Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04705-62

Healthcare Inspection

Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet

December 15, 2014

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections evaluated the Veterans Health Administration's (VHA's) system-wide review of "unresolved" consults and the accuracy of VA's summary of the findings from that review (Fact Sheet). We initiated the review at the request of the Chairman of the House Veterans' Affairs Committee (HVAC).

Unresolved consults are requests for consultations that are still open or active in patients' electronic health records. In late September 2012, VHA initiated a multi-phased review of consults that were unresolved for more than 90 days. By early May 2014, when facilities were expected to have completed their reviews, the number of unresolved consults had decreased considerably. However, because VHA did not implement appropriate controls, we found it lacks reasonable assurance that facilities appropriately reviewed and resolved consults; closed consults only after ensuring veterans had received the requested services, when appropriate; and, where consult delays contributed to patient harm, notified patients as required by VHA policy.

OIG recently published *Healthcare Inspection: Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, Georgia (Report No. 14-03010-251)*, August 12, 2014, regarding consults that were inappropriately closed while veterans were awaiting requested services in an effort to meet VHA's early May 2014 deadline for reviewing and responding to unresolved consults. Similar events may have occurred at other VA facilities.

Furthermore, in reviewing the Fact Sheet we found that several key statements related to the scope and results of VHA's review of unresolved consults were misleading or incorrect. These statements were repeated by VHA leaders during a briefing with congressional staff on April 7, 2014; an HVAC Hearing on April 9, 2014; and during media events. On July 3, 2014, VHA issued a letter to the Chairman of the HVAC that included information intended to clarify statements in the Fact Sheet.

We recommended that the Interim Under Secretary for Health (1) conduct a systematic assessment of the processes each VA medical facility used to address unresolved consults during VHA's system-wide consult review, (2) ensure that if a medical facility's processes are found to have been inconsistent with VHA guidance on addressing unresolved consults, action is taken to confirm that patients have received appropriate care, and (3) review the circumstances of any inappropriate resolution of consults and confer with the Office of Human Resources, the Office of General Counsel, or other relevant agency to determine the appropriate administrative action to take, if any.

Comments

The Interim Under Secretary for Health concurred with our recommendations and provided an acceptable action plan. (See Appendix B, pages 24–26 for the Interim Under Secretary for Health's comments.) We will follow up on the planned actions until they are completed.

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Purpose

As requested by the Chairman of the House Veterans' Affairs Committee (HVAC), the VA Office of Inspector General (OIG) Office of Healthcare Inspections evaluated the Veterans Health Administration's (VHA's) system-wide review of unresolved consults (those that were still open or active in the electronic health record) as well as the accuracy of VA's summary of the findings from the "National Consult Delay Review Fact Sheet" (Fact Sheet). Specifically, the objectives were to:

- Evaluate VHA's review of and response to unresolved consults at VA medical facilities.
- Evaluate whether information presented in the Fact Sheet accurately represented VHA's review of and response to unresolved consults.

Introduction

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

Once a consult request is entered through the consult package, it remains unresolved until a specific action is taken to close it. In particular, the request can be closed (1) administratively (for example, discontinued or cancelled) by non-clinical staff or (2) when a clinician properly enters a progress note into the consult package to indicate that the consult had been completed. When consultants enter a note elsewhere in CPRS—that is, outside of the consult package—the consult remains open.

VHA discovered the extent to which the consult package was being improperly used throughout the system in the summer of 2012 following an event at the William Jennings Bryan Dorn VA Medical Center, Columbia, SC. Specifically, in May 2012 a patient presented to that facility's Emergency Department complaining of a gastrointestinal-related issue and was ultimately diagnosed with cancer. In reviewing this case, the facility found a delay in gastrointestinal care that resulted in patient harm and completed an institutional disclosure to the patient. The patient died in August 2012.[1] VHA subsequently reviewed system-wide data on consults and determined that, as of early September 2012, more than 2 million consults had been unresolved for more than 90 days. VHA was unable to efficiently determine which unresolved consults represented true delays because of the widespread use of the

[1]For additional information, see the OIG report, *Healthcare Inspection: Gastroenterology Consult Delays, William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina (Report No. 12-04631-313),* September 6, 2013.

consult package for other, non-clinical purposes and because some unresolved consults could represent consults that had been completed, but simply were not properly closed in the consult package.

