Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-03010-251

Healthcare Inspection

Improper Closure of Non-VA Care Consults
Carl Vinson VA Medical Center
Dublin, Georgia

August 12, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to an anonymous complaint, followed by a request from Congressman Jack Kingston, regarding allegations of consult mismanagement at the Carl Vinson VA Medical Center in Dublin, GA.

We substantiated the allegation that facility staff improperly "batch closed" more than 1,500 Non-VA Care Coordination (NVCC) consults on April 25, 2014. The batch closure function should not have been used to close current requests for clinical care.

We substantiated that the batch closure was completed to meet organizational goals. NVCC staff had generally been following established procedures, and making progress, to individually close older consults in the months preceding the April 25 batch closure. By batch closing 1,546 NVCC consults, the facility was able to meet the consult closure May 1 deadline by shifting the time-consuming individual consult review and closure steps from pre-May 1 to after May 1. The Veterans Integrated Service Network (VISN) confirmed that the facility did meet the deadline and was "in the green" on May 1.

We substantiated that more than 600 patients whose consults were batch closed had not been seen by the NVCC provider at the time of consult closure. While we substantiated that NVCC staff were instructed to send NVCC consults back to the requesting providers for clinical review and, that in some cases, providers had to re-enter consults, this action was appropriate and followed Consult Clean-Up guidance. We determined that as a result of the batch-closure, NVCC staff had to re-enter fee authorizations when the care was still needed.

We also found that the facility had difficulty scheduling timely non-VA care appointments. While the facility did not monitor the timeliness of NVCC appointments, the VISN provided us with a report showing that for the period October 1, 2013, through March 31, 2014, the facility failed to meet the Veterans Health Administration's 90-day goal each month. The facility is located in a rural area with limited community resources. Because some NVCC providers are overwhelmed with referrals, patients requiring certain types of specialty care can wait months for NVCC appointments.

We recommended that the VISN Director review the circumstances surrounding the batch closures and confer with the appropriate VA offices to determine the need of administrative action, if any. We recommended that the Facility Director track the timeliness of NVCC appointment scheduling and promptly respond to potential delays in care.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 12–16 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to an anonymous complaint, followed by a request from Congressman Jack Kingston, regarding allegations of consult mismanagement at the Carl Vinson VA Medical Center (facility) in Dublin, GA. The purpose of the review was to determine whether the allegations had merit.

Background

The facility is designated as a Veterans Rural Access Hospital. It is located in Dublin, GA, and operates 34 acute care beds, 161 community living center beds, and 145 domiciliary beds. The facility also provides outpatient care at four community based outpatient clinics in Albany, Macon, Brunswick, and Perry, GA. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of approximately 125,000 throughout 52 counties in Georgia.

Non-VA Care Coordination (NVCC)

NVCC, formerly known as Fee Basis, is medical care provided to eligible veterans outside of VA when VA facilities and services are not reasonably available. Use of purchased care may only be considered when the patient can be treated sooner than at a VA facility and the service is clinically appropriate and of high quality.[1] A consult and pre-authorization for treatment in the community is required.[2] NVCC is organizationally aligned under Health Administration Service (HAS), and guidance for managing NVCC consults is found in Veterans Health Administration (VHA) Handbook 1907.01, *Health Information Management and Health Records.*[3]

VHA-Wide Consult "Clean-Up"

In 2013, VHA undertook a series of activities to decrease the number of "unresolved" consults nationwide. Unresolved consults are consults that are still open or active in the electronic health record (EHR).

On May 23, 2013, the Under Secretary for Health (USH) issued a nationwide memorandum regarding "standardization of certain aspects of the electronic consultation process and [to] establish timelines for business rule implementation." The memorandum defined four specific tasks to address unresolved consults and the timelines by which those tasks should be completed. Tasks 1–3 were largely administrative and were to be completed by October 1, 2013.

[1] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
[2] NVCC, formerly known as Fee Basis care, http://www.nonvacare.va.gov/, accessed January 3, 2014.
[3] VHA Handbook, 1907.01, *Health Information Management and Records*, September 19, 2012.

