

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Health Administration

*Review of
Alleged Mishandling of
Ophthalmology Consults
at the Oklahoma City, OK,
VA Medical Center*

August 31, 2015
15-02397-494

ACRONYMS

CBOC	Community Based Outpatient Clinic
CPRS	Computerized Patient Record System
FY	Fiscal Year
NVC	Non-VA Care
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

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Report Highlights: Review of VHA's Alleged Mishandling of Ophthalmology Consults at the Oklahoma City VAMC

Why We Did This Review

On October 6, 2014, the Office of Inspector General (OIG) received an anonymous allegation that ophthalmology staff at the Oklahoma City VA Medical Center (VAMC) inappropriately discontinued consults. The complainant specifically highlighted the ophthalmology clinic's practice of discontinuing consults its staff received from the teleretinal imaging clinic.

What We Found

We substantiated that ophthalmology and teleretinal imaging staff, and referring providers, acted inappropriately on discontinued consults. In fiscal year (FY) 2014, VAMC ophthalmology staff discontinued about 31 percent more consults than the national average, and about 42 percent more in FY 2015 (reported as of March 10, 2015). VAMC teleretinal imaging staff also discontinued about 9 percent and 10 percent more consults, respectively, than the national average during these same periods.

Ophthalmology staff discontinued consults without adequate justification and often because they could not provide eye exams to the patients within 30 days. In addition, ophthalmology staff and referring providers did not take the necessary steps to refer the patients to non-VA care staff to obtain their medical care outside of the VA. Referring providers did not ensure that discontinued teleretinal imaging consults received the appropriate ophthalmology clinic follow-up.

As a result of our inquiries, VAMC leadership reviewed ophthalmology consults discontinued from January 1, 2014, through March 3, 2015, and identified issues with 439 of 1,937 consults. However, ophthalmology leadership did not provide sufficient oversight for processing consults and the VAMC did not have well-defined guidance to ensure staff took appropriate actions when processing consults.

What We Recommended

We recommended the Oklahoma City VAMC Interim Director take appropriate action on patients affected by ophthalmology and teleretinal imaging consults, as well as formalize guidance and train staff on processing consults.

Management Comments

The Interim Director of the Oklahoma City VAMC concurred with the report recommendations and provided appropriate action plans. We will follow up on the implementation of the corrective actions.

A handwritten signature in black ink that reads "Gary K. Abe".

GARY A. ABE
Acting Assistant Inspector General for
Audits and Evaluations

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RESULTS AND RECOMMENDATIONS

Allegation **Oklahoma City VA Medical Center Ophthalmology Clinic Staff Inappropriately Discontinued Consults**

On October 6, 2014, the Office of Inspector General (OIG) received an anonymous allegation that Oklahoma City VA Medical Center (VAMC) ophthalmology clinic staff inappropriately discontinued appointment consults without reviewing patients' medical records. The complainant specifically highlighted the ophthalmology clinic's practice of discontinuing consults sent to ophthalmology from the teleretinal imaging clinic.

Background

The Oklahoma City VAMC is located within the Oklahoma City VA Health Care System, which includes nine Community Based Outpatient Clinics (CBOCs) and is a part of the Veterans Integrated Service Network (VISN) 16. The VAMC provides primary, specialty, and long-term care services to more than 225,000 veterans from Oklahoma and North Central Texas. The VAMC offers eye care services, including ophthalmology and teleretinal imaging.

The VAMC established the teleretinal imaging program to improve rapid diagnosis and timely referral for additional care to reduce the risk of vision loss to diabetic patients. Teleretinal imaging involves the use of digital retinal cameras to scan the retina and peri-orbital area of diabetic patients to screen for diabetic retinopathy. Teleretinal imaging staff perform these scans at a VA facility, transmit the images to another VISN 16 VA medical facilities for medical interpretation, receive the interpretation results, and take action on scheduling patients who may need a follow-up appointment with a VA ophthalmologist. Teleretinal imaging staff explained that while teleretinal imaging is an important part of screening for potentially serious issues in an at-risk population, it is not a substitute for a comprehensive eye exam.