This report evaluates the steps that VHA took in fiscal year (FY) 2012 through FY 2014 to review and resolve consults that had remained unresolved for more than 90 days. This effort was led by leaders from the Office of the Deputy Under Secretary for Health for Operations and Management, Office of Access and Clinic Administration, and Veterans Integrated Service Network (VISN) 12. In addition, this report describes the process by which VHA summarized the findings of this review in the Fact Sheet and evaluates the extent to which the Fact Sheet accurately described this review. (See Appendix A for a copy of the Fact Sheet.)

Scope and Methodology

We evaluated VHA's review of and response to unresolved consults at VA medical facilities within the context of Federal internal control standard for control activities, which emphasizes the need for management to identify risks, analyze the severity of risks, and take appropriate action to mitigate risks.[2] To do so, we interviewed VHA leaders who were involved in developing the methodology for and/or overseeing the system-wide review of consults, and we requested and reviewed relevant documentation, including guidance provided to VISNs and facilities and email correspondence among VHA leaders.

We also interviewed Directors and other staff from five VISNs, which we purposively selected, based on variation in geographic location and numbers of institutional disclosures and deaths reported in the Fact Sheet (see Table 1). To supplement information gathered during those interviews, we requested and reviewed relevant documentation, including correspondence between VISNs and facilities, issue briefs, and case summaries. We also interviewed leadership staff and reviewed relevant documentation provided by leadership from one medical facility, in response to a specific inquiry from the congressional requestor.

Table 1: Characteristics of VISNs Selected for Review

		Numbers Reported in Fact Sheet	
VISN	**Geographic Location**	**Institutional Disclosures**	**Deaths**
3	Northeast	0	0
8	South	14	5
15	Midwest	0	0
19	West	4	1
21	West	3	0

Source: OIG analysis of VHA data

[2]U.S. Government Accountability Office, *Standards for Internal Control in the Federal Government (GAO/AIMD-00-21.3.1),* November 1999.

To evaluate whether information presented in the Fact Sheet accurately described VHA's review of and response to unresolved consults, we compared statements in the Fact Sheet to information we collected through interviews and our review of relevant documentation.

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

Inspection Results

Issue 1: VHA's Review of and Response to Unresolved Consults

In late September 2012, VHA initiated a multi-phased review of consults that were unresolved for more than 90 days. Through early May 2014, when facilities were expected to have completed all reviews, the number of unresolved consults decreased considerably. However, because VHA did not implement appropriate controls, we found it lacks reasonable assurance that facilities closed consults only after ensuring veterans had received the requested services and, where consult delays contributed to patient harm, notified patients as required by VHA policy.

Process Used To Review Consults

When VHA initiated its review of consults that were more than 90 days old, unresolved consults that VHA leadership determined to present the highest risk to patients (referred to as "high-interest consults") were prioritized over other consults. In addition, VHA directed facilities to conduct a focused review of gastrointestinal malignancies identified in FYs 2010 and 2011 to determine whether delays in care contributed to harm to patients (referred to as the "gastrointestinal cancer look-back").

High-Interest Consults

In late September 2012, VHA directed its facilities through the VISNs to begin a review of consults that were unresolved more than 90 days by focusing first on those in seven areas that, based on an evaluation by VHA leadership, posed the highest risk to veterans. These high-interest consults were gastrointestinal endoscopy, cardiac catheterization, cardiology, cardiac surgery, oncology, bronchoscopy, and thoracic surgery. The decision to prioritize those consults was consistent with the Federal internal control standard for risk assessment, which emphasizes the need for management to identify risks, analyze the severity of those risks, and take appropriate action to mitigate those risks.[3]

To review high-interest consults, facility managers were directed to take the following steps:

1. Identify high interest consults that were unresolved for more than 90 days but less than 5 years. Consults that had been unresolved for more than 5 years generally were closed without review.
2. Review all consults identified through step 1 to determine whether care had been rendered.
3. Close the consult if any of the following criteria were met:

[3] *GAO/AIMD-00-21.3.1.*

   a. Care had been rendered, but the consult remained unresolved because the corresponding note was entered outside of the consult package.
   b. The patient was deceased.
4. Take appropriate action, which could include scheduling services, if any of the following criteria were met:
   a. The patient was a no-show for the consult visit.
   b. The service was never scheduled and provided.