Task 4 consisted of five "waves" to close unresolved consults older than 90 days. Waves 1–4 focused on Medicine, Mental Health, Surgery, and Rehabilitation/Extended Care consults, with completion dates ranging from October 1, 2013, through April 1, 2014. Wave 5 focused on "All Other" consults, including NVCC consults, and had a completion date of May 1, 2014.

Facilities were to develop Consult Clean-Up Committees to oversee and manage consult linking (that is, attaching clinical evaluations and results to the consult request that would complete and close the consult) and business rule implementation and sustainment. VHA's guidance was largely found in a series of PowerPoint presentations and on its Consult Switchboard website.

NVCC Consult Closure Options

When clinical documentation from the non-VA provider is secured, it should be scanned into the patient's EHR and be available for VHA care providers. The process of attaching, or "linking," the scanned clinical document to the consult completes and closes the episode of care.

In cases where the status of the consult is unknown, staff are to contact the non-VA care provider and/or the patient to determine whether the patient was seen, document the status of the unresolved consults,[4] document these contacts, and take specified actions depending on the outcome of the contact. For older consults where clinical documentation cannot be obtained after several attempts, or where there is no evidence that non-VA care was provided, VHA requires a clinical review to determine continued need for the consult, documentation of the reason for closure, and approval from a designated official to administratively close the NVCC consult.[5]

In general, administrative closures are completed on an individual basis. When there is no evidence that the care was provided, NVCC staff can choose to administratively close the consult via:

- Cancellation – This option should be used when the consult prework[6] is inadequate, incomplete, or outdated. Cancelling the consult with the appropriate comment allows the sending provider to add the necessary information and resubmit the consult.

- Discontinuation – If a consult has been discontinued and the sending provider wants to request the care again, a new consult will have to be entered. In cases where the patients are deceased, consults should be discontinued.

[4] The status could include whether the appointment was completed, was scheduled pending completion, still needed to be scheduled, or the patient did not show.
[5] Fact Sheet, *Non-VA Care Coordination VISTA Imaging Capture*, March 2014.
[6] The information needed for a complete consult request, for example, history of illness or injury, laboratory results, or imaging studies.

When consults are administratively closed on a case-by-case basis, the ordering provider receives a "view alert" notifying them of the closure. The provider then has responsibility for determining whether the consult is still needed and, if so, either updating the clinical information and resubmitting the consult or generating a new consult for the requested care.

Administrative Closures Using "Group Update"

One function of the Consult Management software package allows designated users to administratively close consults using the "Group Update," or batch closure, option. This option permits all consults in a certain category (for example, by specific clinic) to be closed at the same time. In general, this option is restricted to special circumstances.[7] While group update closures were authorized as part of VHA's Consult Clean-Up effort, clinical review of those consults was expected to determine if the consults were still needed, and if so, to ensure appropriate action. Consult closures completed through the Group Update option do not generate view alerts to the ordering providers.

Allegations

On April 29, 2014, the OIG received an anonymous complaint alleging that:

1. Facility staff "batch closed" over 2,000 consults on April 25, 2014, in order to meet organizational goals.

2. The patients whose consults were closed had not been seen [by the NVCC provider as of the closure date] and may not have gotten the care they needed.

3. NVCC staff have now been instructed to send the consults back to the requesting provider to determine whether the care is still needed and the urgency of the request. This effort requires rework for both NVCC staff and facility providers.

While not one of the original allegations, several employees we interviewed reported delays in processing NVCC consults and scheduling appointments.

Scope and Methodology

We conducted site visits May 9 and May 29–30, 2014. We reviewed VHA and facility policies related to consult management and NVCC care; documents and instructions posted on the Veterans Support Service Center (VSSC) consult management site; facility data on consult closures and corrective actions; quality management documents; and e-mails related to the April 25, 2014, group closure. We also reviewed selected patients' EHRs to determine whether the facility was processing NVCC consults and scheduling appointments in a timely manner.

