VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15

March 13, 2018
17-00481-117

ACRONYMS

FY	Fiscal Year
GAO	Government Accountability Office
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
QASP	Quality Assurance Surveillance Plan
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VCL	Veterans Choice List
VCP	Veterans Choice Program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture
VSE	VistA Scheduling Enhancement
VSSC	Veteran Support Service Center

EXECUTIVE SUMMARY

Access to health care has been a recurring issue in the Veterans Health Administration (VHA). For more than a decade, the Office of Inspector General (OIG), U.S. Government Accountability Office (GAO), Department of Veterans Affairs (VA), and other organizations have issued numerous reports regarding issues with access to VA care such as veteran wait times, scheduling practices, consult management, and the Veterans Choice Program (Choice).

This audit assessed the reliability of wait time data and timely access within an entire Veterans Integrated Service Network (VISN). VHA is divided into 18 regional systems of care called VISNs. Within each VISN are a number of VA Medical Centers (VAMCs) and Community Based Outpatient Clinics. Conducting an audit of a VISN, as presented in this report, is important since the VISN is responsible for allocating appropriate resources to its many medical facilities. Information and data related to access to care needs to be current, accurate, and available to help VISN leaders address significant changes in health care service demands and gaps in service delivery.

The OIG previously audited wait time data for VISN 6.[1] That audit found "VISN 6 did not consistently provide timely access to health care for new patients at its VA medical facilities and through Choice during the" first quarter of FY 2016. VISN 6 "also did not have accurate wait time data. Our assessment of wait times for new patient appointments shows a significant difference when compared to wait time data captured in VHA's electronic scheduling system. As a result, we concluded that VHA and VISN 6 leaders relied on wait time data that did not accurately represent how long veterans were waiting for care."

For this audit, the OIG selected VISN 15 to determine whether it provided new veteran patients timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 15 appropriately managed consults. Although it covered a different period of time, the methodology was generally the same as the OIG's earlier audit of VISN 6. Aside from reviewing the timeliness of access to health care in VISN 15, it also provided a comparison between VISNs. This audit was not a clinical review of health care provided to veterans. Rather, the audit focused on measuring wait times for new patients and the accuracy of wait time data within the VISN 15 medical facilities and through Choice.

VA data reliability continues to be a high-risk area. In 2015, GAO concluded that VA health care was a high-risk area and added it to GAO's High-Risk List.[2] One of the reasons GAO designated VA health care as a high-risk area was because of "inadequate oversight and accountability." In its report, GAO stated, "VA's oversight efforts are often impeded by its reliance on facilities' self-reported data, which lack independent validation and are often inaccurate or incomplete." In

[1] On March 2, 2017, OIG issued a report titled *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6* (Report No. 16-02618-424).
[2] *High-Risk Series—An Update*, February 2015, Report No. GAO-15-290.

2017, GAO recommended that VA place immediate attention on "improving oversight of access to timely medical appointments, including the development of wait-time measures that are more reliable and not prone to user error or manipulation."[3]

In April 2017, VA created a public website showing patient access data, called Access and Quality in VA Healthcare.[4] The website is aimed at providing veterans with an easy, understandable way of accessing wait times and quality of care data. The website includes data showing the average wait times at individual facilities. According to the website, the average wait times are based on appointments completed at VA facilities during the previous month. Similarly, the assessment of wait times for appointments at VA facilities in this report is also based on completed appointments. The appointments the OIG reviewed were prior to VA launching the Access and Quality in VA Healthcare website. As VA works to provide greater transparency in the timeliness of access to care, it is important that the data are reliable.

What the OIG Did

The OIG conducted its audit from January through December 2017. The OIG assessed statistical samples including 653 new patient appointments, 422 Choice authorizations, 210 discontinued or canceled consults, and 209 specialty care consults open more than 30 days.[5] During site visits, OIG staff discussed statistical sample review results with medical facility staff assigned to assist them and received clarification on questions and potential issues.

In February and March 2017, the OIG conducted site visits to the main VA medical facilities in VISN 15.

1. Harry S. Truman Memorial Veterans' Hospital (Columbia, Missouri)
2. John J. Pershing VA Medical Center (Poplar Bluff, Missouri)
3. Kansas City VA Medical Center (Kansas City, Missouri)
4. Marion VA Medical Center (Marion, Illinois)
5. Robert J. Dole VA Medical Center (Wichita, Kansas)
6. VA Eastern Kansas Health Care System (Leavenworth and Topeka, Kansas)
7. VA St. Louis Health Care System (St. Louis, Missouri)

The OIG interviewed over 250 staff from VHA, the VISN 15 office, and the medical facilities the OIG visited. Although this audit was not a clinical review, we referred 83 patient cases from the sample appointments and consults to OIG's Office of Healthcare Inspections (OHI) for review because the patients were deceased or experienced significant delays in care. We referred the medical records for these veterans to OHI to determine whether inappropriate or untimely

[3] *High-Risk Series—Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, February 2017, Report No. GAO-17-317.
[4] https://www.accesstocare.va.gov/.
[5] The OIG used stratified random sampling for all the samples of appointments and consults selected. All records had a known chance of selection. This allowed us to make estimates over the entire population. For additional information on the statistical sampling methodology, see Appendix J.

care resulted in any adverse clinical impact to the veteran. For additional information regarding the extent of this audit, see Appendix I.

What the OIG Found

Overall, new patients who had appointments with clinically indicated dates waited an average of about 18 days. The audit estimated that 18 percent of the appointments for new patients who had an appointment with a clinically indicated date at facilities within VISN 15 during the relevant time period had wait times longer than 30 days. The OIG estimated that the average wait time for this 18 percent was 53 days.

These numbers are higher than the wait time data that VHA's electronic scheduling system showed. VHA's electronic scheduling system data showed that an estimated 10 percent of these new patient appointments had wait times longer than 30 days. Inaccurate wait time data generally occurred when facility staff recorded a preferred date or the actual appointment date when scheduling the appointments instead of using the clinically indicated date. Among other consequences, the inaccurate wait time data resulted in veterans not being identified as eligible for treatment through Choice.

With respect to those veterans in VISN 15 who received their care through Choice, the OIG estimated that 41 percent of the appointments during the relevant time period had wait times longer than 30 days. The OIG estimated that the overall average wait time for those who received their care through Choice was 32 days. For those veterans who did not receive care through Choice within 30 days, the OIG estimated they waited an average of 58 days to receive their care. In addition, VISN 15 medical facility staff discontinued or canceled an estimated 27 percent of consults inappropriately during the first quarter of FY 2017, which led to veterans experiencing additional delays, or in some cases not receiving the requested care.

Of the 83 patient cases from the sample appointments and consults that we referred to OHI for review, OHI's clinical review identified concerns with the delayed care for six patients. Of these six, OHI determined that two patients received acceptable care after a slight delay for the specific consults within the scope of review. However, both patients had delays in care for previous conditions, as their follow-up care was not completed in the time frame recommended by their physicians. One of these patients required surgery to remove a colon mass and a part of the colon. In addition, OHI determined that three patients were still waiting for evaluations following clinical findings at the time of OHI's review. Lastly, one patient likely had an adverse outcome as a result of a delay of care to address a foot infection.

VISN 15 Medical Facilities Did Not Record Accurate Wait Times for an Estimated 38 Percent of New Mental Health or Specialty Care Appointments

Patients who received new mental health or specialty care appointments at VISN 15 facilities experienced some delays that were not consistently represented in VA wait time data. VHA Directive 1230, *Outpatient Scheduling Processes and Procedures* (July 15, 2016), requires schedulers to use the documented clinically indicated date when scheduling patient

appointments. The OIG estimated that staff did not correctly record clinically indicated dates for about 5,300 of approximately 13,900[6] new patient appointments (38 percent) they scheduled. This understated veterans' wait times by about 15 days, because, in these instances, facility staff generally recorded a preferred date or the actual appointment date when scheduling the appointments instead of using the clinically indicated date. Based on the assessment of wait times from the clinically indicated date, the OIG estimated that about 2,500 of 13,900 appointments (18 percent) had wait times greater than 30 days. This was higher than the estimated 1,300 appointments (10 percent) that VHA's electronic scheduling system showed were scheduled greater than 30 days. Overall, the approximately 13,900 new patient appointments had an average wait time of about 18 days. For those 2,500 appointments greater than 30 days, the OIG estimated that veterans waited an average of 53 days. Based on the statistical sample review, the OIG broke down the approximately 13,900 appointments by type and estimated that:

- Of the approximately 780 mental health care appointments, the OIG estimated 150 (19 percent) had wait times greater than 30 days with an average wait time of 42 days for those 150 appointments. This compared to an estimated less than 7 percent in VHA's electronic scheduling system that showed as greater than 30 days.
- Of the approximately 13,000 specialty care appointments, the OIG estimated 2,400 (18 percent) had wait times greater than 30 days with an average wait time of 54 days for those 2,400 appointments.[7] This compared to an estimated 1,300 of 13,000 specialty care appointments (10 percent) that VHA's electronic scheduling system showed as greater than 30 days.

Staff continued to enter the wrong date in the scheduling system primarily because VISN 15 and facility management did not ensure staff consistently implemented VHA's scheduling requirements. For example, local policy at one facility and incorrect guidance provided at another facility led scheduling staff to use the patient's preferred date when scheduling appointments, which conflicted with VHA's policy to enter the clinically indicated date when scheduling appointments. In addition, facilities did not conduct scheduler audits to the extent required by policy, or did not consistently communicate the results of audits to schedulers to help improve performance. VISN 15 facilities were required to use designated scheduler auditors to conduct these audits. However, facilities experienced delays in filling the scheduler auditor positions, including an extended vacancy at two facilities. Schedulers did not consistently receive the results of audits to help improve performance, and VHA policy did not require the audit results be shared with the schedulers.

[6] The approximately 13,900 new patient appointments consisted primarily of mental health and specialty care appointments. More specifically, of the approximately 13,900 new patient appointments reviewed, an estimated 13,026 were specialty care appointments, 784 were mental health appointments, and 46 were primary care appointments. Appointment counts were statistically estimated and rounded. Estimates may not sum exactly due to the rounding. More information can be found in Appendix J.

[7] The OIG included 12 specialty care clinics in the audit: physical therapy, cardiology, audiology, dermatology, podiatry, optometry, orthopedics, gastroenterology, physical medicine and rehabilitation service, urology, ophthalmology, and general surgery.

As a result, VHA and VISN 15 leaders relied on wait time data that did not always represent how long veterans were waiting for care. An accurate measurement of wait time is essential to identify veterans who are eligible for treatment through Choice. Of the estimated 2,500 appointments with wait times greater than 30 days, staff entered a date other than the clinically indicated date for an estimated 1,200 appointments (47 percent), which made it appear as though the wait time was 30 days or less. Of those 1,200, the OIG estimated that staff did not identify about 970 appointments (82 percent) in which the patient should have been offered the option of receiving care in the community through Choice.

During a previous audit of wait time data at VISN 6, the OIG estimated that about 36 percent of these types of appointments had wait times greater than 30 days, which was notably higher than the 10 percent that VHA's electronic scheduling system showed.[8] In that audit, the OIG estimated the average wait time for the 36 percent of appointments greater than 30 days was 59 days. The overall average wait time identified in VISN 6 included an assessment of primary care appointments. During the previous audit of VISN 6, the OIG estimated that 16 percent of mental health appointments had wait times greater than 30 days, and 39 percent of specialty care appointments had wait times greater than 30 days.

This occurred at VISN 6 because "staff entered preferred dates that resulted in inaccurate wait times for an estimated 74 percent of appointments." Applying VHA's new scheduling policy,[9] Directive 1230, to the VISN 6 results, the OIG "still found that staff entered dates that resulted in inaccurate wait times for an estimated 59 percent of appointments." In VISN 15, the OIG estimated that staff did not correctly record clinically indicated dates for about 38 percent of appointments. The OIG found that VISN 6 facility management provided inconsistent guidance on the use of the clinically indicated date. More specifically "VISN 6 facility management—such as facility directors (two), associate and assistant directors (two), and chiefs of staff (two)—disagreed with VHA's guidance related to using the referring provider's clinically indicated date. In these instances, management disagreed because it felt that receiving providers should determine the clinically indicated date; however, this conflicted with VHA's scheduling guidance."

