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Office of Healthcare Inspections

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Healthcare Inspection

Delays in the Evaluation and Care of a Patient with Lung Cancer VA Southern Nevada Healthcare System Las Vegas, Nevada

May 23, 2017

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Executive Summary

The VA Office of Inspector General conducted a healthcare inspection to assess the merit of allegations regarding delays in the evaluation and care of a patient with lung cancer at the VA Southern Nevada Healthcare System (system), Las Vegas, NV in 2014.

We received numerous allegations and complaints regarding a delayed evaluation of a pleural effusion and a delay in the diagnosis and treatment of a patient's lung cancer. Specifically, a complainant alleged the following:

- Delay in evaluation of the patient's left pleural effusion resulted in delayed lung cancer diagnosis and treatment
- Failure to examine the patient during a 2014 primary care provider (PCP) appointment
- Delays in obtaining Non-VA Medical Care Coordination (NVCC) authorizations
- Difficulty in obtaining non-VA prescribed medications
- Lack of continuity of care with four different PCPs

We substantiated that a delay of approximately 6 months occurred in the evaluation of the patient's pleural effusion and that delays occurred in the diagnosis and treatment of the patient's lung cancer. In conjunction with the delay in evaluation, the patient was not timely notified of test results. We identified several contributing factors, including lack of follow up related to a non-VA provider's recommendation for a lung biopsy.

We did not substantiate that a PCP failed to perform a physical examination during a 2014 appointment.

We substantiated delays in obtaining NVCC authorizations. We identified several contributing factors to the delays:

- NVCC staff inconsistently applied the requirement for system providers to see the patient first for services offered at the system before an NVCC consult was approved
- NVCC staff failed to process the request according to the urgency noted by the requesting provider
- Emergency Department (ED) providers failed to follow the NVCC consult request process
- NVCC staff did not appear to be knowledgeable of covered services

We substantiated inadequate medication management due to delays in filling medications ordered by non-VA care providers and problems with delivery of medications.

We did not substantiate a lack of continuity of care due to changes in the patient's PCP. We did not find disruptions in the patient's care due to the changes.

During our inspection, we found inconsistencies with the system's peer review process.

We recommended that the System Director:

- Ensure that providers address and communicate test results to patients within the timeframe required by the Veterans Health Administration (VHA).
- Ensure that providers timely follow up on non-VA care providers' recommendations.
- Ensure the NVCC requirement for patients to be seen by system physicians first for services offered at the system before an NVCC request is authorized does not delay care.
- Ensure NVCC staff process requests according to the urgency noted by the requesting provider.
- Ensure ED providers follow NVCC consult request processes.
- Ensure NVCC staff are knowledgeable of specific services that are authorized when NVCC consults are approved.
- Review existing practices for filling non-formulary/restricted medications to ensure that medications are ordered, reviewed, and processed timely.
- Evaluate patient experience regarding contracted companies' processes for delivery of medications and take appropriate corrective actions if needed.
- Ensure the peer review process is conducted according to current VHA guidance.

Comments

The Veterans Integrated Service Network and System Directors reviewed the report; the System Director concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 17–24 for the full text of the comments.) Based on information received from the system, we consider all recommendations closed.



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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations regarding delays in the evaluation and care of a patient with lung cancer at the VA Southern Nevada Healthcare System (system), Las Vegas, NV.

Background

System Overview

The system is part of Veterans Integrated Service Network (VISN) 21. An estimated 240,000 veterans live in the Las Vegas catchment area. The system operates a 90-bed medical center and provides inpatient and outpatient health care services, including mental health and home care, to more than 45,000 patients annually.¹

The system operates the medical center in Las Vegas, as well as six community clinics, all in Nevada: Laughlin Rural Outreach Clinic, Northeast Primary Care Clinic, Northwest Primary Care Clinic, Pahrump Community Based Outpatient Clinic, Southeast Primary Care Clinic, and Southwest Primary Care.

Non-VA Medical Care Coordination

Non-VA Medical Care Coordination (NVCC)² is medical care provided to eligible veterans outside of VA when VA facilities and services are not reasonably available. The provision of non-VA care is governed by Federal laws and/or regulations that describe eligibility criteria. VA policies also specify requirements regarding when and why non-VA care may be accessed. Except in the event of an emergency, pre-approval for non-VA medical care is required.

The patient's provider places an NVCC request to initiate the process. The Non-VA Medical Care Program Office provides authorization for routine outpatient medical services and selected inpatient services through community providers when it is determined that direct VA services are either geographically not accessible or the VA facilities are not available to meet a veteran's needs. Once the authorization has been approved, the Non-VA Medical Care Program office staff contact the patient and the non-VA care provider. The process can present challenges due to the number of steps required from the submission of the initial consult to the final approval and delivery of care to the veteran.

¹ System website, <http://vaww.va.gov/directory/guide/facility.asp?ID=68&dnum=All>. Accessed February 5, 2016.

² VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013.

Veterans Health Administration Peer Review

A peer review conducted as part of a system's quality management program is a confidential, non-punitive process for evaluating health care provided by an individual provider. This type of review is protected from disclosure outside of the quality management process. It differs from a management review in that the results cannot be used for personnel actions such as reassignment, changes in privileges, performance pay determinations, or disciplinary actions.

A peer review is a critical review performed by a peer or group of peers. The Veterans Health Administration (VHA) peer review directive requires a peer reviewer to be a health care professional who has comparable education, training, experience, licensure, or similar clinical privileges or scopes of practice and is able to make a fair and credible assessment of the episode of care.³

Peer reviewers assess actions taken by other providers relative to an episode of care. Episodes of care are referred for peer review by providers or system leaders with clinical or administrative concerns about the care.³

Pleural Effusion

Roughly 1.5 million people in the United States are diagnosed with a pleural effusion each year.⁴ A pleural effusion is a collection of excessive fluid between the lung and chest wall. Normally, a small amount of fluid may help the lung slide along the chest wall, but an excess may put pressure on the lungs and impede the work of breathing. A pleural effusion can be a sign of a range of disease processes, from benign to malignant, and often does not cause imminent danger. Extra-pulmonary processes (such as heart, kidney, or liver failure) and intrinsic lung diseases (such as bacterial infection or lung cancer) can cause fluid accumulation.⁴

When a provider suspects a pleural effusion, he/she may elect to order a chest x-ray. If a chest x-ray is inconclusive, computed tomography (CT)⁵ or ultrasound⁶ (US) may be helpful for confirmation of excessive fluid. CT may provide the additional advantage of clarifying the underlying etiology in the lung. In some cases, if the patient is not symptomatic and/or the cause of the pleural effusion is known, no further testing is needed and the effusion can be monitored for resolution.

³ VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. The requirements described in the background material are found within this VHA Directive, unless otherwise noted. The Directive expired June 30, 2015, and has not yet been updated.

⁴ Saguil A, Wyrick K, Hallgren J. *Diagnostic Approach to Pleural Effusion*. American Physician. Vol 90, No.2, July 15, 2014. www.aafp.org/afp. Accessed March 15, 2016.

⁵ A CT scan combines a series of x-ray images taken from different angles and uses computer processing to create cross-sectional images, or slices, of the bones, blood vessels, and soft tissues inside the body.

⁶ Diagnostic imaging technique using ultrasound waves to visualize internal body structures such as joints, muscles, and internal organs.

A pleural effusion may also be evaluated by thoracentesis, a procedure in which a fluid sample is obtained via insertion of a needle into the chest cavity. The fluid is sent to the laboratory for analysis to determine what types of cells are present. The protein content of the fluid and type of cells present may suggest a diagnosis, including the presence of a cancer in the lung. If the fluid analysis is inconclusive, a lung biopsy may be required. This may be done by placing a camera and small tools through small incisions in the chest in a video-assisted thoracoscopic (VAT) procedure.

Lung Cancer

Epidemiology

Lung cancer is a disease in which malignant cells form in the lung. It is the leading cause of cancer mortality in the United States for both men and women. In 2012, 210,828 people in the United States were diagnosed with lung cancer, and it accounted for 157,423 deaths.⁷ Smoking is associated with the highest risk of lung cancer.⁸

Symptoms

Symptoms of lung cancer include chest discomfort or pain, persistent cough, dyspnea (difficulty breathing), wheezing, blood in the sputum, hoarseness, loss of appetite, weight loss, fatigue, dysphagia (difficulty swallowing), and swelling in the face and/or neck veins.⁹

Diagnosis and Assessment

Lung cancer may be detected, diagnosed, and staged by various imaging studies such as chest x-ray, CT, positron emission tomography (PET),¹⁰ and magnetic resonance imaging (MRI).¹¹ A definitive diagnosis, which allows providers to determine optimal treatment for specific cancers, cannot be established until a biopsy with a positive lung tissue sample is obtained and analyzed.

Lung cancer generally consists of two major categories: small cell and non-small cell lung cancer (NSCLC). About 85–90 percent of lung cancers are NSCLC.¹² Within this

⁷ Centers for Disease Control and Prevention, *Lung Cancer Statistics*, <http://www.cdc.gov/cancer/lung/statistics/>. Accessed May 14, 2015.

⁸ National Institutes of Health, National Cancer Institute, <http://www.cancer.gov/cancertopics/pdq/treatment/non-small-cell-lung/Patient/>. Accessed May 11, 2015.

⁹ Ibid.

¹⁰ A PET scan is an imaging test that uses a radioactive drug to show how the body's tissues and organs are functioning. The drug is injected, swallowed, or inhaled and it collects in areas of the body that have higher levels of chemical activity, which often corresponds to areas of disease. On a PET scan, these areas show up as bright spots.

¹¹ An MRI uses a magnetic field and radio waves to create detailed images of your body. While lying down in the machine, the magnetic field temporarily realigns hydrogen atoms in your body. Radio waves cause the aligned atoms to produce very faint signals that are used to create cross-sectional MRI images, like slices of bread.

¹² American Cancer Society. *What is non-small cell lung cancer?* <http://www.cancer.org/cancer/lungcancer-non-smallcell/detailedguide/non-small-cell-lung-cancer-what-is-non-small-cell-lung-cancer>. Accessed August 4, 2015.

category, 40 percent are adenocarcinomas in which the lung cancer arises from cells that line the air sacs of the lung. Some lung adenocarcinomas are detected because of incidental findings on studies done for other reasons, such as a chest x-ray ordered to evaluate chest pain.¹³ However, many patients with adenocarcinoma of the lung often do not present until later in the disease, that is, when the cancer is in an advanced stage.¹⁴

Staging and Prognosis

In general, a patient's prognosis depends upon both the stage and type of the lung cancer. Staging is the process that determines the size and location of the tumor and whether the cancer has spread to any lymph nodes¹⁵ and/or other parts of the body.¹⁶ Staging also helps in the selection of appropriate treatment options. The higher the stage number, the more extensive the disease. Stage IV, the highest stage, generally indicates that the cancer has spread to distant tissues or organs. A pleural effusion caused by NSCLC, regardless of the size, automatically puts the patient in stage IV.¹⁷

Stage IV NSCLC is particularly difficult to treat because of its generally widespread nature when diagnosed. Chemotherapy, radiation therapy, and surgery may help relieve symptoms but are unlikely to cure the underlying disease.¹⁸ The goals of treatment may be targeted for symptom relief. Approximately 1 percent of patients with stage IV NSCLC live at least 5 years after diagnosis.¹⁹

Allegations

The complainant alleged that a delay in the evaluation of a patient with a pleural effusion resulted in a delay in the diagnosis of lung cancer. Additional delays occurred in NVCC authorization of treatment for lung cancer. Specifically, the allegations included:

- Delay in evaluation of the patient's left pleural effusion that resulted in delayed lung cancer diagnosis and treatment

¹³ American Cancer Society. *Can non-small cell lung cancer be found early?*

<http://www.cancer.org/cancer/lungcancer-non-smallcell/detailedguide/non-small-cell-lung-cancer-detection>.

Accessed August 4, 2015.

¹⁴ Ibid.

¹⁵ Lymph nodes are small, bean-shaped masses of tissue scattered along the lymphatic system that act as filters and immune monitors, removing fluids, bacteria, or cancer cells that travel through the lymphatic system.

¹⁶ National Institutes of Health, National Cancer Institute, <http://www.cancer.gov/cancertopics/pdq/treatment/non-small-cell-lung/Patient/>. Accessed on May 11, 2015.

¹⁷ American Cancer Society. *How is non-small cell lung cancer diagnosed?*

<http://www.cancer.org/cancer/lungcancer-non-smallcell/detailedguide/non-small-cell-lung-cancer-staging>.

Accessed August 4, 2015.