Facility managers were not explicitly directed to determine whether consult delays contributed to harm to veterans and to disclose any harm to veterans. However, VHA leadership told us that, during the course of this review, facility managers were expected to comply with VHA disclosure policy, which specifies the steps facility managers should take to evaluate and report adverse events—that is, clinical incidents that may pose a risk of injury to a patient as the result of a medical intervention or the lack of an appropriate intervention, such as a missed or delayed diagnosis, rather than that patient's underlying medical condition.[4] Facility managers were directed to complete their review of the high interest consults and sign a statement that they had done so by March 2013.

Gastrointestinal Cancer Look-Back

About 4 weeks after beginning the review of high-interest consults, on November 1, 2012, facility managers were directed to conduct a focused review of gastrointestinal cancers diagnosed in FY 2010 and 2011, including new esophageal, gastric, colon, and rectal cancers, to determine whether a consult delay had contributed to a delay in diagnosis and harm to the patient.[5] In particular, facility managers were directed to take the following steps:

1. Review all gastrointestinal malignancies that were diagnosed and recorded in VHA's central cancer registry in FY 2010 through FY 2011.
2. Determine if any patient identified through Step 1 experienced greater than a 60 day delay in receiving a gastrointestinal endoscopy procedure. In particular, determine whether
   a. A gastrointestinal procedure was performed more than 60 days after a screening test that was positive for blood in stool.
   b. A gastrointestinal procedure was performed more than 60 days after the consult referral was made.

[4]VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012.
[5]VHA defined "delay" as a 60-day or longer interval between the date of a consult request or positive stool test for blood and the date of the requested service (usually an endoscopy). VHA defined "harm" as an advance in the disease (cancer) in direct relationship to the delay in diagnosis which was either associated with an increase in morbidity/mortality, or required a more aggressive treatment.

3. For any patient identified through Step 2, perform a two-level review to determine whether the patient was harmed. The two-level review was intended to be implemented as follows:

    a. First-level review: A physician at the facility should have reviewed the case and the disposition of that review should have been reviewed by the Chief of Staff.[6] If the specialist determined that the patient was harmed, the case did not need to undergo a second-level review.

    b. Second-level review: Cases subject to second-level review should have been reviewed by a second physician external to the facility and assigned by the VISN Chief Medical Officer.

As part of the gastrointestinal cancer look-back, facility managers were explicitly directed to determine whether consult delays contributed to harm to veterans and disclose any harm to veterans. If no harm was identified, no disclosure was required. Facility managers were directed to complete this review within 30 days.

Other Consults

Following the completion of the review of the high interest consults, VHA directed facility managers to review and resolve all other consults, including mental health and surgery consults, that were unresolved for more than 90 days. Facility managers were instructed to review these consults using the same process as that used to review the high-interest consults. Facility managers were provided with interim milestones for completing this task by early May 2014.[7] During the review, facility managers were also directed to adopt new rules governing the use of the consult package that were intended to remedy the improper use of the consult package.[8] These rules included using naming conventions to distinguish among administrative consults, clinical consults, and requests for future care, as well as codes to identify clinics (stop codes) to assist in the national categorization of consults.

[6]Initially, VHA guidance indicated that the review should be completed by a gastrointestinal specialist, though this guidance was later updated to specify that the review could be completed by an internist, oncologist, gastrointestinal specialist, or general surgeon.
[7]Facilities were initially expected to complete this review by May 1, 2014, though an extension to May 9, 2014, was granted.
[8]https://securereports2.vssc.med.va.gov/Reports/Pages/Report.aspx?ItemPath=%2fSystems+Redesign%2fConsults%2fConsult_Switchboard; see also Under Secretary for Health *Consult Business Rules Implementation.* May 23, 2013.

Table 2: Comparison of VHA Activities To Review Consults that Were Unresolved More Than 90 Days, September 2012 through May 2014

	VHA Consult Review Activity		
	High-Interest Consults	**Gastrointestinal Cancer Look-Back**	**Other Consults**
Type(s) of Consults	Gastrointestinal endoscopy, cardiac catheterization, cardiology, cardiac surgery, oncology, bronchoscopy, and thoracic surgery	Gastrointestinal consults	All other clinical consults not covered under the review of high-interest consults
Start Date	September 25, 2012	November 1, 2012	May 23, 2013
Final Due Date	March 1, 2013	November 30, 2012	May 9, 2014
Instructions Included Explicit Expectation to Disclose Harm (Y/N)	N[a]	Y	N[a]