VA providers are expected to use consults to request a clinical evaluation of a patient by another provider or service. According to Veterans Health Administration (VHA) guidance, VA staff must use the discontinue function of the Veterans Health Information Systems and Technology Architecture (VistA) Consult Package when:

- The consult was sent to the wrong service
- A patient meets a facility's threshold for missed appointments
- The service is not needed
- A patient refuses the service
- A patient is deceased
- A duplicate consult was submitted

VA staff are required to use the cancel function when:

- The format of a consult is inadequate
- The service is not available and a non-VA care (NVC) consult will be entered for the same reason

What We Did

We reviewed national and local policies related to consult management practices. We conducted a site visit and interviewed VAMC leadership and staff familiar with consult practices in the ophthalmology clinic. We reviewed national consult data to compare Oklahoma City VAMC's discontinuation rates with national averages in FY 2014 and FY 2015 (as of March 10, 2015). To determine if staff inappropriately discontinued consults, we reviewed non-statistical samples of 50 ophthalmology and 50 teleretinal imaging consults discontinued from October 1, 2014, through February 19, 2015. We also reviewed documentation from an Oklahoma City VAMC internal review of ophthalmology consults discontinued from January 1, 2014, through March 3, 2015. The VAMC Chief of Staff initiated this internal review after seeing the results of our initial review.

What We Found

We substantiated that Oklahoma City VAMC ophthalmology staff and referring providers did not act appropriately on discontinued consults. VAMC staff:

- Did not ensure discontinued ophthalmology consults received a timely referral to NVC when the VAMC could not provide timely care
- Discontinued a consult without adequate justification
- Did not ensure discontinued teleretinal imaging consults received a timely referral for an eye care appointment when patients were unsuitable for the teleretinal imaging procedure

VAMC Has a High Discontinued Rate

To assess the merits of the allegation, we compared discontinued consults with the number of consults completed and found that the Oklahoma City VAMC ophthalmology staff discontinued about 31 percent more consults than the national average in FY 2014, and about 42 percent more in FY 2015 (reported as of March 10, 2015). Additionally, VAMC teleretinal imaging staff discontinued about 9 percent more consults than the FY 2014 national average and about 10 percent more in FY 2015 (reported as of March 10, 2015).

Table 1 describes the rates of discontinued ophthalmology and teleretinal imaging consults by fiscal year.

Table 1. Percentage Rates of Discontinued Consults to All Eye Care Consults

Level of Analysis	FY 2014 Ophthalmology	FY 2015 Ophthalmology	FY 2014 Teleretinal	FY 2015 Teleretinal
Oklahoma City VAMC	44.9	53.8	22.0	21.8
National	14.1	12.2	13.4	12.2
Difference	30.8	41.6	8.6	9.6

Source: VA OIG analysis of Veterans Health Administration Support Service Center's Consults Cube data. FY 2015 rates reflect data as of March 10, 2015

VAMC and ophthalmology clinic leadership told us they were unaware of the comparatively high discontinuation rate until we brought it to their attention. They pointed to an increased effort around October 2014 to reduce a backlog of open consults as a potential explanation for the higher rates. However, they also acknowledged that one staff member—responsible for processing and initiating action on a majority of incoming ophthalmology consults—had not followed local guidance on deciding when to discontinue consults. They stated that there had not been adequate oversight of this staff member's consult processing practices, but that the recent creation of an ophthalmology supervisor position would correct these issues in the future.

VAMC Did Not Take Appropriate Action on Eye Care Consults

We reviewed 50 ophthalmology consults and 50 teleretinal imaging consults discontinued from October 1, 2014, through February 19, 2015. We questioned whether appropriate action was taken by the VAMC on 12 consults—8 of the 50 ophthalmology and 4 of the 50 teleretinal imaging consults we reviewed.

Ophthalmology Consults

Ophthalmology staff and referring providers did not take appropriate action on 8 of the 50 discontinued consults we reviewed (16 percent).

- Ophthalmology staff discontinued seven consults because they could not provide eye exams to the patients within 30 days. Ophthalmology staff and referring providers did not take the necessary next step and refer the seven patients to NVC staff to obtain their medical care outside of the VA. As of March 5, 2015, these seven patients had been waiting about 72 days for their eye exam, with the shortest wait of 31 days and one patient waiting 136 days for care. These discontinuation practices were contrary to VA guidance stating that staff should use the cancel function, not the discontinue function, when entering an NVC consult for the same care.