¹⁸ National Cancer Institute. *Non-Small Cell Lung Cancer Treatments*. <http://www.cancer.org/cancer/lungcancer-non-smallcell/detailedguide/non-small-cell-lung-cancer-treating-by-stage>. Accessed Aug 28, 2015.

¹⁹ American Cancer Society. *Non-small cell lung cancer survival rates by stage*.

<http://www.cancer.org/cancer/lungcancer-non-smallcell/detailedguide/non-small-cell-lung-cancer-survival-rates>.

Accessed August 4, 2015.

- Failure to examine the patient during a 2014 primary care provider (PCP) appointment
- Delays in obtaining NVCC authorizations
- Difficulty in obtaining non-VA prescribed medications
- Lack of continuity of care with four different PCPs

Scope and Methodology

We initiated our review in January 2015 and completed our review in June 2016. We performed an entrance briefing with System Leadership (Director and Chief of Staff) in late January 2015. We conducted interviews with the complainant and system staff, including the System Director, Chief of Staff, Acting Quality Manager, Risk Manager, Chief of Radiology, Clinic Director, Chief of Clinical Informatics, and others knowledgeable of the patient's care. We also interviewed the VHA Risk Management Program Director. We reviewed the patient's VA electronic health record (EHR) and non-VA records that had been scanned into the EHR from 2013 through the time of the patient's death in 2015. In addition, we reviewed VHA and system policies, quality management reports, peer reviews, and relevant literature.

VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 cited in this report, expired June 30, 2015. We considered the policy to be in effect as it had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),²⁰ the VA Under Secretary for Health (USH) mandated the "...continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."²¹ The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "...the timely rescission or recertification of documents over which their program offices have primary responsibility."²²

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is 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.

²⁰ VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

²¹ VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.

²² Ibid.

Case Summary

The patient was a man in his 60s with a history of smoking and multiple chronic medical conditions including chronic obstructive pulmonary disease and chronic back pain. In 2014, the patient underwent an abdominal US to evaluate his liver for possible sequela from one of his medical conditions. The radiology report stated the liver had no focal masses and identified a new left pleural effusion as an incidental finding.²³

Approximately 3 months later, the patient had an appointment with Provider A (Appointment 1) to discuss his pain medications and left shoulder and chest pains that had begun 2 months earlier but had resolved by the date of the visit. Upon our review of the patient's EHR, we noted no documentation regarding a complaint of shortness of breath. Provider A documented a cardiovascular and lung exam and noted that he was unsure what had caused the patient's chest pain. Provider A did not order any tests but urged the patient to stop smoking and go to the nearest Emergency Department (ED) if he had the pains again.

Two months later, a family member told a primary care nurse on the telephone that the patient felt "sick," possibly due to pain medication withdrawal. The nurse urged the family member to take the patient to the nearest ED, but the family member declined because of the long drive (the nearest VA ED was in the main medical center, 120 miles away). At the family member's request, the nurse scheduled an appointment with Provider A that was to occur in approximately 6 weeks (Appointment 2).

Between the phone call reported above and Appointment 2 with Provider A, the family member called the VISN triage nurse three times requesting pain medication refills.²⁴ Provider A followed up on the requests.²⁵ During Appointment 2, the patient again complained of feeling sick. He told Provider A he had a poor appetite and was short of breath at times. With the exception of decreased breath sounds with chest percussion, the patient's physical examination was unchanged from Appointment 1. Provider A documented that he noted the pleural effusion on the US during Appointment 2 and ordered a chest x-ray.

The chest x-ray was completed that same day. It showed a persistent, left-sided pleural effusion. Provider A ordered a pulmonary function test but the test was not scheduled. Provider A also ordered a chest CT scan, which was completed 2 weeks later.

²³ An incidental finding is a previously undiagnosed disease that is discovered unexpectedly, and generally not related to the condition for which the test was ordered. If the incidental finding is clinically significant, needing urgent treatment, then it is considered a critical finding.

²⁴ The triage nurse takes phone calls from patients, determines whether the patient has a life threatening condition, and recommends a course of action. For routine issues like medication refills, the request would be forwarded to the provider.

²⁵ Provider A fulfilled the first request, fulfilled the second request but discontinued the medication 10 days later, and fulfilled the third request but canceled the order the same day.

Provider A did not document that he discussed the chest x-ray result with the patient but noted in the EHR: "follow up when work up is completed." No follow-up appointment was scheduled at that visit.

The day after Appointment 2, the patient presented to a community hospital in Arizona complaining of chest pain, shortness of breath, and weight loss. He was admitted for evaluation and treatment of these symptoms, as well as for his pleural effusion.

During this hospitalization (community hospitalization 1), a thoracentesis was performed and 500 milliliters (ml) of fluid was obtained and sent to the laboratory for analysis. A CT scan showed pleural thickening,²⁶ necrotic lymph nodes,²⁷ and pleural effusion loculations²⁸ that raised a high level of suspicion that the patient had either pleural cancer (mesothelioma) or lung cancer. The physician at the community hospital prescribed antibiotics and urged the patient to follow up with his VA provider in 3 days. After discharge from the community hospital, the patient requested and was granted a change in his VA PCP.

Three days after hospital discharge, the pathologist at the community hospital concluded that the analysis of the pleural fluid was non-diagnostic but "in the setting of a clinically concerning lesion²⁹ [that is, pleural thickening, necrotic lymph nodes, and pleural effusion loculations], biopsy is indicated." This information was uploaded into the VA EHR 2 weeks after the hospital discharge. However, the patient's EHR had no evidence of follow-up on this recommendation.

Four days after discharge from the community hospital, the patient had his first appointment with Provider B. This provider recommended that the patient wait for the results of the pleural fluid analysis from the community hospital. Provider B also told the patient to attend the scheduled appointment for a CT scan (ordered by Provider A) and ordered a pulmonary consult, which was scheduled for 2 weeks later.

Approximately 1 week later, the patient completed his CT scan appointment. At about this same time, he also presented to the system's ED for dyspnea and chest pain. In the course of this ED visit, the patient was found to have a large pleural effusion again. He was transferred to the Department of Defense (DoD) medical center in Las Vegas because inpatient beds were not available at the system. During this admission, he was seen by a pulmonary consultant who reviewed the CT scans from both the system and the community hospital and the pleural fluid results from the community hospital. The pulmonary consultant repeated the thoracentesis the next day, and 700 ml of pleural fluid was removed and sent for laboratory analysis. The patient was discharged home

²⁶ The pleura line the inside of the chest wall and the outside of the lung tissue. Pleural thickening describes the scarring of the pleura that could be caused by benign or malignant conditions.