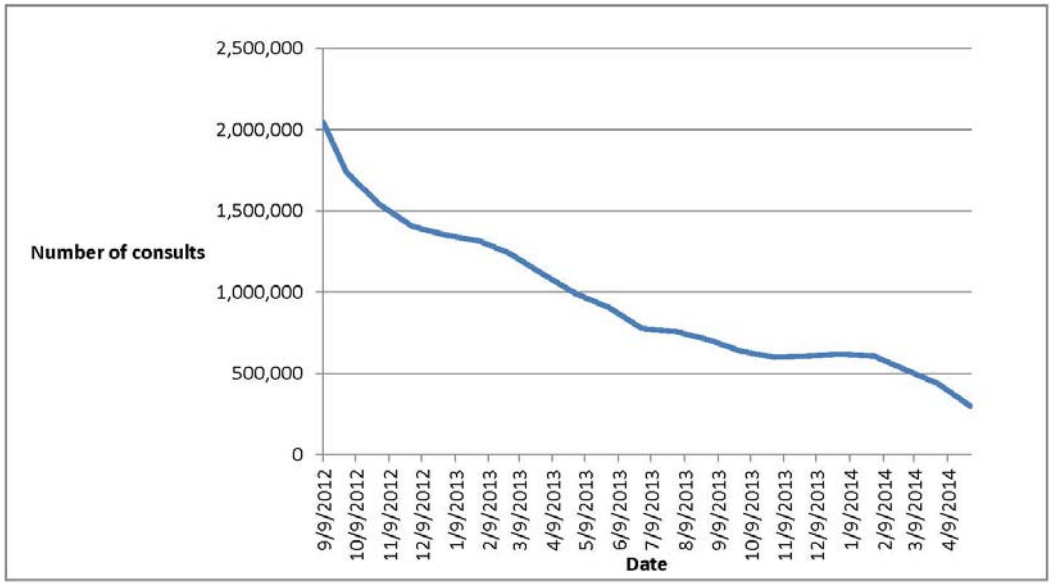
Source: OIG analysis of VA documents

[a]Note: Although facilities were not explicitly directed to determine whether consult delays contributed to harm to veterans and disclose any harm to veterans, VHA leadership told us that, during the course of this review, facility managers were expected to comply with VHA policy, which specifies the steps facility managers should take to evaluate and report adverse events. See VHA Handbook 1004.08.

Lack of Control Activities

During the review of consults that were unresolved for more than 90 days, including high-interest and other consults, the number of such consults decreased considerably. Specifically, the number of consults that were unresolved for more than 90 days dropped from more than 2 million in September 2012 to just under 300,000 at the end of April 2014 (see Figure 1).

Figure 1. Number of Consults that Were Unresolved More Than 90 Days, September 2012 through April 2014



Source: Data from VHA's Consult Switchboard[9]

Consistent with the Federal internal control standard for control activities, we would expect VHA to have taken steps to help ensure that consults that were unresolved for more than 90 days were appropriately reviewed and resolved.[10] Examples of control activities could have included auditing a sample of consults that were closed as a result of the consult delay review and/or requiring facilities to maintain and submit documentation of specific steps taken to review and resolve consults.

However, VHA did not implement appropriate control activities, and VISN leadership we interviewed reported that they relied on facility staff to review and respond to unresolved consults. As a result, VHA lacks reasonable assurance that facilities appropriately reviewed and resolved consults; closed consults only after ensuring veterans had received the requested services, when appropriate; and, where consult delays contributed to patient harm, notified patients as required by VHA policy. OIG recently found that at one medical facility, consults were inappropriately closed while veterans were awaiting requested services in an effort to meet VHA's early May 2014 deadline for reviewing and responding to unresolved consults.[11] Similar events may have occurred at other VA facilities.

[9] https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/Systems+Redesign/Consults/Consult_Performance_By_Stopcode&rs:Command=Render. Accessed September 22, 2014.
[10] *GAO/AIMD-00-21.3.1.*
[11] *Healthcare Inspection: Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, Georgia (Report No. 14-03010-251),* August 12, 2014.

