Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-01489-311

Combined Assessment Program Summary Report

Evaluation of Coordination of Inpatient Consults in Veterans Health Administration Facilities

May 23, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections completed an evaluation of coordination of inpatient consults in Veterans Health Administration facilities. The purpose of the review was to evaluate the consult management process and the completion of clinical consults that clinicians order and expect to be completed during inpatient admissions.

We conducted this review at 54 Veterans Health Administration medical facilities during Combined Assessment Program reviews performed across the country from October 1, 2014, through September 30, 2015.

We observed many positive practices, including oversight committees implementing corrective actions when they identified opportunities for improvement, requesters stating adequate reasons for consult requests, and consultants generally addressing the reasons for the consults. The Veterans Health Administration program office has been proactive in addressing problems and has made several positive changes.

We identified one opportunity for Veterans Health Administration facilities to improve. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility leaders, ensure that facility clinicians consistently include 'inpatient' in the inpatient consult title and that facility managers monitor compliance.

Comments

The Under Secretary for Health concurred with the findings and recommendation. (See Appendix A, pages 5–7, for the full text of the comments.) The implementation plans are acceptable, and we will follow up until all actions 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 evaluated coordination of inpatient consults in Veterans Health Administration (VHA) facilities. The purpose of the review was to evaluate the consult management process and the completion of clinical consults that clinicians order and expect to be completed during inpatient admissions.

Background

In 2013, VHA acknowledged problems with its management of clinical consults and undertook a system-wide performance improvement project. VHA released a set of internal business rules along with a schedule for implementation that was to have been completed by May 2014. This review focused on inpatient clinical consults, which the business rules define as:

> A request for consultative services to be completed during an inpatient admission. All requests should be addressed prior to discharge and completed. This is not for follow up outpatient visits or for initial visits as an outpatient. At the time of discharge, incomplete inpatient clinical consultation requests must be discontinued and the need assessed and addressed by creating an outpatient request or communicating with the primary care provider in the medical record.

Several Office of Healthcare Inspections reports have detailed problems with the consult process in VHA facilities. In one inspection, we substantiated allegations of inappropriate cancellation or discontinuation of consults.[1]

Definitions:

- Consult: A consult is a request for clinical services on behalf of a patient. In VHA, clinicians make consult requests through an electronic document that communicates service requests and/or results.
- Clinical Consult: A clinical consult is a two-way communication on behalf of a patient consisting of a physician or other health care provider request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider.

Scope and Methodology

We performed this review in conjunction with 54 Combined Assessment Program reviews conducted from October 1, 2014, through September 30, 2015. The facilities we visited were a stratified random sample of all VHA facilities and represented a mix of

[1] *Healthcare Inspection – Consultation Mismanagement and Care Delays*, Spokane VA Medical Center, Spokane, Washington, Report No. 12-01731-284, September 25, 2012.

facility size, affiliation, geographic location, and Veterans Integrated Service Networks. OIG generated an individual Combined Assessment Program report for each facility. For this report, we summarized the data collected from the individual facility reviews.

We reviewed facility policies and conversed with applicable managers and employees. Additionally, we reviewed 2,042 patients' electronic health records. We used 90 percent as our expectation for compliance. The patient samples within each facility were probability samples.

Inspectors conducted the reviews 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: Facility Consult Management and Oversight

On May 23, 2013, the VHA Under Secretary for Health sent a memorandum to VHA facilities recommending, "facilities either stand up a committee or assign an existing committee the task of overseeing and managing the consult linking and business rule implementation and sustainment." When facilities' oversight committees identified opportunities for improvement, they generally implemented corrective actions. Major bed services had appointed employees to review and manage consults.

Although many facilities had implemented consult management and oversight committees, 11 percent did not have such committees. The responsible VHA program office informed us that VHA has initiated a 100 percent site visit audit that includes facility oversight committees.

Additionally, 30 percent of facilities did not track consults that were not completed within specified timeframes. The program office has implemented system-wide tracking systems with canned reports available at the facility, Veterans Integrated Service Network, and VHA levels.

Because of the program office's proactive efforts, we did not make a recommendation.

Issue 2: Clinician Documentation

VHA requires that the requesting provider state the reason for requesting the consult and that the responding provider address the reason.[2] Requestors generally stated adequate reasons for consult requests, and consultants generally addressed the reasons for the consults.

The VHA consult business rules require that consultants appropriately change consult statuses (such as from incomplete to complete), link responses to the requests, and complete consults within the specified timeframe. Generally, consultants complied with these requirements.