²⁷ Necrotic lymph nodes, which are lymph nodes with dead tissue, is a non-specific finding. Nodes with dead tissue can be caused by cancer, infection, or inflammation.

²⁸ Loculation refers to fluid in the lungs that is confined to one or more pockets.

²⁹ A lesion is an abnormal change in an organ, typically from disease or injury.

the next day pending results of the thoracentesis and urged to follow up with the system or the DoD pulmonologist.

Three days later, the patient was re-admitted to the community hospital (community hospitalization 2) in Arizona and had a repeat CT scan that revealed a return of the pleural effusion. He underwent a third thoracentesis that was inconclusive. Accordingly, a lung biopsy was recommended and performed. The patient requested discharge from the hospital before completing all of the evaluation because he wanted to go home. His community hospital physician recommended that he obtain urgent treatment as he likely had lung cancer. The physician also recommended thoracic surgery to decorticate (remove) the pleural thickening and loculations. The patient was discharged from the hospital with instructions to continue follow-up care with thoracic surgery and oncology on an outpatient basis, either at the VA or preferably at the community hospital for continuity of care. (See Issues 3–5 for more information on his treatment course.)

The patient's condition steadily deteriorated over the next year. He was readmitted to the community hospital several times, and he was placed on home oxygen. His PCP requested assistance from the palliative care team in managing the patient's symptoms, especially his pain. Ultimately, the patient was admitted to the community hospital and died in the inpatient hospice³⁰ unit approximately 16 months after the 2014 screening US of the liver. A family member informed us that an autopsy was not performed.

Inspection Results

Issue 1: Delay in Evaluation of the Patient's Left Pleural Effusion Resulted in Delayed Lung Cancer Diagnosis and Treatment

We substantiated a 6-month delay in the evaluation of the pleural effusion. The patient had an abdominal US performed in 2014 that incidentally found a left pleural effusion. The diagnostic evaluation for the effusion commenced after Appointment 2, and after several hospitalizations, the patient was diagnosed with stage IV NSCLC approximately 5 weeks later. The lung cancer likely caused the pleural effusion.

In 2014, VHA required providers to communicate noncritical test results to patients "no later than 14 calendar days from the date on which the results are available to the ordering practitioner."³¹ We found that the patient was not notified of 2014 US results until Appointment 2.

³⁰ Hospice is a treatment option for terminally ill patients (expected to live less than 6 months). Unlike traditional medical care that aims to cure disease, hospice aims to assist with symptom management and comfort care.

³¹ VHA Directive 2009-019, *Ordering and Reporting of Test Results*, March 24, 2009. This policy was current at the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015. The 2015 Directive established that, as a general rule, test results are to be communicated to patients within 7 calendar days for results requiring action and 14 days for those that do not require any action.

The system's policy, *Communication of Radiographic Results Including Critical Test Results*, requires direct communication from the radiologist to the provider for critical results.³² Critical results are those where the radiologist determined that urgent treatment is needed, such as appendicitis. A pleural effusion was not on the system's list of critical results. Communication regarding all other results may be through the final written report. The radiologist indicated that the patient's US was "unremarkable" but noted the presence of a left pleural effusion. The EHR did not include documentation that the radiologist attempted to contact the patient's provider. However, the system's chief radiologist did not consider this patient's pleural effusion to be a critical finding, and thus did not require direct communication to the provider.

A pleural effusion may result from a benign or malignant disease process and may not pose an imminent risk. Typically, the provider who ordered the test that revealed a pleural effusion or is knowledgeable about the patient's medical history would determine the appropriate workup, if any. At the time of Appointment 1, the patient saw Provider A with several issues, including chest pain that resolved. This was a chance for intervention, but Provider A did not document a review of the US results and did not order tests to further evaluate the left pleural effusion or the chest pain. During Appointment 2's visit for shortness of breath and feeling "sick," Provider A noted the US results and ordered a chest x-ray that showed a moderate pleural effusion. Provider A then ordered a chest CT scan.

When the pathology results were finalized from the community hospital and uploaded to the patient's EHR, Provider A did not document a plan to follow up on the results with a biopsy as recommended by the pathologist. Providers at the community hospital informed the patient of his lung cancer diagnosis after undergoing a lung biopsy during his hospitalization approximately 4 weeks after Appointment 2.

Even though the patient did not undergo evaluation when the effusion was first noted, the lung cancer likely caused the initial effusion. The patient's complaint of left-sided chest and shoulder pain during the Appointment 1 visit was on the same side as the pleural effusion. Had the effusion been evaluated and found to be due to lung cancer, the patient would have been diagnosed with stage IV NSCLC that carried a poor prognosis and few curative treatment options. However, the patient might have received more timely treatment.

Issue 2: Failure To Examine the Patient During PCP Appointment 2

We did not substantiate that Provider A did not perform a physical examination during Appointment 2. The physician documented cardiovascular and pulmonary exams in the provider note for that visit. These exams were appropriate for the chief complaints of feeling sick, having a poor appetite, and being short of breath at times.

³² VASNHS Medical Center Memorandum 114-13-02, *Communication of Radiographic Results Including Critical Test Results*, February 2013.

Issue 3: Delays in Obtaining NVCC Authorizations

We substantiated the allegations of delays in obtaining NVCC authorizations in several instances and noted the following contributing factors:

- NVCC staff inconsistently applied the requirement that system providers see the patient first for services offered at the system before an NVCC consult was approved
- NVCC staff failed to process requests according to the urgency noted by the requesting provider
- ED providers failed to follow NVCC consult request processes
- NVCC staff did not appear to be knowledgeable of covered services

The requirement that the patient be seen by system providers before an NVCC consult could be authorized was a challenge for the patient because of the distance between the patient's residence and the system's medical center. The patient lived approximately 100 miles from the medical center and his PCPs. This complicated the patient's care, as a family member stated the long trip was "very very hard on [the patient]." While the patient was not required to see the system oncologist before non-VA oncology services were approved, he was required to see the system thoracic surgeon before non-VA thoracic surgery services were approved.