Issue 2: Information Presented in VHA's Report National Consult Delay Review Fact Sheet

In advance of the April 9, 2014, HVAC hearing, *A Continued Assessment of Delays in VA Medical Care and Preventable Deaths*, VHA provided congressional staff with a document entitled, *Department of Veteran Affairs (VA) National Consult Delay Review Fact Sheet, April 2014.* VHA leadership told us that this Fact Sheet was intended to summarize the process VHA used to review consults that were unresolved for more than 90 days as well as the disposition of the review, including the number of patients who were harmed by consult delays. Among other things, the Fact Sheet indicated that, based on findings from a system-wide review of high-interest consults since 1999 and new cases of gastrointestinal cancer, VHA identified 76 patients in the health care system for whom institutional disclosures were provided or attempted. Further, the Fact Sheet indicated that of those 76 patients, 23 had died.

In reviewing the Fact Sheet, we found that several key statements related to the scope and results of the review were misleading or incorrect. In particular, we found the following:

1. The Fact Sheet overstated the timeframe of the consults included in the review. The Fact Sheet indicates that VHA "looked at all open [consults] since 1999 to ensure that proper care has been administered to patients." In contrast to this statement, facility managers were instructed to review consults that had been unresolved for more than 90 days but less than 5 years. Facilities were generally not required to review consults that had been unresolved for more than 5 years and could, instead, close those without review. As a result, VHA's review of unresolved consults actually included open consults since September 2007.

2. The number of institutional disclosures and deaths listed in the Fact Sheet includes errors. For example, in one VISN, one of the institutional disclosures was attributed to the wrong facility in the VISN. In another VISN, the number of institutional disclosures attributed to one of the facilities was incorrect (overstated by two), despite the facility leadership's efforts to correct that information with the VISN prior to publication of the Fact Sheet. In addition, the Fact Sheet may have contained errors, including either overstatements or understatements of institutional disclosures or deaths, for VISNs and facilities that we did not contact as part of our review.

3. The Fact Sheet included an unsupported claim about the extent to which the "vast majority" of unresolved consults represented issues with documentation versus true delays in care. VHA leaders who were primarily involved in designing and overseeing the review of consults were not able to provide support for this assertion. Further, leaders we interviewed from one VISN provided us with self-assessments completed by all facilities in the VISN, indicating that staff from those facilities believed that the majority of their unresolved consults did reflect delays in care. We did not receive comparable information from the other VISNs we interviewed.

These misleading or incorrect statements were repeated during statements made by VHA leadership during a briefing with congressional staff on April 7, 2014; an HVAC Hearing on April 9, 2014; media events proximal to the hearing; and follow-up correspondence with congressional staff. Subsequently, VHA issued an apology that stated, "VA inadvertently caused confusion in its communication on this complex set of reviews that were ongoing at the time. For that, we apologize. There was no intent to mislead anyone with respect to the scope or findings of these reviews."

Conclusions

In late September 2012, VHA initiated a multi-phased review of consults that were unresolved for more than 90 days. Through early May 2014, when facility managers were expected to have completed their reviews, the number of unresolved consults decreased considerably. However, because VHA did not implement appropriate control activities, it lacks reasonable assurance that consults were appropriately reviewed and resolved; that consults were closed only after ensuring veterans had received the requested services, when appropriate, and, to the extent that consult delays contributed to harm to patients, those patients were notified as required by VHA policy.

Based on our review of the Fact Sheet, we found that several key statements related to the scope and results of VHA's review of unresolved consults were misleading or incorrect. These misleading or incorrect statements were repeated during statements made by VHA leadership during a congressional briefing and follow-up correspondence, an HVAC hearing, and media events. VHA subsequently issued an apology for "inadvertently" causing "confusion in its communication."

We made three recommendations.

Recommendations

1. We recommended that the Interim Under Secretary for Health conduct a systematic assessment of the processes each VA medical facility used to address unresolved consults during VHA's system-wide consult review.

2. We recommended that the Interim Under Secretary for Health ensure that if a medical facility's processes are found to have been inconsistent with VHA guidance on addressing unresolved consults, action is taken to confirm that patients have received appropriate care.

3. We recommended that after reviewing the circumstances of any inappropriate resolution of consults, the Interim Under Secretary for Health confer with the Office of Human Resources and the Office of General Counsel or other relevant agency to determine the appropriate administrative action to take, if any.

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Fact Sheet Provided to Congress in Advance of a Hearing for the House Committee on Veterans' Affairs

Department of Veteran Affairs (VA)
National Consult Delay Review
Fact Sheet
April 2014

Summary:
The Department of Veterans Affairs (VA) cares deeply for every Veteran we are privileged to serve. Our goal is to provide the best quality, safe and effective health care our Veterans have earned and deserve. We take seriously any issue that occurs at any one of the more than 1,700 VA health care facilities across the country.