[7] VHA's Consult Clean-up guidance suggested that consults older than 5 years be closed administratively using the Group Update function. No clinical review was required.

We interviewed the facility Director, associate director, and executive assistant to the associate director (EA-AD); the Chief of Staff (COS) and Chief of Social Work; the Chief, Deputy Chief, and acting Chief (during the Chief and Deputy Chief's absences) of HAS; the VISN Quality Management Officer; the NVCC medical director, nurse manager, and several schedulers; a clinical applications coordinator and a primary care provider; a representative from VHA's Clinical Business Systems Office (CBSO); and others with knowledge about this issue.

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.

Event Summary

In late summer 2013, the facility's NVCC had about 10,000 consults in an active, pending, or scheduled status. Per Consult Clean-Up guidance, NVCC staff began the process of linking clinical documentation to consults when available, contacting providers and veterans to determine the status of consult requests, clinically reviewing consults and scheduling appointments when still needed, and cancelling or discontinuing consults after the necessary administrative steps had been completed.

On November 6, 2013, the facility's HAS Chief sought approval to batch close approximately 1,175 unlinked NVCC consults[8] that were between 2–5 years old. Per VISN guidance, the HAS Chief submitted a memorandum requesting and justifying the batch closures; however, the COS did not approve the request.

In January 2014, NVCC staff started intensifying their efforts to resolve consults after individual review of each case. Facility leadership authorized overtime, and NVCC staff and other facility employees who volunteered for the assignment worked additional hours in the evenings and on weekends to complete the NVCC consult clean-up.

While the testimony was somewhat inconsistent, two key employees we interviewed reported that on April 23 or 24, an NVCC scheduler told an administrative employee in the Facility Director's office that the NVCC Consult Clean-Up efforts were faltering and that the facility would not meet the May 1 deadline for Wave 5 consult closures. The HAS Chief was on annual leave, and the HAS Deputy Chief was in training at another VISN 7 facility that week. The EA-AD contacted the facility's Consult Clean-Up team leader who provided a copy of VHA's PowerPoint instructions for reviewing and closing consults greater than 90 days old. The EA-AD also contacted the CBSO[9] for guidance.

The EA-AD sent a follow-up e-mail to the CBSO representative outlining the intended closure process, to include:

- Immediate clinical review of all high-risk/specialty consults (as defined by the Consult Clean-Up Committee)
- Administratively close all primary care routine/non-emergent consults and send them back to the (ordering) provider for clinical review
- If care is still needed, the primary care provider would enter a new consult and either upload into Patient-Centered Community Care (PC3)[10] or the appointment would be rescheduled by the NVCC staff

[8] At the time, some of the consults could not be linked because of software system compatibility issues.
[9] The Purchased Care CBSO provided field support and program oversight during the consult clean-up process.
[10] PC3 refers to non-VA contracted care.

The CBSO representative agreed via e-mail with the intended process and attached procedures devised by another VISN to assist the facility in properly completing and closing outstanding consults.

On April 24 or 25, the EA-AD, the Consult Clean-Up team leader, and a Consult Clean-Up team member met with the Facility Director, Associate Director, and COS, and made a recommendation[11] to batch close the remaining NVCC consults greater than 90 days old. The EA-AD told us that the recommendation was based on the following reasons:

- Vendors were not accepting consults over 90 days old due to a possible change in the patients' status.
- PC3 would allow quicker scheduling due to the contract's additional provider availability.
- Clinical review of all consults over 90 days old was needed to determine whether the care was still needed.

Facility leadership approved the request. The EA-AD then met with the clinical applications coordinator and other members of the Consult Clean-Up team. The group reviewed the plan to assure that no patients would "fall through the cracks," and the clinical applications coordinator assigned the electronic "key" which would allow the EA-AD to batch close the NVCC consults. Reportedly, batch closure keys had not been in use at the facility for 10 years.