After five consult submissions, NVCC for thoracic surgery was approved 3 weeks after the first consult request. The patient had to see the system's thoracic surgeon before the consult could be approved even though the surgeon did not perform the type of surgery that the patient needed. However, we noted that the patient received this service approximately 4 weeks after Appointment 2 during an emergent admission at a community hospital.

The system delayed processing an NVCC request for oncology services for 3 days because it was not ordered by the patient's PCP, and 4 more days elapsed before staff notified the patient of the approval. Additionally, the NVCC office staff was confused about whether intravenous fluid hydration was covered as a part of the oncology approval. The radiation oncology consult placed with a "within 24 hour" urgency took 4 days to approve. The oncologist's request for a US to be done as soon as possible took 2 weeks to approve.

Thoracic Surgery

A family member sent multiple emails to Provider B requesting non-VA care authorization for cardiothoracic surgeon, pulmonologist, and oncologist services as recommended at the time of community hospitalization 2 discharge. Provider B placed NVCC requests for thoracic surgery, pulmonary care, and home health visits. The NVCC consult for thoracic surgery with an urgency of "today" was discontinued 3 days later because "Thoracic Surgery is available within this VA Facility [system] and timeliness cannot be determined since no consult has been entered for Thoracic

Surgery. Please enter a Thoracic Surgery consult.” The system Chief of Staff informed us that the VAT procedure the patient required could not be performed at the system.

On the same day that the thoracic surgery NVCC consult was discontinued, the patient saw the system pulmonologist, who recommended that the patient undergo thoracic surgery with a VAT or open thoracotomy (surgical procedure to cut open the chest wall to access the lungs). At the patient’s request, the system pulmonologist transferred the patient from the VA clinic directly to the community hospital where he was admitted. Provider B submitted an NVCC request for “specialized therapies” with routine urgency, but it was discontinued the next day stating, “Wrong consult title. If you are requesting Thoracic Surgery consult, please place consult for VA services, as we have a Thoracic Surgeon.”

The next day, Provider B placed another NVCC authorization for thoracic surgery evaluation and treatment to be done within 24 hours. Below are the comments regarding the NVCC consult:

- Reason for request: “I have attempted to place multiple fee basis referrals for veteran but they have been declined.... Please approve [as soon as possible] to help with ‘trapped lung’ that [pulmonologist] described in yesterday’s note.”
- The next day, the system thoracic surgeon wrote, “please clarify if this consult for fees issue [sic] or do you want me to see the patient. please call extension...”
- Provider B wrote: Patient “requested fee basis but am not allowed to place fee basis because you are available, please schedule unless you think that this is appropriate for fee basis as patient is currently in [community] hospital with same problem.”
- The system thoracic surgeon wrote: “Patient [is] ... already in [community] hospital, needs urgent surgery.”
- Two days after the consult was placed, the NVCC approving official discontinued the consult stating, “You are not permitted to forward regular consults to Non VA Care consults since the required template fields are missing.”
- Five days later, the system thoracic surgeon responded: “I never seen [sic] this patient and not comfortable with referring [sic] [patient] somewhere else due to fee issue. If you like me to see the [patient] I'll be happy too [sic]. otherwise [the patient's] family physician can refer him to another surgeon of his/her choice.”

Provider B conveyed her frustration over her lack of control in the NVCC process for this urgent situation to a patient’s family member. Because the NVCC was not approved, the patient’s options were to wait to see the system’s thoracic surgeon in another 3 weeks for an urgent issue or pay out of pocket for another surgeon.

While the thoracic surgery NVCC consult was waiting for approval, the patient was in the community hospital where a thoracic surgeon placed an intravenous port³³ into a large vein to allow easy access for medication administration and laboratory blood draws. The surgeon also placed a catheter in the patient's chest to allow pleural fluid to drain from the patient on a regular basis. During this hospitalization, the patient was diagnosed with stage IV NSCLC. He was discharged with instructions to follow up with the community hospital thoracic surgeon, radiation oncology, and oncology.³⁴

The patient followed up with the system's thoracic surgeon a week after this discharge from the community hospital. The surgeon thought it was reasonable for him to follow up with the community thoracic surgeon for a shorter commute. Provider B resubmitted an NVCC thoracic surgery consult with a "within 24 hour" urgency that was approved 4 days later.

Oncology

The patient's family member requested NVCC for oncology services as soon as the patient was diagnosed with lung cancer. However, the process for obtaining care was cumbersome and perplexing. Provider B informed the patient that he had to be seen by the system oncologist before the NVCC consult could be approved because it was a service provided at the system, but no consult was entered for the system oncologist at that time. Six days later, an ED provider placed a STAT consult that was later discontinued by the NVCC approving official stating, "this is not appropriate for ordering by ER Provider. This needs to be ordered by his PCP." Provider B submitted a second NVCC oncology consult with urgency "within 24 hours" that was approved the next day, but the patient was not informed of the result for another 4 days. The EHR did not contain documentation indicating why the patient did not have to see the system oncologist prior to NVCC approval, unlike the thoracic surgery consult.

Radiation Oncology

Provider B placed a radiation oncology consult for "within 24 hours," but it took 4 days to be approved. During the course of the patient's treatment, the non-VA oncologist made several requests to the system for additional approval of intravenous fluid hydration and electrolyte replacement therapy to be administered during clinic visits. The NVCC coordinator expressed some confusion about whether the NVCC oncology visits would cover these requests. Five days elapsed before the NVCC approving official clarified that this therapy was covered. Additionally, the oncologist requested that the patient receive hydration at home from home health services. The system was unable to coordinate hydration provided by the oncologist versus the home health agency

³³ An intravenous port or port-a-cath is a small disc that is placed under the skin. The disc is connected to a large vein. This allows IV medications/fluids to be delivered to the patient on an intermittent basis without having to insert a new IV catheter each time.

³⁴ The discharge summary did not state whether the radiation oncology or oncology care were to be delivered via the VA or the community in 1–2 weeks.

because the two had different approving offices. These systemic issues created delays in treating the patient’s dehydration during chemotherapy.

Ultrasound Diagnosis of Blood Clots

The patient’s family member told us that approximately 7–8 weeks after receiving his lung cancer diagnosis, the patient had “leg pain and much swelling.” The NVCC oncologist requested a US as soon as possible to evaluate for leg clots because leg blood clots could travel to the lungs causing respiratory distress or sudden death if not rapidly diagnosed and treated. The VHA approving official approved the request for the US 14 days later. A week after the US approval, the patient was diagnosed with blood clots in both legs.

