Department of Veterans Affairs
Office of Inspector General

Healthcare Inspections
Inadequate Coordination of Care
Orlando VA Medical Center
Orlando, Florida

Report No. 10-00219-180 **June 24, 2010**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) reviewed allegations of delay of medical care and inadequate care management for Fee Basis Service (FB), Interfacility Consults (IFC), and Project Health Effectiveness through Resource Optimization (HERO) at the Orlando VA Medical Center (OVAMC), in Orlando, Florida. The purpose of this inspection was to determine whether the allegations had merit.

The complainant alleged that: OVAMC lacks an adequate care management system to coordinate care between VA providers and FB providers; majority of patients receiving FB referrals did not receive an authorization letter, did not understand the letter or could not find a doctor willing to see them; OVAMC has not established a system to ensure timeliness of care for veterans requiring IFCs and Project HERO is not meeting its contractual obligations for timely referrals and communication with FB providers.

We substantiated the allegation that OVAMC lacks an adequate care management system to coordinate care between VA providers and FB providers which led to delays in care, but found no evidence that patients were harmed. FB was a new function that transferred to OVAMC in October 2009. We found that there were gaps in the communication and coordination of care as evidenced by our interviews and review of medical records for four patients identified by the complainant. We noted numerous communication breakdowns that included: missing FB results, delays of up to 120 days for scanning of consult records, and missing progress notes in the medical record on consult results or status. We found instances that medical care was affected or delayed due to communication breakdowns: a patient had to undergo a second biopsy because the original FB pathology results could not be located; a patient arranged for care at another VA outside of his geographic region due to FB delays; and delays in finding FB services in the community.

We substantiated the allegation that patients experienced difficulties with either understanding the authorization letter or finding FB providers in the community. We did not find evidence that patients had not received an authorization letter. The FB authorization letters provided little guidance for locating a FB provider and there was no follow up by FB staff to determine why consults were not being performed. We noted a large backlog of open FB consults.

We substantiated the allegation that OVAMC has not established a system to ensure timeliness of care for veterans requiring IFCs. OVAMC reported referral difficulties to the James A. Haley Veterans Hospital (JAHVH) after the October 2009 transition that led to IFC backlogs. IFC reports documented a reduction in availability of IFC consults at JAHVH by approximately 67% for orthopedics and ophthalmology.

We substantiated the allegation that Project HERO was not meeting its contractual obligations for timely referrals and communication with FB providers. Project HERO performance benchmarks indicated contractual compliance levels for access to care and clinical return of medical records exceeded 90% but was below the 100% standard set in the contract.

We recommended that the Veterans Integrated Service Network (VISN) Director ensure that OVAMC Director implement systems that allow FB and IFC consults to be completed and tracked through VistA within time frames established by VHA policy and that patient's electronic medical records be updated accurately and timely to the ordering provider. Both the VISN and OVAMC Directors concurred with the recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Sunshine Healthcare Network (10N8)

SUBJECT: Healthcare Inspection–Inadequate Coordination of Care, Orlando VA Medical Center, Orlando, Florida

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) reviewed allegations that medical care was delayed when obtained through Fee Basis Service (FB), Interfacility Consults (IFC), and Project Health Effectiveness through Resource Optimization (HERO) at the Orlando VA Medical Center (OVAMC), Orlando, Florida. The purpose of the review was to determine whether the allegations had merit.

Background

OVAMC, part of the VA Sunshine Healthcare Network, is located in Orlando, Florida. OVAMC provides outpatient services and includes a community living center, residential rehabilitation program, and six outpatient clinics throughout six counties in East Central Florida. A new hospital with acute inpatient services is scheduled to open in 2012.

OVAMC was a component of the James A. Haley Veterans Hospital (JAHVH), Tampa, Florida, until October 1, 2007. For two years OVAMC continued to rely on the clinical service packages[1] associated with JAHVH's Veterans Health Information System and Technology Architecture (VistA) system while national and local support teams worked to develop and test a new VistA system for OVAMC. On October 1, 2009, the new VistA system was activated and OVAMC assumed primary responsibility for processing consults and FB requests for care. Prior to that time, all inter-facility consults and requests for FB care originating at OVAMC were processed through JAHVH.

