



Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04530-452

Healthcare Inspection

Deficient Consult Management, Contractor, and Administrative Practices Central Alabama VA Health Care System Montgomery, Alabama

July 29, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations of deficient consult management, contractor, and administrative practices at the Central Alabama Veterans Healthcare System (CAVHCS), Montgomery, AL.

We substantiated long delays (greater than 90 days) for Non-VA Care Coordination (NVCC) services and that the percentage of unresolved NVCC consults over 90 days increased between June 2014 and March 2015. We also substantiated a lack of follow-up (defined as the requesting provider having documented knowledge of the NVCC consult results); delays getting NVCC care authorized; staff not verifying eligibility for NVCC care; some NVCC consults being cancelled because they had been open longer than 90 days; and some community-based outpatient clinic (CBOC) nurses scheduling patients directly with community providers, primarily because there were delays in processing NVCC consults. We also substantiated that the NVCC program did not have sufficient staffing to address an increase in workload. Staff we interviewed told us that NVCC's changing leadership over the past 18 months had resulted in role confusion, concerns about consistency in processes, and questions about the adequacy of staff training. We could not substantiate that 8,000 consults were reassigned to NVCC during the consult clean-up process, although this is a plausible scenario.

We could not substantiate that intra-facility consults (those completed within CAVHCS) went unanswered for months or were cancelled or that patients were not notified when appointments are scheduled. We did not substantiate "huge" delays in oncology care or that patients waited 5–6 months to start treatment, nor did we substantiate that a particular patient's colorectal cancer metastasized due to delays in oncology care.

We did not substantiate that the Dothan CBOC primary care (PC) contractor improperly billed for physician-led PC appointments or that contract providers did not notify patients of critical fecal occult blood test results.

We substantiated that a contracted private medical group (PMG) completed inadequate initial history and physical (H&P) exams, that those reports were not always available in the patients' VA electronic health records, and that Columbus CBOC providers had to recomplete portions of, or the entire, H&P. We also substantiated that some patients with care needs identified by PMG during the H&P exam were at risk due to poor or non-existent documentation.

We substantiated that CAVHCS had multiple vacancies in important clinical areas; however, we could not determine with certainty the precise number of vacancies and the Services affected due to deficits in CAVHCS' tracking and reporting processes.

We substantiated that Podiatry Service did not follow appointment scheduling guidelines; however, the condition had been corrected. Scheduling staff received training focusing on appointment management and accurate documentation of desired appointment dates.

We substantiated that Administrative Boards of Investigation (ABIs) were not consistently chartered, completed, or followed through in response to serious events. A total of seven ABIs were chartered between fiscal years 2012–2014, none of which fully complied with Veterans Health Administration (VHA) guidelines.

We substantiated that CAVHCS leaders were aware of many of the issues identified in this report including extensive NVCC consult delays, quality and safety issues related to a PMG contract, and staffing deficiencies. We determined that a fractured organizational culture contributed to the development and perpetuation of these issues. Long-standing resistance to the integration of the Montgomery and Tuskegee campuses into a single unified health system, coupled with recurrent changes in leadership, impaired CAVHCS' ability to identify and respond to deficient conditions.

We were unable to fully evaluate eight additional allegations due to insufficient information and/or details. Those allegations are included in Appendix A. We made seven recommendations.

Comments

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes B–D, pages 24–31 for the Under Secretary's and Directors' comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations of deficient consult management, contractor, and administrative practices at the Central Alabama Veterans Health Care System (CAVHCS), Montgomery, AL. During this review, OIG assessed the merit of the allegations and followed up on survey responses from the 2014 OIG Combined Assessment Program (CAP) review.

Background

More than 15 years ago, the Montgomery VA medical center (VAMC) and the Tuskegee VAMC merged, forming the CAVHCS. This two-division health care system provides a broad range of inpatient and outpatient medical, surgical, mental health (MH), and long term care services. Outpatient care is also provided at four community based outpatient clinics (CBOCs) located in Dothan, Wiregrass, and Monroeville, AL, and Columbus, GA. CAVHCS is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of about 134,000 in central and southeastern Alabama and western Georgia.

CAVHCS Senior Leadership

In August 2014, the CAVHCS Director and long-tenured Chief of Staff (COS) were placed on administrative leave pending the results of an external review. Many of the key leaders and managers were in “acting” roles including the Director, COS, Chief of Ambulatory Care, Chief of MH, Associate Director for Patient Care Services, Chief of Human Resources, Chief of Non-VA Care Coordination (NVCC), Chief of the Business Office, and Chief of Radiology. We were frequently unable to interview people with historical knowledge of, or responsibility for, many of the issues identified in this report.

Workload and Budget

Since fiscal year (FY) 2012, CAVHCS has experienced an increase in outpatient workload, a relatively stagnant medical care budget, and a decrease in medical care full time equivalent (FTE) employees (since 2013), as shown below.

Figure 1. CAVHCS Workload and Budget FYs 2012–2014

Fiscal Year	Total Medical Care FTE	Outpatient Visits	Medical Care Budget
FY 2012	1,460	395,684	\$240,143,850
FY 2013	1,506	406,795	\$238,268,251
FY 2014	1,483	439,137	\$237,963,932

Source: VHA Support Service Center Trip Pack Report II - FY 2014 through September

Quality and Performance Measure Data

The Veterans Health Administration’s (VHA) Office of Operational Analytics and Reporting developed a model for understanding a facility’s performance in relation to

nine quality domains and one efficiency domain in comparison to other VHA medical facilities. The Strategic Analytics for Improvement and Learning (SAIL) model reflects the facility's performance over a rolling 12-month period ending as of the 4th quarter FY 2014. Based on these measures, CAVHCS achieved an overall "1-star in quality" ranking amongst all VHA medical facilities. VHA facilities with 1-star rankings are in the lowest 10 percent of all VHA facilities.

2014 OIG CAP Review

The OIG conducted a CAP review at CAVHCS the week of August 25, 2014. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. One objective of the CAP review is to conduct recurring evaluations of selected health care facility operations. As part of the CAP, we also surveyed all employees via an online employee assessment review (EAR). We made 22 recommendations for improvement; corrective actions are in process. See *Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama*, Report No. 14-02079-10, November 25, 2014, for details.

Allegations

On July 16, 2014, a confidential complainant contacted the OIG Hotline and made a variety of allegations, generally related to MH and primary care (PC) services and practices at the Dothan and Wiregrass CBOCs. Further, 229 CAVHCS employees responded to the EAR survey, many of whom identified potential quality, safety, and staffing concerns across the various CAVHCS facilities. Nearly 58 percent of EAR respondents reported that they believed there were "conditions present in the facility inconsistent with quality medical care, which may put patient(s) at risk."

The allegations below have been grouped into broad categories and encompass the initial complaints, those identified through the EAR survey, and those identified through interviews.¹ This report addresses the following allegations:

- Consult Management Deficiencies including consult response delays, consult cancellations, and lack of consult follow-up
- Inadequate Contractor Services including improper billing and failure to comply with quality and other contractual requirements
- Administrative Deficiencies including inadequate staffing in key clinical areas, failure to follow appointment scheduling guidelines, and non-compliant Administrative Boards of Investigation (ABIs)

Several of the complainants and/or interviewees reported that facility leaders had been notified of many of these concerns; however, the problems frequently persisted.

¹ To promote readability, allegations about MH practices, Emergency Department (ED) issues, and quality of care concerns are being addressed in separate reports.

