



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Review of Referral and Consultation Processes in VISN 20 and Southern Oregon Rehabilitation Center and Clinics at White City, OR

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding poor coordination and resource allocation within the Veterans Integrated Service Network (VISN) 20 and at the VA Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, OR. A complainant alleged that in regard to orthopedic and neurologic surgeries, as well as imaging services, there is a perennial problem obtaining timely care for patients, and that this leads to a standard of care below that mandated by VA.

We did not substantiate allegations regarding poor coordination of care and resource allocation in regard to SORCC. While patients do encounter delays in gaining access to specialty services in non-emergent situations, we found that SORCC, in conjunction with VISN 20, is actively engaged in a process to improve timeliness of surgical and imaging services for its beneficiaries.

We did not substantiate that care we reviewed in orthopedic surgery, neurologic surgery, and imaging services was below VA standards. We found that the completion of consults and the delivery of recommended treatments at SORCC occurred in compliance with VA's *Federal Benefits for Veterans, Dependents, and Survivors* when patients referred for treatment are not service related *and their condition is not considered emergent*, delays of up to 1-2 years for "routine" procedures, such as knee replacements, may permissibly occur. While timeliness of surgical specialty referral appointments and care is not always optimal, this does not equate to a breach in VA standards.

We made no recommendations.



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

TO: Director, Northwest Network (10N20)

SUBJECT: Healthcare Inspection – Review of Referrals and Consultations in VISN 20 and Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, Oregon

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations regarding poor coordination and resource allocation within the Veterans Integrated Service Network (VISN) 20 and at the VA Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, OR.

Background

The SORCC is a Level 3 residential rehabilitation center and clinics for underserved special populations, including homeless, chronically mentally ill, and substance abuse patients. It offers residential treatment in psychiatry, addictions, medicine, biopsychosocial, physical, and vocational rehabilitation. In FY 2010, SORCC had approximately 189,000 outpatient visits in which it provided primary outpatient medical and mental health care.

The SORCC refers veterans to other VISN 20 facilities for specialty care including surgical and imaging services. Although SORCC refers the majority of its surgical cases to Portland, Oregon VA Medical Center (VAMC), VA Puget Sound Health Care System (VAPSHCS) is utilized as well.

A complainant alleged that in regard to orthopedic surgery, neurologic surgery, and imaging services, there is a perennial problem obtaining timely care for patients, and that this leads to a standard of care below that mandated by VA.

According to VA's *Federal Benefits for Veterans, Dependents, and Survivors*,¹ when patients referred for treatment are not service related *and their condition is not considered emergent*, delays of up to 1-2 years for "routine" procedures, such as knee replacements, may permissibly occur.

Scope and Methodology

On March 8–9, 2011, OHI conducted a site visit to the SORCC. Pertinent documents, including VA, Veterans Health Administration (VHA), and SORCC policies and procedures, and medical records were reviewed. We conducted interviews with the SORCC Chief of Staff, Quality Manager, primary care and mental health care physicians and nurse practitioners, a pharmacist, a radiologist, and nurse referral coordinators. On April 20, 2011, and Sept 14, 2011, we conducted interviews with senior VISN 20 staff including the VISN's Director and Chief Medical Officer.

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

Case Summaries

Our review of medical records involved patients who had each waited for recommended surgery close to, or in excess of, a year. Cases reviewed were selected based on specific names provided by the complainant and others interviewed. None of the cases referred for review involved veterans with service related injuries.

Case 1.

The patient is a man in his fifties with onset of upper extremity weakness in February 2010. When evaluated by Portland VAMC's Neurosurgery Service at SORCC in May 2010, the patient was diagnosed with cervical spondylosis² and stenosis. Following a requested Neurology Service evaluation, the Neurosurgery Service's plan was to schedule a cervical³ nerve root decompression procedure.⁴ The patient remained clinically stable from May 2010, through September 2010, and received another evaluation by the Neurosurgery Service. The neurosurgeon documented the patient as "myelopathic"⁵ on physical examination and felt the patient "would benefit from spinal

¹ *Federal Benefits for Veterans, Dependents, and Survivors*. Chapter 1, VA Health Care Benefits (http://www.va.gov/opa/publications/benefits_book/venefits_chap01.asp).

² The stiffening or fusion of segments of the spine.

³ An area of the spine relating to the neck.

⁴ A procedure that is performed in order to remove pressure.