According to Veterans Health Administration (VHA) consult policy,[2] if a service cannot be provided in a timely manner by VHA due to capability, capacity, or accessibility, the service may be provided outside of the VA. Additionally, VHA[3] takes responsibility for providing seamless coordination of its patients' care within the VA as well as with

[1] Clinical service software packages include HealtheVet, Computerized Patient Record System, and more.
[2] VHA Directive 2008-056 VHA Consult Policy, September 16, 2008.
[3] VHA Directive 2006-041 Veterans Healthcare Service Standards, June 27, 2006.

non-VA health care providers. OVAMC is an outpatient provider with limited specialty medical care and no inpatient or acute care services. Because of this, OVAMC has an increased reliance on other VA facilities and FB care, which presents an increased challenge for overall coordination of care. All FB requests are reviewed and, upon approval, authorization is granted for care to be completed outside of OVAMC. The FB staff determines if a veteran is referred to Project HERO[4] or to a FB provider in the community. If Project HERO is not selected, an authorization letter is sent to inform the veteran that FB care has been approved, and further instructs them to find a healthcare provider in the community to perform FB care.

A complainant contacted the OIG hotline on October 16, 2009, with multiple allegations regarding FB and IFC referrals. Specifically, the allegations were:

- OVAMC lacks an adequate care management system to coordinate care between VA providers and FB providers, and primary care providers are not notified of patient visits with a FB provider or about the outcome of visits within a reasonable period of time.

- In the majority of FB referrals, patients never saw the FB provider because they never received a letter approving a FB consult, did not know what to do with the letter if they got one, or they could not find a doctor who would take FB patients.

- OVAMC has not established a system to ensure timeliness of care for veterans requiring IFCs.

- Project HERO is not meeting its contractual obligations for timely referrals and communication with primary care providers (PCPs).

Scope and Methodology

We reviewed information provided by the complainant, the electronic medical record (EMR), VHA policies and procedures, and other pertinent documents. We also compared the number and processing of FB consults at OVAMC with other comparable outpatient VA medical centers. We reviewed FB consults and the associated EMRs for evidence of care provided. We conducted a site visit during the week of January 11, 2010, and interviewed primary care providers, FB staff, and other key staff.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[4] Project HERO is a pilot program that is an alternative to FB and helps veterans get the medical care they need when it is not readily available at their local VA medical center.

Case Summaries

The complainant cited specific cases involving delays in the authorization of FB care, difficulty in obtaining medical records or test results from outside OVAMC and delays in completing IFCs. Also reported were problems with incorporation of consult documents into the EMR, and a lack of communication between the requesting providers, FB staff, and other VA medical centers.

Patient 1

The patient's PCP requested a Computed Tomography-guided biopsy[5] of a mass in the patient's liver. The request for this procedure to be performed outside OVAMC was approved by FB the next day. The date and location of the procedure was not entered on the FB consult, but addendums to the consult state that results were scanned into the EMR two months later. The patient's PCP entered a consult to General Surgery at JAHVH for further evaluation. Progress notes in the EMR indicate that OVAMC had difficulty obtaining records from the FB provider and that the patient had to obtain pathology slides from the private hospital where the biopsy was done to take to his appointment at JAHVH.

Patient 2

The patient's PCP entered a consult into the EMR for FB care to arrange for a biopsy of a lesion in the patient's throat by an Ear, Nose, and Throat (ENT) specialist. FB authorized the consult three days later. The EMR PCP progress notes indicate that the patient had been seen and that a lesion in his throat was biopsied. According to the progress notes, the patient's PCP arranged for pathology slides to be sent from the FB provider to JAHVH. However, when the patient was evaluated by a JAHVH ENT physician, the pathology slides were not available and the patient underwent re-biopsy of the lesion.

Patient 3

The patient's PCP requested an anal manometry test through FB. The request was approved and forwarded to Project HERO for scheduling two weeks later. No further FB entries were made for five months, when FB completed the consult and sent documents to be scanned into the EMR. The completed consult did not indicate when or where the patient was seen, or that the requesting provider was notified that documentation of care had been received and sent to be scanned into the EMR. The patient's PCP entered a second FB consult for follow-up on the test results. This consult also requested that complete test results from the initial consult be scanned into the EMR. FB approved

[5] Computed tomography (CT) is a radiologic procedure using a scanner to examine a body site by taking a series of cross-sectional images one slice at a time in full-circle rotation; a computer synthesizes x-ray transmission data from many different directions to generate an image. Biopsy is the process of removing tissue from the body for diagnostic examination.

further evaluation and treatment, to include surgery, through Project HERO. Two months after the second consult, the patient's PCP contacted FB to inform them that Project HERO had not yet contacted the patient for further evaluation or scheduling of the requested surgery. The patient's provider received a letter seven months later from a FB physician. The letter stated that no surgical follow-up was needed, and further recommendations for care were made. The consult remains open and contains no further information or results.

