ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

VA Medical Center in Boise, Idaho
March 22, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based on information received through the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline from an anonymous source alleging that non-VA medical consultations that had not been scheduled from 14 to 90 days were being canceled by staff per the direction of a manager in Health Administration Services (HAS) at VA Medical Center (VAMC) Boise.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed the VAMC Boise director and the HAS manager.

- **Records Reviewed:** VA OIG consulted closing data for VAMC Boise clinics in Orthopedics, Ophthalmology, Oncology, Cardiology, Gastroenterology (GI), Mental Health, and Sleep Disorders.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The HAS manager stated VAMC Boise had not had an ophthalmologist for 2 years and they sent patients to non-VA providers for a fee using "drop money" and when other funds were available. She stated that, until 2 to 3 months prior to the interview, all eye-related requests went into one template, so it was hard to separate specifics. She stated Ophthalmology patients were also placed on the Electronic Wait List (EWL). When patients were sent on Non-VA Coordinated Care (NVCC) consults, the ophthalmology-specific consult was closed and a new NVCC consult was started. She stated VAMC Boise had just received additional funds and, therefore, she did a large number of consult closings and sent them out on NVCC. She stated that VAMC Boise sent a weekly consult report to all Service Lines with the expectation that those consults waiting more than 90 days will be reviewed and acted on, as appropriate.

- The director advised that VAMC Boise management had known that low staffing levels in certain clinics, such as the Ophthalmology Clinic, and the facility had been aggressively recruiting an ophthalmologist. He stated the facility was aware of the patients on consult waiting lists, and medical staff reviewed the lists to make certain that patients who were in need of urgent care or suffering from a serious condition were quickly provided a fee-basis appointment. He stated that VAMC Boise had sent other patients for fee-basis treatment when funding was available, and additional funding had

been provided by VA for fee-basis appointments and treatment in the few months prior to the interview.

Records Reviewed

Because the complainant was anonymous, there were no specific allegations of patient harm; the complainant did not identify specific types of consults, so the investigation could not focus on individual patients or types of consults. However, the VA OIG Office of Healthcare Inspections (OHI) also conducted a review of consult closing data for VAMC Boise in an attempt to corroborate the allegation and develop leads for possible investigation. An initial review of data indicated there was a sharp decrease in the consult numbers at VAMC Boise, which was determined to be likely related to the national consult initiative described in the VA memo, *Consult Business Rule Implementation*, dated May 23, 2013.

OHI reviewed closed consult metrics related to the following VAMC Boise clinics: Orthopedics, Ophthalmology, Oncology, Cardiology, GI, Mental Health, and Sleep Disorders. The review identified the Ophthalmology and Orthopedic Clinics as having the greatest number of closed consults.

OHI had been conducting a medical record review of consult tracking report data for all consult statuses (pending, active, scheduled, canceled, discontinued, and denied) for the last 24 months for the Ophthalmology and Orthopedic Clinics at the individual patient level. The OHI review of 27 randomly selected closed consults did not identify any significant quality-of-care concerns related to the closed consults. The review, plus an interview with the HAS manager, determined the following:

- VA Ophthalmology Clinic consult patients were placed on the EWL if the patient could not be scheduled for an appointment within 90 days. Prior to May 2014, VA internal Ophthalmology Clinic consults were canceled when the patient was provided a fee-basis consult for care in the community per VA policy. The community fee-based appointments were dependent upon funding available to VAMC Boise. A large number of internal pending consults was referred out for non-VA care when the Accelerated Care Initiative (ACI) took effect in approximately May 2014 because ACl provided sufficient funding for this type of appointment.

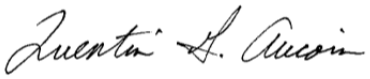
- VA Orthopedic Clinic consults were all related to inpatient care. These consults were canceled due to the provider determining that the consults were no longer medically necessary for the patient.

In summary, OHI's review determined that VAMC Boise did have delays when providing ophthalmology care, which most likely resulted from the fact that VAMC Boise had no ophthalmology provider for 2 years. The review also found that VAMC Boise followed VA policy by placing patients on the EWL if patients were not provided with an internal consult within 90 days, and that patients were referred for NVCC when funding was available.

4. Conclusion

The VA OIG review determined that VAMC Boise did sustain delays in providing ophthalmology and orthopedic care to patients primarily due to lack of VA providers in these clinics. Patients were appropriately placed on the EWL when consults could not be scheduled. VA OIG review of records indicated VAMC Boise closed consults per VA policy. The recent VA ACI has significantly decreased the number of outstanding consults in the system.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 3, 2015.



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