



**Department of Veterans Affairs  
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**Office of Healthcare Inspections**

**Report No. 16-02526-358**

**Healthcare Inspection**

**Physical Medicine and Rehabilitation  
Services Consult Process Concerns  
Central Texas Veterans  
Health Care System  
Temple, Texas**

**September 5, 2017**

**Washington, DC 20420**

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## Executive Summary

The VA Office of Inspector General conducted a healthcare inspection in 2016 in response to a complaint regarding consults at the Central Texas Veterans Health Care System (system), Temple, TX. Specifically, the complainant provided 14 examples of patients at the Olin E. Teague Veterans' Medical Center (facility), Temple, TX, for whom he/she believed Physical Medicine and Rehabilitation Services (PMRS) consults were not scheduled timely and appointments were delayed as a result.

We substantiated the allegation that 12 of the 14 patients experienced delays in scheduling consult appointments and in receiving care. Although the patients experienced delays in response to PMRS consults, primary care teams continued to manage patients. We also found that the problem of delayed consult appointments was not limited to these 12 consults, but was a systemic problem within PMRS. PMRS completed 8,765 routine consults from March 2 through December 31, 2015. Of these consults, we found 4,965 (57 percent) were completed within 30 days and 3,800 (43 percent) were delayed.

We found that some of the facility's PMRS consult procedures, including the clinical review process, did not comply with system policy, and could have contributed to the delay in appointment scheduling.

We found that PMRS had multiple unfilled provider positions and multiple managerial positions filled by temporary personnel. The facility continues to have multiple unfilled positions as of May 25, 2017. This lack of a fully staffed department affected the functioning of the service and contributed to the delays.

Facility managers were aware of these problems and attempted to correct them by forming a Consult Management Committee to review consult data for the facility and by requesting another Veterans Health Administration facility review PMRS and make suggestions to improve functioning. Facility managers directed PMRS managers to develop action plans to improve their consult metrics, employed work-study staff to assist Advanced Medical Support Assistants (AMSA) in scheduling new consult appointments, moved the pain clinic to the Surgery Service for better support, and temporarily redirected electromyography, pain, and physical therapy consults to non-VA care. Although facility managers provided AMSAs with additional scheduling training, AMSAs were still confused about scheduling procedures.

We also found that the facility did not meet current or previous Veterans Health Administration annual scheduling competency evaluation requirements<sup>1</sup> for staff who schedule appointments.

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<sup>1</sup> VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010, revised December 8, 2015. This VHA Directive was rescinded and replaced with VHA Directive 1230, *Outpatient Scheduling Processes, and Procedures*, July 2016, which contains the same or similar training requirements.

Some unintended consequences based on management's actions occurred. As the backlog of new consults improved, patients' access to follow-up appointments decreased. Some providers were scheduling follow-up appointments themselves instead of writing text orders for AMSAs to schedule follow-up appointments. Without the providers documenting the clinically indicated date, PMRS managers were unable to accurately track delays in scheduling follow-up appointments.

We recommended that the Facility Director ensure that:

- Consult clinical reviews and appointment scheduling for patients are conducted in compliance with Veterans Health Administration directives and system policies.
- The Physical Medicine and Rehabilitation Services have sufficient staffing to arrange for timely consultations and appointments within the service.
- Facility staff who schedule Physical Medicine and Rehabilitation Services patient appointments receive annual scheduling competencies to ensure understanding of the correct process for compliance with Veterans Health Administration directives and staff are monitored for compliance.

### Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 19–23 for the Directors' comments.) We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.  
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## Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in 2016 in response to a complaint regarding consults at the Central Texas Veterans Health Care System (system), Temple, TX. Specifically, the complainant provided 14 examples of patients at the Olin E. Teague Veterans' Medical Center (facility), Temple, TX, for whom he/she believed Physical Medicine and Rehabilitation Services (PMRS) consults were not scheduled timely and appointments were delayed as a result.

## Background

The system provides a full range of services including medical/surgical hospital care, a hospice unit, and Community Living Centers. The system serves more than 252,000 Central Texas veterans and consists of a freestanding clinic in Austin, the facility in Temple, a medical center in Waco, and four community based outpatient clinics in Brownwood, Cedar Park, College Station, and Palestine, TX.

The facility is a teaching facility and provides both inpatient and outpatient care through tertiary, primary, and long-term care for medical, surgical, psychiatric, rehabilitation, neurology, oncology, dentistry, and geriatric patients. The facility campus includes two Community Living Centers, a State Veterans Home, a domiciliary, and an Emergency Department that operates 24 hours a day, 7 days a week.

The Doris Miller Department of Veteran Affairs Medical Center in Waco, TX, provides primary, specialty, and psychiatric outpatient care. This campus has two Community Living Centers; two physical rehabilitation care units, a specialized rehabilitation unit for veterans who are blind, a Post-Traumatic Stress Disorder Treatment Program, and a Serious Mental Illness Life Enhancement program.

## PMRS

The goal of the facility PMRS is to utilize individualized treatment plans, education, and consultation by qualified staff to reach achievable outcomes to allow patients to gain independence in function and mobility. PMRS care at the facility includes the following disciplines:

- Chiropractic
- Kinesiotherapy<sup>2</sup>
- Occupational Therapy (OT)<sup>3</sup>
- Pain Management
- Physiatry<sup>4</sup>

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<sup>2</sup> Kinesiotherapy is the treatment of diseases by movements or exercises.

<sup>3</sup> OT is also used as an acronym for Occupational Therapist.

<sup>4</sup> Physiatry is a branch of medicine that diagnoses and treats disease, injury, or resultant impairments using physical agents such as light, heat, cold, water, electricity, and exercise.

