Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02890-497

Healthcare Inspection

Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic VA Greater Los Angeles Healthcare System Los Angeles, California

October 28, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the request of Representative Julia Brownley to assess the merit of allegations regarding a delay in a surgical consult at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System (system), Los Angeles, CA, that may have resulted in the death of a patient in August 2012. The complainant alleged that a veteran experienced a delay in surgical consultation for placement of a feeding tube and that this delay resulted in his death.

We substantiated that the patient experienced a delay in obtaining a surgical consult to address his complaints of dysphagia (difficulty swallowing). We determined that this delay resulted from the primary care provider's failure to diagnose the patient's dysphagia timely and/or failure to coordinate the patient's care by following up on the requested neurology consult, as well as the neurologist's failure to classify the July 2012 surgical consult as urgent.

We could not substantiate that the patient died as a result of the failure to address his dysphagia. The patient did not die in a hospital, and we did not find evidence that an autopsy was performed.

In the course of our review, we found that the facility had significant numbers of neurology consults open longer than 90 days. The system explained that this resulted from a failure to close consults properly after patients had been seen. However, as of March 2015, we found that the next available appointment in the neurology clinic was approximately 6 weeks in the future, suggesting that some patients may experience delays in obtaining timely neurology consults.

We recommended that the Veterans Integrated Service Network Director ensure that the system provides neurology consults within timeframes required by patients' clinical conditions and Veterans Health Administration policy. We recommended that the System Director monitor provider compliance with timeframes for acting on consults in accordance with current consult business rules. We recommended that the System Director ensure that providers categorize consults based on urgency and that program managers verify the accuracy of providers' categorizations.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 8–12, for the full text of the Directors' comments.) We consider recommendation 3 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Representative Julia Brownley to assess allegations regarding a delay in a surgical consult that may have resulted in the death of a patient who was receiving care at the Oxnard Community Based Outpatient Clinic (CBOC), VA Greater Los Angeles Healthcare System (system), Los Angeles, CA.

Background

The System

The Oxnard CBOC is part of the Greater Los Angeles VA Healthcare System (system). The system includes a high complexity[1] tertiary hospital. In 2013, the hospital operated 316 beds, 352 community living center beds, and 296 mental health beds. It supports nine CBOCs, including Oxnard, and provides a service area that includes Los Angeles, Santa Barbara, San Luis Obispo, Ventura, and Kern counties. The system is part of Veterans Integrated Service Network (VISN) 22.

The CBOC offers primary care, telehealth, mental health, some social work services, and nutrition/food services. VA staff provide the services offered at the CBOC with the exception of primary care. The primary care clinic is staffed by contract physicians. In fiscal year 2014, the CBOC served 6,067 unique patients who made a total of 20,756 visits to the facility. The CBOC is classified as a large CBOC by the Veterans Health Administration (VHA).

Consults

The consult process is a method of coordinating patient care among different services. VHA policy states that "a consult is a specific document, usually electronic, that facilitates and communicates consultative and non-consultative service requests and subsequent activities." VHA requires that "all requests for clinical consultation be completed with results consistent with VHA timeliness standards and resolved efficiently taking into account individual health needs."[2] Consults are submitted with different types of urgency—routine, stat, or emergency. In 2012, VHA had not issued specific instructions to medical facilities on timeliness for acting on consults. In 2014, VHA issued business rules that specified that some action should be taken on routine consults within 14 days, stat consults within 6 hours, and emergency consults within 4 hours.

[1] Complexity is determined by elements such as types of surgical procedures performed, number of inpatient beds, presence of an intensive care unit, presence of an Emergency Department.
[2] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2009. This Directive expired September 30, 2013 and has not yet been updated.