Any adverse incident for a Veteran within our care is one too many. When an incident occurs in our system we aggressively identify, correct and work to prevent additional risks. We conduct a thorough review to understand what happened, prevent similar incidents in the future, and share lessons learned across the system.

As a result of the consult delay issue VA discovered at two of our medical centers, the Veterans Health Administration (VHA) continues to conduct a national review of consults across the system. We have redesigned the consult process to better monitor consult timeliness. We continue to take action to strengthen oversight mechanisms and prevent a similar delay at other VA medical centers. We take any issue of this nature extremely seriously and offer our sincerest condolences to families and individuals who have been affected and lost a loved one.

Key Facts:

As a result of the consult delay issue VA discovered at two of our medical centers, VHA continues to conduct a national review of consults across the system, which includes a review of all consults since 1999. Within this time frame over a quarter billion consults were requested across VA's system of care. A consult is a request by one provider for the clinical opinion or services of a second provider or physician.

- During this review, VA looked at all open since 1999 to ensure that proper care has been administered to patients. Within this time frame over a quarter billion consults were requested in VA.
- While these are the results of the review of high interest consults, the system-wide review of consults continues.
- High interest consults are defined as consults in the following seven areas: gastrointestinal endoscopy; cardiac catheterization; cardiology; cardiac surgery; oncology; bronchoscopy; and thoracic surgery.
- VA is re-writing the business practices of its consult system that will allow the system to distinguish true clinical consultation from other administrative uses of the consult package, and clinical staff has undergone training on the use of the system.

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- Based on findings from a system-wide review high interest consults and new cases of gastrointestinal cancer, VA identified 76 patients in our health care system for whom institutional disclosures were provided or attempted, based predominantly on their gastrointestinal care. Of these 76 patients, 23 have passed away.

- VA uses an electronic consult management system containing all electronic consult requests. The system is intended to be used for scheduling appointments for patients in need of clinical consultations with health care providers. However, in additional to clinical consultations, the system also was used for a variety of other purposes including electronic communications between providers and notes to reserve spots in transportation vehicles. A review of data in this system showed that the vast majority of these open consult requests were not clinical in nature, and so were not closed after the request was completed—although the requests were 'open' in the system, they did not correspond to patients awaiting treatment or diagnosis.

- When an adverse event occurs, VHA contacts the patient or their representative when the patient has either been harmed or may have been harmed during their care – this is known as an institutional disclosure. VHA's first priority is to notify the patient or their representative of the adverse event, as well as the patient's rights and recourse. VHA is committed to a process of full and open disclosure to Veterans and their families.

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Data Chart:

The Department of Veterans Affairs (VA) cares deeply for every Veteran we are privileged to serve. Our goal is to provide the best quality, safe and effective health care our Veterans have earned and deserve. We take seriously any issue that occurs at any one of the more than 1,700 VA health care facilities across the country.

Any adverse incident for a Veteran within our care is one too many. When an incident occurs in our system we aggressively identify, correct, and work to prevent additional risks. We conduct a thorough review to understand what happened, prevent similar incidents in the future, and share lessons learned across the system.

As a result of the consult delay issue VA discovered at two of our medical centers, the Veterans Health Administration (VHA) continues to conduct a national review of consults across the system. We have redesigned the consult process to better monitor consult timeliness. We continue to take action to strengthen oversight mechanisms and prevent a similar delay at another VA medical center. We take any issue of this nature extremely seriously and offer our sincerest condolences to families and individuals who have been affected and lost a loved one.

Based on findings from a system-wide review of high interest consults and new cases of gastrointestinal malignancy, VA identified 76 patients in our health care system for whom institutional disclosures were provided or attempted, based predominantly on their gastrointestinal care. Of these 76 patients, 23 have passed away.