- Electromyography (EMG)<sup>5</sup>
- Physical Therapy (PT)<sup>6</sup>
- Prevention of Amputation for Veterans Everywhere (PAVE)
- Recreation Therapy
- Speech-Language Pathology
- Traumatic Brain Injury

## Consults

A consult is a document in the electronic health record (EHR) that facilitates and details communication of consultative service requests and related activities. A physician or other health care staff member provides a response to requesting providers seeking a clinical consultation opinion or expertise regarding evaluation and/or management of a specific patient problem.<sup>7</sup>

Clinical consultations may be acted on by scheduling an appointment within Veterans Health Administration's (VHA) established timeframe. The referring provider determines the clinically indicated date (CID).<sup>8</sup> CID is the date care is deemed clinically appropriate based on the needs of the patient.<sup>9</sup> The goal is to schedule appointments no more than 30 calendar days from the CID.<sup>10</sup> At the time of the events discussed in this review, the specified timeframe for the appointment was the date the provider submitted the consult unless the provider specified otherwise.<sup>11</sup>

The National Timeliness Goals that are in accordance with VHA's strategic mission and vision include:<sup>12</sup>

- *New Patients desiring routine care, must be scheduled as soon as possible, and within 30 days.*<sup>13</sup>
- *Patients must be able to schedule a routine follow-up appointment with their primary care provider within 30 days.*<sup>14</sup>

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<sup>5</sup> Electromyography is a technique used to record the activity of skeletal muscles at rest, during voluntary contractions, and during electrical stimulation.

<sup>6</sup> PT is also used as an acronym for Physical Therapist.

<sup>7</sup> VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This policy was in effect during the timeframe of the events discussed in this report. It was rescinded and replaced by VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016, amended September 23, 2016, and contains the same or similar definition of a consult.

<sup>8</sup> During the timeframe of this review, CID was referred to as the Earliest Appropriate Date or "EAD." We use the current term CID in this report.

<sup>9</sup> VHA Directive 1232.

<sup>10</sup> VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

<sup>11</sup> VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010, revised December 8, 2015. This VHA Directive was rescinded and replaced with VHA Directive 1320, *Outpatient Scheduling Processes and Procedures*, July 2016.

<sup>12</sup> VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006. This directive expired June 30, 2011 and has not yet been updated.

<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

- *Patients must be able to schedule an appointment with a specialist within 30 days of referral.*<sup>15</sup>
- *Patients must be able to schedule an appointment for routine diagnostic tests within 30 days of referral.*<sup>16</sup>

Non-VA care is to be offered when the desired service is not available or not available in a timely manner within VA due to capacity or accessibility. Clinically appropriate non-VA care should be considered when the patient could be treated sooner outside the VA.<sup>17</sup>

### **Veterans Access, Choice and Accountability Act of 2014**

The Veterans Access, Choice and Accountability Act of 2014 provided VA new tools to help increase veterans' access to health care. The Veterans Choice Program (Choice) allows veterans already enrolled in VA health care to receive health care within their own community. A veteran is eligible if the wait for medical care is more than 30 days or if the veteran lives more than 40 miles away from a VA facility.<sup>18</sup>

### **Scheduling Consult Appointments**

A consult's status changes as the request for the patient's appointment proceeds through the scheduling process. Some of the statuses defined by VHA Directive 1232<sup>19</sup> are listed below:

- **Pending**: A consult is automatically placed in pending status when received by the service. The service has 7 days to take action from the date a consult is placed.
- **Active**: The consult is "received" and efforts are underway to fulfill a consult.
- **Scheduled**: An appointment is made and the consult request is linked to the scheduled appointment by using the Veterans Health Information Systems and Technology Architecture (VistA) Menu options.
- **Cancel**: Inappropriate consults are cancelled or denied if the consult pre-work outlined in the care coordination agreement is inadequate. A consult can be cancelled when the service is not available and a non-VA care consult will be entered.
- **Discontinue**: The consult is discontinued if placed to the wrong service, the service is no longer needed, the consult is a duplicate request, or the patient

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<sup>15</sup> VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006.

<sup>16</sup> Ibid.

<sup>17</sup> VHA Directive 2008-056.

<sup>18</sup> VA Fact Sheet Summary, *Veterans Access, Choice and Accountability Act of 2014 (Choice Act)*.

<sup>19</sup> VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016, amended September 23, 2016.



refuses the service. The consult may be discontinued if the threshold for number of no-shows by the patient exceeds the number allowed by facility policy.<sup>20</sup>

- Complete: The complete status is shown when the requested service is completed.<sup>21</sup>

We used VHA's Consult Management Business Rules to define parameters that should be addressed in a facility policy consisting of maximum time frames for consult urgency (the time frame the consult should be completed),

- Emergency: within 4 hours.
- STAT: within 6 hours.
- Routine: to be determined locally.<sup>22</sup>

In October 2015, the Acting Deputy Under Secretary for Health for Operations and Management issued a memorandum standardizing clinical urgency for consults. Facilities were required to use only STAT and Routine categories for consult urgency.<sup>23</sup>

Facility managers revised their consult-related policies March 2, 2015 and March 3, 2016. Both system consult-related policies required that, for outpatient consults, the sending service complete the CID field to determine if the consult was urgent or routine. Outpatient consults were not to be classified as STAT.<sup>24,25</sup>

System policies further required that, for receiving services that conducted a clinical review<sup>26</sup> prior to scheduling consult appointments, the review should be completed by the end of the second business day or the appointment should be scheduled without the review. Urgent consults should be completed within 7 days and routine consults should be completed within 30 days. The provider who submitted the consult determined the CID for the appointment and the consultant had the responsibility to see the patient within the timeframe specified in the request.

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<sup>20</sup> Consult Management Business Rules, Internal VA Website, [https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fSystems+Redesign%2fConsults%2fConsult\\_Switchboard&rs:Command=Render](https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fSystems+Redesign%2fConsults%2fConsult_Switchboard&rs:Command=Render). Accessed April 14, 2016.

<sup>21</sup> VHA Directive 1232.

<sup>22</sup> Consult Management Business Rules, Internal VA website, [https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fSystems+Redesign%2fConsults%2fConsult\\_Switchboard&rs:Command=Render](https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fSystems+Redesign%2fConsults%2fConsult_Switchboard&rs:Command=Render). Accessed April 14, 2016.

<sup>23</sup> Acting Deputy Under Secretary for Health for Operations and Management to Network Directors and VACO Program Offices, October 21, 2015. VHA Consult Initiatives.

<sup>24</sup> System Memorandum 011-015, *Consult Referrals*, March 2, 2015, was rescinded and replaced with the system Memorandum 011-015, *Consult Referrals*, March 3, 2016. The system's new consult management policy contains the same business rule language for processing consults.