- Ophthalmology staff discontinued a consult without adequate justification. The day after a primary care physician created a consult (on October 7, 2014), ophthalmology staff discontinued it because the patient had a history of missed appointments. VAMC consultation policy states that each service should allow for at least two no-shows or patient cancellations before discontinuing a consult and makes no exception based on patient history. The staff noted in the discontinuation justification that the patient could receive care in the clinic on a walk-in basis. However, there is no indication in the patient's record that ophthalmology staff relayed this information to the patient.

A VAMC ophthalmology supervisor agreed with our assessment of the eight discontinued consults. For each of these consults, the supervisor and the VAMC Deputy Chief of Staff had the patients scheduled for an eye care appointment or instructed the referring provider to review the patients' medical records and resubmit a consult as needed.

Teleretinal Imaging Consults

Teleretinal imaging staff discontinued consults for 4 of the 50 we reviewed (8 percent) with notes indicating that ophthalmology staff had seen the veterans for eye care in the past, but provided no other justification for discontinuing the consult. The referral of these four veterans to the teleretinal imaging clinic indicated that the patients were either diabetic or had pre-diabetic conditions, which placed them at high risk for diabetic retinopathy. The VAMC telehealth coordinator with oversight of the program told us that teleretinal imaging staff appropriately discontinued the four teleretinal imaging consults. She explained that the veterans were not suitable for the procedure because of the severity of their existing eye conditions. The coordinator told us that they did not review the discontinued consults to determine if VAMC staff took appropriate follow-up action. VAMC teleretinal imaging policy states that patients who are not suitable for teleretinal imaging require an eye care appointment with a provider.

The ophthalmology supervisor acknowledged that VAMC staff did not take appropriate action to ensure that the four patients with discontinued consults received an eye care appointment. Teleretinal imaging staff and the telehealth coordinator told us that the referring providers on the original consult were responsible for requesting an eye care appointment at the time of these discontinuations. By March 12, 2015, all four patients had received the necessary eye care at the Oklahoma City VAMC. An average of 52 days lapsed between the initial consult request and the time the patients actually received care.

VAMC Follow-up Review

After we provided the Oklahoma City VAMC with examples showing that staff had not taken appropriate action on the 12 eye care consults, the VAMC initiated a follow-up review of 1,937 ophthalmology consults discontinued from January 1, 2014, through March 3, 2015. Of the 1,937 discontinued

consults they examined, VAMC's internal review identified issues with 439 consults (about 23 percent). VAMC found that ophthalmology staff inappropriately discontinued 311 consults without adequate justification and in conflict with VAMC policy. Some of the inappropriate reasons included:

- Patient history of no-shows or cancellations
- Scheduled future appointments
- Absence of medical records from recent non-VA eye care

In addition, the review found that ophthalmology staff discontinued 128 consults because the VAMC could not provide the care. The VAMC Director should ensure patients affected by inappropriately discontinued ophthalmology consults receive the necessary eye care.

The VAMC did not include discontinued teleretinal imaging consults in their review. To help ensure teleretinal patients receive necessary eye care, the VAMC Director needs to expand VAMC's follow-up review to include teleretinal consults and take action to provide appropriate eye care as necessary.

***Insufficient
Oversight and
Inadequate
Guidance***

Contrary to VA guidance, ophthalmology staff discontinued consults without adequate justification. Ophthalmology clinic leadership did not provide sufficient guidance and oversight to the staff member primarily responsible for processing consults. Ophthalmology staff told us that local guidance on consult practices was lacking, not well-defined, and not always followed. A supervisor in the ophthalmology clinic and the Deputy Chief of Staff acknowledged that proper management of consult processing did not occur in the past, but both believed that the recent creation of an ophthalmology supervisor position and the reassignment of consult processing duties would correct these issues.