⁵ A disorder or disease of the spine.

cord decompression.” The patient was wait-listed for surgery and underwent anterior cervical discectomy⁶ and fusion in March 2011 at the Portland VAMC.

Case 2.

The patient is a man in his fifties who experienced a steady progression of neck pain over a two-year period with eventual upper extremity numbness and hand weakness. The patient was first evaluated for this issue at SORCC in August 2010. He was referred from the SORCC to the Portland VAMC where he was evaluated by its Neurosurgery Service in November 2010. A diagnosis of severe cervical spondylosis with myelopathy was made and the patient was recommended for anterior cervical discectomy with fusion. It was noted in a SORCC request for a fee basis consult dated March 2011 that the VA facility (Portland) cannot provide the required service in a timely manner. Consequently, in April 2011, the patient received approval to see a local neurosurgeon for evaluation only. At the time of this report, the patient has received nerve conduction⁷ testing per the recommendation of the fee basis provider and remains on the neurosurgery wait list at the Portland VAMC.

Case 3.

The patient is a man in his fifties with a history of ankle and foot pain secondary to a crush injury that had previously required several orthopedic surgeries for multiple lower extremity fractures. In September 2010, the patient was referred by a SORCC primary care physician for orthopedic surgery consultation. In December 2010, the patient was seen by a general orthopedist at SORCC and referred for subspecialty orthopedic care by a foot and ankle specialist at VAPSHCS. In January 2011, the patient was seen by the foot and ankle orthopedist. At this visit, the consultant orthopedist requested that specific imaging studies be arranged through the patient’s primary care provider at SORCC, with plans to see the patient in follow-up at VAPSHCS. In the interim, the patient decided to leave the area and he relocated his medical care in the process. Though the patient did not undergo surgery within the VA system, subspecialty orthopedic evaluation was afforded in a timely manner.

Case 4.

The patient is a man in his fifties who presented to SORCC in January 2011, complaining of a five-day history of “numbness and weakness of the right hand with accompanying headache.” The examining physician obtained a carotid artery ultrasound⁸ on the day of presentation and documented the results within 24 hours to be “within normal limits.”

⁶ Removal of part, or all, of a spinal disk.

⁷ A test that looks at how well nerves are functioning. It involves placing an electrical stimulator over a nerve and measuring the time required for an impulse to travel over a measured segment of the nerve.

⁸ An imaging technique that helps assess blood flow through the carotid arteries in the neck.

Arrangements were made with the VA Roseburg Healthcare System (HCS) for a CT⁹ imaging study of the head to assess for intracranial bleeding.¹⁰ Six days later, CT imaging of the head was obtained. A VA Roseburg HCS staff radiologist interpreted the study as showing “a generous subdural hematoma,”¹¹ and contacted the ordering clinic with this information. The next day, the patient was admitted to Portland VAMC and underwent burr hole evacuation¹² of the subdural hematoma. This resulted in full resolution of the patient’s headache and hand weakness symptoms.

Inspection Results

We did not substantiate the allegation that delay in treatment was a result of poor coordination and resource allocation between the VISN and SORCC.

We did not substantiate the allegation that VISN 20 and SORCC are failing to address issues of referral timeliness and quality of care issues. Upon review, we found that the completion of consults and the delivery of recommended treatments at VISN 20 facilities occurred in compliance with prioritization as outlined in VA’s *Federal Benefits for Veterans, Dependents, and Survivors*.¹³ When patients referred for treatment are not service related and their *condition is not considered emergent*, delays of up to 1-2 years for “routine” procedures, such as knee replacements, may permissibly occur. While timeliness of surgical specialty referral appointments and care is not always optimal, this does not equate to a breach in VA standards.

We found that SORCC leadership is aware of prolonged waiting times for veterans who are in need of non-emergent neurological and orthopedic surgical services. In addition, we determined that both VISN 20 and SORCC are conducting studies, utilizing workgroups, and investing financial resources to resolve the identified issues. The shortage of specialty care in geographically remote areas is not unique to the VISN, or even VHA, but is recognized as a national healthcare issue.

We found that while timeliness of referral appointments was not always optimal and waits may on occasion be lengthy, given the constraints inherent to a geographically remote facility (such as staff recruitment and transportation for patients), the provision of care in these instances was consistent with VA practice and policy. For example, more urgent cases that cannot be managed within the VISN are fee-based out to the

⁹ Computed tomography is a method of examining body organs by scanning them with X rays and then using a computer to put all of the images together to create the full picture.