Issue 4: Difficulty Obtaining Non-VA Prescribed Medications

We substantiated the allegation of inadequate medication management due to multiple barriers. The patient had to travel 30 miles each way from his home to a system clinic for pharmacist review and approval of his physical prescription. The non-formulary/restricted³⁵ medications needed to be reviewed by a pharmacist for approval. The timeliness for two of the non-formulary/restricted medication reviews exceeded VHA requirements. In one case, the patient had to have his laboratory tests checked before the medication could be approved. The patient also encountered difficulties receiving the medication via United Parcel Service.

Table. Timeliness and Results of Non-Formulary/Restricted Medication Requests

Medication	Number of Requests Submitted	Days Elapsed from Patient Request to Medication Delivery	Non-Formulary/Restricted Request Result
Fentanyl Patch	2	15 days	First request: discontinued because it was a duplicate consult Second request: approved
Erlotinib	2	20 days	First request: not approved until laboratory test done Second request: approved “pt had [laboratory test] done in [a non-]VA center ...”

Source: OIG Analysis of EHR

The patient received pain medication and chemotherapy prescriptions from his non-VA care providers. The patient requested that his PCP fill these prescriptions from the VA pharmacy to minimize out-of-pocket costs. The patient’s family member drove 30 minutes each way to bring the two prescriptions to the nearest VA primary care clinic before his provider would place the non-formulary/restricted medication consult request

³⁵ A formulary lists medications approved for use at the VA. Non-formulary/restricted medications require a consult to the pharmacist to review indications and determine whether it can be approved. If the request is denied, the pharmacist typically suggests an alternative medication in the formulary.

for a pharmacist to review. While waiting for approval for the chemotherapy medicine, the patient's family member told the nurse that the family member paid out-of-pocket for a 14-day supply that cost more than \$4,000 and was concerned that the patient would run out before it would be approved.

VHA requires that a pharmacist complete routine non-formulary/restricted medication requests and notify the requestor within 96 hours (4 days).³⁶ The pharmacists took action within the timeframe for the pain medicine requests but the chemotherapy medicine requests took 5 days each (115 and 125 hours). The delay appeared to be due to untimely receipt of laboratory test results from the NVCC provider. We noted that the request was approved once required laboratory tests had been completed. Despite administrative delays in the approval of the chemotherapy medicine, the patient did not experience a lapse in his medication regimen as he had a non-VA supply. The patient received his VA-approved prescription the same day he completed his initial supply.

The patient's family member also described difficulties receiving medications after they were prescribed. The patient lived in a rural area. The system contracted with the United Parcel Service to deliver medications. The driver did not deliver the medications to the house but, rather, stopped on the main road and honked his horn for someone to pick up the medication. This presented problems if no one was at home, did not hear the driver when he arrived, or could not respond quickly enough. If they missed the delivery, then the patient or his family member had to drive to the United Parcel Service delivery location to pick up the medications.

During the course of our inspection in 2015, the system's lead pharmacy technician contacted the patient's family member, who requested an alternate method of delivery. The technician changed the delivery company to the United States Postal Service, which resolved the delivery issues.

Issue 5: Lack of Continuity of Care With Four Different PCPs

We did not substantiate a lack of continuity of care with four different PCPs. The patient was unhappy with Provider A's care and requested a provider change after Appointment 2. The system assigned the patient to Provider B. Two months later, the patient received notice that he had been reassigned to Provider C as Provider B left that clinic. A few weeks after the patient was diagnosed with lung cancer, the system opened a rural outreach clinic about 30 miles from the patient's residence. The system assigned the patient to Provider D at this new clinic to minimize his commute. The patient saw Provider D for the first time approximately 4 months after he was diagnosed. While the patient preferred fewer provider reassignments, we did not find

³⁶ VHA Handbook 1108.08, *VHA Formulary Management Process*, February 26, 2009. This handbook was in effect during the period of our review; it was rescinded and replaced by VHA Directive 1108.08, *VHA Formulary Management Process*, November 2, 2016. The current Directive contains the same or similar language regarding the 96-hour requirement to process requests.

disruptions in his care due to the changes, and the system made the last transfer to shorten the patient's commute.

Issue 6: Other Finding-Peer Review Process

During our inspection, we found inconsistencies with the system's peer review process. We provided system leaders a summary of our findings.

Conclusions

We substantiated a delay in evaluation of the patient's pleural effusion. Staff did not notify the patient of the US test result within 14 days as required by VHA. We found several contributing factors to the delay of the lung cancer diagnosis including evaluation of the effusion, follow-up on the community pathologist's recommendation for a biopsy, and NVCC authorization for a biopsy.

We did not substantiate that PCP A did not perform a physical examination during the Appointment 2 visit.

We substantiated the delays in obtaining NVCC authorizations in several instances and noted the following contributing factors:

- NVCC staff inconsistently applied the requirement that system providers see the patient first for services offered at the system before an NVCC consult is approved
- NVCC staff failed to process requests according to the urgency noted by the requesting providers
- ED providers failed to follow NVCC consult request processes
- NVCC staff did not appear to be knowledgeable of covered services

We substantiated that the patient experienced difficulty obtaining non-VA prescribed medications. The patient had to travel 30 miles each way from his home to a system clinic for pharmacist review and approval of his physical prescription. The timeliness for two of the non-formulary/restricted medication consult reviews exceeded VHA requirements. However, the patient did not experience a lapse in his medication regimen because he had a non-VA supply.

The patient also encountered difficulties receiving the medication via the United Parcel Service.

We did not substantiate the lack of continuity of care with four different PCPs. The patient requested a provider change after his Appointment 2 visit, but we determined that the other changes were beyond the system's control. The last PCP change was made to shorten the patient's commute to the nearest system clinic.

During our inspection, we found inconsistencies with the system's peer review process and provided system leaders with a summary of our findings.