<sup>25</sup> The Acting Deputy Under Secretary for Health for Operations and Management sent a memo to all Network Directors and VACO Program Offices, dated October 21, 2015 that further explained default CID will not be "today"...clinicians must put in an appropriate date. If the consults were STAT then that date would be the date the consult was placed. The facility policy dated March 2, 2015 was in place prior to this clarification. The facility policy was updated March 3, 2016 to be compliant with the DUSHOM October 21, 2015 memo.

<sup>26</sup> The clinical review process is defined in Inspection Results, Issue 3.

Both the current and previous system consult policies require “timely review and response to consult requests,”<sup>27</sup> but if the service cannot be provided through VA then the service may be obtained from non-VA sources.

### **Scheduling Privileges**

The prior and current VHA directives outlining scheduling practices required a facility to create and maintain a Master List of all staff members having VistA Scheduling options. All staff with scheduling privileges must have completed VHA Scheduler Training. Staff on the scheduling Master List must complete annual competency assessments relevant to their scheduling tasks.<sup>28,29</sup>

### **Allegations**

On March 2, 2016, the OIG Hotline received a call from a confidential complainant alleging PMRS consults were not being scheduled timely and that clinic appointments were delayed. The complainant provided 14 examples of patients for whom he/she believed PMRS consults were not scheduled timely and the appointments were delayed as a result.

## **Scope and Methodology**

We initiated our review in April 2016 and conducted a site visit May 9–11, 2016. We interviewed the complainant, facility managers, PMRS physicians, therapists, Advanced Medical Support Assistants<sup>30</sup> (AMSAs), and other employees knowledgeable about PMRS scheduling and consults. We reviewed relevant VHA directives and system policies and procedures, facility data, and patients’ EHRs.

We reviewed VHA Corporate Data Warehouse data for consults submitted from March 2 through December 31, 2015 for facility outpatient PMRS clinic appointments. We reviewed the status of the consults through July 1, 2016.

VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006, cited in this report, expired June 30, 2011. 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),<sup>31</sup> 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.”<sup>32</sup> The

<sup>27</sup> System Memorandum 011-015, *Consult Referrals*, March 2, 2015, was rescinded and replaced with System Memorandum 011-015, *Consult Referrals*, March 3, 2016.

<sup>28</sup> VHA Directive 1230.

<sup>29</sup> VHA Directive 2010-027.

<sup>30</sup> Advanced Medical Support Assistants are trained to schedule clinical appointments.

<sup>31</sup> VHA Directive 6330 (1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

<sup>32</sup> VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document*, June 29, 2016.

USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "...the timely rescission or recertification of policy documents over which their program offices have primary responsibility."<sup>33</sup>

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.

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<sup>33</sup> Ibid.

## Inspection Results

### Issue 1: Delays in Patient Care

We substantiated the allegation that PMRS consults were not scheduled timely and clinic appointments were delayed for 12 of the 14 examples provided by the complainant. Because of a variety of needs triggering a PMRS consult, there is not a single homogenous group. Therefore, we did not attempt to determine clinical impact for these different groups of patients whose care continued to be managed by their primary care providers.

Table 1 shows the time in days from the submission of the consult to the completed clinical review; the time from the submission to an AMSA’s first attempt to contact the patient to schedule an appointment; and the time from the CID to the initial appointment date scheduled by AMSAs for the 14 examples provided.

**Table 1. Time in Days From Consult Submission to Clinic Appointment for Complainant-Provided Examples**

| Clinic Consulted | Time from Consult Submission to Clinical Review | Time from Consult Submission to First AMSA’s Action/Attempted Patient Contact | Time from CID to Appointment |
|------------------|---|---|------------------------------|
| EMG              | 3   | NA*   | NA*                          |
| EMG              | 16  | 61  | NA**                         |
| EMG              | 18  | 42  | 63                           |
| EMG              | 29  | NA**  | NA**                         |
| EMG              | 46  | 46  | 74                           |
| Pain             | 0   | 37  | 60                           |
| Pain             | 0   | 64  | 95                           |
| Pain             | 0   | 57  | 101                          |
| Pain             | 6   | 62  | 91                           |
| Pain             | 22  | 22  | 151                          |
| PAVE             | 0   | 8   | 74                           |
| Physiatry        | 0   | 69  | 57                           |
| PT               | 2   | 216   | 223                          |
| PT               | 7   | 76  | 86                           |

*Source: VA OIG Analysis of EHRs of Identified Patients*

\*This consult was discontinued by the clinical reviewer. \*\*Appointments were not scheduled for these consults at the facility; the patients received care through non-VA care at 77 and 80 days from the CID.

System policies in effect during the time of the events discussed in this report required clinical reviews to be completed within 2 business days. Requesting providers

submitted routine urgencies for the 14 consults. Clinical reviewers completed 6 of the 14 clinical reviews within the 2-business day timeframe.

VHA business rules in effect during the time of the events discussed in this report required consult action (cancellation, discontinuation, completion, or scheduling) to occur within 7 days. Current VHA business rules allow an additional consult action, active, to occur within 7 days. For 12 of the 14 patients with consults not cancelled or converted to non-VA care, AMSAs did not contact the patient within 7 days. The average time for the first contact attempt by AMSAs was 63 days. Routine consults are to be completed within 30 days of the CID. None of the patients we reviewed had an appointment within this timeframe.<sup>34</sup>

## **Issue 2: Systemic Delays in PMRS**

Although not an allegation, we found that delayed consults were a systemic problem in PMRS. We reviewed all consults submitted to facility PMRS outpatient clinics from March 2 through December 31, 2015. The data collected were through the most recent available date, July 1, 2016.

The 2015 system policy required that routine PMRS consults be completed within 30 days of the CID. System policies included a “Within 1 Week” urgency option that required completion of consults within 7 days. The Acting Deputy Under Secretary for Health for Operations and Management eliminated the “Within 1 Week” urgency status in October 2015. The 30-day completion requirement remained in effect.

From March 2 through December 31, 2015, 14,045 consults were submitted to PMRS. Table 2 shows the urgency status of these consults. We did not include in our review the 3 consults that did not have the urgency specified, nor did we include the 24 STAT/Today consults because STAT/Today consults should not be used in the outpatient setting per system policy.