Veterans in VISN 15 Waited an Average of 32 Days to Receive Health Care through the Veterans Choice Program

VISN 15 veterans who received care through Choice waited more than 30 days from the clinically indicated date for their appointment an estimated 41 percent of the time. The OIG reviewed a statistical sample of 422 Choice authorizations provided to TriWest[10] by VISN 15

[8] Comparisons of sample estimates between VISN 6 and VISN 15 are statistically significant and unlikely to be due to sampling error.
[9] During the audit of VISN 6, the OIG assessed the accuracy of the patient preferred dates entered in the electronic data field based on VHA guidance in place during the scope of the audit, which included that the desired date should be entered in the appointment comments. VHA's new scheduling policy, Directive 1230, requires schedulers to use the documented clinically indicated date when scheduling patient appointments, but does not require additional documentation to support a veteran's preferred date.
[10] TriWest Healthcare Alliance (TriWest) is the contractor VISN 15 used to coordinate veterans' Choice appointments.

medical facility staff from August 1, 2016, through October 31, 2016. The OIG estimated that about 20,300 of 22,200 veterans (92 percent) authorized for Choice—for primary care, mental health care, and specialty care—in VISN 15 during the sample period received, or were scheduled to receive, their authorized care through Choice. Overall, the OIG estimated these 20,300 veterans waited an average of 32 days.[11] This consisted of an average of about six days for VA staff to provide the authorization to TriWest, plus an average of nearly 26 days for TriWest to provide the service. The OIG estimated about 8,300 veterans (41 percent) waited more than 30 days from the clinically indicated date for their appointment. The TriWest contract required the contractor to provide the Choice care appointment within 30 days of the clinically indicated date VA provided to TriWest on the Choice authorization.

Although most veterans received, or were scheduled to receive, authorized Choice care, the OIG determined that VA did not have medical documentation for about 4,400 appointments (20 percent) at the time of the OIG's site visits. TriWest records also indicated this is an ongoing issue, and the records showed they had not provided medical documentation for about 35 percent of the veterans who were authorized Choice care during calendar year 2016.

This occurred because facilities did not have adequate procedures to monitor the aging of veteran referrals from VISN 15 facilities to TriWest. Although VA staff are required to act on a request for care to be provided at a VA medical facility within seven days, the VA does not have a timeliness standard to submit a completed referral to TriWest for Choice care. In addition, the facilities did not consistently monitor the aging of the authorized Choice care to ensure TriWest provided care and medical documentation timely due to manual processes and VA's lack of Choice authorization monitoring requirements. As a result, 41 percent of veterans did not receive care within 30 days, VA medical facilities did not always receive confirmation that the patients completed their scheduled Choice care, and VA medical facilities did not receive pertinent medical documentation important to continuing care at the VA.

During a previous audit of VISN 6, the OIG estimated that "veterans who received Choice care waited an average of 84 days," which was longer than in VISN 15. The 84 days included "an average of 42 days for VA staff to provide the authorization to Health Net[12] and 42 days for Health Net to provide the service." The OIG found that the Choice care wait times in VISN 6 were long "primarily because staffing resources were not sufficient" to effectively manage the increased workload. However, in VISN 15, VA Care in the Community staff stated that staffing was generally adequate to refer authorized veterans to TriWest. Furthermore, the OIG found VISN 15 leaders took a proactive role in facilitating the Choice Program—by creating a Choice Steering Group, supporting adequate key Choice Program staffing levels, conducting monthly coordination meetings with TriWest, and developing a live internet text chat process between VISN 15 facility staff and TriWest staff. However, additional monitoring would improve the timeliness of Choice services in VISN 15.

[11] The OIG calculated the overall Choice wait time from the date a VA provider determined care was clinically indicated to the appointment date.
[12] Health Net Federal Services LLC (Health Net) is the contractor VISN 6 used to coordinate veterans' Choice appointments.

VISN 15 Did Not Consistently Manage Specialty Care Consults in Accordance with Policy

VISN 15 medical facility staff discontinued or canceled an estimated 27 percent of consults inappropriately during the first quarter of FY 2017. This occurred primarily because specialty care clinicians and staff were still unclear on specific VHA consult management procedures regarding discontinuing and canceling consults. In particular, some clinicians stated they did not differentiate between discontinuing and canceling a consult, or understand the significance of the difference. In addition, one VISN 15 facility did not appropriately manage consults that were clinically indicated to be scheduled for a future date, and discontinued the consults with instructions to resubmit later. Another facility continued to send consults to a specialty care service after the facility no longer offered the service.

Staff at one facility discontinued consults for colonoscopies that were clinically indicated to be scheduled in the future, because they did not think it was safe to schedule appointments beyond 90 days as the patient's condition could change. In addition, one facility did not provide guidance to referring providers when a service was no longer available at the facility. Inappropriately discontinued or canceled consults led to veterans experiencing additional delays, or in some cases not receiving the requested care. As a result of staff at one facility discontinuing consults clinically indicated for a future date, primary care providers tracked these patients' consults using tickler notes and spreadsheets, which presented the risk they may not resubmit the consult timely or at all.

During the previous audit of VISN 6, the OIG found that "staff inappropriately discontinued or canceled consults an estimated 26 percent of the time" during the first quarter of FY 2016. Similar to what the OIG found in VISN 15, VISN 6 facility staff "were unaware of specific consult management procedures regarding discontinuing or canceling consults." In addition, some VISN 6 clinicians "disagreed with VHA guidance that requires at least two patient cancelations or no-shows before discontinuing a consult." In VISN 15, staff discontinued consults that should have been canceled, and canceled consults that should have been discontinued. The group practice manager, former and current consult committee chair, and compliance officer at another facility stated clinicians and schedulers were confused by the difference between discontinued and canceled consults.

What the OIG Recommended

In this report, the OIG made 11 recommendations. The OIG made three recommendations to the Executive in Charge, Office of the Under Secretary for Health, regarding automating the use of the clinically indicated date when scheduling appointments, and implementing standard monitoring procedures for VA's Care in the Community staff to effectively monitor Choice referrals. The remaining eight recommendations were to the VISN 15 Director to strengthen controls over access to health care and consult management within the VISN.

Management Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with Recommendations 2, 6, and 7, and provided action plans to address these recommendations. The VISN 15 Director concurred with Recommendations 1, 3, 4, 5, 8, and 11, and concurred in

principle with Recommendations 9 and 10. Regarding Recommendations 9 and 10, VISN 15 will ensure all facilities adhere to the consult processes and procedures for future care consults as outlined in VHA Directive 1232, and create standard operating procedures for deactivating consult services when a service is no longer available. VHA and VISN 15 stated in their responses in Appendices K and L that they have already completed actions to address Recommendations 1, 2, 3, 6, 9, and 11.

VHA and VISN 15 provided responsive action plans to address the recommendations. The OIG considers Recommendations 2 and 11 closed. As of January 2018, VHA and VISN 15 had not provided the evidence necessary to close Recommendations 1, 3, 6, and 9. Once the OIG receives such evidence, we will examine it to determine whether the actions are sufficient to close the recommendations. The OIG will monitor VHA's progress and follow up on the implementation of the recommendations until all proposed actions are completed.

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INTRODUCTION

Access to Care

Access to health care has been a recurring issue in the Veterans Health Administration (VHA). For more than a decade, the Office of Inspector General (OIG), U.S. Government Accountability Office (GAO), Department of Veterans Affairs (VA), and other organizations have issued numerous reports regarding issues with access to VA care, veteran wait times, scheduling practices, consult management, and, more recently, the Veterans Choice Program (Choice). GAO concluded that VA health care is a high-risk area and added it to its High-Risk List in 2015.[13] In its report, GAO stated, "VA's oversight efforts are often impeded by its reliance on facilities' self-reported data, which lack independent validation and are often inaccurate or incomplete." In 2017, GAO recommended that VA place immediate attention on "improving oversight of access to timely medical appointments, including the development of wait-time measures that are more reliable and not prone to user error or manipulation."[14]

In recent years, the OIG has reported that VHA continues to experience significant issues with veteran wait times, scheduling practices, consult management, and Choice. In March 2017, the OIG reported on access to care issues in Veterans Integrated Service Network (VISN) 6. Conducting an audit of an entire VISN, as presented in this report, is important since the VISN is responsible for allocating appropriate resources to its many medical facilities. Information and data related to access to care needs to be current, accurate, and available to help VISN leaders address significant changes in health care service demands and gaps in service delivery.

Objectives

The OIG selected VISN 15 for this audit to determine whether it provided new veteran patients timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 15 appropriately managed consults. Specifically, the OIG conducted this audit to answer the following three objectives.

1. Did VISN 15 record accurate wait time data for new patient appointments and provide veterans with timely access to health care within its VA medical facilities?
2. Did VISN 15 provide veterans with timely access to health care through the Veterans Choice Program?
3. Did VISN 15 appropriately manage consults?

[13] *High-Risk Series—An Update*, February 2015, Report No. GAO-15-290.
[14] *High-Risk Series—Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, February 2017, Report No. GAO-17-317.

This audit was not a clinical review of health care provided to veterans. Rather, the audit focused on measuring wait times for new patients and the accuracy of wait time data within the VISN 15 medical facilities and through Choice.

VISN 15

VHA is divided into 18 regional systems of care called VISNs. Within each VISN are a number of VA Medical Centers (VAMCs) and Community Based Outpatient Clinics. The VA Heartland Network (VISN 15) includes five VA medical facilities located in Columbia, Missouri; Poplar Bluff, Missouri; Kansas City, Missouri; Marion, Illinois; and Wichita, Kansas. VISN 15 also includes two healthcare systems—Eastern Kansas Health Care System located in Topeka and Leavenworth, Kansas, and St. Louis Healthcare System located in St. Louis, Missouri. In addition, VISN 15 has over 50 Community Based Outpatient Clinics located throughout Kansas, Missouri, Illinois, Kentucky, Indiana, and Arkansas. VISN 15 is headquartered in Kansas City, Missouri.

Scheduling Outpatient Appointments

VHA Directive 1230, *Outpatient Scheduling Processes and Procedures* (July 15, 2016), provided policy that "Veterans' appointments are scheduled timely, accurately, and consistently." The goal is to schedule appointments "no more than 30 calendar days from the date an appointment is deemed clinically appropriate by a VA health care provider (Clinically Indicated Date), or, in the absence of a Clinically Indicated Date, 30 calendar days from the date the Veteran requests outpatient health care service (Preferred Date)."

VISN Directors are responsible for the oversight of the scheduling program and monitoring compliance with the directive. Furthermore, VA facility directors are responsible for "providing appropriate resources to adequately perform scheduling tasks," managing processes "for ongoing staff training and scheduling competency," ensuring "continuous audit and improvement process of scheduling activities," annually reviewing "all clinic profiles for accuracy," ensuring an "ongoing review of access to care indicators," and "monitoring compliance" with the directive.

VHA Directive 1230 requires wait time to be measured from the appointment's clinically indicated date, or in the absence of a clinically indicated date, the patient's preferred appointment date. Schedulers must transcribe the clinically indicated date into the Veterans Health Information Systems and Technology Architecture (VistA) scheduling package when creating an appointment. In addition, if a patient cancels their appointment or does not show up for an appointment, the wait time starts from the patient's new preferred appointment date.

VHA defines a new patient[15] as a patient who has not completed an appointment within a specific clinic type within the past 24 months, which also includes newly enrolled veterans who have never had a VA appointment at the medical facility.

Scheduler Audits

VHA Directive 1230 also requires facilities to conduct "standardized biannual" scheduler audits of the "timeliness and appropriateness of scheduling actions and accuracy" of clinically indicated or preferred dates. The "biannual audits must include a review of at least 10 scheduled appointments per scheduler." Scheduler audits have been required since 2008.

Veterans Choice Program

The Veterans Access, Choice, and Accountability Act of 2014 was enacted on August 7, 2014, to improve veterans' access to VA medical services by appropriating $10 billion for veterans to receive care from non-VA providers. The Act defines VHA's wait time goal as no more than 30 days from either the clinically indicated date, or, if no such clinical determination has been made, the date a veteran prefers to be seen. Veterans are eligible for Choice when a:

- VA medical facility cannot directly provide the necessary care,
- A VA medical facility cannot provide the veteran with an appointment within 30 days of the clinically indicated or preferred date, or
- A veteran resides more than 40 miles from the VA medical facility that is closest to the veteran's residence (or the veteran faces an unusual or excessive burden traveling to the closest VA medical facility).

