Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04049-379

Healthcare Inspection

Alleged Consult Processing Delay Resulting in Patient Death VA Eastern Colorado Health Care System Denver, Colorado

July 7, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of an allegation made by a complainant that a consult delay may have resulted in a patient's death at the VA Eastern Colorado Health Care System (facility) in Denver, CO.

We substantiated that there was a delay in surgery; however, we could not substantiate that it contributed to the patient's death. According to the patient's death certificate, the patient died of natural causes, specifically, hypertension and cardiovascular disease. Without an autopsy, we cannot determine that the patient died of a ruptured aortic or common iliac artery aneurysm. The patient's surgery was delayed due to the unavailability of the facility's endovascular surgeon and the subsequent referral for non-VA medical care.

Prior to our site visit, facility managers had identified the possible delay in processing the patient's Non-VA Care Coordination (NVCC) consult and instituted corrective actions. However, we found that there was still confusion between the requesting provider and the NVCC staff in the interpretation of the "urgency" field in the consult request and what it meant to "process" the consult.

We recommended that the Facility Director ensure that the NVCC consult process is clearly defined, the facility has appropriate processes in place to identify and address potential delays, and that compliance is monitored.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 6–8 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 to assess the merit of an allegation made by a complainant that a consult delay may have resulted in a patient's death at the VA Eastern Colorado Health Care System (facility) in Denver, Colorado.

Background

The facility provides primary, tertiary, and long-term care with a broad range of inpatient and outpatient health care services. It is part of Veterans Integrated Services Network (VISN) 19. The facility is affiliated with the University of Colorado at Denver and Health Sciences Center (UH).[1] The facility serves a veteran population of about 350,000 throughout the Front Range of Colorado and into Wyoming. Outpatient care is also provided at nine community based outpatient clinics.

In early November 2013, all scheduled endovascular surgeries[2] were temporarily suspended due to the unavailability of the facility endovascular surgeon. The Chief of Surgery, who was the Acting Chief of Vascular Surgery at the time, reviewed all cancelled endovascular surgeries and referred each for follow-up.

Allegation. In June 2014, the OIG received an allegation from a confidential complainant that a Non-VA Care Coordination (NVCC) consult delay may have resulted in a patient's death because the patient did not receive timely surgery to repair an abdominal aortic aneurysm (AAA) and a common iliac artery (CIA) aneurysm.[3]

Non-VA Medical Care Program. Formerly known as fee basis care, NVCC is provided to eligible veterans when a service is not available in a timely manner within VA due to capability, capacity, or accessibility. 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.[4,5] A consult and pre-authorization for treatment in the

[1] The Anschutz Medical Campus includes the School of Dental Medicine, School of Medicine, School of Pharmacy, College of Nursing, and UH.
[2] Endovascular surgeries are minimally invasive surgeries in which the body is operated on by accessing blood vessels, rather than by performing an open procedure using a wider incision.
[3] An AAA is formed when the aorta, the largest artery in the body, becomes weak and expands or bulges in the abdominal area. The CIA occurs in the common iliac arteries that branch off the abdominal aorta in the pelvic area. Aneurysms are a health risk because they can rupture and cause fatal internal bleeding.
[4] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures,* June 9, 2010.
[5] VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013.

community is required.[6] According to Veterans Health Administration (VHA) consult policy, "…a clear and solid consultation process is vital to patient care."[7]

Facility Processing of NVCC Vascular Consult. The facility tracks NVCC vascular consults through the Computerized Patient Record System (CPRS). The process begins when a facility provider determines that the care a patient needs is not available at the facility. The provider initiates a NVCC request, including the reason for the request, type of service, chief complaint, clinical history, and urgency, for review and processing by the NVCC staff. Within the NVCC office, a registered nurse (RN) conducts a review for medical necessity and administrative eligibility. If the RN approves the consult, an RN, Licensed Practical Nurse (LPN), or medical support assistant ensures that authorizations are entered into the system, contacts the patient to choose a non-VA facility, submits the authorization and clinical information to the non-VA facility, and coordinates the scheduling of an appointment between the patient and the non-VA facility.