Patient 4

The patient's PCP requested an evaluation by Orthopedic Service at OVAMC. Orthopedic Service forwarded the request to FB five days later. The PCP was not notified that Orthopedic Service at OVAMC would not be seeing the patient. Approval for the FB consult was completed one week after the original PCP request. FB documentation does not indicate when or where the patient was seen after approval was given, but the EMR progress notes reflect that the patient and his PCP repeatedly tried to get approval from FB for further follow-up and surgery over the next 3 months. Three further follow-up visits were approved five months after the original request. The patient requested his surgery be at the Ralph H. Johnson VA Medical Center, Charleston, SC. Attempts by the PCP to arrange this were unsuccessful. The patient went to the Mountain Home, TN VA Medical Center (MHVAMC) on his own, had an appointment with a PCP seven months after the original request, and was referred to Orthopedic Service. He was seen by MHVAMC Orthopedic Service 30 days after the referral.

A month later, the EMR indicates that the patient returned to OVAMC and was seen by his PCP. At that time, the patient requested a FB referral back to a local orthopedic surgeon because he was no longer able to drive to MHVAMC. The EMR further reflects that the orthopedic surgeon he previously saw through FB would no longer see VA patients due to lack of payment. The patient was advised by his PCP to go to another orthopedic surgeon. A month later, the EMR indicates that another orthopedic surgeon saw the patient, and the patient's PCP and FB attempted to assist the patient in getting appropriate records to and from this orthopedic surgeon so further treatment could be authorized and scheduled. The patient was subsequently seen and treated by a FB surgeon, and the consult was completed within the month. Additional progress notes reflect that the patient had surgical repair of the right shoulder performed the following month.

Interfacility Consults (IFC)

VHA policy[6] states that a clear and solid consultation process is vital to patient care. In order for the consultation process to be effective, relationships need to be established between sending and receiving services (or between facilities) with defined work flow

[6] VHA Directive 2008-056 VHA Consult Policy September 16, 2008.

rules and clear processes. Typically, medical centers establish service agreements between facilities for better coordination for the scheduling of appointments and patient care. If a patient requires medical care that cannot be provided by OVAMC, an IFC should be requested, if availability exists.

OVAMC had two Memorandum of Understanding (MOU) agreements in place with JAHVH and North Florida South Georgia Veteran Health System (NFSG). MOU agreements clarify responsibilities of the sending and receiving facilities. The MOU with JAHVH dated September 25, 2008, addressed administrative responsibilities during the transition time when OVAMC shared the VistA system with JAHVH. The MOU was to be reviewed annually but had not been updated since 2008. Prior to the transition on October 1, 2009, OVAMC PCPs referred patients for care through an internal consult system. After the transition, a process for IFC's was put in place. The IFC has a lower priority and requires more coordination to get patient scheduling done.

Immediately after the transition of the VistA system, OVAMC experienced referral difficulties at JAHVH, which required OVAMC to find alternative sources of medical care at other VA medical centers or through FB. In some specialties such as orthopedics and ophthalmology, availability of appointments at JAHVH decreased to less than a third of previous levels. OVAMC identified that more sources for inpatient and specialty medical care needed to be located. OVAMC assigned a process improvement team to address some of the IFC delays and coordination issues. This resulted in the implementation of a Care Management Team in December 2009 to improve coordination and tracking.

Fee Basis (FB)

Prior to October 1, 2009, all FB referrals were processed by JAHVH FB staff. During the transition period from JAHVH VistA system 673 to OVAMC VistA system 675, dual system access was available so PCPs could easily track FB consult activities. Consults that were not closed on 673 were migrated over to the 675 system, causing a large backlog of open consults. On March 31, 2010, six months after system transition, the number of open consults pending resolution totaled over 7,700. Over 4,000 of these were FB consults forwarded from the JAHVH VistA system. We note that the facilty is working on a process to administratively close these consults.