In the early afternoon of April 25, the facility batch closed/discontinued 1,546 NVCC consults prior to conducting a clinical review. The batch closure included neurology, pain, mammography, imaging, and gastroenterology referrals, amongst others. According to staff we interviewed, high-risk consults (such as cardiology, oncology, and others), optometry, and audiology were not included in the batch closure.[12]

The high number of consult closures alerted VISN staff, who then contacted facility staff inquiring about the closures. The VISN also contacted the CBSO about the batch closure, to which the CBSO representative reportedly said she was not aware the facility intended to close via a group method (rather than individually). The VISN directed the facility to retract the batch closure, but retraction was not possible.

The facility implemented a plan to clinically review the batch closed consults. As of June 6, the facility had completed the clinical review of all 1,546 consults and was in the process of scheduling appointments for patients still in need of the requested services.

[11] One of the team members had previously voiced concerns about batch closure but told us that, at this point, "the decision [to batch close] had already been made."
[12] Facility-designated high-risk consults were reviewed individually per the facility's consult-closure action plan. NVCC consults for optometry and audiology services were being processed through other mechanisms and were excluded from the batch closure.

Inspection Results

Issue 1: Batch Closure of NVCC Consults

We substantiated the allegation that facility staff batch closed 1,546 NVCC consults (not over 2,000)[13] on April 25, 2014. Batch closures were permitted under certain circumstances during the national Consult Clean-Up effort but should not have been used in this case. Specifically, Consult Clean-Up guidance states, "Group Update is intended to close consults that are of no further clinical use. It must not be used to close current requests for clinical care."[14] More than 1,400 of the consults were less than 1 year old, and many of those patients still required the requested clinical care.

Based on our interviews and review of e-mails, it appeared that employees involved in preliminary discussions about the proposed batch closure that occurred in April 2014 did not agree on the action or the best way to proceed. The EA-AD, who had limited involvement in Consult Clean-Up efforts, was detailed on April 24 to HAS to lead the NVCC consult closure effort. She sought guidance from facility and VHA experts, but some of the guidance and communications were confusing. For example, while the EA-AD told us she specifically discussed batch closure with the CBSO representative during their telephone conversation on April 24, the CBSO representative told us she was not aware that the facility intended to batch close NVCC consults. The EA-AD's e-mail communication on April 25, which was intended to confirm the CBSO's concurrence with the plan, did not explicitly state the consults would be batch closed; rather, it stated old consults would be administratively closed. This is the plan that the CBSO representative concurred with.

Further, the facility did not review the batch closure plan with the VISN. When the VISN learned of the action, it attempted to have the files restored.

Organizational Goals

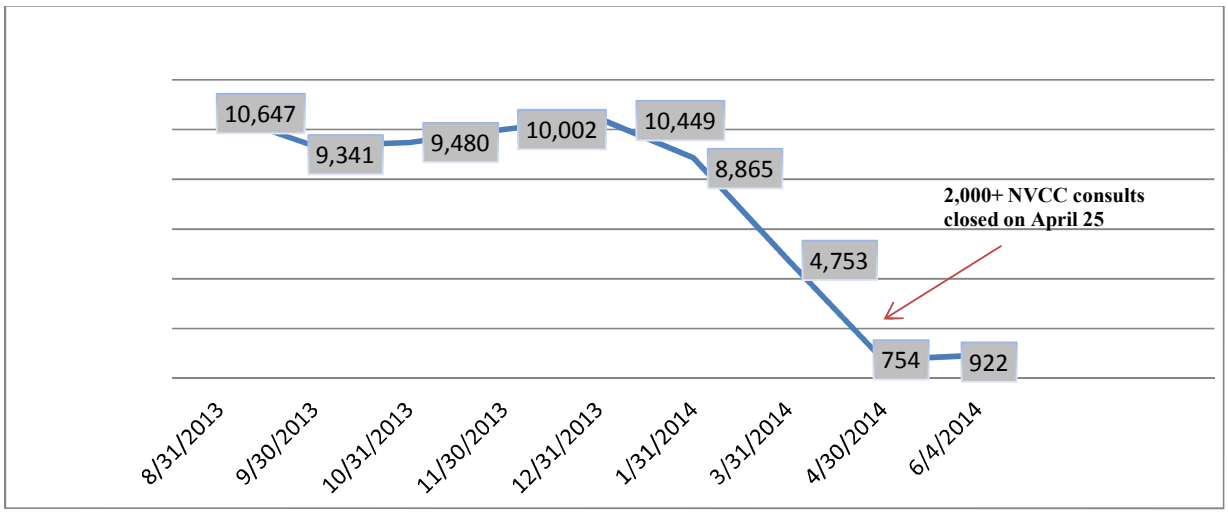
We substantiated the allegation that the batch closure was completed to meet organizational goals. We received conflicting testimony as to the urgency of, and rationale for, the batch closure on April 25; however, the proximate timing of the action to the May 1 deadline supports the allegation.