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<sup>34</sup> System Memorandum 011-015, *Consult Referrals*, March 2, 2015, was rescinded and replaced with System Memorandum 011-015, *Consult Referrals*, March 3, 2016.

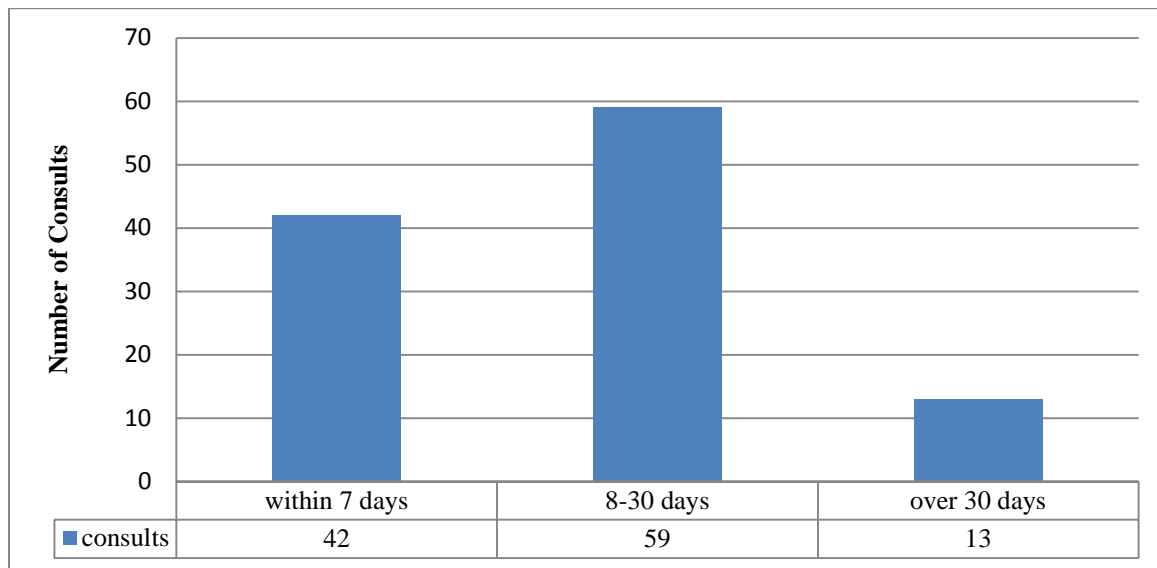
**Table 2. March 2–December 31, 2015 Facility PMRS Consults by Urgency Status**

| Urgency Status         | Number of Consults |
|------------------------|--------------------|
| No Urgency Specified   | 3                  |
| STAT/Today             | 24                 |
| Within 1 Week          | 176                |
| Routine/Within 1 month | 13,842             |
| <b>Total</b>           | <b>14,045</b>      |

Source: VA OIG

Of the 176 consults to be completed “Within 1 Week,” 114 (65 percent) were completed, 21 (12 percent) were cancelled, and 41 (23 percent) were discontinued. Forty-two (37 percent) of the 114 consults were completed within 7 days, while 72 (63 percent) of these consults were delayed. (See Figure 1.)

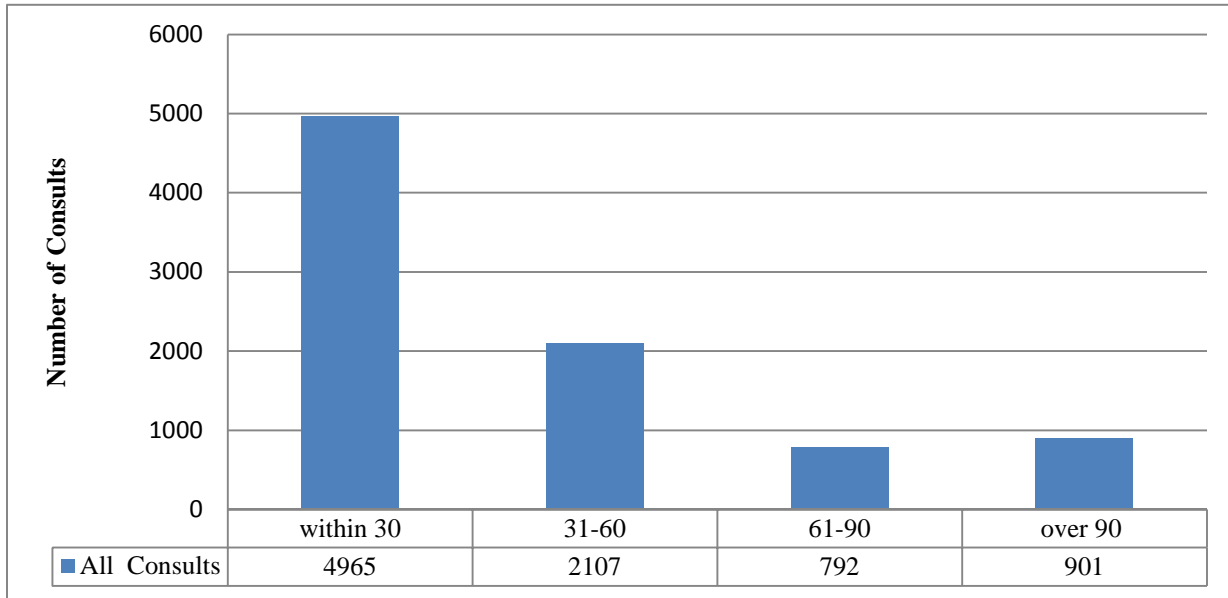
**Figure 1. Time From CID to Completion "Within 1 Week" Consults**



Source: VA OIG analysis of PMRS consults submitted from March 2 through December 31, 2015

Of the 13,842 routine consults, 1076 consults (8 percent) were cancelled and 3983 consults (29 percent) were discontinued. (See Figure 2.) Of the remaining 8,783 consults, 8,765 (99.8 percent) were completed and 18 (0.2 percent) remained open by the end of the data collection period, July 1, 2016. The 18 open consults were delayed an average of 208 days as of July 1, 2016. Of the 8,765 completed consults, 4,965 (57 percent) were completed within 30 days and 3,800 (43 percent) were delayed. Figure 2 shows the time in days for completion of routine consults.