Scope and Methodology

The period of this review was August 25, 2014, to April 2015. We conducted site visits August 25–28, September 22–25, and November 3–5, 2014. We interviewed the initial complainant; the acting CAVHCS Director, acting COS, Associate Director, acting Chief of Ambulatory Care, acting Chief of MH, and the acting Chief of the Emergency Department (ED); acute care, ED, and outpatient nurse managers; Human Resource, Business Office, and NVCC managers and staff; Quality Management staff and the Patient Safety Manager; a patient advocate; clinical and administrative staff from all four CBOCs; VISN employees; and other staff knowledgeable about the issues.

To understand the scope of concerns and to assess the physical environments, we visited all four CBOCs and the Tuskegee and Montgomery campuses and conducted an unannounced inspection of the ED in Montgomery. We interviewed more than 150 employees.

We reviewed extensive system documentation, including VHA and local policies, the Human Resources Restoration and Revitalization (HR³) Program site visit report, meeting minutes, ABIs, and other performance data. We also reviewed electronic health records (EHRs), Issue Briefs, staffing data, and relevant literature.

OIG did not evaluate a variety of Radiology Service and imaging consult-related concerns, as those issues are currently under review by VHA.

Many of the complaints identified, primarily through the EAR survey, did not contain sufficient detail for us to fully evaluate the issue. We reviewed CAVHCS policies and data to determine whether the alleged conditions were possible and/or problematic. Those complaints are included in Appendix A.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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. Consult Management Deficiencies

We substantiated multiple deficiencies in the consult management process. Many of the examples provided by employees we interviewed related to delayed or unanswered imaging consults. As noted previously, imaging consults and processes are currently under review by VHA and are not discussed further in this report.

Other than imaging consults, a vast majority of the remaining complaints we received involved NVCC consults. This section focuses largely on NVCC consults but also includes a sample of in-house (within CAVHCS or VHA) consults.

NVCC Consultation Requests

NVCC, formerly known as Fee Basis (FEE), is medical care provided to eligible veterans outside of VA when VA facilities and services are not reasonably available.² Requesting providers can submit an NVCC consult, which the NVCC staff should review to determine administrative eligibility.³ The NVCC consult is then reviewed for clinical appropriateness and confirmation that any prerequisite testing has been completed. A designated clinical leader, such as an Associate COS, approves the consult, and NVCC staff generate an “authorization” for non-VA care. NVCC staff then send the consult, authorization, and supporting documents to a community-based provider or a medical practice for completion of the consultation and/or evaluation. NVCC case managers and schedulers coordinate the scheduling and follow-up process.

Once a patient completes the NVCC appointment, the community-based provider or medical practice is to send the results of the consultation and further recommendations back to the requesting VHA facility so that the documentation can be scanned into the patient’s EHR and requesting providers can determine the patient’s needs for continued treatment. When community-based providers or medical practices do not return the consultation results in a timely manner, NVCC or other clinical staff must intervene to secure the documentation.⁴ This follow-up component has proven challenging for VHA facilities given the limited staffing and high volume of many NVCC consult requests.

² VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive expired September 30, 2013 and has not yet been updated.

³ Review for administrative eligibility includes confirming the patient is eligible for VA care and that the requested care or service is not reasonably available—in terms of time or distance—within CAVHCS or via an interfacility consult to another VHA facility.

⁴ NVCC, formerly known as Fee Basis care, <http://www.nonvacare.va.gov/>, accessed January 3, 2014.

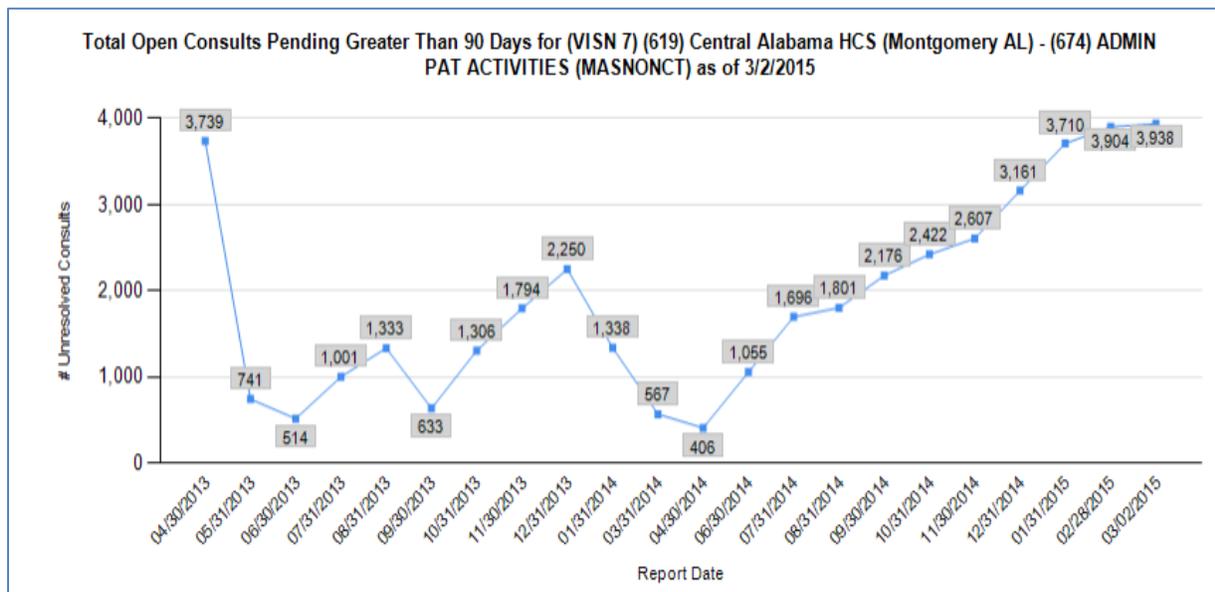
Allegation: NVCC consults are not managed appropriately. Specifically:

- a) There are long delays (greater than 90 days) for NVCC services.
- b) There is a lack of follow-up when services are received through NVCC.
- c) There are delays getting NVCC care authorized [through the leadership team].
- d) Staff are not verifying patients’ administrative eligibility for NVCC care.
- e) Eight-thousand consults were “dumped” into NVCC.
- f) Consults are “timing out” without action and are subsequently cancelled, so requesting providers have to restart the process.
- g) CBOC nursing staff are [improperly] scheduling appointments with community-based specialists because of slow NVCC processing times.
- h) The NVCC program has inadequate resources to handle the influx of consults.

Long Delays for NVCC Services

We substantiated long delays (greater than 90 days) for NVCC services. The graph below reflects unresolved NVCC consults older than 90 days from April 30, 2013 through March 2, 2015.

Figure 2. Unresolved Consults Greater Than 90 Days Old – April 30, 2013–March 2, 2015



Source: VHA Consult Switchboard

VHA has recently developed and implemented a national Metric Plan to permit VHA Central Office to track the success of NVCC deployment at individual medical centers. 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. The January 2015 report reflects that CAVHCS averaged 109 days to close NVCC consults.

To confirm the data reflected above, we reviewed four NVCC consult specialties (see Figure 3, below) that were either provided as case examples or mentioned by an interviewee, or that the specialty being consulted cared for patients with potentially high-risk conditions. We randomly selected 50 consults from each of the four specialties entered in FY 2014 to evaluate whether, and the extent to which, delays existed in processing, scheduling, and completing those consults. We then excluded patients who no longer needed or wanted the care (for example, patients who relocated, died, or were subsequently seen at CAVHCS or by another specialist), thus accounting for the difference in denominators reported below.