If a veteran opts in to Choice, staff electronically provide the authorization and other related medical documents, via the contractor portal, to TriWest Healthcare Alliance Corporation (TriWest).[16] After Choice care is authorized and accepted by TriWest, VA staff must monitor the authorization by querying information contained in TriWest's online web portal. VA's contract requires TriWest to submit medical documentation of the services provided to VA within 75 calendar days of the initial appointment. Timely receipt enables VA to ensure the veteran received the requested care and coordinate the veteran's future medical care.

Consult Management

A clinical consultation is provided by a physician or other health care provider in response to a request seeking opinion, advice, or expertise regarding evaluation or management of a specific patient problem. Furthermore, a clinical consultation request is initiated by a physician or appropriate source with the expectation that a reply will be provided timely.

[15] According to VHA Support Service Center Completed Appointments Cube data definitions (Last updated June 20, 2016).
[16] TriWest is the contractor VISN 15 used to coordinate veterans' Choice appointments.

VHA Directive 1232, *Consult Processes and Procedures* (August 24, 2016, and amended September 23, 2016), provided policy on appropriate consult management, standardized consult processes, and oversight responsibilities. This directive states, "it is VHA policy to ensure timely and clinically appropriate care to all Veterans by standardizing and managing consultation processes. The sending provider determines" the clinically indicated date, and the date "may not be changed by the receiving service due to lack of availability of appointments." The clinically indicated date "should be entered into the scheduling package when the appointment is made." This directive also states that clinicians and non-clinicians may discontinue consults under certain circumstances, and facilities are required to document the reason for discontinuing a consult. The directive specifies that a clinician should review the consult prior to discontinuing when the patient canceled or "no-showed" more than once, or did not respond to the minimum scheduling efforts.

Detailed information about VHA's scheduling and consult directives can be found at Appendix H.

RESULTS AND RECOMMENDATIONS

Finding 1 VISN 15 Medical Facilities Did Not Record Accurate Wait Times for an Estimated 38 Percent of New Mental Health or Specialty Care Appointments

Patients who received new mental health or specialty care appointments at VISN 15 facilities experienced some delays that were not always represented in VA wait time data. The OIG estimated that staff did not correctly record clinically indicated dates for about 5,300 of 13,900 new patient appointments (38 percent) they scheduled, which understated veterans' wait times. These 13,900 new patient appointments consisted primarily of mental health and specialty care appointments.[17] Based on the assessment of wait times from the clinically indicated date, the OIG estimated that about 2,500 of 13,900 appointments (18 percent) had wait times greater than 30 days. This was higher than the estimated 1,300 appointments (10 percent) that VHA's electronic scheduling system showed were scheduled greater than 30 days. Overall, the 13,900 new patient appointments had an average wait time of about 18 days. For those 2,500 appointments greater than 30 days, the OIG estimated that veterans waited an average of 53 days.

This occurred primarily because VISN 15 and facility management did not ensure staff consistently implemented VHA's scheduling requirements. More specifically, facility management provided guidance to scheduling staff that conflicted with policy, did not consistently conduct scheduler audits, or did not consistently communicate the results of audits to schedulers to help improve performance. As a result, VHA and VISN 15 leaders relied on wait time data that did not always represent how long veterans were waiting for care. Of the estimated 2,500 appointments with wait times greater than 30 days, staff entered a date other than the clinically indicated date for an estimated 1,200 appointments (47 percent), which made it appear as though the wait time was 30 days or less. Of those 1,200, the OIG estimated that staff did not identify about 970 appointments (82 percent) in which the patient should have been offered the option of receiving care in the community through Choice.

Inaccurate Wait Time Data

VISN 15 did not capture accurate wait time data when medical facility staff did not consistently follow VHA's scheduling policy for entering the clinically indicated date when scheduling appointments. VHA Directive 1230 states that when scheduling patients, schedulers must use the

[17] The approximately 13,900 new patient appointments included an estimated 13,026 specialty care appointments, 784 mental health appointments, and 46 primary care appointments. Appointment counts were statistically estimated and rounded. Estimates may not sum exactly due to the rounding. More information can be found in Appendix J.

documented clinically indicated date. The OIG reviewed a statistical sample[18] of 653 new patient appointments completed at VISN 15 medical facilities in the first quarter of FY 2017. Out of the 653 appointments, the OIG identified 275 with a clinically indicated date that was determined by a clinician. The OIG reviewed the 275 appointments with a clinically indicated date to assess the accuracy of VISN 15 wait time data and determine whether medical facilities provided timely access for new patient appointments. The remaining 378 appointments the OIG reviewed[19] did not contain a clinically indicated date from a provider, and therefore required a scheduler to obtain and enter the patients' preferred date. VHA Directive 1230 does not require additional evidence of a patient's preferred date in the scheduling system. Because the OIG were unable to verify the patient's preferred date, the OIG did not assess the timeliness and accuracy of these 378 appointments.

Based on the review of the 275 appointments with a clinically indicated date, the OIG estimated that staff did not correctly record clinically indicated dates for about 5,300 of 13,900 new patient appointments (38 percent) they scheduled, which understated veterans' wait times by about 15 days. These 13,900 new patient appointments consisted primarily of mental health and specialty care appointments. In these instances in which a clinically indicated date was present, facility staff generally recorded a preferred date or the actual appointment date when scheduling mental health and specialty care appointments.

Table 1 estimates the percentage of mental health and specialty care appointments in which staff did not enter the clinically indicated date that resulted in inaccurate wait times. The table also depicts the difference in wait times for mental health and specialty care appointments in which schedulers did not use the clinically indicated date.[20]

[18] See Appendix J for a detailed description of the sampling methodology.
[19] This included over 200 primary care appointments, nearly 100 mental health appointments, and 65 specialty care appointments where a clinically indicated date was either absent or no longer applicable because the patient canceled or did not show up to their scheduled appointment.
[20] The sample included primary care appointments; however, only two primary care sampled appointments had a clinically indicated date. Therefore, the OIG did not discuss primary care appointments because the sample of data was too small to make generalized conclusions for this subgroup.

Table 1. Accuracy of Scheduling New Patient Appointments

Appointment Type	Schedulers Did Not Use the Clinically Indicated Date	VA-Calculated Wait Time	OIG-Determined Wait Time	Difference
Mental Health	52%	2 Days	24 Days	22 Days
Specialty Care	38%	10 Days	24 Days	15 Days
Totals*	**38%**	**9 Days**	**24 Days**	**15 Days**

Source: VA OIG analysis of statistically sampled new patient appointments. All figures were rounded based on the overall weighted average results of the statistical analysis. Estimates may not sum exactly due to the rounding.

**Note: Totals includes one primary care appointment where schedulers did not use the clinically indicated date. Individual results were not discussed for primary care because sample data were insufficient.*

New Patient Appointment Timeliness

VISN 15 medical facility appointments for new patients were not always timely. Based on the assessment of wait times from the clinically indicated date, the OIG estimated that about 2,500 of 13,900 new patient appointments (18 percent) had wait times greater than 30 days.[21] For those 2,500 appointments greater than 30 days, the OIG estimated that veterans waited an average of 53 days.

This is significant because when a veteran is scheduled for an appointment more than 30 days from the clinically indicated date, medical facility staff must provide veterans with the option to receive care in the community through the Choice Program.

Table 2 provides details on the delays for new mental health and specialty care appointments and an overview of the timeliness and accuracy of the estimated 13,900 new patient appointments.

[21] VHA Directive 1230 requires that wait time be measured from the appointment's clinically indicated date, or in the absence of a clinically indicated date, the patient's preferred date.

Table 2. Average Wait Times of New Patient Appointments

Appointment Type	OIG-Determined Wait Times Over 30 days	VA-Calculated Wait Times Over 30 days	OIG-Determined Wait Time, Overall (Days)	VA-Calculated Wait Time, Overall (Days)
Mental Health	19%	7%	17	5
Specialty Care	18%	10%	19	13
All Appointments	18%	10%	18	13

Source: VA OIG analysis of statistically sampled new patient appointments

**Note: "All Appointments" was calculated based off all new patient appointments from the sample that had a clinically indicated date, which included two primary care appointments. Individual results were not discussed for primary care because sample data were insufficient.*

Mental Health Care

The OIG sampled 214 new mental health care appointments completed at VISN 15 medical facilities during the first quarter of FY 2017. From the sample, the OIG assessed 115 mental health care appointments that had a clinically indicated date. The OIG estimated that there were 780 new mental health care appointments with a clinically indicated date. Based on this review, the OIG estimated that 150 of 780 appointments (19 percent) had wait times greater than 30 days, while VHA's electronic scheduling system showed less than 7 percent with wait times greater than 30 days. For those 150 appointments greater than 30 days, veterans waited an average of 42 days.

The OIG also determined veterans waited longer for new mental health care appointments as compared to what VISN 15 captured for its wait time data. For all new patient mental health appointments completed during the period, the OIG estimated an average wait time of 17 days, while VHA data represented an estimated average wait time of five days. Example 1 details a mental health care appointment where a veteran experienced delays in receiving care.

Example 1

On September 7, 2016, a provider requested a consult for behavioral health with a clinically indicated date of the same date. A clinician reviewed the consult within five days, but a total of 45 days passed before a scheduler made the first attempt to schedule the appointment. On November 4, 2016, a scheduler made the appointment for December 9, 2016. The scheduler inaccurately entered the appointment date of December 9, 2016, into VA's electronic scheduling system, instead of entering the clinically indicated date of September 7, 2016. As a result, VA's scheduling system showed a zero-day wait time for this appointment when the veteran actually

waited 93 days for the appointment. Furthermore, this veteran was not provided the option to receive Choice care.

Specialty Care

The OIG sampled 223 new specialty care appointments completed at VISN 15 medical facilities during the first quarter of FY 2017. From the sample, the OIG assessed 158 new specialty care appointments that had a clinically indicated date. The OIG estimate that there were 13,000 new specialty care appointments with a clinically indicated date. Based on this review, the OIG estimated that 2,400 of 13,000 appointments (18 percent) had wait times greater than 30 days, while VHA's electronic scheduling system showed an estimated 1,300 of 13,000 appointments (10 percent) had wait times greater than 30 days. For those 2,400 appointments greater than 30 days, veterans waited an average of 54 days.

The OIG also determined veterans waited longer for new specialty care appointments as compared to what VISN 15 captured for its wait time data. For all new patient specialty care appointments completed during the period, the OIG estimated an average wait time of 19 days, while VHA data represented an estimated average wait time of 13 days. Example 2 details a specialty care appointment where a veteran experienced a delay in receiving care that was not accurately represented in VHA's electronic scheduling system.

Example 2

On August 17, 2016, a provider requested a consult for podiatry with a clinically indicated date of the same date. On August 29, 2016, a scheduler scheduled the appointment for October 6, 2016. However, on September 24, 2016, the clinic canceled this appointment because a provider would not be available. A scheduler rescheduled the appointment for October 3, 2016, and entered September 25, 2016, into VHA's electronic scheduling system instead of the clinically indicated date of August 17, 2016. As a result, VA's scheduling system showed an eight-day wait time for this appointment when the veteran actually waited 47 days to receive care.

Appointments without a Clinically Indicated Date

VHA's scheduling procedures require that, in the absence of a clinically indicated date from a provider, schedulers are to obtain and enter the patient's preferred appointment date in the scheduling data field. This procedure also applies when staff attempt to reschedule an appointment after a patient cancels or does not show for their appointment. Out of the 653 appointments the OIG reviewed, the OIG identified 378 appointments in which a scheduler needed to obtain and enter the patients' preferred date, in the absence of a clinically indicated date from a provider. These 378 appointments included over 200 primary care appointments, nearly 100 mental health appointments, and 65 specialty care appointments where a clinically indicated date was either absent or no longer applied because the patient canceled or did not show up to their scheduled appointment. Based on

data in VHA's scheduling system, these patients waited on average nine days.

As VA works to provide greater transparency in the timeliness of access to care, it is important that the data are reliable. The policy does not require additional evidence of a patient's preferred date in the scheduling system. Therefore, the OIG was unable to determine the accuracy of the entered preferred date in order to verify whether schedulers established the preferred date without regard to existing schedule capacity. Because the OIG was unable to verify patients' preferred dates, the OIG did not assess the timeliness and accuracy of those 378 appointments.