Ophthalmology staff and referring physicians did not properly refer veterans for ophthalmology care or NVC following discontinued consults. This occurred because VAMC leadership never formalized local guidance on follow-up responsibilities into a written policy. Instead, on October 27, 2014, the Co-Chief of Ophthalmology sent an email to primary care to communicate a change in procedures for following up discontinued consults. The email shifted follow-up responsibilities from the ophthalmology staff who discontinued consults to the referring provider. Teleretinal staff sent a similar email to primary care staff on November 20, 2014, directing the same shift in responsibilities. In March 2015, local guidance for the teleretinal imaging clinic reverted to its original practice of reassigning the responsibility for following up on discontinued consults to the teleretinal imaging staff. We identified VA guidance stating that the VAMC staff should use the cancel function, not the discontinue function, when the service is not available. The VAMC Director needs to ensure that guidance and

responsibilities for making referrals on discontinued and cancelled consults is well-defined and formalized into policy. In addition, the VAMC Director needs to ensure that staff responsible for initiating and processing consults are properly trained on all applicable guidance and policies.

According to the Deputy Chief of Staff, providers may have also missed following up on patients because they did not take immediate action when they received the electronic notification of the discontinued consult. In general, when staff discontinue a consult, the referring provider receives a notification in the Computerized Patient Record System (CPRS), which is VA's electronic medical records system. This notification only appears once and, if the provider does not take action before moving to another task or clinical activity, the notification is no longer available for viewing or subsequent action. The Deputy Chief of Staff sent messages in CPRS to the requesting providers to follow up on the discontinued consults when referrals for NVC did not occur. Referring providers were required to review these notes and to provide an electronic signature to remove the associated electronic notification. To ensure referring providers have a clear understanding of their roles in consult processing, especially in light of numerous recent guidance changes, the VAMC Director needs to make sure that all referring providers with electronic notifications responsibility receive adequate training.

Conclusion

We substantiated that ophthalmology staff did not act appropriately on discontinued consults. VAMC ophthalmology and teleretinal imaging staff discontinued consults at significantly higher rates than the national average in FY 2014 and FY 2015 (reported as of March 10, 2015). Ophthalmology staff discontinued consults without adequate justification. In addition, ophthalmology staff and referring providers did not ensure that discontinued consults received the appropriate NVC or ophthalmology clinic follow-up. As a result, VAMC lost reasonable assurance that patients were receiving the appropriate care.

Recommendations

1. We recommended the Interim Director of the Oklahoma City Veterans Affairs Medical Center ensure patients affected by inappropriately discontinued ophthalmology consults receive the necessary eye care.
2. We recommended the Interim Director of the Oklahoma City Veterans Affairs Medical Center initiate a review of discontinued teleretinal imaging consults and take action to provide eye care when necessary.
3. We recommended the Interim Director of the Oklahoma City Veterans Affairs Medical Center ensure that guidance and responsibilities for making referrals on discontinued and cancelled consults is well-defined and formalized into policy.

4. We recommended the Interim Director of the Oklahoma City Veterans Affairs Medical Center ensure that staff responsible for initiating and processing consults are properly trained on all applicable guidance and policies.
5. We recommended the Interim Director of the Oklahoma City Veterans Affairs Medical Center ensure that all referring providers with electronic notifications responsibility receive adequate training.

**Management
Comments**

The Interim Director of the Oklahoma City VAMC concurred with our recommendations and stated that the VAMC completed its review of discontinued ophthalmology consults, scheduled patients for appointments and placed them on the Veterans Chice List, as appropriate. The VAMC will conduct a review of discontinued teleretinal imaging consults and provide eye care when necessary. The VAMC updated local policy to ensure guidance and responsibilities for making referrals on discontinued and cancelled consults is well-defined, and ensure that applicable staff complete training on consult guidance and policies. Finally, the VAMC will create local training to ensure referring providers are properly trained on electronic notifications.

OIG Response

The Interim Director's planned corrective actions are acceptable. We will monitor the facility's progress and follow up on the implementation of our recommendations until all proposed actions are completed. We consider recommendations 1 and 3 closed based on the corrective actions implemented. Appendix B provides the full text of the Interim Director of the Oklahoma City VAMC's comments.

Appendix A Scope and Methodology

Scope

We conducted our review from February through June 2015. We focused on the Oklahoma City VAMC ophthalmology and teleretinal imaging consult processing during FYs 2014 and 2015. We reviewed 50 consults from a population of 1,402 ophthalmology consults discontinued from October 1, 2014, through February 19, 2015. We also reviewed 50 consults from a population of 1,423 teleretinal imaging consults discontinued from October 1, 2014, through February 19, 2015.

