Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04194-118

Healthcare Inspection

Alleged Consult Management Issues and Improper Conduct W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina

February 18, 2015

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 (OIG) Office of Healthcare Inspections reviewed allegations that a physician improperly closed Non-VA Care Coordination (NVCC) consults and an inappropriate comment was made about a patient at the W.G. (Bill) Hefner VA Medical Center in Salisbury, NC.

We did not substantiate the allegation that a physician improperly cancelled or discontinued NVCC consults, thus denying patients needed care. Record reviews of 214 consults revealed that the reasons for cancellation or discontinuation were logical, met Veterans Health Administration and/or local guidelines, and were appropriately documented.

While we substantiated the allegation that a physician made an inappropriate comment about a patient, we found that the facility took appropriate action and the physician apologized for the statement.

We made no recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report. (See Appendixes A and B, pages 5–6 for the Directors' comment.) No further action is required.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed allegations that a physician improperly closed Non-VA Care Coordination (NVCC) consults and an inappropriate comment was made about a patient at the W.G. (Bill) Hefner VA Medical Center (the facility) in Salisbury, NC. The purpose of the review was to determine whether the allegations had merit.

Background

The facility is a tertiary care medical center with 159 hospital and 270 community living center beds located in Veterans Integrated Service Network 6. The facility provides inpatient and outpatient medical, surgical, rehabilitative, and long-term care services and is affiliated with Wake Forest University School of Medicine.

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 the VA facility.[1] A consult and pre-authorization for treatment in the community is required.[2] After administrative and clinical eligibility is determined, a designated facility physician approves the NVCC care. The consult is then forwarded to a community provider to schedule and complete the requested service. The facility's top five NVCC consult requests are for radiology, orthopedics, neurology/neurosurgery, gastroenterology, and cardiology services.

Allegations

In July 2014, OIG received a complaint alleging that a physician:

- Improperly discontinued or cancelled NVCC consults, thus denying patients needed care
- Made inappropriate comments about a patient

Scope and Methodology

We interviewed facility personnel, including a physician and the NVCC administrative coordinator. We reviewed Veterans Health Administration (VHA) and facility policies related to NVCC, reviewed an Administrative Board of Investigation, and evaluated a random selection of NVCC consults that were cancelled or discontinued by the subject physician.

[1] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
[2] www.nonvacare.va.gov, accessed January 3, 2014.

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: NVCC Consults

We did not substantiate the allegation that a physician improperly cancelled or discontinued NVCC consults, thus denying patients needed care.

According to VHA guidelines, consults should be cancelled when the consult prework[3] 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. Consults should be discontinued when the care is no longer needed, such as when the patient is deceased.

We reviewed a random sample of 214 (of 1,414) NVCC consults cancelled or discontinued by the physician during the period January 1, 2013, to August 31, 2014. We found that, in general, the consults were cancelled or discontinued for logical reasons and that the rationales were appropriately documented. Common reasons for consult cancellation or discontinuation included that the consult was no longer needed, the consult was a duplicate, the service was available at a VA facility, or the consult was not used (within the authorized time frame).[4]

Issue 2: Physician's Comments

We substantiated the allegation that a physician made an inappropriate comment about a patient.

The facility conducted a fact-finding and confirmed an inappropriate comment was made. The comment was not made to the veteran or in the presence of the veteran. The acting Chief of Staff addressed the issue of the inappropriate comment made about the patient, and the physician made a public apology. For the last 3 years (fiscal years 2012–2014), the physician's professional practice evaluations have not disclosed any patient or employee concerns. In addition, the physician has met or exceeded expectations in the "professionalism" category, which includes respect, compassion, honesty, acceptance of responsibility, and consideration of the needs of others.

[3] The information needed for a complete consult request, such as history of illness or injury, laboratory results, or imaging studies.

[4] Consults are authorized for a specific time frame. If the patient does not use the consult within the authorized time frame, then the consult is discontinued. The ordering provider is notified, and a new consult can be entered as needed.

Conclusions

We did not substantiate the allegation that a physician improperly cancelled or discontinued NVCC consults, thus denying patients needed care. Record reviews of 214 consults revealed that the reasons for cancellation or discontinuation were logical, met VHA and/or local guidelines, and were appropriately documented.

While we substantiated the allegation that a physician made an inappropriate comment about a patient, we found that the facility took appropriate action and the physician apologized for the statement.

We made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 9, 2015

From: Director, VA Mid-Atlantic Healthcare Network (10N6)

Subj: **Draft Report**—Healthcare Inspection—Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, NC

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

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

1. The attached subject report is forwarded for your review and further action. I have reviewed the response of the W. G. (Bill) Hefner VA Medical Center, and concur with the facility's recommendations.

2. If you have further questions, please contact Lisa Shear, VISN 6 QMO, at (919) 956-5541.

DANIEL F. HOFFMANN, FACHE

Appendix B

Facility Director Comments

Department of
Veterans Affairs

Memorandum

Date: January 6, 2015

From: Director, W.G. (Bill) Hefner VA Medical Center (659/00)

Subj: **Draft Report**—Healthcare Inspection—Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, NC

To: Director, VA Mid-Atlantic Healthcare Network (10N6)

1. I have reviewed the draft report of the Office of Inspector General and I concur with the conclusions.

2. Please contact me if you have any questions or comments.

(original signed by:)
Kaye Green FACHE
Director, W. G. (Bill) Hefner VA Medical Center (659/00)

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix D

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