Why This Occurred

These wait time issues occurred primarily because VISN 15 and medical facility management did not ensure staff from medical facilities consistently implemented VHA's scheduling requirements. VHA Directive 1230 states that VISN Directors are responsible for the oversight of the scheduling program and patient wait times in order to ensure timely access to care for eligible veterans. Furthermore, VA medical facility directors are responsible for monitoring compliance with this directive, and for continuous auditing and improvement of scheduling activities (including the timeliness and appropriateness of scheduling actions), and for the accuracy of the clinically indicated or patient preferred dates. The OIG determined there was an inconsistent understanding among staff about using the clinician's clinically indicated date when scheduling new appointments.

Facility Management Provided Conflicting Guidance

The OIG found that VA medical facility management at two facilities provided guidance to scheduling staff that conflicted with VHA scheduling policy. VA Eastern Kansas Health Care System managers told us their schedulers were unclear about when to use the preferred date and clinically indicated date during the time frame of the sample data. The assistant chief of Health Administration Services provided guidance as early as July 2015 instructing schedulers to use the clinically indicated date when scheduling. However, she stated that schedulers received conflicting guidance from their direct supervisors regarding the use of the clinically indicated date. This occurred because not all schedulers reported to Health Administration Services. The assistant chief of Health Administration Services stated the VISN and VA facility directors reinforced the guidance to use the clinically indicated date again in December 2016. However, the OIG also identified local policy in effect during the scope of the data review that conflicted with VHA Directive 1230 regarding when to use the clinically indicated date. More specifically, the local policy instructed schedulers to use the patient's preferred date when scheduling consult appointments.

At the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri, the mental health administrative lead told us he verbally instructed schedulers not to use the sending provider's clinically indicated date, but rather the patient preferred date, because he misunderstood the scheduling

policy. The guidance was later clarified as a result of the OIG's site visit. Recommendation 1 addresses the need to ensure that staff at all VISN 15 VA medical facilities use the clinically indicated date in accordance with VHA policy.

VHA policy requires that wait time be measured from the clinically indicated date, when available. Recommendation 2 addresses the need to initiate a process to automate the use of the clinically indicated date when scheduling appointments, when applicable.

Scheduler Audits Not Complete

VISN 15 medical facilities did not consistently conduct scheduler audits, which have been required since January 2008.[22] VHA Directive 1230 states that the audits must assess the timeliness and appropriateness of scheduling actions and the accuracy of the clinically indicated date or patient preferred date for all active schedulers, regardless of position or title. Table 3 illustrates the scheduler audit requirements since 2008.

Table 3. VHA and Network Policy Scheduler Audit Requirements

Policy	Effective Date	Appointments to Be Audited, Per Scheduler	Frequency
Monitoring Tool for Supervision of Schedulers	2/18/2008	10 appointments	Yearly
Network Policy 15E-15-12	10/1/2015	30 appointments	Yearly
Outpatient Scheduling Processes and Procedures (VHA Directive 1230)	7/15/2016	10 appointments	Biannually

Source: VA OIG comparison of VHA and Network criteria

[22] VHA Memorandum, *Monitoring Tool for Supervision of Schedulers* (January 11, 2008), formalized the process for VHA facilities to assure effective, ongoing oversight of VistA menu options to schedule outpatient appointments.

The OIG determined that not all schedulers received the minimum required number of audits. Tables 4 and 5 illustrate the number of audits the facilities completed for appointments made in FY 2016 (Table 4) and the first two quarters of FY 2017 (Table 5).[23]

Table 4. VISN 15 Facility Scheduler Audits Completed in FY 2016

Facility	Schedulers	Schedulers Audited on 10 or More Appointments	Compliant with National Policy*
Harry S. Truman Memorial Veterans' Hospital	182	11 (6%)	No
John J. Pershing VAMC	62	42 (68%)	No
Kansas City VAMC	313	149 (48%)	No
Marion VAMC	171	47 (27%)	No
Robert J. Dole VAMC	214	105 (49%)	No
VA Eastern Kansas Health Care System	325	76 (23%)	No
VA St. Louis Health Care System	419	65 (16%)	No

Source: VA OIG analysis of Supervisory Appointment Tool data (Note: VISN 15 policy required all scheduler audits be completed using the Supervisory Appointment Tool. According to the VISN 15 Compliance Officer, this was the tool used to monitor scheduler audit compliance.)

**National policy required a minimum of 10 appointments be audited per scheduler.*

[23] The OIG assessed scheduler audits compliance based on VHA Directive 1230, which requires audits of 10 appointments biannually, because this was a less demanding requirement than VISN 15 Network requirements (Network Policy 15E-15-12, which requires audits of 30 appointments per year). In addition, the OIG assessed audits only for staff who made at least 10 appointments.

VHA Directive 1230 requires a minimum of 10 audited appointments per scheduler, biannually. Although FY 2017 was not complete at the time of the data review, Table 5 shows the percent of schedulers that were audited on 10 or more appointments during the first six months of the fiscal year.

Table 5. VISN 15 Facility Scheduler Audits Completed in FY 2017 (October 2016–March 2017)

Facility	Schedulers	Schedulers Audited on 10 or More Appointments
Harry S. Truman Memorial Veterans' Hospital	186	13 (7%)
John J. Pershing VAMC	75	61 (81%)
Kansas City VAMC	299	149 (50%)
Marion VAMC	163	13 (8%)
Robert J. Dole VAMC	214	106 (50%)
VA Eastern Kansas Health Care System	291	256 (88%)
VA St. Louis Health Care System	412	290 (70%)

Source: VA OIG analysis of Supervisory Appointment Tool data

VISN 15 policy requires facilities use designated scheduler auditors to conduct scheduler audits. However, VISN 15 facilities experienced delays in filling the scheduler auditor position, and at the Harry S. Truman Memorial Veterans' Hospital and the Marion VAMC, there were extended vacancies. In addition, the OIG identified 36 schedulers from the sample data who received the required number of scheduler audits, but did not always correctly use the clinically indicated date when scheduling. The OIG followed up with these schedulers to determine whether any scheduling audit results had been shared with them to help improve performance. The OIG found that the results were not consistently shared with all schedulers.[24] Over half of the respondents (17 of 30) indicated scheduler audit results were not communicated to them.

Recommendation 3 addresses the need for VISN 15 to ensure network medical facilities appropriately manage the scheduler audit tool in order to conduct the required scheduler audits, communicate specific audit results to scheduling staff, and to take corrective actions based on audit results.

[24] VHA policy did not require audit results to be shared with schedulers.

What Resulted

These issues resulted in veterans experiencing delays in receiving new mental health care and specialty care appointments. In addition, wait time data for new patient appointments at VISN 15 medical facilities did not always reflect actual wait times experienced by veterans.

Inaccurate wait time data also affected veterans' access to care in the community through Choice. Of the estimated 2,500 appointments that the OIG identified with wait times greater than 30 days, staff entered a date other than the clinically indicated date for an estimated 1,200 appointments (47 percent), which made it appear as though the wait time was 30 days or less. This occurred because VHA staff used other dates such as the appointment date or the preferred date when scheduling appointments, which resulted in staff not identifying about 970 of 1,200 veterans (82 percent) that should have been added to the Veteran's Choice List (VCL). These 970 veterans were not provided the option to receive care in the community through Choice. Even though staff did not enter the correct clinically indicated date for the remaining veterans, staff did offer Choice to them.

Clinical Impact of Delays

We consulted with OIG's Office of Healthcare Inspections (OHI) to review electronic health records of 38 patients in this sample who received primary care, mental health care, or specialty care during FY 2017. We referred these sample patients' cases to OHI because we determined they either died during FY 2017 or experienced significant delays in care. Health system specialists and a medical consultant in OHI reviewed the clinical care of the patients to render an opinion of potential or actual patient adverse outcomes caused by a delay in care or lack of care.

Of these 38 patients, OHI identified concerns with the care for two patients. OHI found that the delays in completing the consults specific to the scope of this audit did not affect care. However, OHI found that both patients had delays in care for previous conditions, as follow-up care was not completed as recommended by their physicians.

Patient 1

One patient had a greater than 10-year delay for follow-up care regarding findings on a colonoscopy completed in February 2005. At that time, a physician recommended a repeat colonoscopy in six months because of an incomplete study. No documentation of that requested colonoscopy was located in VHA's electronic health records. In June 2016, this patient tested positive for blood in his stool that prompted his primary care physician to order a colonoscopy consult. As a result of the consult, the patient was seen in August 2016 by a gastroenterologist who ordered a computerized tomography scan of the colon that confirmed a large mass. In October 2016, the patient completed surgery to remove the mass. It is possible that the large colon mass was related to a 10-year delay in surveillance. The patient, who had a history of multiple medical conditions, incurred a fatal outpatient cardiac arrest about two months

after the surgery. OHI was unable to determine if the patient's death was related to the surgery or not.

Patient 2

One patient had at least a six-year delay in follow-up for findings on a colonoscopy. In March 2005, a physician recommended a follow-up colonoscopy in three to five years. No documentation of that requested colonoscopy was located in VHA's electronic health records. In October 2016, a primary care provider referred the patient for a colonoscopy. In December 2016, a gastroenterologist completed the colonoscopy and identified pre-cancerous polyps. Given the known history of polyps, it is possible that the patient had more polyps than would have been the case if he had undergone a colonoscopy sooner, in the recommended time interval suggested by the physician in March 2005.

According to VISN 15 staff, in 2015 they implemented a process to monitor the quality of and follow-up for colonoscopy care. This quarterly process entails that each facility track information on the first 10 colonoscopy cases for each month onto a tracking sheet. However, it is unclear whether this process would ensure that facilities complete surveillance colonoscopies for all necessary patients in a timely manner. Recommendation 4 addresses the need for VISN 15 to examine processes to improve monitoring and tracking for timely surveillance colonoscopies.

Conclusion

VISN 15 and medical facility leaders did not ensure staff consistently implemented VHA's scheduling requirements, including providing clear guidance on when to use the clinically indicated date and consistently completing required scheduler audits for all schedulers during the relevant time periods. The OIG identified more delays for new patient appointments for mental health care and specialty care than what VHA reported. This occurred because VA medical facility staff did not consistently enter correct clinically indicated dates when scheduling appointments. As a result, VHA and VISN 15 leaders relied on wait time data that did not always represent how long veterans actually waited for care.

Recommendations

1. The OIG recommended the Veterans Integrated Service Network 15 Director ensure that staff at all network facilities use the clinically indicated date, when available, when scheduling new patient appointments.
2. The OIG recommended the Veterans Health Administration Executive in Charge initiate a process to automate the use of the clinically indicated date, when applicable, when scheduling appointments.
3. The OIG recommended the Veterans Integrated Service Network 15 Director ensure network facilities appropriately manage the scheduler

audit tool in order to conduct the required scheduler audits, communicate specific audit results to scheduling staff, and take corrective actions as needed based on audit results.

4. The OIG recommended the Veterans Integrated Service Network 15 Director examine processes to improve monitoring and tracking for timely surveillance colonoscopies.

Management Comments

The VISN 15 Director concurred with Recommendations 1, 3, and 4 and the Executive in Charge, Office of the Under Secretary for Health, concurred with Recommendation 2.

To address Recommendation 1, the VISN 15 Director reported they established a VISN Scheduling Taskforce in December 2016 to promote compliance with VHA Scheduling Directive 1230. The Scheduling Taskforce oversees the scheduling program, completion of training of scheduling staff, and ensures that internal monitors are set up and reviewed at the VISN and facility level. The VISN 15 Director requested closure of this recommendation.

To address Recommendation 2, the Executive in Charge reported VHA completed implementation of VistA Scheduling Enhancement (VSE) software that includes the process for automatically populating the clinically indicated date in the scheduling software. The VSE software was released in the summer of 2017 and, as of January 2018, 97 percent of sites report schedulers are using VSE to schedule appointments. She reported that the VSE automatically populates the clinician's clinically indicated date into the scheduler's software, and no staff, including schedulers, are able to change the automatically populated clinically indicated date. The Executive in Charge requested closure of this recommendation.

To address Recommendation 3, the VISN 15 Director reported the VISN has met and completed the National Audit Requirement for FY 2017. He further reported that as of September 2017, all facilities have a full-time Scheduling Auditor, each of which has a process to ensure communication of audit results at the local level. The VISN 15 Director requested closure of this recommendation.

To address Recommendation 4, the VISN 15 Director reported VHA has developed a Colorectal Cancer Screening Surveillance System to be used VHA-wide. This system will allow for tracking future care needs. The Director reported VISN 15 is included in Phase 2 of the system roll out, and that phase started in December 2017.