¹⁰ A bleed in the portion of the skull that encloses the brain.

¹¹ A form of brain injury in which blood gathers in the outer part of the brain.

¹² A medical procedure that attempts to relieve pressure on the brain caused by a subdural or extradural hematoma. The hematoma (clot) is evacuated through the burr hole.

¹³ *Federal Benefits for Veterans, Dependents, and Survivors*. Chapter 1, VA Health Care Benefits (http://www.va.gov/opa/publications/benefits_book/venefits_chap01.asp).

community. In addition, we found that in select cases, SORCC attempted to procure a patient's consultative care at VA medical centers outside of VISN 20 such as the San Francisco, CA; Albuquerque, NM; and Palo Alto, CA VAMCs.

We found that VISN 20 leadership recognized the difficulty in recruiting orthopedists and neurosurgeons for some of its available positions in VISN facilities such as SORCC, and is working to develop partnerships with local community hospitals to help address such needs. Recent clinical investments include:

- A VISN-wide Neurosurgery Workgroup creating decision trees and algorithms based on analysis of the current demand for neurosurgical consults and services and the VISN's ability to meet the demand.
- In September 2011, the Neurosurgery Workgroup established a plan for triaging cases and increasing capacity.
- Last year the VISN invested \$10.7 million in supporting specialty care; \$5 million for orthopedics and \$1.8 million for neurosurgery.
- In FY 2011, the VISN spent \$2.7 million to improve surgical capacities at the Portland VAMC.
- The VISN is hiring additional surgeons to increase its neurosurgery capacity at Portland VAMC to three FTE and at VAPSHCS to one FTE.
- VISN 20 has invested in Transfer Coordinators at each medical facility as well as standardizing referral templates and case managing patients.

Conclusions

We did not substantiate allegations regarding poor coordination of care and resource allocation in regard to SORCC. While patients do encounter delays in gaining access to specialty services in non-emergent situations, we found that SORCC, in conjunction with VISN 20, is actively engaged in a process to improve timeliness of surgical and imaging services for its beneficiaries.

We did not substantiate that care we reviewed in orthopedic surgery, neurologic surgery, and imaging services was below VA standards. We found that the completion of consults and the delivery of recommended treatments at SORCC occurred in compliance with prioritization as outlined in VA's *Federal Benefits for Veterans, Dependents, and Survivors*.

Therefore, we make no recommendations.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with the report. No further action required.

A handwritten signature in black ink that reads "John D. Daigh, Jr., M.D." The signature is written in a cursive style.

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 17, 2011

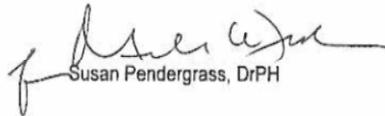
From: Director, Northwest Network (10N20)

Subject: **Healthcare Inspection – Review of Referral and Consultation Processes in VISN 20 and Southern Oregon Rehabilitation Center and Clinics SORCC, White City, OR**

To: Director, Seattle Office of Healthcare Inspections (54SE)

Thru: Director, Management Review Services (10A4A4)

Thank you for the opportunity to review the report as a continuing process to improve care for our Veterans.



Susan Pendergrass, DrPH

Director, Northwest Network (10N20)

**Department of
Veterans Affairs**

Memorandum

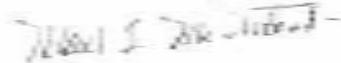
Date: November 16, 2011

From: Director, VA SORRC, White City, OR

Subject: Healthcare Inspection – Review of Referral and Consultation Processes in VISN 20 and Southern Oregon Rehabilitation Center and Clinics SORCC, White City, OR

To: Director, Northwest Network (10N20)

1. Thank you for your comments. Noted that there are no recommendations. Southern Oregon Rehabilitation Center and Clinics (SORCC) intend to remain vigilant and monitor all our service in accordance with VA standards.
2. SORCC appreciates the opportunity for the review as a continuing process to improve care for our Veterans.


Max E. McIntosh, PhD, MBA
Director (662/00)

**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:

We made no recommendations.

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Karen A. Moore, RNC, Project Leader Noel Rees, MPA, Team Leader Gail Bozzelli, RN Sarah Lutter, RN, JD Marc Lainhart, BS, Program Support Assistant Thomas Jamieson, MD, JD

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