When a patient is approved for FB care, the FB staff sends the patient an authorization letter. These letters described the procedure or service authorized, but did not provide guidance or a suggested provider list. Furthermore, the patient had the responsibility to find a provider and to ensure that medical records from the consult were sent to the OVAMC.

We did not find evidence that authorization letters were not received by the veterans, however, the large number of open FB consults reflects that follow-up coordination is required, and that the current process is difficult for the patients to comply with.

VHA policy[7] requires that patients should be seen for routine appointments within 30 days and that overall coordination of patient care is the responsibility of the VA regardless if the care is provided by a non-VA provider. We found that OVAMC was not tracking and following up with patients to ensure that they were seen or that medical records from providers outside the VA were received and scanned into the patient's EMR. We reviewed FB referrals[8] that required specialty care by a physician during November 2009 and January 2010 showed that 54 (30 percent) of 180 EMRs reviewed did not reflect that the patients had received the requested FB care.

Project HERO

Humana Veterans Health Services (HVHS) is the provider of medical care for Project HERO. OVAMC utilizes Project HERO for specialized FB services including, allergy, immunology, neurology, orthopedics and audiology services.

We reviewed HVHS performance reports and the contractually required performance metrics in the Quality Assessment and Surveillance Plan (QASP). QASP defines the HVHS quality control process designed to measure performance against contract requirements. The performance metrics measured include patient safety/satisfaction, quality of care, access to care, appointment scheduling, clinical information return, and other measures. HVHS maintains a database to monitor patient consult data from referral date to return of clinical information. This data is used to report compliance with performance metrics to the VA's Project HERO program management office and to the OVAMC. HVHS. Performance results were available through December 31, 2009, and were measured against contractual acceptable quality levels (AQL) including the following:

- Appointment Scheduling - AQL- 85 percent of appointments for routine care must be scheduled within 5 working days of receipt of the authorization.
- Access to Care - AQL- 100 percent of patient appointments for specialty and diagnostic services must be scheduled within 30 days of receipt of referral or authorization by the provider.
- Clinical Information Return - AQL- 100 percent of routine care and diagnostic testing and inpatient care must be returned within 30 days of the episode of care, patient discharge or referral.

[7] VHA Directive 2006-041 Veterans Healthcare Service Standards, June 27, 2006.
[8] We did not include routine tests or services like a MRI or Dialysis, but those that required a physician's care and included oncology, CT-guided biopsies, surgeries.

HVHS performance metrics for the months of October through December 2009 are reported below in Table 1. HVHS reported appointment scheduling exceeding AQL, but did not meet the AQL of 100% compliance for access to care or clinical return of medical records.

Table 1: Selected HVHS Performance Metrics

Performance Metrics (reported in percentages)	October	November	December
Appointment Scheduling	92	90	96
Access to Care	94	88	89
Clinical Return of Medical Records	85	95	92

We reviewed a random sample of 20 neurology and oncology consults from a population of 207 Project HERO consults from November and December 2009, to compare the date OVAMC scanned the Project HERO medical records into the patient's EMR with the HVHS appointment date. Table 2 below shows the results of our review, with 17 (85 percent) of 20 medical records scanned into EMRs 30 or more days past the appointment date. Project Hero would monitor that records were sent within days of the appointment so Table 2 reflects OVAMC delays in scanning the medical records .

Table 2: Length of Time beween Appointment Date and OVAMC Scan Date of Medical Records

Length of Time between Appointment Date and OVAMC Scan Date of Medical Records (reported in days)	Number of Medical Records Scanned into EMR
0-29	3
30-59	4
60-89	6
90 -119	5
120 and over	2
Total	20

Inspection Results

Issue 1: Lack of an Adequate Care Management System

We substantiated the allegation that OVAMC lacks an adequate care management system to coordinate care between VA providers and FB providers. We found breakdowns in coordination and communication that delayed care; however, we did not find evidence that patients were harmed.

Issue 2: Lack of communication between Veterans and Fee Basis Staff

We did find evidence to substantiate the allegation that veterans did not know what to do with the letter if they received one or could not find a doctor who would accept FB patients. The lack of FB providers in certain specialties was identified by the FB staff during our interviews as an issue during the first few months that OVAMC started FB referrals. The FB staff have been developing a provider list to give to veterans. We found that the authorization letters provided limited specific guidance and could be made more veteran friendly. laAdditionally, we found that that FB staff had not been tracking or following up for FB patients to determine why the consults were not being performed or medical records not received. The large number of open FB consults was a concern that indicates that there is a problem that needs to be addressed.