OIG Response

VISN 15 and VHA provided responsive action plans to address these four recommendations. The OIG obtained clarification from VHA regarding their actions to address Recommendation 2, and considers this recommendation closed. As of January 2018, VISN 15 had not provided the evidence

necessary to close Recommendations 1 and 3. VISN 15 established a Scheduling Taskforce to promote compliance with the scheduling program, and provided summary data of scheduling accuracy during FY 2017 to address Recommendation 1. Prior to closing Recommendation 1, the OIG requests VISN 15 provide evidence of the details supporting their summary data. To address Recommendation 3, VISN 15 reported they had met and completed the National Audit Requirement for FY 2017. Prior to closing Recommendation 3, the OIG requests that VISN 15 provide evidence that supports all schedulers were audited 10 times, biannually, per policy, as well as evidence that supports the audit results were communicated to staff and corrective actions were taken as needed. Once the OIG receives such evidence, we will examine it to determine whether their actions are sufficient to close the recommendations. The OIG will monitor and follow up on the implementation of these recommendations until all proposed actions are completed.

The VISN 15 Director responded to Finding 1 that "Per the OIG estimates, more than 93% of Veterans (12,930 of 13,900 Veterans) were appropriately marked as having a wait less than 30 days based on the CID [clinically indicated date]." However, as reported on page 5, the OIG found an estimated 18 percent (2,500 of 13,900) of the appointments for new patients had wait times longer than 30 days. This was higher than the estimated 1,300 appointments (10 percent) that VHA's electronic scheduling system showed were scheduled greater than 30 days. Furthermore, the OIG reported that of those 2,500 estimated appointments over 30 days, staff entered a date other than the clinically indicated date for an estimated 1,200 appointments (47 percent), which made it appear as though the wait time was 30 days or less. This resulted in staff not identifying approximately 970 appointments in which the patient should have been offered the option of receiving care in the community through Choice. The full text of the responses from VHA and VISN 15 and are located in Appendix K and Appendix L.

Finding 2 Veterans in VISN 15 Waited an Average of 32 Days to Receive Health Care through the Veterans Choice Program

VISN 15 veterans who received care through Choice waited more than 30 days from the clinically indicated date for their appointment an estimated 41 percent of the time. The OIG estimated that about 20,300 of 22,200 veterans (92 percent) authorized for Choice—for primary care, mental health care, and specialty care—in VISN 15 during the sample period received, or were scheduled to receive, their authorized care through Choice. Overall, the OIG estimated these 20,300 veterans waited an average of 32 days.[25] This consisted of an average of about six days for VA staff to provide the authorization to TriWest, plus an average of nearly 26 days for TriWest to provide the service.

Although most veterans received, or were scheduled to receive, authorized Choice care, the OIG determined that VA did not have medical documentation for about 4,400 appointments (20 percent) at the time of the OIG's site visits. TriWest records also indicated this is an ongoing issue, and records showed TriWest had not provided medical documentation for about 35 percent of the veterans who were authorized Choice care during calendar year 2016.

This occurred primarily because facilities did not have adequate procedures to monitor the aging of veteran referrals to TriWest, Choice care authorizations provided to TriWest, or the receipt of medical documentation from TriWest upon completion of the care. As a result, veterans did not consistently receive care within 30 days, VA medical facilities did not always receive confirmation that the patients completed their scheduled Choice care, and VA medical facilities did not receive pertinent medical documentation important to continuing care at the VA.

Timeliness of Choice Care

The OIG reviewed a statistical sample[26] of 422 Choice authorizations provided to TriWest by VISN 15 medical facility staff from August 1 through October 31, 2016. The OIG estimated that, overall, about 22,200 veterans were authorized for Choice care in VISN 15 during that period. Of these, the OIG estimated 20,300 veterans (92 percent) were scheduled[27] for Choice care. The OIG estimated the 20,300 veterans who were scheduled for Choice care waited an average of 32 days. This consisted of an average of about six days for VA staff to provide the authorization to

[25] The OIG calculated the overall Choice wait time from the date a VA provider determined care was clinically indicated to the appointment date.
[26] See Appendix J for a detailed description of the sampling methodology.
[27] The OIG did not consider an appointment as scheduled if the appointment was canceled and the authorization was returned to the VA without a completed appointment.

TriWest, plus an average of nearly 26 days for TriWest's scheduled appointment date. The TriWest contract required the contractor to provide the Choice care appointment within 30 days of the clinically indicated date VA provided to TriWest on the Choice authorization.

The OIG estimated about 8,300 veterans (41 percent) waited more than 30 days from the clinically indicated date for their appointment. Of those veterans who did not receive an appointment within 30 days, the OIG estimated they waited an average of 58 days for their scheduled appointment.

Primary care patients waited the longest—an average of about 41 days. Specialty Choice care and mental health care patients had average wait times of 31 days and 29 days, respectively. Analysis of the Choice authorization process showed that about 98 percent of the Choice care authorized by VISN 15 medical facilities was for specialty care.

The remaining 1,900 of 22,200 veterans (9 percent) authorized for Choice care did not receive a scheduled Choice appointment. Based on information provided by TriWest staff for the sampled authorizations, TriWest returned unfulfilled authorizations to VISN 15 facilities primarily because the veteran did not want care or TriWest was unable to schedule care agreeable to the veteran. The OIG estimated that about 800 of these 1,900 veterans eventually received care either through the VA or through a non-Choice community provider.

TriWest Did Not Provide Choice Medical Documentation

Although the OIG identified a high rate of veterans who received, or were scheduled to receive authorized care, the OIG determined that VA did not have medical documentation for about 4,400 Choice appointments (20 percent). According to VA's contract with TriWest, the contractor shall submit medical documentation of the services provided to VA within 75 calendar days of the initial appointment.

Based on the sample review, for which 98 percent of the authorizations were scheduled more than 75 days prior to the review, the OIG estimated TriWest provided medical documentation for only about 11,000 of the 22,200 Choice authorizations (49 percent). In addition, the OIG estimated VA staff acquired the medical documentation for another 5,000 appointments (22 percent) directly from non-VA providers.

This has been an ongoing issue since the beginning of the Choice Program. According to TriWest's own records, they had not provided medical documentation for about 35 percent of the veterans who were authorized Choice care during calendar year 2016. In addition, TriWest still had not provided documentation for about 33 percent of care authorized by VISN 15 in calendar year 2015. Table 6 shows the number and percentage of VISN 15 appointments for which TriWest's data show they provided medical documentation to VA.

Table 6. Medical Documentation Provided by TriWest to VISN 15 Facilities

Calendar Year	Total VISN 15 Choice Authorizations	Medical Documentation Received	Medical Documentation Not Received	Percent of Medical Documentation Not Received
2015	34,700	23,200	11,500	33%
2016	92,000	59,700	32,300	35%

Source: VA OIG analysis of TriWest data

Timely receipt of medical documentation enables VA medical staff to ensure that the veteran received the requested care, evaluate whether the care was appropriate, and coordinate the veteran's future medical care.

Why This Occurred

VISN 15 facility staff did not have adequate procedures to monitor the aging of referrals to TriWest or the aging of the authorized Choice care to ensure TriWest provided care within 30 days.

Timeliness of VA Referrals

VISN 15 facilities did not have adequate procedures to monitor the aging of referrals for Choice care to TriWest. VA staff request specific Choice care for a veteran by electronically submitting a Choice referral and any necessary VA medical documentation to TriWest. Although VA staff are required to act on a request for care to be provided at a VA medical facility within seven days, the VA does not have a timeliness standard to submit a completed referral to TriWest for Choice care.

Of the estimated 20,300 veterans who were scheduled for Choice care, the OIG determined the facility staff provided approximately 13,700 referrals to TriWest in seven days or less from the clinically indicated date. The OIG estimated about 25 percent (3,400) of these veterans eventually waited more than 30 days for their scheduled Choice appointments. Conversely, the facility staff took more than seven days to provide 6,600 referrals to TriWest. The OIG estimated about 74 percent (4,900) of these veterans eventually waited more than 30 days for their scheduled Choice appointments.

Recommendation 5 addresses the need for VISN 15 to implement additional standard monitoring procedures sufficient to enable network facility staff to accurately manage the aging of all referrals for Choice care.

Timeliness of TriWest Appointments

TriWest also did not consistently provide veterans with timely appointments after the VISN 15 medical facilities submitted authorizations. The OIG estimated that about 6,200 of 20,300 veterans (31 percent) received a Choice appointment date greater than 30 days after TriWest received the referral. Based on the sample review of 210 Choice specialty care authorizations, the OIG determined dermatology, neurology, orthopedics, radiology, and sleep

studies made up about 50 percent of the specialty care for which TriWest was not able to provide an appointment within 30 days.

VISN 15 Efforts to Implement Choice Program

VISN 15 leaders took multiple actions early in the implementation of the Choice Program to facilitate providing veterans with overall timely Choice care. The VISN conducted a Choice Summit in April 2015 that included relevant TriWest, VISN, and medical facility staff. The summit resulted in a Choice Steering Group led by the VISN Business Implementation Manager. The VISN 15 Director and the VISN 15 facility directors supported adequate staffing levels in key Choice Program positions. These positions were given high priority in establishing budgeting levels, and the VISN Committee Chair declared them to be critical hire positions to expedite hiring. VA Care in the Community staff stated that staffing was generally adequate to refer authorized veterans to TriWest.

The VISN 15 Director also stated he established monthly coordination meetings to work directly with TriWest. VISN and TriWest staff initiated and developed a live internet text chat process that provided instant contact between the staffs to facilitate the immediate resolution of specific issues for individual veterans. In addition, TriWest embedded staff at four VISN 15 facilities to enable direct interaction with facility staff and veterans.

No Comprehensive Authorization Monitoring

Although VISN 15 implemented a number of actions to manage the Choice Program, Care in the Community staff at VISN 15 medical facilities were still limited by varying manual processes and procedures that hindered their ability to adequately monitor authorizations. VA did not have Choice authorization monitoring requirements, and VISN 15 facilities did not sufficiently track all Choice authorizations through the process.

VISN 15 facilities made varying attempts to track the aging of Choice authorizations. Some VISN 15 facilities used spreadsheets or VistA reports to track authorizations. Some facilities monitored Choice authorizations for services the VA was unable to provide (Choice First) because they created an internal consult document for these services, but they did not monitor authorizations for veterans not able to be seen within 30 days (Choice 30) because the facilities did not create a consult for these authorizations.

Examples 3 through 5 detail monitoring systems in place at three facilities.

Example 3

Staff at the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri, tracked authorizations using spreadsheets, which included the clinically indicated date, referral date, and upload date. Each staff person created and monitored their own spreadsheet, and tracked the aging of the authorization until completion by monitoring TriWest notifications and data.

Example 4

Staff at the VA St. Louis Health Care System created paper charts to assist them in monitoring the status of each authorization. Staff placed new charts in the front of their file system, and as they aged, they were moved to the back of the file. Staff monitored TriWest portal notifications daily, and updated charts in the file system as needed. When a veteran received a Choice appointment, staff removed the chart from the file. Staff did not have a system to track Choice 30 authorizations after they uploaded those authorizations to the TriWest portal.

Example 5

Staff at the John J. Pershing VA Medical Center in Poplar Bluff, Missouri, also did not have a system to track the aging of Choice 30 authorizations once they uploaded them to the TriWest portal. Staff monitored reports from VistA to track Choice First consults that were active greater than 14 days, pending, and scheduled. For those authorizations, staff checked the TriWest portal for updates.

Starting in October 2016, the Marion VA Medical Center in Marion, Illinois, implemented a database tool to facilitate monitoring the progress of every request for Choice care. This tool allows all Care in the Community staff to access the history of each authorization in one place. This facilitates their ability to manage the authorizations from the beginning of the process to closing the authorization, including monitoring when the medical documentation is received. Responsibility for completing the next step in the process is assigned to individual staff for follow-up and review as the authorization moves through the Choice process.

Recommendation 6 addresses the need for VISN 15 to implement standard monitoring procedures across the facilities to ensure medical appointment timeliness standards are met, as required under Choice contracts.

No Effective Medical Documentation Enforcement

VA's Office of Community Care manages the TriWest contract and has attempted to enforce the medical documentation provisions. However, these efforts did not result in TriWest timely providing medical documentation during the audit period.