VHA's business rules for consult management nationwide do not include a specific timeframe for consult completion. However, VHA established a dashboard that allows facilities to readily identify and address consults that have been open for more than 90 days. In April 2014, the system distributed a facility-specific standard operating procedure for outpatient consult management. This procedure also does not define specific timeframes for consult completion but does contain the following statement: "Services must regularly monitor consults and meet with clinic support staff to minimize unresolved consults greater than 90 days." In addition, VHA policy states that, optimally, appointments scheduled in response to consults should be scheduled on the same day that the consult was ordered. National efforts are underway to help ensure that patients' appointments are within 30 days of the clinically indicated or preferred date for services.[3]

Neurology Service

The system's neurology service (neurology) is located at the main campus in West Los Angeles. It offers services in a number of different clinics, including general neurology, seizure, stroke, movement disorder, and epilepsy. Limited services are also offered at the Sepulveda and Los Angeles Ambulatory Care Center locations. The staff comprises 9 full-time physicians, 11 part-time physicians, 1 physician assistant, 1 registered nurse, and 2 EEG (electroencephalogram) technicians. According to the Chief of Staff, the service had adequate physician staffing but probably needed additional administrative staff.

Allegations

The OIG reviewed the following allegations:

- A veteran experienced a delay in surgical consultation for placement of a feeding tube.
- This delay resulted in the veteran's death.

Scope and Methodology

The period of our review was June 2014 to May 2015. OIG staff interviewed the complainant, the Chief of Medicine, Chief of Staff, Deputy Chief of Staff for Clinical Informatics, and others knowledgeable about the patient's care by telephone in March and April 2015.

We reviewed the patient's electronic health record (EHR), administrative and quality peer reviews, and facility policies and procedures. We also reviewed VHA Directives

[3] http://www.va.gov/HEALTH/docs/VA_Report_Section101-PL_113-146-Final.pdf. Report to Congress on the Veterans Choice Program Authorized by Section 101 of the Veterans Access, Choice, and Accountability Act of 2014, 10/3/14, accessed 4/27/15.

and Business Rules pertaining to consult management. We obtained and analyzed data regarding consult completion and wait times at the facility.

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.

Case Summary

At the time of his death, the patient was a male veteran in his 70s with a history of multiple vascular medical problems including a stroke. According to his EHR, the patient began to complain of severe dysphagia (difficulty swallowing) in February 2011; at that time, he weighed 130 pounds. In June 2011 and January 2012, the patient continued to complain of severe dysphagia. His weight in June 2011 was 129 pounds. In January 2012, the patient saw his primary care provider (PCP), who noted again that the patient complained of worsening dysphagia. At that visit, the patient weighed 118 pounds. The PCP requested a routine neurology consult. Five days later, neurology staff commented on the consult, requesting that the PCP obtain imaging studies of the head and neck prior to the consult. However, it does not appear that the studies were ever done nor do any of the progress notes discuss the request.

The PCP saw the patient approximately 5 months later in May 2012. The progress note does not refer to the pending neurology consult request or to the patient's continuing dysphagia. However, in June, neurology clinic staff noted the consult from January was incomplete and scheduled an appointment with the patient even though the previously requested imaging studies had never been performed. The patient saw a neurologist in July. At this visit, the neurologist found that the patient was experiencing dysphagia and tongue fasciculations,[4] raising the possibility of a neurodegenerative[5] process. In addition, neurological exam findings were consistent with possible cervical spine pathology. The neurologist recommended consultation with surgery for a feeding tube placement. This "routine" consult was ordered by neurology the same day; an appointment was scheduled for 3 weeks later. However, the patient expired a week before the appointment. The patient did not die in a hospital, and we found no indication that an autopsy was performed.

Inspection Results

Issue 1: Alleged Delay in Care

We substantiated a delay in obtaining a surgical consultation to address the patient's complaint of dysphagia. The patient experienced poor access to care because the delay in obtaining the neurology consult contributed to a delay in obtaining a surgery consult for feeding tube placement. We determined that these delays resulted from the PCP's failure to diagnose the patient's dysphagia timely and/or failure to coordinate the patient's care by following up on the requested neurology consult as well as the neurologist's failure to classify the surgical consult as urgent.

Although the PCP's notes reference the patient's complaints of dysphagia as early as February 2011, the PCP did not address the dysphagia until January 2012, when he requested a neurology consult. We found no explanation in the EHR as to why the PCP

[4] Fasciculation is small, involuntary muscle twitching of the tongue.
[5] Neurodegenerative refers to a condition that primarily affects the neurons in the brain.

failed to address the patient's complaints of dysphagia for almost 1 year. When neurology responded to the consult request by asking for additional studies, the PCP did not order those studies nor otherwise address the need for a neurology consult again, despite seeing the patient in May 2012.