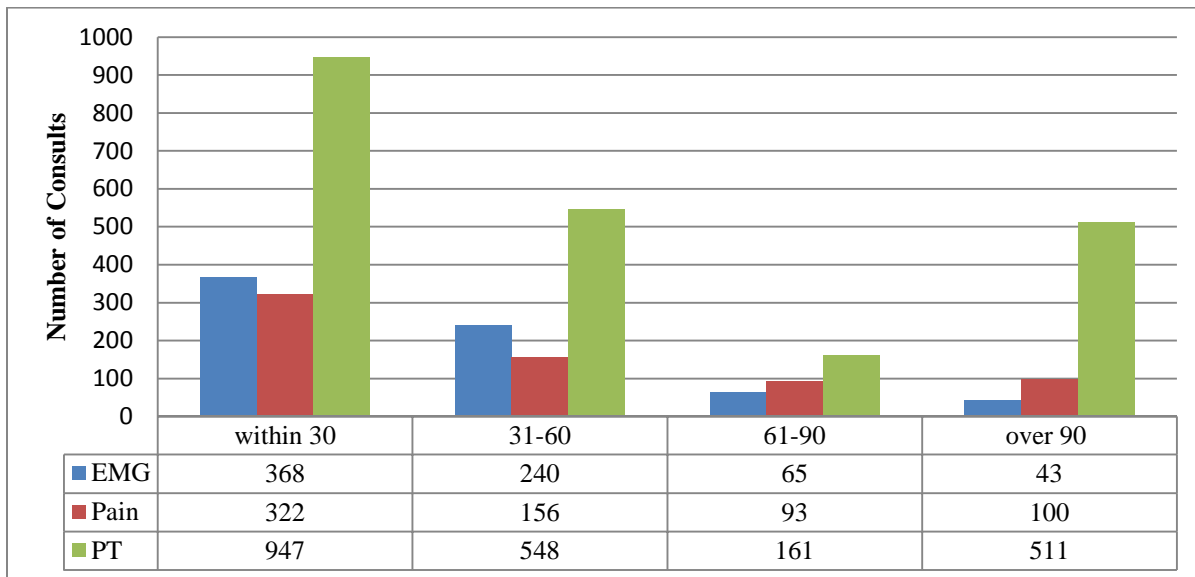
**Figure 2. Days From CID to Completion for Routine Consults**



Source: VA OIG analysis of PMRS consults submitted from March 2 through December 31, 2015

Facility managers identified the EMG, Pain, and PT clinics as clinics requiring non-VA Care referrals to alleviate internal backlogs. (See Issue 3.) We reviewed the completed routine consults for these three clinics. (See Figure 3 below.) EMG, Pain, and PT clinic consults were delayed 348 of 716 (49 percent), 349 of 671 (52 percent), and 1,220 of 2,167 (56 percent) respectively.

**Figure 3. Days from CID to Completion for Routine EMG, Pain, and PT Clinics**



Source: VA OIG analysis of EMG, Pain, and PT consults submitted from March 2 through December 31, 2015

### **Issue 3: Problems With the Facility Consult Process**

#### Scheduling Process

We found deficiencies with the facility's PMRS scheduling process, including the clinical review and scheduling procedures. To determine the facility's procedures for scheduling consult appointments, from clinical review through appointment scheduling or discontinuation, we interviewed providers who performed clinical reviews and AMSAs who scheduled appointments.

#### *Clinical Reviews*

Each PMRS discipline (section) had staff members that reviewed their own consults to determine whether referred consults were clinically appropriate prior to scheduling patients for clinic appointments. We found that not all sections had the same process for reviewing consults. Some sections had supervisors review consults; others had specified providers review consults; while still others had any/all providers review consults as they had time available. Some sections had specific days for reviewing consults, while other sections' staff reviewed consults as they were received throughout the day and when time was available.

Once the clinical review was completed and the consult approved for scheduling, the clinical reviewer entered a comment on the consult in the EHR for AMSAs to make an appointment for the patient and change the consult status to active. The change in status alerted AMSAs that a consult was ready for the scheduling process. We found this procedure to be consistent except for one clinic in one of the sections where the provider scheduled consults without the assistance of AMSAs.

The 2015 system policy required the clinical review to be completed within 2 business days of consult origination for those consults needing clinical review.<sup>35</sup> Some clinics had 2 designated days each week to review consults for clinical appropriateness, thus would often not meet the 2-day requirement.

The policy also stated that if a consult was not clinically reviewed within 2 days, AMSAs should schedule a clinic appointment for the patient. In interviews, we were told the facility process required providers to perform the clinical review and then alert AMSAs to schedule the consult appointment. This practice was inconsistent with the system policy because not all clinical reviews were being performed timely.

#### *Appointment Scheduling*

Each morning, AMSAs printed a list of all active status consults and attempted to call patients on the list to schedule appointments. AMSAs documented their contact with, or attempted contact with, patients using comments visible under consults in the patients'

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<sup>35</sup> System Memorandum 011-015, *Consult Referrals*, March 2, 2015, was rescinded and replaced with System Memorandum 011-015, *Consult Referrals*, March 3, 2016.



EHRs. AMSAs destroyed the paper list at the end of each day. Any patient not scheduled for an appointment would appear on the next day's active status consult electronic list.

AMSAs reported they made two attempts to reach a patient by phone. If unable to contact a patient by phone, they sent a letter to the patient requesting he/she contact the clinic to schedule an appointment. If the patient made no contact to schedule the appointment within 14 days of the letter being mailed, the consult information was sent to the receiving service provider for instruction as to either discontinue the consult or continue attempting to schedule the appointment.

When AMSAs contacted a patient, they attempted to make the appointment within the appropriate timeframe. For routine consults, the appointment was made within 30 days of the CID. Some AMSAs scheduled appointments using the CID and calculated the appointment window correctly. Others; however, asked the patient for the date he/she would like to be seen and used the patient's preferred date as the start date for the 30-day scheduling window. The patient was then scheduled outside the actual 30-day timeframe with a delayed appointment.