VISN 1	Station Name	Institutional Disclosures	Mortality
1	VA Maine HCS	0	0
1	VA Connecticut HCS - West Haven	0	0
1	Bedford VAMC	0	0
1	VA Boston HCS	0	0
1	Northampton VAMC Central Western Massachusetts	0	0

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1	Manchester VAMC	0	0
1	Providence VAMC	0	0
1	White River Junction VAMC	0	0
VISN 2	Station Name	Institutional Disclosures	Mortality
2	Bath VAMC	1	0
2	Canandaigua VAMC	0	0
2	Albany	0	0
2	Syracuse	0	0
2	Western NY HCS	0	0
VISN 3	Station Name	Institutional Disclosures	Mortality
3	New Jersey HCS	0	0
3	Bronx VAMC	0	0
3	Northport VAMC	0	0
3	Hudson Valley HCS	0	0
3	NY Harbor HCS	0	0
VISN 4	Station Name	Institutional Disclosures	Mortality

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4	Wilmington VAMC	0	0
4	Coatesville VAMC	0	0
4	Erie VAMC	1	0
4	Altoona VAMC	0	0
4	Lebanon VAMC	0	0
4	Philadelphia VAMC	2	0
4	Butler	0	0
4	Pittsburgh HCS	0	0
4	Wilkes-Barre VAMC	0	0
4	Clarksburg	0	0
VISN 5	Station Name	Institutional Disclosures	Mortality
5	Washington, DC VAMC	0	0
5	Maryland HCS	0	0
5	Martinsburg VAMC	0	0
VISN 6	Station Name	Institutional Disclosures	Mortality
6	Asheville VAMC	0	0

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6	Durham VAMC	0	0
6	Fayetteville VAMC	0	0
6	Salisbury VAMC	0	0
6	Hampton VAMC	7	2
6	Richmond	0	0
6	Salem VAMC	0	0
6	Beckley VAMC	0	0
VISN 7	Station Name	Institutional Disclosures	Mortality
7	Birmingham VAMC	0	0
7	Central Alabama HCS	1	0
7	Tuscaloosa VAMC	0	0
7	Atlanta VAMC	0	0
7	Dublin	0	0
7	Augusta	7	3
7	Charleston	2	1
7	Columbia	20	6

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VISN 8	Station Name	Institutional Disclosures	Mortality
8	Bay Pines	2	0
8	Miami	2	1
8	Tampa	1	0
8	North Florida/ South Georgia HCS	4	2
8	Orlando	0	0
8	West Palm Beach	5	2
8	Caribbean HCS	0	0

VISN 9	Station Name	Institutional Disclosures	Mortality
9	Lexington VAMC	0	0
9	Louisville VAMC	1	0
9	Mountain Home	0	0
9	Memphis VAMC	0	0
9	Tennessee Valley HCS - Nash	0	0
9	Tennessee Valley HCS - York	0	0
9	Huntington VAMC	1	1

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VISN 10	Station Name	Institutional Disclosures	Mortality
10	Columbus	0	0
10	Chillicothe VAMC	0	0
10	Cincinnati VAMC	0	0
10	Dayton VAMC	0	0
10	Cleveland	3	1
VISN 11	Station Name	Institutional Disclosures	Mortality
11	Iliana HCS	0	0
11	Indianapolis	0	0
11	Northern Indiana HCS	0	0
11	Saginaw	0	0
11	Battle Creek VAMC	0	0
11	Detroit	1	0
11	Ann Arbor HCS	0	0
VISN 12	Station Name	Institutional Disclosures	Mortality
12	Hines	0	0

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12	James A. Lovell FHCC (N. Chicago)	0	0
12	Iron Mountain	0	0
12	Milwaukee	0	0
12	Tomah VAMC	0	0
12	Madison	0	0
12	Jesse Brown	0	0
VISN 15	Station Name	Institutional Disclosures	Mortality
15	Marion HCS	0	0
15	Wichita	0	0
15	Eastern Kansas HCS	0	0
15	Columbia	0	0
15	Poplar Bluff	0	0
15	Kansas City VAMC	0	0
15	St. Louis VAMC	0	0
VISN 16	Station Name	Institutional Disclosures	Mortality
16	Central Arkansas HCS	1	0

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16	Ozarks HCS	0	0
16	Alexandria VAMC	0	0
16	Overton Brooks, Shreveport	0	0
16	Southeast Louisiana HCS	0	0
16	Jackson	0	0
16	Gulf Coast HCS	0	0
16	Muskogee	0	0
16	Oklahoma City VAMC	1	0
16	Houston	0	0
VISN 17	Station Name	Institutional Disclosures	Mortality
17	Central Texas HCS	0	0
17	South Texas HCS	1	0
17	Texas Valley Coastal HCS	0	0
17	North Texas HCS	0	0
VISN 18	Station Name	Institutional Disclosures	Mortality
18	Northern Arizona HCS	2	1