We did not substantiate the allegation that for the majority of FB referrals the patient never saw the FB provider because they never received a letter approving a FB consult. We inquired about complaints from veterans regarding the FB process and did not find evidence to support that authorization letters were not received.

Issue 3: Lack of Communication Between FB and Primary Care Providers

We did substantiate the allegation that there was a lack of communication between the FB staff and the PCPs. We did not find evidence that PCPs were not routinely notified of FB activities. There was no follow up or tracking of FB consults by FB staff to let the PCP know the status of the patient's FB care. Notations in the EMR and alerts to inform the PCP that a patient was seen were found to be sporadic and inconsistent. We found that once received there were delays in scanning the consult results into the EMR. PCPs needed to make calls to determine the status of the patient or track down the results of the test or procedure.

Issue 4: Lack of Timeliness of Care for Inter-Facility Consults

We did substantiate the allegation that OVAMC had not established a system to ensure timeliness of care for veterans requiring IFCs. After the VistA transition to OVAMC 675 the availability of care at JAHVH was significantly reduced. OVAMC had to find alternative sources of care within the VA, or refer the consult to FB, which resulted in delays scheduling appointments. In December 2009, OVAMC incorporated a care management team to coordinate and manage IFCs, which improved timeliness.

Issue 5: Project HERO Contractual Obligations Issues

We did substantiate the allegations that Project HERO was not meeting its contractual obligations for timely referrals and communication with FB providers. Overall we felt that Project HERO was providing a much needed service to our veterans. Project HERO

had access to care and return of medical records rates that averaged over 90 percent, but did not meet the stated contract requirement of 100 percent.

Conclusions

There were a number of factors identified as contributing to breakdowns in coordination of patient care. The transition from the JAHVH 673 to OVAMC 675 VistA system was a significant undertaking that required a great deal of planning and coordination to minimize the impact on patient care. We did not find evidence that the VistA system did not perform, but found that OVAMC's internal processes were not adequate to meet the increased demand for IFCs and FB medical care.

In addition to the software transition the following factors were identified as contributing to the delay of care:

- Internal consults with JAHVH now required an IFC, requiring additional coordination.
- Reduced availability of surgery and specialty medical care at JAHVH.
- The FB administrative functions transitioned to OVAMC from JAHVH.
- An increase in the amount and reliance on FB at OVAMC.
- The large number of open consults that were duplicative or out of date in part due to the software transition.
- The service agreements (MOU) to facilitate the coordination of patient care with other facilities in the VA were outdated or not in place.
- Local policies providing guidance to staff for FB care and IFC were not in place.
- The FB staff had not developed a list of FB providers to help veterans more easily find providers in the community.
- A lack of an internal process for FB consults to let PCPs know the veteran had an appointment or was being seen on a timely basis.
- Medical records were not scanned into the patient's EMR on a consistant or timely basis.

We noted discrepancies in how medical records and test results were scanned into the EMR. In one case, scanned records were duplicated, and in all cases, there were inconsistencies in whether the scanned documents were entered by the date of entry or the actual date of service. Significant delays were also noted between the date the patient was seen by a healthcare provider and the date records were scanned in the EMR.

We found that many of these issues had been identified by OVAMC at the time of our site visit, and were in the process of being addressed. OVAMC has been making significant changes with IFC and FB processes and was bringing new staff on board to meet those needs. In the cases that we reviewed we found that the perserverance and dedication of the PCPs helped ensure that the veterans received the needed medical care.

Recommendations

Recommendation 1.

We recommend that the VISN Director ensure that the OVAMC Director requires that FB and IFC consults be completed within the time frames established by VHA policy and tracked to completion through the VistA and CPRS systems.

Recommendation 2.

We recommend that the VISN Director ensure that the OVAMC Director requires that the patient's EMR accurately reflect consult activity and results, and these be communicated to the ordering provider in a timely fashion.