We found that patients were still awaiting NVCC care in all four specialties; however, Physical Medicine and Rehabilitation (PM&R) and Orthopedic consults were particularly problematic.

Figure 3. Results from the NVCC Random Sample Review

	PM&R	Orthopedics	Pulmonary	Cardiology
Excluded	9	13	12	10
Total Number Reviewed	41	37	38	40
Seen as of March 2, 2015	10	31	30	36
Seen > 90 days	9 (90%)	16 (52%)	4 (13%)	1 (3%)
Average # of days to appointment	139	103	53	23
Not seen	31	6	8	4
Logical reason not seen ⁵	0	1	1	2
Still waiting	31	5	7 ⁶	2
Consult dating back to:	January 2014	September 2014	July 2014	May 2014

Source: OIG random review of NVCC consults

We provided the acting CAVHCS director with the list of patients who were waiting for appointments to address as appropriate.

Lack of Follow-Up

We substantiated a lack of follow-up on NVCC consults that we reviewed. The complainant did not specify the concern about lack of follow-up after services were provided through NVCC. Therefore, we randomly selected 10 consults each from the NVCC consults reviewed for PM&R, orthopedics, pulmonary, and cardiology. We found documented follow-up, defined as the requesting provider having documented knowledge of the consult results, for all of the cardiology and orthopedic cases reviewed. However, six PM&R and five pulmonary records did not contain evidence

⁵ Logical reasons patients were not seen included: patient no-showed for the appointment, the facility/vendor was unable to reach the patient to reschedule or the vendor was unable to reach the patient to schedule an appointment.

⁶ Four appointments had been scheduled, but there is no documentation that the patient had been seen.

that the referring providers were aware of the results or, in some cases, did not contain documentation of the visit.

We provided the NVCC nurse manager with the list of 11 patients whose EHRs lacked evidence of follow-up.

Delays Getting NVCC Care Authorized

We substantiated delays in getting NVCC care authorized. While the complainant implied that the designated approving officials were the cause for the delays, our review of the 156⁷ EHRs reflected that, often, the incoming consult requests were not administratively reviewed and processed timely by the NVCC staff, and several weeks elapsed before they were sent to the designated approving official for authorization. The average number of days from consult request to authorization for the selected specialties is as follows:

- PM&R = 27 days
- Orthopedics = 32 days
- Pulmonary = 14 days
- Cardiology = 2 days

Although VHA has no timeline for authorizing NVCC consults, the national goal to complete and close NVCC consults is 90 days or less. We noted that the NVCC scheduler and case manager assigned to process cardiology consults promptly forwarded NVCC consults to designated officials for approval where NVCC staff assigned to PM&R, pulmonary, and orthopedic consults were less timely.

Administrative Eligibility Not Verified

We substantiated the allegation. The *Introduction to Non-VA Care Consult/Referral Review Process*, December 2013, Version 5, states that part of the Administrative Review includes “verifying administrative eligibility and enrollment for VHA Care” and that this should be documented on the consult. Staff uniformly told us that they were not verifying eligibility; rather, they processed all consults of patients referred for NVCC care (reportedly due, in part, to the volume of consults).

8,000 “Dumped” NVCC Consults

We could not substantiate the allegation. The EAR respondent did not provide details regarding the timeframe when the consults were allegedly “dumped” or the types of consults involved. Based on our experience at other VISN 7 facilities, we believe that the EAR respondent was referring to CAVHCS’ consult clean-up efforts.⁸ Specifically,

⁷ The total number of records reviewed from row #2 of Figure 3 (41+37+38+40=156).

⁸ In 2013, VHA undertook a series of activities to “clean up” the number of unresolved consults nationwide. Unresolved consults are consults that are still open or active in the electronic health record (EHR).

when different clinical Services were closing their unresolved consults in response to VHA's pre-established deadlines, those consults that could not be scheduled and completed promptly were routinely reassigned to NVCC.

We could not retrospectively determine whether 8,000 consults were reassigned to NVCC during the consult clean-up process, although this was a plausible scenario.

Consults "Timing Out" and Being Cancelled

We substantiated that some consults were being cancelled because they had been open longer than 90 days. According to VHA guidelines, appointments for clinical care should be scheduled within 90 days of the consult. If an appointment cannot be scheduled within the 90-day timeframe, patients are to be placed on the receiving clinic's electronic wait list (EWL).⁹ While NVCC did not utilize an EWL, we were told that program managers still applied the 90-day standard. When some NVCC consults "timed out," they were cancelled with the following notation:

This consult was entered over 90 days ago which exceeds VHA guidelines for processing and closing. Due to the age of the consult the CAVHCS non-VA Care Program (NVCP) ask[s] that you please enter a new consult for processing if the services are still needed.

When a consult is cancelled, the requesting provider will generally receive a View Alert.¹⁰ If the provider believes the consult is still indicated, he or she will need to update any clinical information and resubmit the request. In some cases, this may require a substantial amount of rework. For example, an NVCC consult for orthopedics or PM&R may require that x-rays be no older than 90 days. Therefore, another radiograph would be required before the NVCC consult could be resubmitted.

Many of the consults we reviewed were substantially older than 90 days and were still in an open, active, or pending status. Therefore, we determined that cancellation of consults because they had "timed out" was not a consistent practice.

CBOC Staff Scheduled NVCC Appointments

We substantiated that some CBOC nurses scheduled patients directly with community providers, primarily because there were delays with NVCC. However, when CBOCs bypass the NVCC consult process, eligibility determinations and payment authorizations may not have been generated appropriately.

Inadequate NVCC Resources

We substantiated that the NVCC program did not have sufficient staffing to address the increased workload in late FY 2013–2014.

⁹ VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

¹⁰ Automated notification of important clinical information.

Prior to August 2013, patients could receive medical care in the community through the FEE program. At that time, the FEE staff (two schedulers and two nurses) were responsible for scheduling and tracking consults that had already been approved. We were told that the FEE program received about 30 consults per day.

The NVCC program was officially implemented in August 2013 under the CAVHCS' Central Business Office (CBO). With this implementation, NVCC staff received all community-based consults and were responsible for reviewing for eligibility, ensuring prerequisite testing was complete, securing Associate COS approval, generating the authorization, sending the authorization and supporting documents to the vendor, securing and uploading consult results to the EHR, and coordinating with appropriate staff to ensure that the vendor's recommendations were followed up. Despite the increase in duties, however, it did not appear that additional staff were designated to the program. In late August, and again in November, an NVCC employee e-mailed the CBO supervisors and then the Director, COS, and other clinical leaders to report on the overwhelming workload within NVCC and the inability to manage the demand for services. At that time, the employee reported that NVCC was receiving between 60–100 consults per day.

We could not verify that CAVHCS leadership responded to the repeated requests for assistance; however, in February 2014, NVCC was realigned under Nursing Service due to "imminent patient care concerns relating to the current backlog" of NVCC consults. Based on our interviews, it appeared that this realignment may have been due, in part, to Nursing Service's ability to assign light-duty nursing staff to help reduce the backlog. NVCC staffing increased to six nurse case managers and eight schedulers. We noted that between February and August 2014, the number of unresolved consults (over 90 days old) initially decreased slightly, but then began to steadily increase. See Figure 2 on page 5 for details. In June 2014, under Nursing Service leadership, unresolved NVCC consults were, on average, about 55 days old.

In August 2014, NVCC was realigned back under the CBO, and the staffing remained at six case managers and eight schedulers. We received differing accounts of the reasons for the realignment, although employees we interviewed implied that Nursing Service's goal was to close backlogged consults, not adopt and staff the program indefinitely. As of November 3, 2014, under the CBO, unresolved NVCC consults were, on average, 74.2 days old.