If an appointment opening was not available for the patient within the 30-day window used by the AMSAs, they offered the patient an appointment through Choice.<sup>36</sup> If the patient accepted, he/she was placed on the Choice List (CL) and scheduled for the next available clinic date. Once the patient was scheduled for an appointment through CL, the facility clinic appointment should have been cancelled. If the patient declined the CL, he/she was given the next available clinic appointment at the facility. AMSAs gave patients the clinic phone number so the patients could call back to check for appointment cancellations in case the appointment could be moved to an earlier date. However, if the 30-day timeframe within which an appointment needed to be scheduled was not calculated from the CID, but instead from the patient's preferred date, the date when a patient should have been offered a Choice referral may have been miscalculated.

### Resources

Although not an allegation, many of the staff we interviewed stated that a lack of resources prohibited timely scheduling of consult appointments.

### AMSAs

The PMRS service had four AMSAs; a supervisory AMSA position did not exist. During our interviews, we found that experienced AMSAs left PMRS in early 2015. The most senior AMSA started in March 2015, and the most recent staff started at the end of March 2016. None had extensive experience.

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<sup>36</sup> The Veterans Choice Program is for non-VA medical care. Veterans are eligible if their wait is more than 30 days to receive the requested medical care or they live more than 40 miles from a VA medical facility.

A facility manager told us that PMRS AMSAs had more duties than AMSAs in other departments. PMRS AMSA duties included:

- Scheduling consult appointments.
- Scheduling follow-up appointments written in text orders.
- Answering clinic telephones.
- Checking patients into the clinic for scheduled appointments.

Through an interview, we found AMSAs made 60–80 outgoing calls, received 40–60 incoming calls, and checked-in 30–50 clinic patients each working day. PMRS received approximately 150 consults per day. This was a very different workload from that of AMSAs who worked in primary care clinics where automated call systems were used for inbound calls. Facility management did not approve an automated call system for PMRS. In addition, when an AMSA was on annual or sick leave, remaining AMSAs absorbed the additional workload.

The backlog of unscheduled consults increased because more consults were submitted per day than could be addressed or scheduled. One AMSA summarized the process as follows: after receiving the active consult list on Monday, attempts were made to call at least 15–20 patients per day but the names on the active status consult list stayed on the list until the consult was placed in scheduled status. Meanwhile, new consults were added daily to the active consult list. If an AMSA was unable to call all the patients on his/her respective active consult list, then consults for patients not contacted rolled over to the next day's active consult list. It may have taken several days before a second call was attempted because the active consult list continued to grow. The AMSA estimated that it might take a week before he/she made a second call to a patient.

### *PMRS Providers*

The facility's Human Resource Employee Service Listing, as of May 2, 2016, listed openings for a psychiatrist in the Amputee/EMG section, two physician assistants in the pain section, and PT and OT assistants, and PTs, and OTs. OT had a supervisory OT position open and Speech Therapy did not have a supervisory speech therapist nor was an open position listed. We requested a facility update and as of May 25, 2017, the facility had filled the open psychiatrist position and was recruiting for an assistant chief for the service. Vacancies existed in Speech Therapy, Kinesiotherapy, OT, PT, Recreation Therapy, and for therapy assistants.

### *PMRS Management*

PMRS has been without a service chief since October 2015. The Deputy Chief of Staff acted as the service chief until November 2015 when the current acting service chief was detailed to the service. Previously, a clinical coordinator position and an Associate Chief of Service position existed, but these positions were eliminated in the summer of 2015. The duties of the clinical coordinator position were transferred to the individual section supervisors.

The PMRS Administrative Officer position was vacant in September 2015 and acting Administrative Officers were assigned from November 2015 until May 2016, when a permanent Administrative Officer was hired<sup>37</sup>. The PMRS management analyst position became open May 2016.

### Choice

We found issues with the facility staff offering Choice to patients. Patients should have been offered care through Choice when needed care could not be provided at the VA facility within 30 days of the CID.<sup>38</sup>

Interviewees told us that many of the patients offered care through Choice declined it. Staff said two of the reasons patients refused Choice were that patients were required to pay a co-payment when using Choice and Choice appointments took longer than appointments with the facility.

For patients who opted for Choice care, AMSAs also scheduled facility appointments to ensure patients were provided care if a Choice appointment could not be arranged. The facility appointment was supposed to be cancelled when the patient was scheduled for a Choice appointment. Interviewees said that facility appointments were not cancelled which created two issues: (1) If patients did not attend the facility appointment, this created an empty appointment slot that could not be filled with another patient, and (2) patients who attended both the facility and Choice appointments had an unnecessary duplication of services.

We were told that a Choice appointment could take over 10 days from consult to approval and the information about the Choice appointment was not available to facility staff. Staff needed to be alerted of the Choice appointment in order to know when to cancel the facility appointment. Staff were unsure if the breakdown was with Tri-West<sup>39</sup> staff alerting an AMSA of the Choice appointment or if an AMSA did not have the time to cancel the facility appointment because of the volume of information received from Tri-West.

### **Issue 4: Facility Management's Awareness of Problems and Actions Taken**

We found facility management was aware of the delay in PMRS consult appointments and had taken the following corrective actions prior to our initiating this review.

A Consult Management Committee was formed mid-2015. We reviewed the committee's minutes from June 2015 through May 2016 and found that in January 2016, the committee documented increased delays in PMRS consult timeliness. In March 2016, committee members asked PMRS managers to provide

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<sup>37</sup> An Administrative Officer is responsible for the operating management of the assigned service by managing operating officials in getting things done through her/his knowledge and skills in dealing with the organization, funds, people, equipment, and other tools or resources of management needed for the service.

<sup>38</sup> VA Fact Sheet: Veterans Access, Choice and Accountability Act of 2014 (Choice Act).

<sup>39</sup> Tri-West is a VA contracted company that schedules Choice appointments for the facility.

corrective action items because of a multi-month upward trend in consult metrics and volume of consults requiring action.<sup>40</sup>

PMRS managers submitted an action plan to the committee in April 2016, which included requesting a locum tenens<sup>41</sup> physician for a staff physiatrist and an additional staff physiatrist position, as well as adjusting AMSAs' clinic assignments. Committee minutes in May 2016 documented an improvement in PMRS consult metrics. The minutes also documented the temporary, sole use of non-VA care for pain, EMG, and PT services that should help improve PMRS consult metrics. The changes were temporary. Per a facility update we requested on May 25, 2017, the Chief of PMRS reported the service did have positions approved and reallocated; however, multiple vacancies continued throughout the service.