Due to the VA medical providers' need for these missing records, VISN 15 medical facilities have implemented varying processes to obtain outstanding Choice medical notes directly from the Choice providers. For example, Kansas City VAMC Care in the Community leaders designated three nurses to work only on obtaining Choice medical notes directly from the Choice providers. Care in the Community staff stated that these positions could have been used more productively if TriWest provided documentation timely.

Recommendation 7 addresses the need for VA to implement controls to ensure VA medical facilities obtain Choice medical documentation timely, in accordance with Choice contracts.

What Resulted

Although VISN 15 medical facilities provided about 12,000 veterans with scheduled Choice appointments within 30 days of the clinically indicated date, as intended by the Choice Program, about 8,300 veterans did not receive their scheduled appointments within 30 days. For those veterans who did not receive scheduled appointments within 30 days, the OIG estimated they waited an average of 58 days. Within the specialty care sample, the OIG determined dermatology, neurology, orthopedics, radiology, and sleep studies accounted for about 50 percent of the authorized care for which TriWest was not able to provide an appointment within 30 days. In addition, VA medical facilities did not always receive confirmation that the patients completed their scheduled Choice care, and did not receive pertinent medical documentation important to continuing care at the VA.

We consulted with OHI to review the electronic health records of 13 patients who received authorizations for Choice care to determine whether the patients received the requested services, and if not, the extent to which the patients were potentially harmed by not receiving the services. We referred these patients' cases because we determined the facility labeled their care as urgent, or the veteran died after the Choice care was authorized. Of these 13 patients, OHI found no adverse outcomes associated with these authorizations for care.

Conclusion

VISN 15 leaders took a proactive role with their medical facilities in facilitating the Choice Program since its inception in November 2014. However, the OIG concluded that additional monitoring would improve the timeliness of Choice services in VISN 15. The numerous steps and manual processes that VISN 15 facilities used limited staff's ability to sufficiently monitor authorized Choice care. Without adequate tracking processes in place, some veterans continued to wait more than 30 days to receive Choice care, and VA staff are unlikely to identify veterans whose authorizations for Choice care are not progressing timely.

Recommendations

5. The OIG recommended the Veterans Integrated Service Network 15 Director implement additional standard monitoring procedures sufficient to enable network facility staff to accurately manage the aging of all referrals for eligible veterans for Choice care.
6. The OIG recommended the Veterans Health Administration Executive in Charge implement standard monitoring procedures to ensure medical appointment timeliness standards are met as required under Choice contracts.
7. The OIG recommended the Veterans Health Administration Executive in Charge implement controls to ensure Choice medical documentation is received timely in accordance with Choice contracts.

Management Comments

The VISN 15 Director concurred with Recommendation 5 and the Executive in Charge, Office of the Under Secretary for Health, concurred with Recommendations 6 and 7.

To address Recommendation 5, the VISN 15 Director reported the VISN has implemented the use of the Consult Toolbox to improve documentation of actions for community care consults, and will continue to provide training to staff on how to use the Consult Toolbox reports to improve operations. The Director reported that all sites will implement use of the Consult Toolbox management reports by March 2018.

To address Recommendation 6, the Executive in Charge reported VHA established and implemented standard monitoring procedures and controls to ensure all Veterans Choice Program (VCP) contract performance standards and requirements, including those standards for medical appointment timeliness, are met. She further reported that the VCP Quality Assurance Surveillance Plan (QASP) sets forth the procedures and guidelines VHA uses to ensure the required performance standards and service levels are achieved by the VCP Third Party Administrators. VHA provided summary data of QASP monitoring results from January through October 2017 that showed results within VHA's performance standards during the latter months. The Executive in Charge requested closure of this recommendation.

To address Recommendation 7, the Executive in Charge reported VHA established and implemented standard monitoring procedures and controls to ensure that all VCP contract performance standards and requirements, including those for submission of medical documentation, are met. These are incorporated in the VCP contract's QASP. She further reported that VHA will continue to monitor TriWest's performance and improvement progress in this regard, and VHA will request closure of this recommendation when TriWest has achieved performance at the 90/95 percent standard levels.

OIG Response

VISN 15 and VHA provided responsive action plans to address the recommendations. The OIG will monitor and follow up on the implementation of the recommendations until all proposed actions are completed. As of January 2018, VHA had not provided us with the evidence necessary to close Recommendation 6. VHA reported they implemented controls to ensure all contract performance standards and requirements are met, and provided summary data of QASP monitoring results. The OIG obtained from VHA an additional month of QASP monitoring results and clarification regarding how they are monitoring timeliness standards. Prior to closing this recommendation, we request that VHA provide current monitoring results. Once the OIG receives such evidence, we will examine it to determine whether their actions are sufficient to close the recommendations. The OIG will monitor and follow up on the implementation of the recommendations until all proposed actions are completed. The full text of the responses from VHA and VISN 15 and are located in Appendix K and Appendix L.

Finding 3 VISN 15 Did Not Consistently Manage Specialty Care Consults in Accordance with Policy

VISN 15 medical facility staff discontinued or canceled an estimated 27 percent of consults inappropriately during the first quarter of FY 2017. One VISN 15 facility did not appropriately manage consults that were clinically indicated to be scheduled for a future date, and discontinued the consults with instructions to resubmit later. Another facility continued to send consults to a specialty care service after the facility no longer offered the service. In addition, as identified in Finding 1, VISN 15 medical facility schedulers did not always use the referring providers' clinically indicated dates when scheduling appointments for consults.

This occurred primarily because specialty care clinicians and staff were still unclear on specific VHA consult management procedures regarding discontinuing and canceling consults. Staff at one facility discontinued consults for colonoscopies that were clinically indicated to be scheduled in the future, because they did not think it was safe to schedule appointments beyond 90 days, as the patient's condition could change. In addition, one facility did not provide guidance to referring providers when a service was no longer available at the facility.

Inappropriately discontinued or canceled consults led to veterans experiencing additional delays, or in some cases not receiving the requested care. As a result of staff at one medical center discontinuing consults clinically indicated for a future date, primary care providers tracked patients' consults using tickler notes[28] and spreadsheets, which presented the risk they may not resubmit the consult timely or at all.

Inappropriately Managed Consults

VISN 15 medical facility staff inappropriately discontinued and canceled consults. The OIG reviewed a statistical sample[29] of 210 specialty care consults discontinued and canceled during the first quarter of FY 2017. This was from an estimated 15,900 consults that VISN 15 medical facility staff discontinued or canceled. Based on the review, the OIG determined staff inappropriately discontinued or canceled an estimated 4,300 of 15,900 consults (27 percent). Staff inappropriately closed consults for numerous reasons that were not in accordance with VHA Directive 1232,[30] including the following.

[28] A tickler note is a feature in VA's Computerized Patient Record System and is used to allow providers to track information and/or follow up on individual patients.
[29] See Appendix J for a detailed description of the sampling methodology.
[30] VHA Directive 1232, *Consult Processes and Procedures* (issued August 24, 2016, and amended September 23, 2016).

- **Incorrect Closure Action**: Staff discontinued consults that should have been canceled, and canceled consults that should have been discontinued. For example, staff canceled consults when the patient refused care or when the patient was an established patient to the service, instead of discontinuing the consult. VHA Directive 1232 requires consults to be discontinued when the patient refuses care and a consult is no longer needed. This differentiation is important because a canceled consult can be resubmitted and the consult will retain the original request date, while a discontinued consult is closed and the referring provider has to submit a new consult if necessary.
- **No Documented Reason:** Staff discontinued or canceled consults without providing a documented reason why the consult was being discontinued. VHA Directive 1232 states that staff should always document the reason for discounting a consult, with instructions to re-order or copy to a new consult, if appropriate.
- **One No-Show or Patient Cancelation:** Staff discontinued or canceled consults following a single patient cancelation or no-show. VHA Directive 1232 requires at least two patient cancelations or no-shows in most services before a clinician discontinues a consult.
- **No Clinical Review**: Staff discontinued consults when clinical input was necessary. VHA Directive 1232 requires clinical review if the patient does not respond to the minimum scheduling efforts or no-shows or cancels more than once. This is important because individual clinical services may decide that additional scheduling efforts are warranted before discontinuing the consult.
- **No Prerequisite Tests:** Staff discontinued or canceled consults that needed prerequisite tests completed. VHA Directive 1232 states that e-consults[31] should be used when the ordering provider did not complete necessary prerequisite tests or treatments.

Discontinuing and Holding Consults for Future Care

One VISN 15 facility did not appropriately manage consults with a clinically indicated date well into the future. The receiving service, gastroenterology, discontinued the consults with instructions to resubmit closer to when the colonoscopy was clinically appropriate. To manage the returned consults, the primary care providers maintained tickler notes, worksheet paper, and huddle worksheet templates[32] to track these discontinued consults.

[31] An e-consult is a consult where a clinical question can be answered without requiring an in-person examination.

[32] A tickler note is a feature in VHA's Computerized Patient Record System and is used to allow providers to track information and/or follow up on individual patients. A worksheet paper is an electronic or hard copy document a provider uses to assist in case management for a patient. A huddle worksheet template is a hard copy document that a primary care team uses to assist in case management for patients.

According to VHA data, the Kansas City VA medical facility completed about 930 gastroenterology consults during the first quarter FY 2017, and discontinued about 570 during the same period. Of those consults, the OIG identified eight specific examples of discontinued consults in which gastroenterology services staff instructed the referring provider to resubmit the consult closer to when clinically appropriate. In some instances the clinically indicated date had already passed. As a result, primary care providers tracked the consults using various other mechanisms, but did not always resubmit another consult to gastroenterology.

Example 6

> In December 2016, a primary care provider submitted a consult to gastroenterology with a clinically indicated date of May 15, 2017. Gastroenterology staff discontinued the consult and noted, "Please discontinue this consult. New consult to be placed closer to 5/2017." According to facility staff, the primary care provider kept an electronic word document as a "self-tickler" list. However, the facility did not provide documentation that this patient was tracked on such a list. In April 2017, primary care submitted a new consult to gastroenterology.

Consults Sent to Unavailable Service

One facility continued to send consults to a specialty care service after the facility no longer offered the service. From about March 2016 through March 2017, the pain management service received over 70 consults that staff ultimately discontinued because the facility did not provide the service. Referring providers resubmitted the majority of the discontinued consults, primarily to Choice, but patients experienced an additional delay of about 57 days. The OIG identified 10 consults that were not resubmitted, and the OIG determined those patients were still waiting for the requested care. VHA Directive 1231[33] states that facility leaders are responsible for working with the Clinic Practice Management team to establish written contingency plans to provide guidance in the event of unplanned and planned provider and support staff absences.

Incorrect Use of the Clinically Indicated Date

As identified in Finding 1, VISN 15 medical facility staff did not always use the referring providers' clinically indicated date when scheduling appointments for consults of new patients. VHA policy states the clinically indicated date should be entered into the scheduling package when an appointment is made.

Based on the review of a statistical sample of 209 open specialty care consults, the OIG estimated schedulers entered a date in the scheduling system that was later than the referring provider's clinically indicated date for an estimated 660 of 1,700 consults (39 percent) scheduled at the time the OIG obtained the data. In those instances, the OIG estimated that schedulers

[33] VHA Directive 1231, *Outpatient Clinic Practice Management* (issued November 15, 2016).

recorded a date that was an average of 36 days later than the referring provider's clinically indicated date. For additional information on the statistical sampling methodology, see Appendix J. According to Compliance and Business Integrity officers at two facilities, capturing the clinically indicated date accurately was the most common finding during scheduler audits.

Timeliness of Specialty Care Open Consults

Over 3,700 patients were waiting for about 3,900 open consults that exceeded 30 days, as of October 31, 2016. The OIG reviewed a statistical sample of 209 open specialty care consults at VISN 15 medical facilities from the population of consults that exceeded 30 days. Subsequently, during the review from January through May 2017, the OIG found that patients received the requested care, staff closed their consults, or consults were still open.

Patients received the requested care for an estimated 2,900 of 3,900 consults (74 percent) at the time of review in May 2017. The OIG determined those patients waited an average of 34 days to receive the requested care, based on the statistical sample results. However, for about half of the sampled consults, veterans waited more than 30 days for care.

Example 7

> After receiving a consult on June 2, 2016, with a clinically indicated date of June 8, 2016, facility staff failed to attempt to contact the patient to make an appointment until September 20, 2016. The scheduler made a second attempt to contact the patient on October 5, 2016, and scheduled the patient for an appointment on November 21, 2016. This veteran waited 166 days for care beyond the clinically indicated date.