Scope and Methodology

We interviewed the complainant on July 21, 2014. We conducted a site visit on August 13. We interviewed the Chief of Staff; Acting Chief of Surgery; Chief of Vascular Surgery (former Chief of Surgery and VISN 19 Surgical Consultant); Chief of Anesthesiology; Vascular Surgery Coordinator; the patient's primary care provider; and clinical, administrative, and quality management staff with knowledge relevant to the allegation.

We reviewed the patient's VA electronic health record and non-VA medical records, VHA and facility policies related to NVCC consult review and scheduling process and management, NVCC process guides and standard operating procedures, and other relevant documents.

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.

[6] U.S. Department of Veterans Affairs, Chief Business Office Purchased Care. NNPO Non-VA Medical Care Coordination. http://www.va.gov/PURCHASEDCARE/docs/pubfiles/factsheets/NVC_Authorizations.pdf accessed September 4, 2014.
[7] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive expired September 30, 2013 and has not yet been updated.

Case Summary

The patient was a male in his mid-sixties. Among other problems, he had a history of coronary artery heart disease, intracoronary stents,[8] and high blood pressure. Since 2000, the patient sporadically sought care at the facility. In July 2013, the patient was seen by a newly appointed PCP and received an initial history and physical examination. At this visit, the patient told his PCP that he was "ready to take control of his life and start to manage his health." Based on the history and physical examination, the PCP referred the patient to the Gastroenterology Service (GI) for evaluation and colorectal cancer screening. In September, an ultrasound identified an AAA and a right CIA aneurysm. On a subsequent computerized tomography scan (CT), these aneurysms measured 5.6 centimeters (cm) for the AAA,[9] and 5.8 cm for the CIA aneurysm.[10]

A radiologist placed an urgent consult with vascular surgery. The size of the aneurysms was further evaluated and confirmed with a CT-Angiography in October. Within 2 days of the CT-Angiography, a vascular surgeon saw the patient and recommended an endovascular repair of the aneurysms. He directed that the patient be placed on the operating room (OR) schedule. The patient received a preoperative evaluation by anesthesia, and the patient was scheduled for surgery at the facility for the first week of November. However, at the end of October, the facility attempted to contact the patient to notify him that the case had been canceled due to the unavailability of a vascular surgeon.

In the beginning of November, the Chief of Surgery placed a NVCC consult request for endovascular repair of the patient's AAA and CIA aneurysm with an urgency of "Within 1 mo [month]." Seven days after the consult request, the NVCC RN reviewer confirmed administrative eligibility and medical necessity. Ten days after the consult request, the patient saw his PCP, who noted that the patient's blood pressure was consistently elevated, but the patient declined additional medication. This was the patient's last documented visit to the facility.

Thirty-eight days after the consult request, an NVCC Coordinator LPN contacted the patient and gave him a choice of non-VA surgical facilities in which to receive care. The patient chose UH. In mid-December, the NVCC office faxed the patient's medical information and authorization to UH. Fifty-five days after the consult request, the patient contacted the NVCC office inquiring about the status of the referral to UH. The NVCC Coordinator LPN contacted UH and learned that the referral had been misplaced. The facility re-faxed the referral to UH on the same day.

The patient had his first appointment at UH in mid-January 2014. The UH vascular surgeon concurred with the decision to perform an endovascular surgery.

[8] A stent is a small mesh tube that is used to treat narrow or weak arteries. Arteries are blood vessels that carry blood away from your heart to other parts of your body.
[9] Surgical repair is generally indicated when an AAA exceeds 5.5 cm.
[10] A CIA aneurysm with a diameter that reaches or exceeds 2.0 cm.is an indication for surgical repair.

Approximately 1 month later, UH anesthesia conducted a pre-operative assessment of the patient and cleared him for surgery. The patient was scheduled for surgery 4 days later; however, the patient died the day before surgery was to take place.

Inspection Results

Issue 1: NVCC Consult Delay Resulting in Patient Death

We substantiated that there was a delay in surgery; however, we could not substantiate that this contributed to the patient's death. One hundred days lapsed between the patient's original date of surgery at the facility and the date of the scheduled non-VA surgery at UH. According to the patient's death certificate, the patient died of natural causes, specifically, hypertension and cardiovascular disease. An autopsy was not performed. The patient's surgery was delayed due to the unavailability of the facility's endovascular surgeon and the subsequent referral for non-VA care.