NVCC staff had generally been following established procedures to close older consults in the months preceding the April 25 batch closure and had been making progress as evidenced by the table below. However, several of the staff members we interviewed told us that there was "no way" the facility would meet the May 1 deadline even though staff were working late and on weekends to individually review, update, and close consults. Only after an NVCC scheduler told an administrative employee in the Facility

[13] The facility did close over 2,000 NVCC consults on April 25. Of these, 1,546 were group closed; the remainder were individually closed.
[14] Consult Switchboard website, Group Update for Admin Close tab, retrieved June 6, 2014.

Director's office around April 23 or 24 that NVCC consult closure efforts were faltering did managers begin discussing batch closure.

Table 1. Consult Closure Performance Report for DSS Stop Code 674[15]



Source: VSSC VHA Consult Performance by Stop Code, retrieved June 10, 2014

By closing more than 2,000 NVCC consults—1,546 via the batch-close method—the facility was able to meet the Wave 5 consult closure deadline because it essentially shifted the time-consuming individual consult review and closure steps from pre-May 1 to after May 1. The VISN confirmed that the facility did meet the Wave 5 deadline and was "in the green"[16] on May 1.

Discontinuation of Needed Care

We substantiated that many of the patients whose consults were batch closed had not been seen by the NVCC provider at the time of consult closure:

- 648 consults were in an active status, meaning that the patients were awaiting an appointment date and time with the NVCC provider
- 863 consults were in a scheduled status, meaning that the patient (1) had a scheduled appointment in the past and the facility was awaiting medical documentation that the patient had been seen or (2) had a scheduled future appointment
- 35 consults were in a pending status, meaning that the consults were pending review and authorization for NVCC care

[15] Stop code 674 includes NVCC consults and other administrative activities such as orienting new clients to Primary Care or updating Means Tests. However, NVCC represents the vast majority of activity in this stop code.
[16] VHA measures progress on completing/closing unlinked consults via a red/green indicator. Green is achieved once the consults open greater than 90 days are "less than 1 % of all consults in the last 365 days" within the same category represented in the wave (in this case, wave 5 – All Others).

From April 28 to June 5, 2014, facility staff clinically reviewed all of the batch-closed consults to determine whether those consults were still indicated. As of June 6, the facility had resolved a majority of the batch-closed consults, either through completing and closing them with accompanying NVCC reports or notes or by requesting NVCC notes for completed appointments so that they can be linked and the consults can be closed. Of the remaining consults:

- 257 patients needed appointments or had pending appointments
- 224 patients did not show for scheduled appointments and appropriate resolution of the consults was being evaluated

We learned that the batch-closure did not automatically cancel appointments that had already been scheduled, although new consults and fee authorizations were required.

Re-Entry of NVCC Consults

We substantiated that NVCC staff were instructed to send the consults back to the requesting providers to determine whether the care was still needed and determine the urgency of the request. We also substantiated that, in some cases, providers had to re-enter consults and NVCC staff had to re-enter fee authorizations when the care was still needed.

VHA's Consult Clean-Up guidance outlines the expectations for closing consults older than 90 days, and providers were aware that they would be reviewing old consult requests and that they may need to update clinical information and reinitiate some consults. We did not find this to be unexpected re-work for the providers.