Staff either discontinued or canceled, in some cases inappropriately, an estimated 810 of 3,900 consults (21 percent) as of the time of review in May 2017. These consults were closed an average of 86 days after the request. Based on notes within the consults, staff could not reach the patient for scheduling, or the patient canceled or did not show for their appointment.

Consults were still open for an estimated 210 of 3,900 consults (5 percent). They were open an average of 200 days at the time of review in May 2017. The majority of these consults were from one facility, and the patients were scheduled for Choice care, but the facility did not have documentation that care was provided. According to facility staff, their process was to leave the consults open until medical documentation was received to ensure care was provided.

Why This Occurred

Staff inappropriately closed consults because they were unclear about the specific consult management procedures. In addition, staff at one facility tracked consults outside of the consult package because they stopped using future care consults for colonoscopies. At another facility, management did

not provide guidance when the pain management provider was no longer available.

Unclear about Consult Rules

VISN 15 medical facility staff inappropriately closed consults because they were unclear on the specific consult management procedures regarding discontinuing or canceling consults. Clinicians inappropriately discontinued the majority of these consults. Clinicians told us they did not understand the difference between discontinuing and canceling a consult, or the significance of the difference. Staff at one facility stated they learned through clinician exit interviews that clinicians were frustrated with not knowing when to discontinue or cancel a consult. The group practice manager, former and current consult committee chair, and compliance officer at another facility stated that clinicians and schedulers were confused by the difference between discontinued and canceled consults.

According to VHA staff, in September 2016 and January 2017, VHA's Compliance and Business Integrity office completed a nationwide audit of consults that included an assessment of completed, discontinued, and canceled consults. The national audit assessed the timeliness of consult actions and whether documentation was sufficient to merit the consult action. In addition, the Compliance and Business Integrity audit tool contains review points that assess whether the consult was completed, discontinued, or canceled in accordance with policy. However, these audits are limited to reviewing about 65 consults for each of the primary VAMCs. According to the results of VHA's nationwide FY 2016 and 2017 audits, Compliance and Business Integrity staff identified errors similar to those the OIG identified during the review. For example, VHA found staff inappropriately canceled consults when the consult should have been discontinued, staff did not document the reason for discontinuing the consult or the documentation was insufficient, and staff did not document the minimum scheduling efforts when a patient did not respond or could not be reached to schedule an appointment. According to VHA staff, the nationwide audit results are disseminated to each VISN Compliance and Business Integrity officer.

Compliance and Business Integrity officers at four VISN 15 facilities told us they do not specifically review discontinued or canceled consults for appropriateness. In addition, facility staff stated they did not review discontinued or canceled consults unless there was a clinical concern or complaint related to the consult.

Recommendation 8 addresses the need for VISN 15 to communicate specific audit results of VHA's audit of consults to all VISN 15 facility staff involved in consult management, and to implement specific training and take corrective actions where needed to ensure they are in accordance with VHA policy.

Consults for Future Care Not Appropriately Managed

Staff at the Kansas City VAMC discontinued consults with instructions to resubmit closer to when the needed care was clinically appropriate because they did not think it was safe to schedule patient appointments beyond 90 days. According to the facility chief of staff, the service stopped using future care consults—which are appropriate for consults with a clinically indicated date of greater than 90 days—from spring 2015 through February 2017. Therefore, gastroenterology staff put the burden upon primary care providers to monitor when the patient should be scheduled for a colonoscopy and then submit a consult closer to the clinically indicated date. The chief of staff acknowledged the facility was not following VHA policy regarding future care consults.

Recommendation 9 addresses the need for VISN 15 to ensure network facilities manage consults clinically indicated for the future in accordance with VHA policy.

Consults Not Directly Referred to Community Care

Providers at the John J. Pershing VAMC continued to submit consults to an unavailable pain management service because facility management did not effectively communicate responsibilities or consult procedures to staff for requesting pain management services in absence of a pain clinic provider. The facility did not have a plan to ensure continuity of patient care after the facility no longer provided the service. The specialty clinic nurse manager stated that she discontinued the consults, and the referring providers were to submit consults to non-VA care. The associate chief of staff for Specialty Care stated they did not have specific action plans to clarify responsibilities and ensure timely care.

Recommendation 10 addresses the need for VISN 15 to implement appropriate contingency plans to maintain normal clinic operations in the absence of providers, in accordance with VHA's outpatient clinic practice management policy, and communicate those plans to referring providers.

Clinically Indicated Dates Not Used

As identified in Finding 1, staff did not always use the referring provider's clinically indicated date when scheduling consults. An administrative officer at one facility stated schedulers identified the next available appointment in VistA scheduling and entered that date as the desired date, instead of using the referring provider's clinically indicated date. In addition, the OIG observed schedulers entering the next available appointment date in the desired date field instead of the referring provider's clinically indicated date. A Group Practice Manager at one facility stated staff were still confused about using the clinically indicated date.

As stated in Finding 1, Recommendation 1 addresses the need to ensure VISN 15 medical facilities accurately record patient wait times based on the referring provider's clinically indicated date.

What Resulted

Inappropriately discontinued and canceled consults led to patients not receiving the requested care or experiencing additional delays in requested care. The OIG determined staff inappropriately discontinued and canceled an estimated 4,300 of 15,900 consults (27 percent). For those estimated 4,300 consults, the OIG found that patients had yet to receive care, experienced delays in care, or there was no effect on patient care. Specifically,

- For an estimated 2,700 of 4,300 inappropriately discontinued or canceled consults (63 percent), patients had yet to receive the requested care at VA based on evidence in the electronic health record as of the time of review from January through May 2017.[34]
- For an estimated 1,100 of 4,300 inappropriately discontinued or canceled consults (25 percent), patients later received the requested care, but experienced additional delays. On average, the OIG estimated these patients waited over 51 more days after staff discontinued or canceled the consult.
- For an estimated 530[35] of 4,300 inappropriately discontinued or canceled consults (12 percent), there was no effect on patient care because patients refused care or received care through Choice or another consult.

As a result of the Kansas City VAMC discontinuing consults clinically indicated for future dates, primary care providers tracked these patients using tickler notes, spreadsheets, and physical worksheets, which presented the risk they may not resubmit the consult timely or at all. As of May 2017, the facility initiated new consults and scheduled appointments for six of the eight patients the OIG identified in this audit. In addition, because facility leaders at Poplar Bluff VAMC did not provide guidance to referring providers regarding how to manage pain clinic consults when no provider was available, 10 veterans did not receive care and 43 veterans experienced additional delays for the requested care.

Clinical Impact of Delays

The OIG consulted with OHI to review electronic health records of 32 patients in this sample where the patient was deceased, had not received care following an inappropriately closed consult, or the consult was open greater than 30 days and appeared to have potentially caused an adverse clinical impact. Health system specialists and a medical consultant in OHI reviewed the clinical care of the patients to render an opinion of potential or actual patient adverse outcomes caused by a delay in care or lack of care.

[34] Some of these patients received care in other services within the VA medical facilities.
[35] The estimate of 530 above has a high margin of error due to the small number of samples cases it represents (seven). It is included in the above total because the other two values of 1,100 and 2,700 have reasonable margins of error and the three values sum to the total of 4,300.

Of these 32 patients, OHI identified concerns with the care of four patients. OHI found that three patients were still waiting for evaluations following clinical findings at the time of the review, and one patient likely had an adverse outcome as a result of a delay of care to address a foot infection.

Patient 3

A patient with a history of colon cancer received a computerized tomography scan in February 2016. The provider noted thickening of the urinary bladder wall. Although a urology consult was placed for the patient in June 2016, the patient had yet to complete that care. OHI determined that this patient's urology consult for an abnormal finding had not been completed. The patient canceled his scheduled appointment on one occasion, and did not show for his rescheduled appointment.

Patient 4

A primary care resident physician referred a patient to a gastroenterologist in October 2016. However, no appointments were available until December 2016, so the patient was referred for a Choice appointment. During a primary care appointment in February 2017, the patient had blood in his stool, which had not been evaluated. In March 2017, the patient completed the Choice appointment with a gastroenterologist, who recommended a colonoscopy. As of April 30, 2017, OHI did not find any documentation of the requested colonoscopy in VHA's electronic health records. However, subsequent to OHI's review, the audit team identified a primary care resident physician's note in the records from May 2017, which indicated the patient reported he had received a colonoscopy. The actual report indicates this procedure was completed in April 2017.

Patient 5

A patient with a history of an elevated prostate-specific antigen and an abnormal magnetic resonance imaging of the prostate was still waiting for additional care in response to a urology consult ordered in April 2016. Upon receipt, urology services recommended that the patient be scheduled in the urology clinic in four weeks, but then discontinued the consult. OHI found no information in the records that indicated the patient was contacted to schedule an appointment. OHI determined that with these abnormal findings the possibility of undetected disease remains. In February 2017, a urologist placed a Choice consult for the patient to receive a prostate biopsy. A urology note in the electronic health record in May 2017 stated the biopsy was still pending. A urology staff physician's note in the records from August 2017 indicated the patient had a fee-basis prostate biopsy in July 2017. The August 2017 note indicated a discussion of the biopsy results and treatment plan for the diagnosed prostate cancer occurred that day. While the patient has received care, the results of his prostate biopsy obtained through a non-VA provider have not been scanned into the electronic health record. The inability to easily verify the

patient's cancer diagnosis by accessing the pathology report scanned into the electronic health record might provide difficulties for other physicians involved in the treatment of this patient.

Patient 6

A patient likely had an adverse outcome as a result of a delay of care to address a foot infection. The patient declined a foot examination according to a nursing note on the day that the patient saw his physician. There was no documentation that his provider discussed or performed a foot exam at the time of his primary care visit in September 2016. The primary care provider placed a non-VA care podiatry consult, due to geographic inaccessibility. However, the patient experienced a delay in receiving care for the podiatry consult after the deputy chief of staff stated on the consult that services were readily available within the VA. OHI determined that no further action was taken on this consult for over three months. These issues likely resulted in hospitalization for a foot infection, multiple surgeries, and long-term antibiotic administration, approximately two months after the provider placed the podiatry consult. It is possible that a more timely intervention could have avoided the hospitalization and complications of a diabetic foot infection. According to the electronic health record, in October 2017, this patient underwent a surgical procedure for a left below-the-knee amputation at the facility.

Recommendation 11 addresses the need for VISN 15 to follow up on the patients identified in the patient summaries of this report to evaluate and take appropriate action. As stated in Finding 1, Recommendation 4 addresses the need for VISN 15 to improve monitoring and tracking for timely surveillance colonoscopies.

Conclusion

During the relevant time period, VISN 15 medical facilities did not always manage specialty care consults appropriately. The OIG found that inappropriately closed consults led to veterans not receiving the requested care or experiencing additional delays in requested care.

Recommendations

8. The OIG recommended the Veterans Integrated Service Network 15 Director communicate specific audit results of VHA's audit of consults to all network facility staff involved in consult management, implement specific training, and ensure corrective action is taken as needed.
9. The OIG recommended the Veterans Integrated Service Network 15 Director ensure network facilities manage consults that are clinically indicated for the future in accordance with VHA's consult policy.
10. The OIG recommended the Veterans Integrated Service Network 15 Director ensure network facilities implement contingency plans in accordance with VHA's outpatient clinic practice management policy

and communicate to providers regarding how to process consults when a service becomes unavailable.

11. The OIG recommended the Veterans Integrated Service Network 15 Director ensure the care of patients identified in the patient summaries of this report are evaluated, take action, if appropriate, and confer with Regional Counsel regarding the appropriateness of disclosures to patients and families.

Management Comments

The VISN 15 Director concurred with Recommendations 8 and 11 and concurred in principle with Recommendations 9 and 10.

To address Recommendation 8, the VISN 15 Director reported the VISN compliance officer performs biannual consult audits in accordance with VHA Directive 1232. In addition, he reported that random out-of-cycle audits are conducted for the appropriate use of the discontinued and canceled consult statuses. The Director reported that the VISN will ensure consult audit results are communicated to facility compliance officers and VISN 15 consult workgroup members.

To address Recommendation 9, the VISN 15 Director reported the VISN will ensure all facilities adhere to the consult processes and procedures for future care consults as outlined in VHA Directive 1232. The Director reported that the Kansas City VAMC reinstated the use of future care consults for the gastroenterology service in April 2017. The VISN 15 Director requested closure of this recommendation.