When a neurologist saw the patient in July 2012, approximately 6 months after the original consult request, the neurologist requested a surgical consult for placement of a feeding tube. The neurologist classified the request as "routine" despite documentation that the patient could not eat. Although the surgical consult was scheduled within 3 weeks of the patient's neurology appointment, the patient died before he was seen by a surgeon.

While we concluded that a delay occurred in obtaining a surgical consult for the patient's dysphagia, we could not substantiate that the patient died as a result of this delay. The patient did not die in a hospital, and the VA EHR contains no documentation of the circumstances of his death. We could not find evidence that an autopsy was done. As a result, while we concluded the patient received poor access to care, which resulted in poor quality of care, we could not determine whether the patient's dysphagia contributed to his death or whether he died of other causes.

The facility conducted a review of this case. Facility staff informed us that the contract PCP involved in this patient's care no longer worked for the facility at the time of our review.

Issue 2: Consult Management

The patient's neurology consult had been open for more than 6 months. We asked the facility how a consult could be open for more than 6 months and not come to the attention of the service or facility leadership.

We were informed that in 2012, the system had no standard process for addressing the scheduling of appointments in response to consults, but staff attempted to ensure patients were seen for their appointments within 14 days. Once a consult was ordered, it was automatically placed in a "pending" status. System staff would enter actions taken regarding the consult request, including whether it had been scheduled, completed, discontinued or canceled. However, the status of the neurology consult ordered for this patient was not changed, and it remained "pending." The PCP failed to respond to neurology's request for additional tests, so no further action occurred on the consult request for 6 months, at which time the neurology service scheduled an appointment that occurred 7 months after the original "routine" consult request.

In 2012, as part of a nationwide initiative, the system began reviewing all open consults and closing those that were no longer clinically relevant.[6] The system also implemented a standard operating procedure for consult management in April 2014. In accordance

[6] For example, system staff began closing consults if the patient had expired, the consult had been completed, or there was a duplicate consult.

with this standard operating procedure, consults were expected to be screened within 3 working days of the date the consult was created in the EHR. Although a specific time frame for completing the consult was not specified, the standard operating procedure did include a review of all consults open for longer than 90 days.

Incidental to our review, we identified potential delays in neurology and general surgery consults, based on our analysis of facility consult data through March 19, 2015. Using this data, we determined that 548 neurology consults were open for more than 30 days, 234 of which were open for more than 90 days. Of the 234 neurology consults open more than 90 days, 214 were scheduled. As of March 2015, over half of the neurology patients had received care. In addition, we determined that 105 general surgery consults had been open for longer than 30 days, 23 of which were open for longer than 90 days. Of the 23 general surgery consults open more than 90 days, 21 were scheduled. The Associate Chief of Staff for Operations and Informatics told us that neurology and general surgery consults remained open because providers did not complete the consult or chose the wrong note title. However, staff informed us during interviews that the next available appointment for the neurology clinic as of March 2015 was approximately 6 weeks away. As a result, we concluded that some patients may be experiencing delays in obtaining appointments in response to neurology consults.

Conclusions

We substantiated that the patient experienced a delay in obtaining a surgical consult to address his complaints of dysphagia. We determined that this delay resulted from the PCP's failure to diagnose the patient's dysphagia timely and/or failure to coordinate the patient's care by following up on the requested neurology consult, as well as the neurologist's failure to classify the surgical consult placed in July 2012 as urgent. At the time of our March 2015 review, the contract PCP involved in the care of this patient no longer worked for VHA.

We could not substantiate that the patient died as a result of the failure to address his dysphagia. The patient did not die in a hospital, and we found no evidence of an autopsy being performed.

Consult data available as of March 2015 showed significant numbers of neurology consults open longer than 90 days. The system explained that this resulted from a failure to close consults properly after the patients had been seen. However, we determined that the next available appointment in the neurology clinic was approximately 6 weeks in the future, suggesting that some patients may experience delays in obtaining timely neurology consults.

Recommendations

1. We recommended that the Veterans Integrated Service Network Director ensure that the system provides neurology consults within timeframes required by patients' clinical conditions and current Veterans Health Administration policy.

2. We recommended that the System Director monitor provider compliance with timeframes for acting on and closing consults in accordance with the current Veterans Health Administration policy.