### Pain Clinic

Beginning in January 2016, the Chief of Staff sought help from another VA facility to review PMRS processes and give recommendations to improve its functioning. South Texas Veteran Health Care System staff visited the facility March 17–18, 2016, and made recommendations for PMRS improvement. Their main recommendation was to realign the Pain Management Section under the Anesthesia Service. However, because the facility Anesthesia Service did not provide care at outpatient clinics, facility leaders decided to realign the Pain Management Section under the Surgery Service, which had outpatient clinics, procedure rooms, and a recovery area, similar to resources available in the Pain Management Section.

Facility leaders anticipated that realignment of the Pain Management Section from PMRS to Surgery Service would decrease the workload of PMRS AMSAs. This section was busy and utilized a large portion of AMSAs resources. The move to Surgery Service provided the Pain Management Section with management and support staff familiar with the services this section provided. The realignment occurred in May 2016. Because our site visit occurred in May 2016, we were unable to determine the effectiveness of this realignment. Per a facility update we requested May 24, 2017, the Chief of PMRS reported that the service was still working on realigning scheduling functions, as they had not hired three additional clerks. She further stated a restructuring proposal for the entire service was sent to the Chief of Staff and they were waiting for a response.

### Attempts to Decrease Backlog of Unscheduled Consults

Facility leaders employed work-study personnel to assist in scheduling new consults. A request for a lead AMSA position was submitted by PMRS and was pending approval in

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<sup>40</sup> System Memorandum 011-015, *Consult Referrals*, March 3, 2016. Per the 2016 system consult policy, monthly reporting of consult metrics, such as number of consults active over 30 days and number of consults pending over 7 days, are reported to the committee. The upward trend for PMRS indicated that the processing for PMRS consults was worsening.

<sup>41</sup> A locum tenens physician is a contracted physician that fills a physician's position on a temporary basis.

May 2016. Providers in some clinics were given the option of scheduling follow-up appointments for their patients themselves instead of writing text orders for AMSAs to schedule follow-up appointments.

On April 26, 2016, the facility Chief of Staff sent a memorandum to all facility staff stating that consult referrals to Pain, PT, and EMG clinics would go to non-VA care through the month of May, instead of the facility, because of the backlog in appointment scheduling occurring in these clinics. Facility leaders determined that this would decrease demand on the clinic providers and AMSAs to schedule consults.

### Training

Facility staff provided multiple scheduling training sessions for AMSAs between July 2015 and January 2016. We reviewed the most recent 49 competency assessments of the 50 rehabilitation therapists who had scheduling privileges. We did not receive an annual competency for one of the therapists. We found that 18 of the 49 (37 percent) therapists had signed competencies for scheduling appointments within the last year.<sup>42</sup>

We interviewed eight PMRS managers and staff and found that half did not understand the meaning of CID; the difference between CID and the patient's preferred date; or in which instances CID versus the patient's preferred date should be used when scheduling an appointment.

### Unintended Consequences

Facility leaders focused on decreasing the backlog of new consults and providing additional resources to staff who scheduled new consult appointments. Interviewees told us that providers were finding it hard to schedule patients' follow-up appointments because the increased number of new patient appointments reduced the number of openings available for follow-up appointments.

Additionally, with providers scheduling follow-up appointments themselves instead of writing text orders for AMSAs to schedule these appointments, interviewees told us that patients were possibly given the next available appointment instead of the CID appointment. Without documentation of the correct starting date (CID), PMRS managers were unable to accurately track delays in scheduling follow-up appointments.

## **Conclusions**

We substantiated the allegation that 12 of the 14 patients we reviewed experienced delays in scheduling consult appointments and in receiving care. Although the patients experienced delays in response to PMRS consults, primary care teams continued to manage patients. We also found that the delay in consult appointments was not

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<sup>42</sup> We reviewed the training records to determine if staff received training between July 1, 2015 and June 30, 2016.

limited to these 12 consults, but was a systemic problem within PMRS. From March 2 through December 31, 2015, 63 percent of "Within 1 Week" urgency consults were delayed beyond 7 days and 43 percent of routine urgency consults were delayed beyond 30 days.

We found that two of the facility's consult procedures did not comply with the system's consult policy. Clinical reviews were not consistently completed within 2 business days. We also found that AMSAs did not schedule appointments when the clinical review was not completed within 2 days, as policy requires. Both could delay appointment scheduling.

We found that PMRS had multiple unfilled provider positions and multiple managerial positions filled by temporary personnel. As of May 24, 2017, the service was working on restructuring and continued to have multiple vacancies. The lack of a fully staffed department affects the functioning of the service.

AMSAs said during interviews that they were not able to keep up with the scheduling demand because of the number of consults submitted daily. In addition, despite recent training on how to schedule consults, AMSAs expressed confusion on the use of the CID versus the patient's preferred date. This could reduce the ability to schedule consults efficiently.

We found issues with Choice processes affecting clinic scheduling and appointment availability as well. Through interviews, we were told that many patients declined Choice appointments. For those patients who chose Choice appointments, some had appointments at the facility made concurrently that were intended to be cancelled but were not.

Facility managers were aware of these problems and attempted to correct them by forming a Consult Management Committee to review consult data for the facility and by requesting another VHA facility review PMRS and make suggestions to improve its functioning. Managers provided additional scheduling training to AMSAs; directed PMRS staff to develop action plans to improve their consult metrics; employed work-study staff to assist AMSAs in scheduling new consult appointments; moved the pain clinic to the Surgery Service to assist with its functioning; and temporarily redirected EMG, pain, and PT consults to non-VA care.

We also found that the facility did not meet current or previous VHA annual scheduling competency evaluation requirements for staff who schedule appointments.

As the backlog of new consults improved, patients' access to follow-up appointment openings decreased. In addition, some providers were scheduling follow-up appointments themselves instead of writing text orders for AMSAs to schedule follow-up appointments. Without the providers documenting the CID, PMRS managers were unable to accurately track delays in scheduling follow-up appointments.