CAVHCS leaders again realigned NVCC under Nursing Service effective November 18, 2014, reportedly because the "steady increase in unresolved consults introduces an unacceptable risk."

Staff we interviewed told us that NVCC's ever-changing leadership over the past 18 months had resulted in role confusion, concerns about consistency in processes, and questions about the adequacy of staff training. NVCC had reportedly lost two schedulers within the past few months. In addition, staff reported that the Patient-Centered Community Care (PC3) program, which uses an

intermediary corporation to coordinate veterans' health care with community providers, had not been effective or helpful in securing community-based care for patients, and in some cases, may have delayed care. Under the terms of PC3, the intermediary has 5 days to locate a community-based specialist to provide the requested service or care. If that cannot be accomplished, PC3 returns the consult to NVCC for regular processing. Staff also told us that they had not received guidance on how to assist patients using their Veterans Choice¹¹ cards. One NVCC employee described the current (as of March 2015) NVCC program and climate as "chaotic."

We compared the total number of unresolved NVCC consults with the number of unresolved NVCC consults over 90 days old at three points over the past 9 months. The data reflects the following:

- In June 2014, consults over 90 days old represented about 25 percent of all unresolved consults.
- In November 2014, consults over 90 days old represented about 30 percent of all unresolved consults.
- In March 2015, consults over 90 days old represented about 50 percent of all unresolved consults.

It did not appear that the programmatic realignment back to Nursing Service in November 2014 has been effective in reducing the NVCC backlog, nor was staffing adequate to meet workload demand.

Within-VHA Consultation Requests

Allegation: Some consults go unanswered for months or are cancelled, and patients are not notified when appointments are scheduled.

We could not substantiate the allegation that intra-facility consults (those completed within CAVHCS) went unanswered for months or were cancelled or that patients were not notified when appointments were scheduled. Because we had few details about this allegation, we selected three consult clinics that were either mentioned by an EAR respondent or interviewee, or clinics that provide care for patients with potentially high-risk conditions. We randomly selected 50 consults entered in FY 2014 for cardiology, pulmonary, and general surgery, respectively.

In general, we found that consults were acknowledged and appointments were scheduled appropriately. Further, when patients were not seen by the VHA specialist, we found that the EHR generally reflected the reason the consult was cancelled or discontinued. Reasons cited included that the patient was already seen by a specialist in the community (NVCC or private-pay), the patient no-showed or cancelled his/her

¹¹ The Veterans Choice Act of 2014, signed into law in August 2014, allows veterans to seek care outside of VA if wait times exceed 30 days or if VA care is not easily accessible (distance-wise) from their homes.

appointment, the patient died; the consult was inappropriate, or the consultant recommended another course of treatment or referral to another specialty. Twenty-seven cardiology consults, 24 pulmonary consults, and 15 general surgery consults were cancelled for one of the above reasons.

Cardiology saw 23 patients, 7 of whom waited longer than 90 days for an appointment. The average elapsed days from consult date to cardiology appointment was 63 days. Patients were consistently notified of their scheduled cardiology appointments.

Pulmonary saw 26 patients, 2 of whom waited longer than 90 days for an appointment. The average elapsed days from consult date to pulmonary appointment was 52 days. Patients were generally notified of their scheduled pulmonary clinic appointments. However, in three cases when the patients no-showed for their appointments, we could not find documentation in their EHRs that they had been advised of the scheduled appointment dates.

General surgery saw 35 patients, 4 of whom waited longer than 90 days for an appointment. The average elapsed days from consult date to general surgery appointment was 40 days. Patients were consistently notified of their scheduled general surgery appointments.

Allegation: There are huge delays in oncology care. CAVHCS patients get reviewed by the Atlanta (VAMC) Review [Tumor] Board, but are usually seen in Birmingham (VAMC). Some patients wait 5–6 months to get tissue diagnosis and start treatment. One patient’s colon cancer metastasized in the interim.

We did not substantiate “huge” delays in oncology care or that patients waited 5–6 months to get tissue diagnosis and start treatment. We reviewed 30 randomly selected consults sent to the Atlanta VAMC Tumor Board;¹² 12¹³ of those patients underwent tissue biopsy for the purpose of diagnosis and treatment. We found that from the time the [cancer] concern was initially identified, it took an average of 70 days to complete tissue diagnosis and initiate treatment.

We also reviewed 30 randomly selected consults sent to the Birmingham VAMC and 30 randomly selected consults sent to the Atlanta VAMC (same as those identified above) to assess whether consults were responded to timely. Most of these were electronic consults seeking a specialist’s recommendations for further care, if indicated. In general, these consults were responded to timely. In cases where patients needed to be seen, the patients were contacted, given appointments, and seen timely.

We did not substantiate that a particular patient’s colorectal cancer (CRC) metastasized due to delays in oncology care. The patient in question presented to the ED with

¹² Tumor Boards are a multidisciplinary treatment planning approach where physicians from different specialties review and discuss the medical condition and treatment options.

¹³ A 13th patient also underwent tissue diagnosis but was excluded from the denominator because the patient was considering his treatment options and locations.

symptoms in late winter 2012 and was evaluated by Surgery in the ED. The patient received a medical pre-operative clearance for endoscopy 12 days later and completed an upper endoscopy and colonoscopy 34 days after the ED visit, when a tissue specimen was obtained. Biopsy results were reported within 48 hours of the procedure and discussed with the patient during a follow-up visit 13 days after the procedure. A computed tomography the same day revealed liver metastases. Three weeks later, the patient underwent surgical removal of a rectal mass at the Birmingham VAMC. Approximately a month after the removal of the rectal mass, the patient was evaluated by Oncology and started on chemotherapy. As of December 2014, the patient continued to be followed by the Birmingham VAMC Oncology Clinic. In this case, we found no delay in tissue diagnosis or commencement of treatment. It is likely that the patient already had Stage 4 CRC (metastasis) when he presented to the ED in late winter 2012.

Issue 2. Contractor Services

Allegation: The Dothan PC CBOC contractor is billing for physician-led PC appointments, but some of these appointments are only for Coumadin^{®14} monitoring.

We did not substantiate this allegation. The Dothan CBOC provides PC through a contract with a local medical group, and the contractor gets paid per vested patient and not per office visit. The contractor does not bill for individual appointments. However, we found errors in how the contractor documented encounter¹⁵ information for walk-in patients to the Coumadin[®] Clinic.

We requested appointment information for several Coumadin[®] Clinic patients for January, April, and July 2013. While researching our request, CAVHCS identified an error in coding¹⁶ for Coumadin[®] Clinic appointments.

Patients taking Coumadin[®] routinely have their blood drawn to test their blood clotting time and assure they are not taking too much medicine.¹⁷ Often, Coumadin[®] clinics offer open “walk-in” hours several times per week for patient lab testing and monitoring. Prior to July 2013, walk-in patients received a lab visit, but not a provider encounter (because there was no provider appointment), for the visit. Because progress notes must be associated with an encounter, the Dothan contractor linked the Coumadin[®]

¹⁴ Coumadin[®] is the brand name for warfarin sodium which is used to treat blood clots and to lower the chance of blood clots forming in your body. <http://www.coumadin.com/html/index.htm>, retrieved February 17, 2015.

¹⁵ An encounter is a professional contact between a patient and a practitioner for the purpose of diagnosing, evaluating, and treating the patient’s condition. VHA Directive 2009-002, *Patient Care Data Capture*, January 23, 2009.