Comments

The VISN Director and Medical Center Director comments and implementation plans are responsive to the recommendations. See pages 11-14 for the full text of their comments.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 10, 2010

From: Director, VA Sunshine Healthcare Network (10N8)

Subject: **Healthcare Inspection – Inadequate Coordination of Care Orlando VA Medical Center, Orlando, Florida**

To: Assistant Inspector General for Healthcare Inspections (54)

I concur with both recommendations made by the OIG

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the OVAMC Director requires that FB and IFC consults be completed within the time frames established by VHA policy and tracked to completion through the VistA and CPRS systems.

Concur/~~Do Not Concur~~

Recommendation 2. We recommend that the VISN Director ensure that the OVAMC Director requires that the patient's EMR accurately reflect consult activity and results, and these be communicated to the ordering provider in a timely fashion.

Concur/~~Do Not Concur~~

Nevin M. Weaver

Nevin M. Weaver, FACHE
Network Director, VISN 8

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 3, 2010

From: Director, Orlando VA Medical Center (675)

Subject: **Inadequate Cordination of Care, Orlando VAMC, Orlando, Florida**

To: Director, VA Sunshine Healthcare Network (10N8)

We concur with both recommendations made by the OIG. Since the inception of the Care Management Center in September 2009, inter-facility consults have been tracked through the process until completion. The process begins at the point the consult has been entered and completes when the inter-facility has scheduled the patient. The monitoring includes tracking how many consults are scheduled for fee service. The tracking is done daily, weekly, monthly and quarterly to assure timelines are met per VHA Policies

I appreciate the recognition and validation the OIG made regarding the steps that we had implemented prior to their review and we will assure that we continue to follow through with those identified actions.

Timothy W. Liezert

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the OVAMC Director requires that FB and IFC consults be completed within the time frames established by VHA policy and tracked to completion through the VistA and CPRS systems.

Concur.

Response: A new tracking report which will monitor the active, pending, scheduled, and active/pending Consults over 7 days has been developed and is utilized as part of our process which was implemented this fiscal year. This process is as follows:

a) The Care Management Center (CMC) performs weekly reviews of the internal-electronic HAS report to identify any consult on "pending status" longer than 7 days and Case Managers intervene accordingly to ensure processing. Any necessary travel arrangements for an IFC consult are coordinated at the CMC through the Referral Case Manager. The CMC also reviews and tracks reasons for any cancelled/discontinued IFC clinic consults in an attempt to identify barriers or availability issues at the remote sites which prevent the delivery of services. Requests through local Fee Services are made as needed. Requesting physician is able to follow the progress on the specific consult through clinic alerts/notifications.

b) Since November 2009 the consults coming from Tampa or North Florida South Georgia VHS requiring some type of follow up or requesting diagnostic tests are entered into a monthly tracking tool. The tool includes all necessary details to document consult progress through completion as well as any delay caused by no-shows, patient transfers or refusal. Direct contact with other departments like Radiology or Laboratory takes place on a daily basis to enhance communication among services and ensure consult completion, especially on consults with urgent needs. The mid-level provider at the CMC alerts Orlando PCPs through CPRS notes regarding any request made by remote facilities on OVAMC Veterans. The requesting facility is notified of all results through the consult completion process.

The letter for fee basis that is sent to the Veteran is being modified to clarify in a step-by-step manner the instructions to the Veteran for implementing the fee basis authorization letter and seeking a non-VA appointment. This revised letter will be more user friendly to assist Veterans in obtaining the care needed. In addition, the letter that is sent to fee basis venders is also being improved. Both letters are in the final review process and will be complete by June 30, 2010.

The new process for requesting and tracking care purchased through the fee basis program has been designed to ensure that the providers receive electronic notification of updates in the status of their requests through the electronic consult package of CPRS. New employees are coming on board at the end of June and beginning of July. They will have to undergo a short training period. We anticipate implementation of this new process to begin on July 12, 2010.

Recommendation 2. We recommend that the VISN Director ensure that the OVAMC Director requires that the patient's EMR accurately reflect consult activity and results, and these be communicated to the ordering provider in a timely fashion.

Concur. Standard terminology for scanned documents on notes for easy retrieval will be developed to help assure that providers can easily find the scanned images. This will be completed by the Chief Fee Basis and Chief Health Information Management by July 6, 2010.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Anthony Murray Leigh 410-637-4723
Acknowledgments	Jerome Herbers, M.D. Darlene Conde-Nadeau David Griffith Alice Morales-Rullan Thomas Seluzicki Carol Torczon

Appendix D

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