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18	Phoenix HCS	0	0
18	Southern Arizona HCS	1	1
18	New Mexico HCS	0	0
18	Amarillo HCS	0	0
18	El Paso HCS	0	0
18	West Texas HCS	0	0
VISN 19	Station Name	Institutional Disclosures	Mortality
19	Eastern Colorado HCS	0	0
19	Grand Junction VAMC	3	1
19	Montana HCS	0	0
19	Salt Lake City HCS	0	0
19	Cheyenne VAMC	1	0
19	Sheridan VAMC	0	0
VISN 20	Station Name	Institutional Disclosures	Mortality
20	Alaska HCS	0	0
20	Boise VAMC	0	0

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20	Portland VAMC	1	0
20	Roseburg HCS	0	0
20	Walla Walla VAMC	0	0
20	Spokane VAMC	0	0
20	Southern Oregon Rehabilitation Center & Clinics	0	0
20	Puget Sound HCS	0	0
VISN 21	Station Name	Institutional Disclosures	Mortality
21	San Francisco VAMC	0	0
21	Central California HCS	3	0
21	Northern California HCS	0	0
21	Palo Alto HCS	0	0
21	Pacific Islands HCS	0	0
21	Sierra Nevada HCS	0	0
21	Manila	0	0
VISN 22	Station Name	Institutional Disclosures	Mortality
22	Greater Los Angeles HCS	0	0

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22	Loma Linda HCS	0	0
22	Long Beach HCS	0	0
22	San Diego HCS	0	0
22	Southern Nevada HCS	0	0
VISN 23	Station Name	Institutional Disclosures	Mortality
23	Central Iowa HCS	0	0
23	Iowa City HCS	1	1
23	Minneapolis VAMC	0	0
23	St. Cloud VAMC	0	0
23	Nebraska-Western Iowa HCS	0	0
23	Fargo VAMC	0	0
23	Sioux Falls VAMC	0	0
23	Black Hills HCS	0	0
TOTAL		76	23

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Appendix B

Interim Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: NOV 2 1 2014

From: Interim Under Secretary for Health (10)

Subj: OIG Draft Report, Health Care Inspection: Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet (VAIQ 7544160)

To: Assistant Inspector General for Health Care Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations. Attached is the Veterans Health Administration's corrective action plan for recommendations 1-3.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Karen Rasmussen, M.D., Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.

Carolyn M. Clancy, MD

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Interim Under Secretary for Health conduct a systematic assessment of the processes each VA medical facility used to address unresolved consults during VHA's system-wide consult review.

Concur

Target date for completion: February 2015

VHA response: The Office of Medical Inspector (OMI) in collaboration with the Office of Compliance and Business Integrity (CBI) and input from the Office of the Deputy Under Secretary for Health for Operations and Management will conduct a systematic assessment of the processes used by Veterans Health Administration (VHA) facilities to address unresolved consults from VHA's series of consult reviews and "look backs." OMI and CBI will determine whether facilities' processes were consistent with VHA guidance on addressing unresolved consults and make appropriate recommendations for further actions at those medical facilities found to have processes that were inconsistent with VHA guidance on addressing unresolved consults.

Recommendation 2. We recommended that the Interim Under Secretary for Health ensure that if a medical facility's processes are found to have been inconsistent with VHA guidance on addressing unresolved consults, action is taken to confirm that patients have received appropriate care.

Concur

Target date for completion: May 2015

VHA response: The Office of the Deputy Under Secretary for Health will institute prompt action on the Medical Inspector's recommendations for those medical facilities found to have processes that were inconsistent with VHA guidance on addressing unresolved consults. These actions will include ensuring that patients have received appropriate care at facilities whose processes were inconsistent with VHA guidance on addressing unresolved consults.

Recommendation 3. We recommended that after reviewing the circumstances of any inappropriate resolution of consults, the Interim Under Secretary for Health confer with the Office of Human Resource and the Office of General Counsel or other relevant agency to determine the appropriate administrative action to take, if any.

Concur

Target date for completion: July 2015

VHA response: In cases where inappropriate resolution of consults may be identified, VHA will confer with the Office of Human Resources and the Office of General Counsel or other relevant agency to determine appropriate administrative actions including but not limited to administrative investigations, disciplinary actions, and institutional disclosure.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Melanie Krause, PhD, RN, Team Leader Kathy Gudgell, JD, RN Jerome Herbers, MD

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