Methodology

We examined applicable national and local policies, procedures, and guidance related to eye care and consult processing. We conducted interviews with key Oklahoma City VAMC staff members and leadership. We obtained and analyzed national consult data to determine if VAMC discontinuation rates were comparable to the national average. We reviewed discontinued ophthalmology and teleretinal imaging consults to determine if discontinuations were appropriate and if additional actions were taken when needed. We also analyzed documentation from an internal review of ophthalmology consults.

Data Reliability

We used computer-processed data from Veterans Health Administration Support Service Center's Consults Cube, as well as consult data provided by a site representative. To assess the reliability of Consults Cube data, we compared the details of consults selected for review with the clinical data available for each patient in CPRS. We compared the date and time of entry, type, and status of each consult to ensure that the consults selected were valid and applicable for our review. We did not identify any instances of invalid data, nor did we identify any instances in which data were inconsistent between the two systems.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation.

Appendix B Management Comments

Department of Veterans Affairs

Memorandum

Date: July 31, 2015

From: Interim Medical Center Director, OKC VAHCS (635/00)

Subj: Oklahoma City VA Health Care System Response to Recommendations in Draft Report, Review of Alleged Mishandling of Ophthalmology Consults at the VA Medical Center, Oklahoma City, OK. Project Number 2015-02397-R5-0123

To: Assistant Inspector General for Audits and Evaluations (52)

We appreciate the opportunity to work with the Office of Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans.

I concur with the findings and recommendations of the OIG Team. The importance of this review is acknowledged as we continually strive to provide the best possible care.

OKC VA HCS' response and follow-up to the OIG's recommendations are as follows:

Recommendation 1: OKC VA HCS concurs with the OIG's recommendation that the Interim Director of the Oklahoma City Veterans Affairs Medical Center ensure patients affected by inappropriately discontinued ophthalmology consults receive the necessary eye care.

OKC VA HCS conducted a review of ophthalmology consults discontinued from January 2014 to March 2015. All patients have been scheduled appointments and placed on the Veterans Choice List (VCL), as appropriate.

Completion date: June 1, 2015

Recommendation 2: OKC VA HCS concurs with the OIG's recommendation that the Interim Director of the Oklahoma City Veterans Affairs Medical Center initiate a review of discontinued teleretinal imaging consults and take action to provide eye care when necessary.

OKC VA HCS will conduct a review of discontinued teleretinal imaging consults and take action to provide eye care when necessary.

Target completion date: October 30, 2015

Recommendation 3: OKC VA HCS concurs with the OIG's recommendation that the Interim Director of the Oklahoma City Veterans Affairs Medical Center ensure that guidance and responsibilities for making referrals on discontinued and cancelled consults is well defined and formalized into policy.

OKC VA HCS has updated local policy to ensure that guidance and responsibilities for making referrals on discontinued and cancelled consults is well defined.

Completion date: July 10, 2015

Recommendation 4: OKC VA HCS concurs with the OIG's recommendation that the Interim Director of the Oklahoma City Veterans Affairs Medical Center ensure that staffs responsible for initiating and processing consults are properly trained on all applicable guidance and policies.

OKC VA HCS will ensure staff responsible for initiating consults complete VA course 24762 "What Every VA Clinician Needs to Know About Consults."

OKC VA HCS will also ensure staff responsible for processing consults receive training on VHA guidance and policies related to scheduling and discontinuing consults via the VHA Outpatient Scheduling training.

Target completion date: October 30, 2015

Recommendation 5: OKC VA HCS concurs with the OIG's recommendation that the Interim Director of the Oklahoma City Veterans Affairs Medical Center ensure that all referring providers with electronic notifications responsibility receive adequate training.

OKC VA HCS is creating local training to ensure all referring providers receive training on electronic notifications. All referring providers will complete this training.

Target completion date: October 30, 2015.

If you have any questions, please contact Adrienne Riesenbeck, Director, Office of Quality, Safety, and Value, OKC VA HCS, at 405-456-3146.



Gerald K. Darnell, Psy.D.
Interim Medical Center Director

Appendix C **OIG Contact and Staff Acknowledgments**

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Larry Reinkemeyer, Director Josh Belew Ken Myers

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