The VHA consult business rules also require that a consult expected to be completed while the patient is an inpatient must have 'inpatient' in the consult title. Use of a standard note title allows for easy monitoring of open consults. Fifteen percent of inpatient consult requests did not include 'inpatient' in the consult title.

We recommended that facility clinicians consistently include 'inpatient' in the inpatient consult title and that facility managers monitor compliance.

[2] VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.

Issue 3: Clinician Training

The VHA consult business rules require all facilities to provide clinician training in the use of the consult computer package. We focused on major bed services (medicine, mental health, surgical, and rehabilitation) and found evidence that 89 percent of facilities had provided clinician training, so we did not make a recommendation. In addition, the VHA program office told us that it has provided extensive training to VHA clinicians.

Conclusions

We observed many positive practices, including oversight committees implementing corrective actions when they identified opportunities for improvement, requesters stating adequate reasons for consult requests, and consultants generally addressing the reasons for the consults. However, when clinicians initiate consults they expect to be completed during the inpatient stay, they need to consistently include 'inpatient' in the consult title.

Recommendation

1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that facility clinicians consistently include 'inpatient' in the inpatient consult title and that facility managers monitor compliance.

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: May 6, 2016

From: Under Secretary for Health (10)

Subject: **Office of Inspector General (OIG) Draft Report, Combined Assessment Program (CAP) Summary Report: Evaluation of Coordination of Inpatient Consults in Veterans Health Administration Facilities (Project No. 2016-01489-HI-0642) (VAIQ 7670845)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report. The Veterans Health Administration (VHA) is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the Department of Veteran Affairs (VA) health care system. VHA is using the input from the VA's Office of Inspector General, and other advisory groups to identify root causes and to develop critical actions. As VHA implements corrective measures, we will ensure our actions are meeting the intent of the recommendations. VHA is dedicated to sustained improvement in the high risk areas.

2. The recommendations in this report apply to GAO high risk area 1. VHA's actions will serve to address ambiguous policies and inconsistent processes.

3. I have reviewed the draft report, and provide the attached action plan to address the report's recommendation (1).

4. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10ARMRS2@va.gov.

David J. Shulkin, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, CAP Summary Report – Evaluation of Coordination of Inpatient Consults in Veterans Health Administration Facilities

Date of Draft Report: January 15, 2016

Recommendations/ Actions	Status	Completion Date

OIG Recommendation

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that facility clinicians consistently include 'inpatient' in the inpatient consult title and that facility managers monitor compliance.

VHA Comments: Concur

In May 2015, VHA's consult business rules were originally shared with the field through a Deputy Under Secretary for Health for Operations and Management memorandum. The consult business rules establish the requirements for 'inpatient' in the appropriate consult titles. The consult business rules have since been updated and incorporated into the revised consult policy. The VHA Office of Regulatory and Administrative Affairs is reviewing VHA's revised consult policy. Additionally, the draft consult policy assigns local facility consult steering committees the responsibility for monitoring consult service titles. Compliance with consult titles will be monitored by the Office of Compliance and Business integrity through a national audit beginning in the third quarter of FY 2016. The VHA Support Service Center electronically monitors and reports consult titles that are in an incorrect format. Training on consult service titles has been created and delivered to assure that inpatient consult titles are assigned to the appropriate inpatient consults. As of January 5, 2016, a total of 85,396 employees completed the Talent Management System training. Of these, 64,899 (98.4 percent) Licensed Independent Practitioners completed the training.

In efforts to bring this recommendation to closure, VHA will review the first quarter of gathered data and consult with OIG to develop a course of action.

Status:	Target Completion Date:
In Process	December 2016

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720
Inspection Team	Julie Watrous, RN, MS, Project Coordinator Annette Acosta, MN, RN Gail Bozzelli, RN Craig Byer, MS Victoria Coates, LICSW, MBA Myra Conway, MS, RN Laura Dulcie, BSEE Wachita Haywood, RN LaFonda Henry, MSN, RN-BC Yoonhee Kim, PharmD Alison Loughran, JD, RN Carol Lukasewicz, RN, BSN Cindy Niemack-Brown, CMSW, LMHP Lauren Olstad, LCSW Sami O'Neill, MA Melanie Oppat, MEd, LDN Glen Pickens, RN, MHSM Larry Ross, MS Jennifer Tinsley, LMSW-C Susan Tostenrude, MS Emorfia Valkanos, RPh Ann Ver Linden, RN, MBA Cheryl Walker, ARNP, MBA Jovie Yabes, RN, BSN
Other Contributors	Elizabeth Bullock Lin Clegg, PhD

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