¹⁶ Current Procedural Terminology (CPT) codes are numbers assigned to every task and service a medical practitioner may provide to a patient including medical, surgical, and diagnostic services. They are typically used by insurers to determine payment.

¹⁷ Providers perform Coumadin[®] (warfarin) dosage adjustments and monitor lab work according to the Outpatient Warfarin Dosing and Monitoring Guidance. MCM 119-13-23, *Anticoagulation Management*, February 6, 2013.

Clinic progress note to a previous PC appointment. This action may have appeared improper to someone without knowledge of the CAVHCS-contractor payment arrangement.

The Dothan CBOC contract administrator stated that, starting in July 2013, patients received same-day provider appointments that allowed appropriate encounter linkage after the provider received notice from “someone at CAVHCS” to correct the coding process. However, CAVHCS management told us that the facility was not aware of the coding issues until OIG’s inquiry. CAVHCS managers maintained that the encounter-linkage mistakes had no impact on the quality of patient care. CAVHCS leaders provided evidence of the corrected encounter coding; therefore, we made no recommendations.

Allegation: The Dothan PC CBOC contracted providers are not notifying patients of “critical”¹⁸ laboratory test results that have major medical implications, specifically, fecal occult blood tests (FOBTs).

We did not substantiate the allegation. CRC is the third most common cancer and the second leading cause of cancer deaths in the U.S.¹⁹ VHA requires all eligible veterans at average or high risk for CRC who may benefit to be offered CRC screening.²⁰ The facility uses the FOBT, which detects blood in the stool, as the primary screening tool. Any positive screening tests must be followed up with a diagnostic colonoscopy unless contraindicated. Facility policy states that abnormal or critical test results are “communicated to the provider who ordered the test, who in turn, will take appropriate action, including notification of the veteran/significant other.”^{21,22}

From October 1, 2013, through September 24, 2014, there were 31 patients with positive FOBT results followed by Dothan PC CBOC providers. All 31 patients received notification of positive FOBT results within 6 days of provider notification and had diagnostic colonoscopies ordered and completed, when indicated.

Allegation: A contracted private medical group (PMG) is completing inadequate initial history and physical (H&P) exams, and those reports are not always available in the patients’ VA EHRs. As a result, Columbus CBOC providers must re-complete portions of, or the entire, H&P during the first CBOC follow-up visit.

We substantiated the allegation. Effective January 2014, CAVHCS signed a memorandum of understanding (MOU) with a PMG to complete initial H&Ps on new

¹⁸ Facility policy defines critical test results as those results that may be life threatening or require timely clinical intervention.

¹⁹ Centers for Disease Control and Prevention, <http://www.cdc.gov/cancer/colorectal/statistics/>, retrieved November 26, 2014.

²⁰ VHA Directive 2007-004, *Colorectal Cancer Screening*, January 12, 2007 (corrected copy). This version was current at the time of the events discussed, but has since been rescinded.

²¹ Facility Memorandum 113-11-04, *Performance of Occult Blood Testing*, April 19, 2011.

²² VISN 7 Memorandum 10N7-101, *Colorectal Cancer Screening Policy*, December 1, 2007.

patients waiting for a PC appointment with a Columbus PC provider. This MOU specified that PMG would be paid \$260 per completed H&P and that follow-up care and services would be provided through the Columbus PC provider. CAVHCS initially anticipated referring about 450 patients on the PC EWL to PMG although more than 700 patients were actually seen by PMG providers.

We reviewed a sample of 34 EHRs (26 selected randomly and 8 provided by an interviewee) and found that less than 50 percent contained a scanned PMG summary. In multiple cases, the Columbus PC provider documented that PMG information was not available and proceeded to complete a new H&P.

Allegation: Some patients with care needs identified by PMG during the H&P exam are at risk due to poor or non-existent documentation.

We substantiated the allegation. Six of the 34 patients we reviewed who may have had care needs had not been seen for follow-up at the Columbus CBOC after their PMG visit.²³ We notified CBOC staff of one patient with a history of diabetes and heart attack who had abnormal laboratory values (per the PMG initial lab work) requiring follow-up. The patient was subsequently scheduled for follow-up care at the CBOC in late August 2014. We notified the acting CAVHCS Director of our concern that other patients seen initially by PMG may have been at risk as they may have had care needs that had not been followed up.

As of March 4, 2015, CAVHCS staff had reviewed all 720 patients referred to PMG and found no record of the PMG visit in 422 EHRs. Of the 422, it was later determined that:

- CAVHCS had received, but had not yet scanned, almost 250 PMG H&Ps into patients' EHRs. These were subsequently scanned.
- PMG had completed, but had not forwarded, a substantial number of H&Ps. These were subsequently provided.
- PMG did not see 23 of the referred patients, either due to no-shows or because the patient was seen by a CAVHCS provider instead and the consult was cancelled. These cases were clinically reviewed and forwarded to appropriate managers.
- One patient still had an active PMG consult.

In all, CAVHCS received 696 PMG records. Those records have been reviewed for PC provider assignment and follow-up, as indicated.

²³ Three patients' EHRs included the scanned PMG summary that contained recommendations for follow-up. The other three EHRs did not include the PMG summary; therefore, it is unknown whether they had care needs requiring follow-up.

Issue 3. Administrative Deficiencies

Allegation: There is inadequate staffing in key clinical areas including MH, PC, Radiology, Laboratory and Pathology, and Pharmacy.

We substantiated that CAVHCS had multiple vacancies in important clinical areas; however, we could not determine with certainty the precise number of vacancies and the Services affected. According to the HR³ site visit report dated September 2014, CAVHCS did not have position management tracking capability. The HR³ report stated, “One of the most important things an organization must do to stay effective is to be able to identify positions that are filled, and what positions are vacant...it is evident that Central Alabama does not have such capability.”

A comparison of actual FTE to authorized FTE for FYs 2012–2014 for the selected clinical areas reflected that the actual FTE was consistently below the authorized FTE as shown in Figure 4 below. Because of CAHVCS’ tracking and reporting inconsistencies, we could not independently verify staffing data. We are including CAVHCS’ self-reported data to provide the reader with a general sense of staffing deficiencies.

Figure 4. Comparison of Authorized Versus Actual FTEs

Service	FY 2012		FY 2013		FY 2014	
	Authorized FTE	Actual FTE	Authorized FTE	Actual FTE	Authorized FTE	Actual FTE
MH	86	62.2	86	80.4	86	75.4
PC	98.9	70.2	98.9	79.8	98.9	74.4
Radiology	36	32.8	36	30.9	36	29
Laboratory/Pathology	45	41.2	45	39.1	45	40
Pharmacy	65.25	48.6	65.25	59	65.25	59.5
Total	421.5	339.2	421.5	370.9	421.5	359.6

Source: Facility provided comparison table of authorized versus actual FTEs

Resource Committee minutes reflected recruitment efforts in many areas. We were told, however, that some positions were difficult to recruit for, some areas were prone to high staff turnover (resulting in the need for on-going recruitment), and some recruitment request “packets”²⁴ were difficult to get through the Resource Committee. Numerous employees reported that the process for hiring new staff was inadequate, with positions remaining vacant for extended periods of time.