Recommendations

1. We recommended that the System Director ensure that providers address and communicate test results to patients within the timeframe required by the Veterans Health Administration.
2. We recommended that the System Director ensure that providers timely follow up on non-VA providers' recommendations.
3. We recommended that the System Director ensure the Non-VA Medical Care Coordination requirement for patients to be seen by system physicians first for services offered at the system before a Non-VA Medical Care Coordination request is authorized does not delay care.
4. We recommended that the System Director ensure Non-VA Medical Care Coordination staff process requests according to the urgency noted by the requesting provider.
5. We recommended that the System Director ensure Emergency Department providers follow Non-VA Medical Care Coordination consult request processes.
6. We recommended that the System Director ensure that Non-VA Medical Care Coordination staff are knowledgeable of specific services that are authorized when Non-VA Medical Care Consults are approved.
7. We recommended that the System Director review existing practices for filling non-formulary/restricted medications to ensure that medications are ordered, reviewed, and processed timely.
8. We recommended that the System Director evaluate patient experiences regarding contracted companies' processes for delivery of medications and take appropriate corrective actions if needed.
9. We recommended that the System Director ensure the peer review process is conducted according to current Veterans Health Administration guidance.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 20, 2017

From: Director, Sierra Pacific Healthcare Network (10N21)

Subj: Healthcare Inspection— Delays in the Evaluation and Care of a Patient with Lung Cancer, VA Southern Nevada Healthcare System, Las Vegas, Nevada

To: Director, Los Angeles Office of Healthcare Inspections (54LA)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for allowing the facility to review the draft report. The actions they have taken over the past few years have resolved the identified deficiencies.
2. If you have any further questions, please contact Terry Sanders, Deputy Quality Manager for V21 at (707) 562-8350.

(original signed by:)
Sheila M. Cullen
Network Director

System Director Comments

Department of Veterans Affairs

Memorandum

Date: March 20, 2017

From: Director, VA Southern Nevada Healthcare System (593/00)

Subj: Healthcare Inspection— Delays in the Evaluation and Care of a Patient with Lung Cancer, VA Southern Nevada Healthcare System, Las Vegas, Nevada

To: Director, Sierra Pacific Healthcare Network (10N21)

1. Thank you for the opportunity to review the referenced case from 2014. Since that time, there have been numerous, nationally mandated changes to the Non VA Care coordination processes. Process corrections and modifications have been made and VASNHS has established a functioning care coordination team. We represented the Office of Nursing Service as a participant in the national care coordination project.
2. VASNHS has made great strides in care coordination and has created a working relationship with the 3rd party administrator and has positive interactions with Veterans as we continue the care coordination program that began in 2015 and ensure alignment with national guidelines using a consistent and vigilant patient-centered approach.
3. Attached is a description of our actions to improve and refine our care coordination processes.

(original signed by:)

Peggy W. Kearns, MS, FACHE
Medical Center 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 1. We recommended that the System Director ensure that providers address and communicate test results to patients within the timeframe required by the Veterans Health Administration.

Concur

Completed: March 10, 2017

Facility response: VA Southern Nevada Health Care System (VASNHS) has established a process for communicating test results to patients. Monitoring the results for FY 2017, we have stabilized the process and demonstrated sustained compliance with the VA time frame of communication of test results within 14 days. We also use telephonic notifications, secure messaging notifications, and traditional mailing notifications.

Primary Care Communication of Test Results FY 2017						
Quality Element	OCT 2016	NOV 2016	DEC 2016	JAN 2017	FEB 2017	MAR 2017
Notification Of Patients With Results Within 14 Days	83	100	72	70	68	26
Percent Compliance	69%	85%	100%	100%	97%	100%
# of Charts Reviewed	120	118	72	70	70	26*

OIG Comment: Based on information received from the system, we consider Recommendation 1 closed.

Recommendation 2. We recommended that the System Director ensure that providers timely follow up on non-VA providers' recommendations.

Concur

Completed: March 10, 2017

Facility response: The implementation of the Choice program, which occurred shortly after this incident, has resulted in a more streamlined process to provide authorizations for care in the community. VASNHS has proactively established a review process with case managers to ensure consults to the community are progressing, completed, and results are retrieved from the community providers if the results are not sent to VASNHS within the allotted time frame. CHOICE recommendations/requests for

additional services are reviewed by a Nurse Practitioner and a Physician Assistant in the VA Community Care (VACC) Department. Upon review, the recommendation/request is either approved or denied. Denial requires justification and communication with the community provider and the referring provider to ensure the patient receives appropriate and timely care. Based upon the requested service and priority rating of the request, the patient may receive continued care through VASNHS or in the community. VACC receives approximately 75 requests weekly and requests are acted upon within the 2 week time frame designated by contract. A 6-month review of the data indicates an average of 5 days to adjudicate secondary requests, which is within the 14-day timeframe. In addition, notifications can be sent by the community provider to the TriWest portal asking for clarification, additional information, or requesting a phone call.

Additionally, patients sent from VASNHS Emergency Department to community hospitals are followed by our Case Management team which communicates daily with the community organizations in an effort to ensure care is appropriate and facilitate discharge planning. Appointments for the next level of care, durable medical equipment, and medications are arranged through the Case Management team.

OIG Comment: Based on information received from the system, we consider Recommendation 2 closed.

Recommendation 3. We recommended that the System Director ensure the Non-VA Medical Care Coordination requirement for patients to be seen by system physicians first for services offered at the system before a Non-VA Medical Care Coordination request is authorized does not delay care.

Concur

Completed: March 10, 2017

Facility response: With the introduction of CHOICE and the recent expanded definition of unusual or excessive burden, patients are offered the option of receiving care with the VA medical center or if access is not available within 30 days (for routine care), we immediately offer CHOICE and connect the patient to the 3rd Party Administrator service to assist in creating appointments for the patient to receive care from a community provider. This process has been in place since 2015. CHOICE representatives are stationed on campus as we work closely with the administrator of the CHOICE program to enhance communication, facilitate care, and the receipt of results.

For the past 6 months, VACC has received approximately 16,186 notifications regarding the 12,429 patients which have accessed the CHOICE program and there have been no reported significant delays in care that impacted outcomes of care. If a CHOICE appointment cannot meet the timeframe needed for the patient's care, traditional Non VA Care is used to establish prompt care and when feasible and appropriate, the care is converted to the CHOICE program or to the VA Southern Nevada Health Care

System. VACC consults may be entered by any VA provider that has assessed the patient and determined the need for care. By contract, VASNHS cannot retrieve reports until day 91, because the 3rd Party Administrator has 90 days to obtain and transmit results. The table below [Table redacted pursuant to 38 U.S.C. §5705]³⁷ includes all VACC CHOICE consults and over the past 2 years the result turn-around-time has steadily decreased.

OIG Comment: Based on information received from the system, we consider Recommendation 3 closed.

Recommendation 4: We recommended that the System Director ensure Non-VA Medical Care Coordination staff process requests according to the urgency noted by the requesting provider.