When the consults were batch closed, the associated fee authorizations were no longer valid. Thus, NVCC staff had to re-enter fee authorizations for patients with scheduled appointments or pending appointments. This effort required re-work by NVCC staff.

Issue 2: Timeliness of NVCC Consult Scheduling

While not one of the original allegations, during the course of our review several employees we interviewed told us of delays in processing and scheduling NVCC appointments.

Only NVCC consults greater than 90 days old were included in the batch closure. We reviewed the 648 NVCC consults that were in an "active" status at the time of the batch

closure and found that about half were between 91–180 days old, and the remaining consults were 181–468[17] days old. See details in Table 2.

Table 2. Elapsed Days from Date of Consult Request to Batch Closure

Elapsed days from date of request	91–180 days	181–270 days	271–360 days	Greater than 360 days
NVCC Consults	329	180	113	26
Percentage	51%	28%	17%	4%

Source: OIG Analysis of VA data

VHA has recently developed and implemented a national Metric Plan to measure the success of NVCC deployment.[18] Metric 2.2 reflects the average number of days from referral/consult submission to closure using the "Non VA Care Consult Result Note"; the goal is to schedule and complete the appointment and link the results to the consult request in less than 90 days. At our request, the VISN provided a report reflecting that, for the period October 1, 2013, though March 31, 2014, the facility exceeded the 90-day goal each month, with a 1st quarter fiscal year (FY) 2014 average of 109 days and a 2nd quarter FY 2014 average of 139 days.[19] The facility did not have a method to track NVCC appointment timeliness.

As a secondary care rural designation hospital, the facility relies heavily on community-based providers and specialists to meet patient care needs. The city of Dublin and surrounding counties have limited community resources and specialists. Every NVCC employee we interviewed told us that VA is "at the mercy" of community providers when scheduling veterans' appointments and that some NVCC providers are so overwhelmed with referrals that they are scheduling veterans 6–7 months in the future or have stopped taking VA referrals altogether. As a result, patients requiring certain types of specialty care can wait months for NVCC appointments.

Conclusions

We substantiated the allegation that facility staff improperly batch closed more than 1,500 NVCC consults on April 25, 2014. The batch closure function should not have been used to close current requests for clinical care.

[17] The 468-day-old consult was submitted in January 2013 for NVCC gastroenterology evaluation. The patient had been complaining of recurrent abdominal pain and diarrhea with minimal relief from medications. The NVCC triage nurse reviewed the consult for clinical appropriateness 5 days later, and NVCC care was authorized the end of January. In mid-May, the requesting provider inquired about the status of consult, but there is no documented evidence that the patient was referred to an NVCC gastroenterologist. The consult was batch closed on April 25, 2014. The patient was contacted after the consult closure and reported that she was never contacted by a community provider and she continues to have abdominal pain and diarrhea. The facility is following up to arrange appropriate care.

[18] http://nonvacare.hac.med.va.gov/nvcc/, accessed June 9, 2014.

[19] At this stage, only "champion" facility data is tracked and available via the NVCC website.

We substantiated that the batch closure was completed to meet organizational goals. NVCC staff had generally been following established procedures, and making progress, to individually close older consults in the months preceding the April 25 batch closure. Once staff in the Director's office learned around April 23 or 24 that NVCC consult closure efforts were faltering, however, managers began discussing batch closure. By batch-closing 1,546 NVCC consults, the facility was able to meet the consult closure deadline by shifting the time-consuming individual consult review and closure steps from pre-May 1 to after May 1. The VISN confirmed that the facility did meet the deadline and was "in the green" on May 1.

We substantiated that more than 600 patients whose consults were batch closed had not been seen by the NVCC provider at the time of consult closure. The facility has completed clinical reviews and dispositioned a majority of the batch-closed consults, and, as of June 6, 2014, 257 patients still needed appointments or had pending (future) appointments.

While we substantiated that NVCC staff were instructed to send NVCC consults back to the requesting providers for clinical review, and that in some cases, providers had to re-enter consults, this was appropriate and followed Consult Clean-Up guidance. We determined that as a result of the batch-closure, NVCC staff had to re-enter fee authorizations when the care was still needed.