We did not identify, nor were we told about, specific cases when patients experienced clinically significant negative outcomes *due to staffing deficiencies* in these areas. We noted, however, that CBOC clinicians, for instance, accommodated the increased

²⁴ Packets include the recruitment request with the position description, updated organizational chart, strength report, and position justification, as applicable.

workload by working late and through lunch to “keep up.” We were provided with e-mails and meeting agendas reflecting that CAVHCS leaders were aware of staffing shortages at the Columbus and Dothan CBOCs, as follows:

- The Columbus CBOC had multiple vacancies, and employees repeatedly notified leaders of the need for additional staffing (physicians and nurses). They also suggested that PC providers be given the option to “close” their panels to new patients [until additional staffing and clinic space could be arranged]. These requests were unresolved at the time of our site visit.
- The Dothan MH CBOC staff also expressed concern about the volume of work and resulting delays in patient care. Dothan had submitted multiple requests for more clinical staff, but additional hiring was pending.
- Although the CBOCs used to have site-specific clinic coordinators to oversee administrative functions, none of the CBOCs had clinic coordinators at the times of our visits. The CBOC coordinator’s role is to ensure “efficient, effective, responsive, and accurate clinic operations for all Service lines.” CBOC staff told us that they primarily reported to their respective off-station Service Line managers, and coordination between the various clinical and administrative disciplines was disjointed and sub-optimal. CBOC employees uniformly reported that they needed onsite coordinators for all clinic operations.

Allegation: Podiatry Service is not following appointment scheduling guidelines.

We substantiated the allegation; however, the condition has been corrected.

Guidance for appointment scheduling is found in VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, which requires patient appointments to be scheduled on or as close to the patient’s desired date as possible. Schedulers are responsible for recording the desired appointment date accurately, and once the desired date is established, “it must not be altered for lack of appointment availability on the desired date.”

Around September 2014, managers became aware that a podiatry scheduling clerk was making scheduling errors by entering “T” for today as the desired date rather than entering the patient’s or provider’s actual future desired date. If an appointment creation date and a desired date for a future appointment are the same, a scheduling error occurs.²⁵ To improve compliance with scheduling policies, the scheduling staff received training focusing on appointment management and accurate documentation of desired appointment dates.

²⁵ This type of scheduling error would have made the clinic’s wait times look worse. By defaulting to a desired appointment date for “today,” but scheduling an appointment for 1 month in the future, it appeared that the facility was not able to schedule the patient when the patient requested “T” for today.

The nurse manager in charge of the Podiatry Clinic told us that delays in scheduling podiatry patients occurred in the past, primarily related to one podiatrist's panel assignments. The nurse manager reported that Podiatry staff currently schedule patients in accordance with guidelines and that at the time of our interview in November 2014, only one "backlogged" patient was still pending scheduling (beyond 90 days).

Allegation: ABIs are not consistently chartered, completed, or followed through in response to serious events.

We substantiated the allegation. VHA Handbook 0700, *Administrative Investigations*, requires a Convening Authority to establish an ABI when they receive reports, allegations, or evidence regarding significant misconduct, neglect of duty, prohibited personnel practices, or violation of statutes, regulations, policies, or individual rights by VA employees. ABIs should be completed within 45 days although extensions can be granted when justifications exist.

A total of seven ABIs were chartered between FY 2012–2014, none of which fully complied with VHA guidelines. Specifically:

- ABIs were not completed within the required 45 days, and none of the seven had the required extension letters reflecting the justifications.
- One of the ABIs was never finalized after the interviews were conducted, reportedly as a result of the ABI chair, located at another facility, not providing the final report to CAVHCS.
- Documentation of the former CAVHCS Director's final decisions on the actions to be taken was inconsistent.
- Documentation that the actions assigned were implemented and/or addressed was inconsistent.
- The ABI files did not contain evidence that the former CAVHCS Director certified the completion of actions, which signifies that the ABI could be closed.

We noted that CAVHCS' current draft ABI policy was not consistent with the VHA Handbook relative to the Director's certification of completed actions.

Without adequate follow through of recommendations, deficient conditions could continue unabated.

Issue 4: Leadership Responsiveness

Good leadership is central to the health and success of any organization. The Joint Commission devotes several chapters to leadership standards in the *2009 Comprehensive Accreditation Manual for Hospitals*, and the executive core

qualifications²⁶ for senior executives²⁷ include leading change and people. Leaders establish the organization's culture through their words, expectations for action, and behavior.²⁸ Responsiveness to employee concerns is a basic tenet of good organizational leadership.

Allegation: CAVHCS leaders had been notified of many of the concerns [detailed in this report]; however, the problems frequently went unaddressed.

We substantiated that CAVHCS leaders were aware of many of the concerns detailed in this report. During the course of this review, we identified, were told of, or were provided evidence showing that CAVHCS leadership was aware of extensive NVCC consult delays, quality and safety issues related to a PMG contract, and staffing deficiencies. Because we were unable to interview the former director and COS, we could not evaluate whether, and the extent to which, legitimate management reasons (such as budget priorities and mandates) justified CAVHCS leaders taking some actions but not others.

We have observed that, despite the years-long merger, some staff continue to resist CAVHCS as an integrated health care system, and a climate of “us” versus “them” (Tuskegee versus Montgomery) continues to exist. Some staff perceive inequities in the distribution of resources among the campuses and view management decisions with suspicion. After visiting the CBOCs and interviewing multiple staff members, it appears that the CBOCs also feel that the “outposts are neglected.” In that climate, a leadership team must be particularly adept at assuring open and consistent communication and fostering relationships across the system. We found that the previous leadership team did not effectively “bridge the divide” as perceived by many of the staff. In August 2014, VHA senior leaders removed the CAVHCS Director and COS from their positions. Further, at the time of our review, multiple high-level key positions had been vacant for months, and in some cases, for more than a year. Often, other CAVHCS managers were assigned to cover the duties of the vacant positions while also retaining responsibility for their current duties.

²⁶ <http://www.opm.gov/policy-data-oversight/senior-executive-service/executive-core-qualifications/>, retrieved January 7, 2015.

²⁷ Most medical center directors and COSs are senior executives and must meet executive core qualification requirements.

²⁸ Leadership in Healthcare Organizations. A Guide to Joint Commission Leadership Standards. A Governance Institute White Paper, Winter 2009

Conclusions

We substantiated allegations related to the NVCC program, including delays for services; inconsistent follow-up for PM&R and pulmonary consults; delays in care authorization and eligibility verification; inconsistent processing and management of consults; insufficient staffing to address workload increases; and an ever changing leadership that has resulted in confusion about staff roles, inconsistency of processes, and inadequate staff training.

We could not substantiate that 8,000 consults were reassigned to NVCC during the consult clean-up process, that intra-facility consults went unanswered for months or were cancelled, or that patients were not notified when appointments were scheduled. In general, we found that consults were acknowledged and appointments were scheduled appropriately.

We did not substantiate delays in oncology care or long waits for tissue diagnosis and treatment initiation or that a particular patient's colorectal cancer metastasized due to delays in oncology care. We also did not substantiate that the Dothan PC CBOC contractor was inappropriately billing for physician-led PC appointments or that Dothan PC CBOC contracted providers were not notifying patients of "critical" FOBT results.

We substantiated allegations that documentation of H&P exams conducted by a PMG contractor was not consistently complete or available in the EHR and, as a result, that some patients' care needs could have been lost to follow-up.

We substantiated that CAVHCS had multiple vacancies in important clinical areas. A comparison of actual FTE to authorized FTE for FYs 2012–2014 for selected clinical areas reflected that the actual FTE was consistently below the authorized FTE. Because of CAVHCS' tracking and reporting inconsistencies, we could not independently verify staffing data.

We substantiated that Podiatry Service was not following appointment scheduling guidelines; however, the condition had been corrected. We also substantiated that ABIs were not consistently chartered, completed, or followed through in response to serious events.