Concur:

Completed: March 10, 2017

Facility response: In 2016, VA National clarified the referral terminology to promote understanding and efficiency. Per national mandate we have the following type/frequency of referrals:

Type/Frequency	Definition
STAT	A consult that clinical care is required within the next 24-48 hours and there is a provider to provider communication documented on the consult.
Routine	All other consults.

STAT consults are entered into CPRS with an accompanying telephone contact to VACC to ensure prompt receipt and processing of the services requested. Less than 2 percent of the consults are STAT. Routine consults must be processed within 7 days and VACC at VASNHS meets and exceeds the targeted time frame. The majority of routine consults are processed within the 7-day time frame.

For fiscal year 2017, VASNHS has scheduled greater than 90 percent of STAT consults within 48 hours.

OIG Comment: Based on information received from the system, we consider Recommendation 4 closed.

Recommendation 5: We recommended that the System Director ensure Emergency Department providers follow Non-VA Medical Care Coordination consult request processes.

Concur:

³⁷ 38 U.S.C §5705 prohibits the unauthorized disclosure of VA medical quality assurance records.

Completed: March 10, 2017

Facility Response: Emergency Department providers have been instructed in the use of consults and understand the use of the traditional Non VA care program when sending patients to community facilities. Since March 2016, Case Managers have been stationed in the ED as a resource to assist providers with care options/issues, utilization management, and care coordination. A team of nurses follow each patient transferred to a community hospital to ensure admission and discharge needs are met. On average there are 52 patients in community hospitals daily that are being followed by VAMC case managers. Several modalities are available for the Emergency Department physicians to communicate with the Primary Care providers to ensure specialty services needed are addressed either within VASNHS or through the community programs of Non-VA Care or CHOICE. Modalities include: telephonic, view alerts, additional signage of progress notes, and email.

Consults are tracked on a daily basis through the phases of pending, active, and completed and reported weekly to the Executive Leadership Team during the Morning Meeting. VACC Program Analysts review the records of patients sent to the community by the ED to ensure consult placement is completed appropriately on a daily basis.

OIG Comment: Based on information received from the system, we consider Recommendation 5 closed.

Recommendation 6. We recommended that the System Director ensure that Non-VA Medical Care Coordination staff are knowledgeable of specific services that are authorized when Non-VA Medical Care Consults are approved.

Concur:

Completed: March 10, 2017

Facility response: In November, 2015 the Non VA Care and CHOICE program was realigned and the program has since expanded to 42 trained staff that include Program Support Assistants, RNs, LPNs, and Providers. Process guides and algorithms guide communication flow and consult decisions; however, the providers (including a physician) are available to answer questions, provide clarification, and support for the process. Staff receive daily calls from patients and readily answer their questions. Working with the CHOICE representatives on campus has resulted in expedited clarifications. Care Coordination ensures care is authorized timely, with the appropriate provider, and with the appropriate services requested. A Secondary Request process and notifications are in place to provide a mechanism for consult clarification and/or request for subsequent/additional service/treatment. This latter process ensures continuity and continued care is sustained.

Employees new to the VACC Department participate in a 6 month orientation which includes training via national and local online learning modules. Staff are assigned a mentor and receive hand-on training to ensure accuracy of information gathering and transmitting for community providers. Education is ongoing throughout the department

because the CHOICE program is evolving. Staff meetings share new guidelines and the team participates in national calls.

The Associate Nurse Executive (ANE) responsible for the VACC Department was selected by National to participate in the coordination of care component of the “Sprint 3” project which reviewed the entire CHOICE program and recommended changes, clarifications, and designed training tools to distribute the information. Our ANE represented the Office of Nursing Service for this national project. The ANE communicated the project activities to leadership and to the VACC team to promote support and compliance with the evolutionary changes.

OIG Comment: Based on information received from the system, we consider Recommendation 6 closed.

Recommendation 7. We recommended that the System Director review existing practices for filling non-formulary/restricted medications to ensure that medications are ordered, reviewed, and processed timely.

Concur:

Completed: March 10, 2017

Facility response: Pharmacy service follows VA national formulary and established criteria-for-use for non-formulary/restricted medications prescribed by VA or Non-VA providers. When a non-formulary/restricted medication is prescribed, a pharmacist reviews the patient’s chart and if needed requests additional information from prescriber. Once all missing information is made available, VA pharmacist has 96 hours to complete the request and process the medication. VA National requires each facility to complete 95 percent of non-formulary consults within 96 hours. Currently, VASNHS exceeds the standard at 97.7 percent.

OIG Comment: Based on information received from the system, we consider Recommendation 7 closed.

Recommendation 8. We recommended that the System Director evaluate patient experience regarding contracted companies’ processes for delivery of medications and take appropriate corrective actions if needed.

Concur:

Completed: March 10, 2017

Facility response: Pharmacy service is now contracted with United States Postal Services (USPS) which delivers to patient’s mail box or P.O. Box on file. Patient can contact the VA pharmacy to receive package tracking information and/or sign up for 24/7 tracking services via <https://my.usps.com/mobileWeb/pages/intro/start.action>. Consolidated Mail Outpatient Pharmacy (CMOP) is a contracted service that uses USPS for the majority of medications. Sometimes for refrigerated items CMOP uses

United Parcel Service (UPS). All pharmacy-related concerns were investigated and resolved.

OIG Comment: Based on information received from the system, we consider Recommendation 8 closed.

Recommendation 9. We recommended that the System Director ensure the peer review process is conducted according to current Veterans Health Administration guidance.

Concur:

Completed: March 10, 2017

Facility response: VASNHS Protected Peer Review process is active and in compliance with the VHA Directive for Peer Review. The local policy was reviewed in June 2016 which included a comparative analysis of the local policy with the VA National Directive 2010-025 to ensure continued alignment. Risk Management staff who manage the Peer Review program have attended training offered by the VA National Risk Management office. Protected Peer Review Committee led by the Chief of Staff meets at least monthly and reports to the Quality, Safety, Value Council. Quarterly reports are submitted to the VISN for entry into the national peer review database.

In September 2015, the OIG performed an on-site review and inspected the VASNHS Peer Review program and zero deficiencies were identified. In July 2016, VISN 21 completed an on-site review as part of our VISN Organizational Readiness Program inspection with no significant findings.

OIG Comment: Based on information received from the system, we consider Recommendation 9 closed.

OIG Contact and Staff Acknowledgments

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