We also found that the facility had difficulty scheduling timely non-VA care appointments. While the facility did not monitor the timeliness of NVCC appointments, the VISN provided us with a report showing that for the period October 1, 2013, through March 31, 2014, the facility failed to meet VHA's 90-day goal each month. The facility is located in a rural area, and every NVCC employee we interviewed told us that the facility is "at the mercy" of community providers when scheduling veterans' appointments. Because some NVCC providers are overwhelmed with referrals, patients requiring certain types of specialty care can wait months for NVCC appointments.

Recommendations

1. We recommended that the VISN Director review the circumstances surrounding the batch closures and confer with appropriate VA offices to determine the need for administrative action, if any.

2. We recommended that the Facility Director track the timeliness of NVCC appointment scheduling and promptly respond to potential delays in care.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 21, 2014

From: Director, Veterans Integrated Service Network (10N7)

Subject: **Draft Report**—Healthcare Inspection – Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, GA

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. VISN 7 concurs with the findings and submits the enclosed action plans to correct.

2. If you have any additional questions or concerns, please contact Judy Finley, RN, Acting VISN 7 QMO.

//original signed by Robin E. Jackson, PhD, for://

Charles E. Sepich, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 17, 2014

From: Director, Carl Vinson VA Medical Center (557/00)

Subject: **Draft Report**—Healthcare Inspection – Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, GA

To: Director, Veterans Integrated Service Network (10N7)

1. I concur with the attached facility draft responses to the recommendations. I have provided information to be included in the report.

2. If you have any additional questions or concerns, please contact Jahmel Yates, Quality Manager at 478-272-1210 ext. 2446

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

The facility would like to request OIG include in their report, Carl Vinson VAMC's most recent data related to the 1546 consults impacted by the reset.

As of July 17, 2014, 1546 consults have been assessed for ongoing clinical need, Veterans have been scheduled and seen, resulting in a remaining 40 to be closed. Of the remaining 40 still open, the Veteran was seen by a provider with results forthcoming or has not received care due to repeated missed appointments. Veterans with repeated missed appointments are being case managed with appropriate follow-up with a VA provider scheduled. Five Veterans remain open with future appointments scheduled. These 5 are scheduled between July 21 and August 27, 2014. The 5 Veterans are scheduled for the first available appointment as determined by the Non-VA vendor. All Veteran care has been tracked, results have been received or are being case managed to closure.

OIG Recommendations

Recommendation 1. We recommended that the VISN Director review the circumstances surrounding the batch closures and confer with appropriate VA offices to determine the need for administrative action, if any.

Concur

Target date for completion: September 1, 2014

VISN Response: The VISN Director has reviewed the circumstances and appropriate action is being addressed in collaboration with VACO Workforce Management Office. The VISN concurs with the action plan that has been recommended.

Recommendation 2. We recommended that the Facility Director track the timeliness of NVCC appointment scheduling and promptly respond to potential delays in care.

Concur

Target date for completion: September 1, 2014

Facility response: On April 25, Dublin VAMC made a decision to group reset 1546 NVCC consults over 90 days old. Although the OIG draft report indicates the reset was completed to meet organizational goals, this was not the intent of the medical center. The objective of the group reset was to ensure every Veteran with a consult over 90 days old, received expeditious one-on-one case management, clinical review and medical care as deemed appropriate. This decision was not made lightly. Leadership was informed by a NVCC staff member that efforts to resolve the consults were faltering. There were significant challenges prohibiting the consults from being

scheduled and/or completed causing additional delays in timely care and posing additional risks to Veterans' care. The barriers included vendors not accepting consults over 90 days old; the inability of the facility to utilize PC3 due to the age of the consults and mileage requirements; and a need to clinically review each consult due to possible changes in the Veterans' health status. Proceeding with the group reset enabled the medical center to meet the objective of obtaining more timely care for Veterans. At no time during this process did the medical center claim to meet the target for Wave 5 NVCC consults as indicated in the certification memo signed by the Director on April 30, 2014.