We substantiated that CAVHCS leaders were aware of many of the issues identified in this report. We concluded that a fractured organizational culture contributed to the development and perpetuation of these issues. Long-standing resistance to the integration of the Montgomery and Tuskegee campuses into a single unified health system, coupled with recurrent changes in leadership, impaired CAVHCS' ability to identify and respond to deficient conditions. CAVHCS needs highly skilled, permanent leaders who can lead systemic improvements and cultural change.

We were unable to fully evaluate eight additional allegations due to insufficient information and/or details.

Recommendations

1. We recommended that the Under Secretary for Health provide consistent interim leadership to Central Alabama Veterans Health Care System in the form of highly skilled leaders who can lead systemic improvements and cultural change until such time as the leadership positions can be filled permanently.
2. We recommended that the Under Secretary for Health directly monitor corrective actions taken to remedy the deficiencies identified in this report and routinely assess their effectiveness at least annually for a period of 3 years.
3. We recommended that interim Central Alabama Veterans Health Care System leadership begin, and permanent leadership continue, to make systemic improvements to the Non-VA Care Coordination consult process, to include ensuring that patients receive services timely; that the backlog is resolved; that staff comply with business rules governing the process; and that the program is provided with adequate staffing, training, and a consistent leadership structure.
4. We recommended that the interim Central Alabama Veterans Health Care System leadership develop processes to ensure that Human Resource tracking and reporting is accurate and that Central Alabama Veterans Health Care System either has adequate staffing to meet patient care needs in a timely manner or adequate processes to ensure patients receive timely care in the community.
5. We recommended that the interim Central Alabama Veterans Health Care System leadership identify opportunities to improve system integration between the Montgomery campus, the Tuskegee campus, and the community based outpatient clinics, to include evaluating the need for dedicated community based outpatient clinic coordinators.
6. We recommended that the interim Central Alabama Veterans Health Care System leadership ensure that the system Administrative Boards of Investigation policy reflects all required elements outlined in the Veterans Health Administration Handbook.
7. We recommended that the interim Central Alabama Veterans Health Care System leadership ensure that all previously chartered Administrative Boards of Investigations have been conducted and finalized to include documentation of decision for final action(s), evidence that actions have been implemented and/or addressed, and appropriate certification of completion per Veterans Health Administration guidelines.

Allegations Lacking Adequate Detail To Permit Full Review

The allegations listed below were primarily identified through the EAR survey comments. Many of the complaints lacked sufficient detail for us to fully or reasonably evaluate the issue(s). As noted in the Scope and Methodology section of this report, we **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

Allegation: An ultrasound consult went unanswered for about 1 month, resulting in a patient losing a lower limb due to arterial blockage.

We could not substantiate the allegation. The complainant did not provide us with the patient's name or a timeframe. We were unable to identify cases matching this description.

As noted previously, Radiology Service and imaging consult-related issues are currently under review by VHA's Clinical Operations Division.

Allegation: An ASAP [as soon as possible] imaging consult was not responded to for 5 months.

We could not substantiate the allegation. Without specific details, we could not fully evaluate the circumstances of this case. However, during the course of our interviews, we were provided with other examples of imaging consult delays, many of them several months old. Radiology Service and imaging consult-related issues are currently under review by VHA's Clinical Operations Division.

Allegation: A patient was not notified of an abnormal esophagogastroduodenoscopy²⁹ (EGD) result, experienced similar symptoms 2 months later, and was then found to have untreatable stomach cancer.

We could not substantiate the allegation, as the respondent did not provide us with the patient's name or other details that would have allowed us to identify the case. We reviewed the list of patients who died with a primary diagnosis of stomach cancer in the past 2 years and identified one case that appeared similar to the respondent's description. In that case, the patient had an EGD and biopsy completed at a private-sector hospital in early 2013. An oncologist at the Birmingham VAMC documented 11 days later that the biopsy results appeared consistent with gastric cancer. The oncologist explained the diagnosis to the patient and recommended palliative care. The patient was discharged with home hospice and died within 4 weeks.

²⁹ EGD is a test to examine the lining of the esophagus, stomach, and first part of the small intestine. <http://www.nlm.nih.gov/medlineplus/ency/article/003888.htm>. Retrieved December 23, 2014.

Allegation: Providers do not have adequate administrative time to review lab and other test results or read and respond to computerized patient record system alerts.

We could not substantiate the allegation, as the respondent did not provide details as to specific providers or clinical areas affected. Given the number of CAVHCS providers, we could not reasonably evaluate provider workloads and schedules to determine whether administrative time was appropriately allotted.

Columbus and Dothan CBOC providers told us that, due to high workload demands, they often used their administrative time to see walk-in or backlogged patients.

Allegation: At one point, there were more than 400 unanswered FOBT consults.

We could not substantiate the allegation as we could not fully evaluate what condition existed in the past. It appears, however, that CAVHCS had not been meeting the timeliness standard for completing diagnostic colonoscopies within 60 days of a positive FOBT (as required at the time of the complaint). VHA Support Service Center data for FY 2014 shows CAVHCS' compliance with this metric had decreased in each successive quarter, as follows:

Figure 5: Percent of Patients with Follow-up Colonoscopy within 60 days of Positive FOBT (FY 2014)

	QTR 1	QTR 2	QTR 3	QTR 4
VHA (National)	30	34	31	31
VISN 7	42	48	42	39
CAVHCS	37	36	35	24

Source: VHA Support Service Center data for FY 2014

Allegation: Dothan PC CBOC contracted providers do not follow up on critical lab alerts. In one case, the alert indicated a possible malignancy, but the alert was not “read” [acknowledged] for more than 2 years.

We could not substantiate the allegation, as we were unclear about the precise concern and we were not provided with sufficient detail to review the case. Because of the reference to a possible malignancy, we believe the complainant was concerned about imaging, rather than laboratory, results. According to CAVHCS policy, ordering providers can be notified of a “possible malignancy” through an electronic View Alert. It is incumbent upon the ordering provider to read the View Alert and take the appropriate clinical actions.

Without specific patient information, we could not evaluate whether the possible malignancy was cancer and whether the provider's alleged failure to read the View Alert resulted in the patient not receiving appropriate and timely treatment.

Allegation: CBOC PC providers are not consistently notified of abnormal radiology results.

We could not substantiate the allegation, as we were not provided with specific cases where PC providers did not receive appropriate notifications. The Clinical Applications Coordinator (CAC) told us that CAVHCS uses electronic View Alerts to notify providers of abnormal test results, and that these View Alerts are mandatory, meaning they cannot be “turned off.”

Allegation: PC providers are not contacted when their patients are in the ED or are admitted to the hospital [CAVHCS].

We could not substantiate the allegation, as we could not reasonably evaluate the View Alert settings for all PC providers. We found no requirement that PC providers must receive notification of ED visits or hospital admission. However, the CAC told us that, depending on the patient’s PC Management Module assignment, View Alerts can be sent to the entire patient-aligned care team if one of their assigned patients has been admitted to or discharged from a CAVHCS inpatient unit. The View Alert for these patient movements would need to be set up and activated. The CAC told us that in January 2015, individual providers (in cases where patients do not have team assignments) can now set their View Alerts for notification of patients’ admissions and discharges. There is no similar View Alert for ED visit notification.

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 15, 2015
From: Under Secretary for Health (10)
Subj: Healthcare Inspection—Deficient Consult Management, Contractor,
and Administrative Practices, Central Alabama VA Health Care
System, Montgomery, Alabama
To: Assistant Inspector General for Healthcare 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 and 2.
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.