## Recommendations

1. We recommended that the Facility Director ensure that consult clinical reviews and appointment scheduling for patients are conducted in compliance with Veterans Health Administration directives and system policies.
2. We recommended that Physical Medicine and Rehabilitation Services have sufficient staffing to arrange for timely consultations and appointments within the service.
3. We recommended that the Facility staff who schedule Physical Medicine and Rehabilitation Services patient appointments receive annual scheduling competencies to ensure understanding of the correct process for compliance with Veterans Health Administration directives and staff are monitored for compliance.

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** July 13, 2017

**From:** Director, VA Heart of Texas Health Care Network (10N17)

**Subj:** Healthcare Inspection— Physical Medicine and Rehabilitation Services Consult Process Concerns, Central Texas Veterans Health Care System, Temple, Texas

**To:** Director, Dallas Office of Healthcare Inspections (54DA)  
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review and respond to the report, Healthcare Inspection—Physical Medicine and Rehabilitation Services Consult Process Concerns, Central Texas Veterans Health Care System, Temple, Texas
2. I have reviewed and concur with the recommendations in the report. If you have any questions or require further information, please contact Leslie Whitaker, Quality Specialist for VISN 17 at 806-355-9703 X7007 or 806-683-0873.



Mark Doskocil

Deputy Network Director, VA Heart of Texas Health Care Network (10N17) (Acting Network Director 7/13/2017)



## System Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

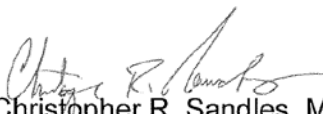
**Date:** July 13, 2017

**From:** Director, Central Texas Veterans Health Care System (674/00)

**Subj:** Healthcare Inspection— Physical Medicine and Rehabilitation  
Services Consult Process Concerns, Central Texas Veterans Health  
Care System, Temple, Texas

**To:** Director, VA Heart of Texas Health Care Network (10N17)

1. We thank you for the opportunity to submit a response to the proposed recommendations for the Central Texas Veterans Health Care System, Temple, Texas.
2. We concur with the conclusion and recommendations presented by the Office of the Inspector General. Corrective action plans and compliance monitoring plans have been established and target dates have been set for the recommendations as detailed in the attached report.

  
Christopher R. Sandles, MBA, FACHE  
Director, Central Texas Veterans Health Care System (674/00)

## 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 Facility Director ensure that consult clinical reviews and appointment scheduling are conducted in compliance with Veterans Health Administration directives and system policies.

Concur

Target date for completion: August 11, 2017

Facility response:

### **Consult Clinical Reviews**

In June 2016, the service implemented daily monitoring of pending consults and established a goal to review all consults within 48 hours. A daily list of all STAT and Pending consults is sent to staff for action. The service performs all consult process and procedures within the guidelines of VHA Directive 1232 - Consult processes and procedures, and compliance is monitored by PM&RS supervisory staff. CTVHCS executive leadership further monitors consult compliance through data reporting during the Director's morning report.

### **Appointment Scheduling**

Physical Medicine and Rehabilitation Service performs all scheduling processes and procedures within the guidelines of VHA Directive 1230 – Outpatient Scheduling Process and Procedures. A Supervisory Medical Support Assistant was hired in September 2016 to directly manage Advanced Medical Support Personnel and further support the directive scheduling compliance through continuous monitoring of all scheduling tasks.

**Recommendation 2.** We recommended that Physical Medicine and Rehabilitation Services have sufficient staffing to arrange for timely consultations and appointments within the service.

Concur

Target date for completion: September 1, 2017

Facility response:

### **Timely Appointments**

Physical Medicine and Rehabilitation Service (PMRS) has utilized temporary supplemental scheduling staff, clinical staff, and overtime to assist in scheduling patient appointments. Beginning in September 2016, and as a result of this site visit, CTVHCS intended to detail Advanced Medical Support Assistants (AMSAs) to PMRS; however, this never occurred until the receipt of this draft report. On July 3, 2017, PMRS received approval to hire an additional 3.0 full-time scheduling staff. In the interim and to fulfill the original detail approval in September 2016, there will be 3 AMSAs detailed to PMRS for 90 days, effective July 25, 2017.

### **Timely Consultations**

Executive Leadership utilized non-VA care capacity from April 28, 2016 to July 1, 2016 to offer Physical Medicine and Rehabilitation Service the ability to focus on reducing the backlog of consults and the opportunity to reevaluate clinical structure. The service evaluated and modified clinics to improve consult and treatment availability

**Recommendation 3.** We recommended that the Facility staff who schedule Physical Medicine and Rehabilitation Services patient appointments receive annual scheduling competencies to ensure understanding of the correct process for compliance with Veterans Health Administration directives and staff are monitored for compliance.

Concur

Target date for completion: September 1, 2017

Facility response:

At the time of the May 2016 site visit, VHA required completion of 3 modules and a soft skills training for any employee to be granted scheduling access. All Advanced Medical Support Assistants (AMSAs) onboard at the time completed this training. In FY17, VHA implemented a requirement for schedulers to complete a 2.5 day National Standardized refresher training. This has been completed for all AMSAs currently onboard. They will continue to complete training requirements annually.

There are currently five Advanced Medical Support Assistants onboard within PMRS. PMRS was approved for six initially and one of those is currently vacant. The three additional Advanced Medical Support Assistant positions that will be detailed effective July 25, 2017 have already completed all required initial and annual scheduling training for FY17. These staff will be in place for 90 days or until the recruitment of the recently approved additional 3.0 AMSA full-time employee equivalents (FTE) are onboard and fully trained. Effective July 25, 2017, all clinical staff (except for 4.0 FTE) will cease scheduling activities and their access will be removed. These 4.0 FTE clinical are needed to continue scheduling activities since weekend scheduling

coverage is not provided by the current AMSA staff. PMRS will recruit the new AMSA FTE recently approved to work alternate tours on the weekend to provide this coverage. Once those AMSAs are onboard and fully trained then scheduling activities will cease for these remaining 4.0 FTE clinical staff and their access will be removed.

## OIG Contact and Staff Acknowledgments

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|---------------------------|--|
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