Prior to our site visit, facility managers had modified the NVCC vascular consult process. Currently, RNs process all vascular consults. Additionally, managers provided education to NVCC clinical staff on the proper tracking of consults, how to identify possible consult delays, proper documentation of consult-related events, and how to assist patients in obtaining timely appointments with the non-VA providers.

Despite these improvements, we found that there was still confusion between the requesting provider and the NVCC staff in the interpretation of the "urgency" field in the consult request and what it means to "process" the consult. The requesting provider told us that when he requested a consult with an urgency of "within 1 month" he expected the patient to have an appointment and be seen by a non-VA provider within 1 month. The NVCC RN told us that a consult with an urgency "within 1 month" meant that the consult request would be sent and the appointment would be scheduled with a non-VA provider within 1 month; however, the actual appointment date may be later.

Conclusions

We substantiated that there was a delay in surgery; however, we could not substantiate that it contributed to the patient's death. According to the patient's death certificate, the patient died of natural causes, specifically, hypertension and cardiovascular disease. Without an autopsy, it is unknown whether or not the patient died of a ruptured aneurysm. The patient's surgery was delayed due to the unavailability of the facility endovascular surgeon and the subsequent referral for non-VA care.

Prior to our site visit, facility managers had identified the possible delay in processing the patient's NVCC consult and instituted corrective actions. However, we found that there was still confusion between the requesting provider and the NVCC staff in the interpretation of the "urgency" field in the consult request and what it meant to "process" the consult.

Recommendation

1. We recommended that the Facility Director ensure that the NVCC consult process is clearly defined, the facility has appropriate processes in place to identify and address potential delays, and that compliance is monitored.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: March 13, 2015

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado

To: Director, Denver Office of Healthcare Inspections (54DV)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

I have reviewed and concur on the response from VA Eastern Colorado HCS to the remaining recommendation to the above Healthcare Inspection report.

If you have any questions, please contact Ms. Susan Curtis, VISN 19 HSS at (303) 639-6995.

Ralph T. Gigliotti

Ralph T. Gigliotti, FACHE

Appendix B

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 13, 2015

From: Director, VA Eastern Colorado Health Care System (554/00)

Subj: Healthcare Inspection—Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado

To: Director, Rocky Mountain Network (10N19)

1. We are submitting written comments in response to the above referenced Healthcare Inspection report received February 25, 2015.

2. In reviewing the draft report, the facility has addressed the Recommendation by the Office of Inspector General Healthcare Inspections and provided our response and action plan.

3. If you have any questions regarding this response, please contact Mr. Keith Harmon, Chief, Organizational Improvement at (303) 399-8020, extension 7469.

Natalie A. Merckens, Acting Director, ECHCS

Comments to OIG's Report

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

OIG Recommendation

Recommendation 1. We recommended that the Facility Director ensure that the Non-VA Care Coordination consult process is clearly defined, the facility has appropriate processes in place to identify and address potential delays, and that compliance is monitored.

Concur

Target date for completion: 6-16-2015

Facility response: The NVCC policy will be reviewed and updated to include clarification on consult urgency determinations and the NVCC process by May 11, 2015. In addition, a NVCC Training Plan will be developed and published by April 20, 2015, and NVCC will become a standing agenda item for the Consult Review Committee. The training plan with clear instructions for consult triage, process for referral, timelines for referral and follow-up care completion and documentation requirements for all staff involved in the NVCC process. Starting March 9, 2015, we implemented additional oversight of the NVCC Department through the provision of weekly updates of the existing workload, backlog, performance and Choice Program to the executive team, to our higher headquarters monthly, and to our local Governing Board quarterly. Weekly updates to the leadership team will help ensure that barriers and staffing delays to processing consults are eliminated. By April 20, 2015 expectations for NVCC work audits and a backlog reduction plan will be established.

Appendix C

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Cheryl Walker, ARNP, MBA, Team Leader Clarissa Reynolds, CNHA, MBA Ann Ver Linden, RN, MBA George Wesley, MD

Appendix D

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