//Original signed by://

David J. Shulkin, MD

Attachment

Comments to OIG's Report

The following Under Secretary for Health comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health provide consistent interim leadership to Central Alabama Veterans Health Care System in the form of highly skilled leaders who can lead systemic improvements and cultural change until such time as the leadership positions can be filled permanently.

Concur

Target date for completion: November 30, 2015

VHA Comments: On behalf of the Under Secretary for Health, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will assign an experienced interim leadership team to the Central Alabama Veterans Health Care System while recruiting for a permanent leadership team. Within sixty days of the leadership team being in place, using the tools available (such as Strategic Analytics for Improvement and Learning (SAIL), All Employee Survey (AES), Ethics survey, and National Center for Organization Development (NCOD) assessments, the Veterans Integrated Service Network in conjunction with the interim leadership team will develop an action plan with measurable outcomes to achieve systematic improvements and address the cultural issues. This plan will be submitted to the DUSHOM for review and concurrence.

To complete this action, the DUSHOM will provide documentation of:

1. An action plan with measurable outcomes and systematic improvements that addresses cultural issues.

Recommendation 2. We recommended that the Under Secretary for Health directly monitor corrective actions taken to remedy the deficiencies identified in this report and routinely assess their effectiveness at least annually for a period of 3 years.

Concur

Target date for completion: November 30, 2015

VHA Comments: Concur. In conjunction with the Under Secretary for Health, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will monitor the action plan for this report quarterly with the Veterans Integrated Service Network and Facility leadership until all deficiencies in this report are corrected. Annually, the DUSHOM will assign a team to evaluate the effectiveness of the actions

put into place as a result of this report for a minimum of 3 years. These evaluations will be made available to the OIG upon request.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: July 17, 2015

From: Interim Director, VA Southeast Network (10N7)

Subj: Transmittal: Healthcare Inspection—Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama

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

1. In reference to Healthcare Inspection – Deficient Consult Management Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery (CAVHCS), Alabama, VISN 7 submits the following corrective action plan.
2. CAVHCS has submitted a corrective action plan for recommendations 3 through 7. The responses are attached.
3. If you have additional questions or need further information, please contact Brenda Winston, Chief Quality Management – Brenda.Winston@va.gov at (334)-272-4670 ext. 6297.

//Original signed by Brenda Schmitz for://

Thomas C. Smith, III, FACHE

Attachments

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 16, 2015

From: Acting Director, Central Alabama Veterans Health Care System (619/00)

Subj: Healthcare Inspection—Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama

To: Interim Director, VA Southeast Network (10N7)

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 3 through 7.
2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Brenda G. Winston Chief of Quality Management at 334-272-4670 ext. 6297.

//original signed by://

Srinivas Ginjupalli, MD, CMD

Attachment

System Director Comments to OIG's Report

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

OIG Recommendations

Recommendation 3. We recommended that interim Central Alabama Veterans Health Care System leadership begin, and permanent leadership continue, to make systemic improvements to the Non-VA Care Coordination consult process, to include ensuring that patients receive services timely; that the backlog is resolved; that staff comply with business rules governing the process; and, that the program is provided with adequate staffing, training, and a consistent leadership structure.

Concur

Target date for completion: October 31, 2015

Facility response: CAVHCS underwent a realignment of leadership of Non-VA Care Coordination to improve efficiency. A System Redesign team was identified and employed to evaluate the process and develop standardization of the process for NVCC consults. Policies were reviewed and revised to ensure compliance with national policy and business rules. With the addition of Veterans Choice Program and First Choice we are modifying our process to include the additional steps. Non VA Care has increased authorized FTEE by 5 RNs and 14 MSAs for a total of 10 RNs and 14 MSAs. As of June 23, 2015 the five RNs were on board and as of 7/3/2015, 7 MSAs were selected and anticipated onboarding by 8/7/2015. We are currently recruiting for additional seven MSAs and 3 Social Worker Navigator added to the NVCC staff. All staff hired are formally trained to the process and policies. New staff will be orientated and trained.

Recommendation 4. We recommended that the interim Central Alabama Veterans Health Care System leadership develop processes to ensure that Human Resource tracking and reporting is accurate, and that Central Alabama Veterans Health Care System either has adequate staffing to meet patient care needs in a timely manner or adequate processes to ensure patients receive timely care in the community.

Concur

Target date for completion: September 30, 2015

Facility response: The new Chief of Human Resources is onboard and an Assistance Chief has been hired. The new leadership will be apprised of the necessity to expeditiously evaluate current processes and practices, develop efficiency to ensure that Human Resource tracking and reporting is accurate, and that processes are in place to improve where needed to ensure adequate staff are recruited and hired timely to meet patient care needs.

Recommendation 5. We recommended that the interim Central Alabama Veterans Health Care System leadership identify opportunities to improve system integration between the Montgomery campus, the Tuskegee campus, and the community based outpatient clinics, to include evaluating the need for dedicated community based outpatient clinic coordinators.

Concur

Target date for completion: September 30, 2015 and ongoing

Facility response: Integration between Montgomery and Tuskegee campuses and CBOC's has begun. Leadership positions for the Tuskegee campus have been hired to ensure leadership is available at all times. The Pentad increased rotation of days on both campuses. Additional leadership and reporting has been heightened to improve communication and immediate actions take place.

1. Monroeville and Columbus CBOC Chief Medical Officers (CMOs) have been hired and we are actively recruiting for the Wiregrass CBOC. CMO's report the Deputy ACOS, Ambulatory Care, on Montgomery campus who is actively involved in the processes and patient care needs in the CBOC's.
2. Administrative Officers (AOs) have been hired. Montgomery campus AO oversees and distributes work to CBOC AO's and oversees overall ambulatory care needs for both Montgomery Campus and CBOC's. CBOC AO's report to AO Ambulatory Care for guidance.
3. Nurse Managers have been hired for the CBOC's and report the Associate Chief Nurse on Montgomery campus.

MSA's and MSA Supervisors have been hired for the CBOC's and received training and guidance from Business Office on Tuskegee Campus

Senior Leadership conducts Town Hall meetings on both campuses to provide updates to staff and to receive questions and offer suggestions for improvements. The Pentad travels to the CBOCs.

Recommendation 6. We recommended that the interim Central Alabama Veterans Health Care System leadership ensure that the system Administrative Boards of Investigation policy reflects all required elements outlined in the Veterans Health Administration Handbook.

Concur

Target date for completion: July 24, 2015

Facility response: The Chief of Quality Management immediately reviewed the current CAVHCS Administrative Investigation policy memorandum and cross-walked all required elements outlined in the Veterans Health Administration Handbook 0700 Administrative Investigation. Changes were made and implemented to include tracking

recommendations to closure and the Director certifying completion. The revised policy will be circulated for approval and signatures.

Recommendation 7. We recommended that the interim Central Alabama Veterans Health Care System leadership ensure that all previously chartered Administrative Boards of Investigations have been conducted and finalized to include documentation of decision for final action(s), evidence that actions have been implemented and/or addressed, and appropriate certification of completion per Veterans Health Administration guidelines.

Concur

Target date for completion: September 30, 2015

Facility response: The recommendations for all previously chartered Administrative Investigations Boards from 2012 - 2014 will be reviewed, appropriate actions will be taken, finalized and include documentation of decision for final action(s). Evidence that actions have been implemented and/or addressed will be tracked until closure. One AIB that was not completed will be re-convened for final resolution, completion of recommendations made and tracked to closure. All AIBs will have appropriate certification of completion of actions by the Director to signify the AIB is closed, per the Veterans Health Administration guidelines.

OIG Contact and Staff Acknowledgments

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

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