candidates.

### *Updating Clinic Profiles*

The facility's primary care clinic profiles were reviewed and updated in 2017 to ensure that providers' appointment schedules accurately reflected actual provider availability.<sup>66</sup> The Director of Primary and Ambulatory Care reported that primary care underwent a review of local Patient

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<sup>65</sup> VHA's *Hire Right, Hire Fast* initiative provided guidance on processes for improving the efficiency and effectiveness of facilities' hiring processes, with an identified goal of onboarding qualified MSAs within 30 days of positions becoming vacant.

<sup>66</sup> Clinic profile refers to customized parameters in VA's scheduling software that defines an outpatient clinic. These parameters include the provider, location, start and end times for the clinic, and frequency and length of appointments.

Centered Management Module data.<sup>67</sup> Analysis of the data prompted review of primary care staffing and clinic space to align resources with demand. The facility director is responsible for ensuring “[a]nnual review of all clinic profiles for accuracy, necessity and appropriate utilization.”<sup>68</sup> The updating of clinic profiles allows for improved accuracy in scheduling and monitoring of provider availability. Data on clinic utilization was impacted by the accuracy of clinic profiles, and facility leaders considered utilization data when determining if a service had sufficient staff resources to meet patient care demands.

## VISN Oversight

The VISN Quality Management Officer stated that the VISN provides oversight for tracking access, managing consults, and other performance measures for the facility. According to VHA, the VISN Director has “[o]verall responsibility to regularly review and apply corrective measures to address VISN data on consult quality outcomes” and “[i]mplementation of standardized processes for consult management and reporting across the VISN.”<sup>69</sup> The VISN Compliance and Business Integrity Officer is responsible for “[e]nsuring consistency in consult management auditing and monitoring practices at each facility within the VISN.”<sup>70</sup>

VISN leaders conducted monthly management meetings to review access and consult processing concerns, as well as performance data with facility leaders. Facility Group Practice Managers provided monthly reports on access and consult processing to the VISN-level Group Practice Manager, who tracked facility action plans related to access.

The VISN Quality Management Officer identified provider recruitment and retention as challenges across the VISN and identified timeframes for consult management and access as national priorities. The VISN Quality Management Officer informed the OIG team that, based on the number of consults the facility processes, the facility was performing well with consult processing.

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<sup>67</sup> The Patient Centered Management Module, formerly known as the Primary Care Management Module, is a software application used to set up health care teams, assign staff and associated FTEs to positions within teams, assign patients to teams, and assign patients to specific team members. VHA Directive 1406, *Patient Centered Management Module (PCMM) For Primary Care*, June 20, 2017.

<sup>68</sup> VHA Directive 1230.

<sup>69</sup> VHA Directive 1232(1).

<sup>70</sup> VHA Directive 1232(1).

## Conclusion

Although the OIG identified some deficiencies in consult processing and timeliness in some services, facility leaders had consult policies and processes in place. The OIG team's review did not find occurrences of adverse clinical outcomes related to delays caused by consult wait times. The OIG also determined that facility staff used non-VA care to ensure timely appointments, yet patients sometimes preferred to wait for VA care rather than take an appointment sooner with a non-VA provider.

Clinical and administrative issues contributed to delays in consult processing. Facility and service leaders implemented action plans to mitigate the impact of the identified causes for delays and reported plans for continuing improvement efforts.

The OIG determined that facility leaders monitored consult timeliness and implemented action plans in response to consult delays. Facility leaders were knowledgeable about the facility's performance in meeting VA consult standards, monitoring consult timeliness, identifying challenges related to access, implementing informed action plans in response to identified problems, and assessing the results of actions implemented. The VISN Quality Management Officer informed the OIG team that, based on the number of consults the facility processes, the facility was performing well with consult processing.

Based on interviews, review of facility committee minutes, and facility leaders' action plans, the OIG team concluded that facility leaders were actively engaged and had performance improvement and consult management processes in place. Therefore, the OIG made no recommendations.



## Appendix A: VISN Director Comments

### Department of Veterans Affairs Memorandum

Date: March 7, 2019

From: Director, VA New England Healthcare System (10N1)

Subj: Healthcare Inspection—Review of Delays in Clinical Consult Processing at VA Boston Healthcare System, Massachusetts

To: Director, Office of Healthcare Inspection (54CH02)

Director, Management Review Service (VHA 10EG GOAL Action)

1. I have reviewed the draft report and concur with the Office of Inspector General's (OIG) review of the allegations related to delays in clinical consult processing at VA Boston Healthcare System, Massachusetts.
2. Additionally, I concur with the Medical Center Director's response including the ongoing oversight and process improvements.

Respectfully submitted,

*(Original signed by:)*

Ryan S. Lilly, MPA

Director

VA New England Healthcare System

## Appendix B: Facility Director Comments

### Department of Veterans Affairs Memorandum

Date: February 20, 2019

From: Director, VA Boston Healthcare System (523/00)

Subj: Healthcare Inspection—Review of Delays in Clinical Consult Processing at VA Boston Healthcare System, Massachusetts

To: Director, VA New England Healthcare System (10N1)

1. We have conducted a thorough review of the draft report of Review of Delays in Clinical Consult Processing at VA Boston Healthcare System. OIG conducted an inspection to assess the merit of allegations to review delays in clinical consult processing and subsequently made no recommendations.
2. I concur with the report and the concerns identified. While there were no findings I take this opportunity to share some of the improvements that were in progress at the time of the review.

Process improvements related to “Cancellations and No Shows” significantly reduced the percent of consults open >365 days due to GI/Endoscopy consults that were awaiting provider review from 85% to 7%.

Process improvements regarding insufficient documentation in PATS data have been addressed by the Patient Experience Officer and included: development of an auditing tool, development of SOP to monitor and improve PATS documentation and monthly discussions with staff.

Respectfully submitted,

*(Original signed by:)*

Vincent Ng

Medical Center Director

VA Boston Healthcare System

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Director, VA Boston Healthcare System (523/00)

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