On April 23, Dublin VAMC staff began discussing the possibility of a group reset. During the early discussions, a plan was developed for tracking and managing the consults involved in the potential group reset. The case management team would track, schedule and ensure results were received for every consult included in the potential reset. One hundred percent of the consults impacted by the group reset were clinically reviewed. At the time of the reset, 648 of the 1546 consults were in an active status and awaiting an appointment with 35 awaiting review and authorization. Dublin VAMC staff continues to track and case-manage every consult to completion. As of July 17, 40 of the 1546 consults are pending completion, with 5 remaining open with future appointments scheduled from July 21 thru August 27. While Dublin VAMC leadership recognizes technical closure of the consults could have been managed on an individual basis in lieu of the group reset, this action allowed the medical center to gain traction and effect timely care for every Veteran impacted.

In an effort to implement a consult management process that addresses consults in real time and thus, prevents a large backlog of unaddressed workload, Dublin VAMC initiated numerous process changes related to NVCC and consult management. To ensure strong leadership of this patient care process, the Chief of Staff has been assigned to chair the Dublin VAMC consult management team effective July 21. On May 1, the Chief of HAS assumed responsibility of the NVCC consult management process to include case management of the consults impacted by the reset.

The actions implemented include:

- Daily review and tracking the timeliness of NVCC scheduling by the Chief of HAS.

- Daily review and tracking, by specialty, for consults currently managed in NVCC. Schedulers will review by specialty service instead of by Veteran's last name, to ensure the significance of the consult is recognized and appropriately prioritized. Schedulers are responsible for pulling the consults related to their assigned specialty on a daily basis. This process is monitored daily by the NVCC Supervisor.

- Establishing specialty teams to include 1 NVCC nurse and 3 clerks. Prior to the reset, NVCC was made up of 2 nurses, 10 claims clerks and 1 NVCC supervisor. Once NVCC is fully staffed, the department will have 1 nurse manager, 6 nurses,

20 claims clerks, 1 lead claims clerk and 1 NVCC supervisor. Establishing a team of designated staff for each specialty enables the medical center to better track and case manage the Veterans receiving care in that area. Vendors are able to work one-on-one with designated NVCC staff assigned to their specialty. The NVCC staff are able to build positive working relationships with the Veterans and Vendors assigned to their area.

- Developing two automated reports designed to pull consults identified as urgent and/or stat, which will be used by NVCC staff to further prioritize workload and ensure timely care and follow-up.

- Hiring additional NVCC nurses and claims clerks. Hiring processes were initiated in May to recruit and hire additional NVCC staff to include 1 nurse manager, 4 nurses, 1 lead claims clerk and 10 claims clerks. We are working diligently to ensure all new staff will be on board by September 1.

- Identifying clearly defined roles and responsibilities for each NVCC staff member. The Chief of HAS has completed this process for existing staff. This is an ongoing process as new staff join the department. All additional staff should be on board by September 1. This process enabled the Chief of HAS and NVCC leadership to establish a higher level of staff accountability.

- Holding daily staff meetings to include NVCC leadership who report up to the Associate Director.

During the week of June 9–13, the National Non-VA Medical Care Program, Chief Business Office (CBO) completed a site visit to assess the NVCC consult process at Dublin VAMC. Extensive training related to FBCS reports, claim processing, and cost estimations was provided to NVCC staff. CBO developed an improvement action plan for the medical center. Key staff from CBO are continuing to monitor Dublin VAMC NVCC efforts and are working closely with Dublin VAMC leadership and NVCC staff to provide ongoing guidance until the action plan is completed. CBO staff are conducting weekly calls with medical center leadership and NVCC staff. Dublin VAMC has made significant improvements in the NVCC area over the last few months and continues to move in the right direction.

This process brought a sense of urgency to Dublin VAMC staff in regards to consult management and addressing potential delays in care to Veterans. This renewed sense of urgency remains prominent within the medical center and is reflected in the daily actions of Dublin VAMC staff.

Appendix C

OIG Contact and Staff Acknowledgments

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Appendix D

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