3. We recommended that the System Director ensure that providers categorize consults based on urgency and that program managers verify the accuracy of categorizations.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: July 12, 2015

From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California

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

1. I concur with the findings and recommendations in the report of the Healthcare Inspections—Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California, (Report Number—DRAFT) open recommendations 1-3.

2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (562) 826-5963.

Marie L. Weldon

Marie L. Weldon, FACHE

Attachment

Comments to OIG's Report

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

OIG Recommendation

Recommendation 1: We recommended that the Veterans Integrated Service Network Director ensure that the system provides neurology consults within timeframes required by patients' clinical conditions and current Veterans Health Administration policy.

Concur

Target date for completion: September 30, 2015

VISN response: Network Director will ensure VA Greater Los Angeles Healthcare System (GLA) has implemented a change to consult requests requesting provider input the "clinically indicated date" for the consult. If the patient cannot be scheduled within 30 days of that clinician-directed timeframe, the patient is offered Choice care, if eligible. GLA is working with neurology to enhance neurology access and ensure maximal use of neurology clinic time. Neurology clinic grids are being actively evaluated. Additionally, neurology staff are in the process of being hired.

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: July 15, 2015

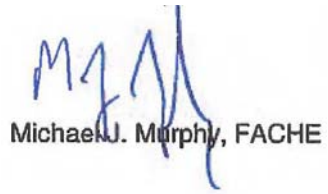
From: Acting Director, VA Greater Los Angeles Healthcare System (691/00)

Subj: Healthcare Inspection—Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California

To: Desert Pacific Healthcare Network (10N22)

1. Attached is VA Greater Los Angeles Healthcare System's response to Healthcare Inspection—Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System (GLA), Los Angeles, California.

2. For questions or concerns, please contact Dave Holt, Associate Director for Ambulatory Care, or Dr. Caroline Goldzweig, Deputy Chief of Staff, at (310) 268-3132.



Comments to OIG's Report

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

OIG Recommendations

Recommendation 2. We recommended that the System Director monitor provider compliance with timeframes for acting on and closing consults in accordance with the current Veterans Health Administration policy.

Concur

Target date for completion: October 1, 2015

Facility response: GLA monitors consult statuses on a regular basis using both VSSC and locally developed tools to ensure that consults to any clinical service are attended to in a timely manner. This data is presented to the Deputy Chief of Staff and the Chief of Staff on a regular basis. GLA has a Consult Management Committee, that meets monthly, and that includes members from all relevant clinical disciplines and administrative stakeholders to review consult policies and procedures as well as consult timeliness. On a weekly basis, the Chief of Staff office sends out a report to Service and Section Chiefs regarding pending consults older than 7 days and unresolved consults greater than 90 days; and, monitors for response. The office also monitors scheduling practices for all services and works closely with Health Administration Services when there appear to be delays in scheduling of consults. At the time of this report, Neurology has 9 consults pending greater than 7 days and 2 consults in the active status > than 90 days.

Recommendation 3. We recommended that the System Director ensure that providers categorize consults based on urgency, and that program managers verify the accuracy of categorizations.

Concur

Target date for completion: Completed

Facility response: GLA has implemented a VACO-requested change to consults whereby the "earliest appropriate date" field in a consult request no longer defaults to "today" but must be set by the requesting provider based on the specific condition and clinical status of the patient. This is in line with nationally recommended standards on consult management. This date becomes the "clinically indicated date" used by schedulers to determine whether a patient is Choice-eligible and to guide appropriate appointment management. The VACO Consult Workgroup does not recommend reliance on the urgency status of consults because there are no set definitions for all of the currently available statuses. Future versions of CPRS will allow for only a few urgency statuses. This field is not a required field and many providers ignore it or do

not make the appropriate selection. For this reason, the "earliest appropriate date" field is being used to designate urgency, because it is a mandatory field. All providers at GLA have been notified on multiple occasions and via different communication pathways (i.e. email, staff meetings) that any emergency or urgent consult requires a "warm hand-off" in addition to an electronic consult – i.e. a call to the consult service regarding the patient. If the case is urgent or emergent, the consult service arranges for an "overbook" as necessary.

Appendix C

OIG Contact and Staff Acknowledgments

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

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