To address Recommendation 10, the VISN 15 Director reported the VISN will ensure all facilities create and communicate standard operating procedures for deactivating consult services when a service is no longer available.

To address Recommendation 11, the VISN 15 Director reported that all the patients identified in this report have had their care evaluated, and an institutional disclosure was completed for Patient 5. The VISN 15 Director requested closure of this recommendation.

OIG Response

VISN 15 provided responsive action plans to address the recommendations. The OIG considers Recommendation 11 closed. As of January 2018, VISN 15 had not provided us with the evidence necessary to close Recommendation 9. Prior to closing this recommendation, the OIG requests that VISN 15 provide evidence supporting the Kansas City VAMC reinstated the use of future care consults, and evidence supporting all facilities' adherence to the consult processes and procedures for future care consults. Once the OIG receives such evidence, we will examine it to determine whether their actions are sufficient to close the recommendations. The OIG will monitor VISN 15's progress and follow up on the implementation of the recommendations until all proposed actions are completed. The full text of

the responses from VHA and VISN 15 and are located in Appendix K and Appendix L.

Appendix A Summary Results - Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri

The OIG conducted a site visit to the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri, during the week of February 13, 2017. The OIG interviewed 34 employees and conducted observations in the Primary Care, Mental Health, and Specialty Care Clinics. The numbers in the tables in Appendices A through G reflect the raw sample results per facility and were used to project the overall weighted averages, VISN-wide. These individual facility results should not be compared with results at other facilities. Table 7 summarizes results of the statistical sample review of new patient appointments.

Table 7. Sample Results—New Patient Appointments with Clinically Indicated Dates

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number with Incorrect Date Used
Specialty Care	21	14 (67%)	7 (33%)	18 Days	32 Days	11 (52%)
Mental Health	20	12 (60%)	8 (40%)	2 Days	23 Days	17 (85%)
Totals	**41**	**26 (63%)**	**15 (37%)**	**10 Days**	**28 Days**	**28 (68%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 8 summarizes results of the statistical sample review of veterans' health care through Choice.

Table 8. Sample Results—Choice Care

Appointment Type	Cases Reviewed*	Veterans Who Received Choice Care	Average Time to Authorize**	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	27 (90%)	-1 Days	22 Days	3 (10%)
Primary Care	1	1 (100%)	-35 Days	0 Days	0 (0%)
Mental Health	30	25 (83%)	0 Days	22 Days	5 (17%)
Totals	**61**	**53 (87%)**	**-1 Days**	**22 Days**	**8 (13%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

** The OIG reviewed all authorizations for strata with fewer than 30 valid authorizations during the sample period.*

*** The OIG calculated the time to authorize from the date a VA provider determined care was clinically indicated. When VA medical facility staff sent the referral to TriWest before the clinically indicated date, it resulted in a negative value.*

Table 9 summarizes results of the statistical sample review of open specialty care consults that exceeded 30 days as of October 31, 2016.

Table 9. Sample Results—Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Consults Remain Open	Average Days Open (OIG)	Veterans' Consult Was Closed
30	22 (73%)	60 Days	1 (3%)	132	7 (23%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of the review from January through May 2017

Table 10 summarizes results of the statistical sample review of discontinued and canceled consults.

Table 10. Sample Results—Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans' Care Not Affected**
30	23 (77%)	7 (23%)	2	0	5

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of the review from January through May 2017

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of the review.*

*** Of the inappropriately discontinued or canceled consults, these veterans refused care or received care through the Choice Program or another VA consult, or were treated without a new consult entered.*

Appendix B Summary Results - John J. Pershing VAMC in Poplar Bluff, Missouri

The OIG conducted a site visit to the John J. Pershing VAMC in Poplar Bluff, Missouri, during the week of March 20, 2017. The OIG interviewed 24 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics.

Table 11 summarizes results of the statistical sample review of new patient appointments.

Table 11. Sample Results—New Patient Appointments with Clinically Indicated Dates

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number with Incorrect Date Used
Specialty Care	25	22 (88%)	3 (12%)	13 Days	17 Days	3 (12%)
Mental Health	20	20 (100%)	0 (0%)	7 Days	7 Days	2 (10%)
Totals	**45**	**42 (93%)**	**3 (7%)**	**10 Days**	**13 Days**	**5 (11%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 12 summarizes results of the statistical sample review of veterans' health care through Choice.

Table 12. Sample Results—Choice Care

Appointment Type	Cases Reviewed*	Veterans Who Received Choice Care	Average Time to Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	30 (100%)	14 Days	42 Days	0 (0%)
Primary Care	2	2 (100%)	5 Days	12 Days	0 (0%)
Mental Health	30	23 (77%)	12 Days	31 Days	7 (23%)
Totals	**62**	**55 (89%)**	**13 Days**	**36 Days**	**7 (11%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

** The OIG reviewed all authorizations for strata with fewer than 30 valid authorizations during the sample period.*

Table 13 summarizes results of the statistical sample review of open specialty care consults that exceeded 30 days as of October 31, 2016.

Table 13. Sample Results—Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Consults Remain Open	Average Days Open (OIG)	Veterans' Consult Was Closed
29	20 (69%)	29 Days	1 (3%)	89 Days	8 (28%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of the review from January through May 2017

Table 14 summarizes results of the statistical sample review of discontinued and canceled consults.

Table 14. Sample Results—Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans' Care Not Affected
30	22 (73%)	8 (27%)	1	7	0

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of the review from January through May 2017

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of the review.*

Appendix C Summary Results - Kansas City VAMC in Kansas City, Missouri

The OIG conducted a site visit to the Kansas City, Missouri, VAMC during the week of February 27, 2017. The OIG interviewed 33 employees in the Primary Care, Mental Health, and Specialty Care Clinics. The OIG also conducted scheduler observations of employees in Specialty Care clinics.

Table 15 summarizes results of the statistical sample review of new patient appointments.

Table 15. Sample Results—New Patient Appointments with Clinically Indicated Dates

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number with Incorrect Date Used
Specialty Care	20	18 (90%)	2 (10%)	12 Days	17 Days	5 (25%)
Mental Health	8	6 (75%)	2 (25%)	14 Days	21 Days	2 (25%)
Totals	**28**	**24 (86%)**	**4 (14%)**	**12 Days**	**18 Days**	**7 (25%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 16 summarizes results of the statistical sample review of veterans' health care through Choice.

Table 16. Sample Results—Choice Care

Appointment Type	Cases Reviewed*	Veterans Who Received Choice Care	Average Time to Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	27 (90%)	7 Days	37 Days	3 (10%)
Primary Care	0	N/A	N/A	N/A	N/A
Mental Health	14	12 (86%)	0 Days	19 Days	2 (14%)
Totals	**44**	**39 (89%)**	**5 Days**	**31 Days**	**5 (11%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

** The OIG reviewed all authorizations for strata with fewer than 30 valid authorizations during the sample period.*

Table 17 summarizes results of the statistical sample review of open specialty care consults that exceeded 30 days as of October 31, 2016.

Table 17. Sample Results—Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Consults Remain Open	Average Days Open (OIG)	Veterans' Consult Was Closed
30	20 (67%)	43 Days	0 (0%)	N/A	10 (33%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of the review in January through May 2017

Table 18 summarizes results of the statistical sample review of discontinued and canceled consults.

Table 18. Sample Results—Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans' Care Not Affected
30	25 (83%)	5 (17%)	4	1	0

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of the review from January through May 2017

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of the review.*

Appendix D Summary Results - Marion VAMC in Marion, Illinois

The OIG conducted a site visit to the Marion, Illinois, VAMC during the week of March 20, 2017. The OIG interviewed 36 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics.

Table 19 summarizes results of the statistical sample review of new patient appointments.

Table 19. Sample Results—New Patient Appointments with Clinically Indicated Dates

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number with Incorrect Date Used
Specialty Care	19	17 (89%)	2 (11%)	10 Days	10 Days	0 (0%)
Primary Care	1	1 (100%)	0 (0%)	0 Days	0 Days	0 (0%)
Mental Health	22	20 (91%)	2 (9%)	6 Days	10 Days	5 (23%)
Totals	**42**	**38 (90%)**	**4 (10%)**	**7 Days**	**9 Days**	**5 (12%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 20 summarizes results of the statistical sample review of veterans' health care through Choice.

Table 20. Sample Results—Choice Care

Appointment Type	Cases Reviewed*	Veterans Who Received Choice Care	Average Time to Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	26 (87%)	-6 Days**	22 Days	4 (13%)
Primary Care	30	22 (73%)	17 Days	45 Days	8 (27%)
Mental Health	11	5 (46%)	11 Days	29 Days	6 (55%)
Totals	**71**	**53 (75%)**	**6 Days**	**32 Days**	**18 (25%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

** The OIG reviewed all authorizations for strata with fewer than 30 valid authorizations during the sample period.*

*** The OIG calculated the time to authorize from the date a VA provider determined care was clinically indicated. When VA medical facility staff sent the referral to TriWest before the clinically indicated date, it resulted in a negative value.*

Table 21 summarizes results of the statistical sample review of open specialty care consults that exceeded 30 days as of October 31, 2016.

Table 21. Sample Results—Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Consults Remain Open	Average Days Open (OIG)	Veterans' Consult Was Closed
30	22 (73%)	19 Days	0 (0%)	N/A	8 (27%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of the review from January through May 2017

Table 22 summarizes results of the statistical sample review of discontinued and canceled consults.

Table 22. Sample Results—Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans' Care Not Affected
30	21 (70%)	9 (30%)	6	3	0

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of the review from January through May 2017

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of the review.*

Appendix E Summary Results - Robert J. Dole VAMC in Wichita, Kansas

The OIG conducted a site visit to the Wichita, Kansas, VAMC during the week of February 13, 2017. The OIG interviewed 39 employees in the Primary Care, Mental Health, and Specialty Care Clinics. The OIG also conducted scheduler observations of employees in Mental Health and Specialty Care Clinics.

Table 23 summarizes results of the statistical sample review of new patient appointments.

Table 23. Sample Results—New Patient Appointments with Clinically Indicated Dates

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number with Incorrect Date Used
Specialty Care	21	15 (71%)	6 (29%)	15 Days	21 Days	11 (52%)
Mental Health	23	18 (78%)	5 (22%)	2 Days	23 Days	18 (78%)
Totals	**44**	**33 (75%)**	**11 (25%)**	**8 Days**	**22 Days**	**29 (66%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 24 summarizes results of the statistical sample review of veterans' health care through Choice.

Table 24. Sample Results—Choice Care

Appointment Type	Cases Reviewed*	Veterans Who Received Choice Care	Average Time to Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	8	7(88%)	13 Days	24 Days	1 (13%)
Primary Care	0	N/A	N/A	N/A	N/A
Mental Health	30	25(83%)	0 Days	12 Days	5 (17%)
Totals	**38**	**32 (84%)**	**11 Days**	**21 Days**	**6 (16%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

** The OIG reviewed all authorizations for strata with fewer than 30 valid authorizations during the sample period.*

Table 25 summarizes results of the statistical sample review of open specialty care consults that exceeded 30 days as of October 31, 2016.

Table 25. Sample Results—Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Consults Remain Open	Average Days Waiting (OIG)	Veterans' Consult Was Closed
30	23 (77%)	26 Days	0 (0%)	N/A	7 (23%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of the review from January through May 2017

Table 26 summarizes results of the statistical sample review of discontinued and canceled consults.

Table 26. Sample Results—Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans' Care Not Affected**
30	25 (83%)	5 (17%)	3	1	1

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of the review from January through May 2017

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of the review.*

***Of the inappropriately discontinued or canceled consults, these veterans refused care or received care through the Choice Program or another VA consult, or were treated without a new consult entered.*

Appendix F Summary Results - VA Eastern Kansas Health Care System

The OIG conducted a site visit to the VA Eastern Kansas Health Care System in Leavenworth and Topeka, Kansas, during the week of March 20, 2017. The OIG interviewed 38 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics.

Table 27 summarizes results of the statistical sample review of new patient appointments.

Table 27. Sample Results—New Patient Appointments with Clinically Indicated Dates

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number with Incorrect Date Used
Specialty Care	25	18 (72%)	7 (28%)	11 Days	17 Days	12 (48%)
Primary Care	1	1 (100%)	0 (0%)	0 Days	14 Days	1 (100%)
Mental Health	14	10 (71%)	4 (29%)	4 Days	18 Days	9 (64%)
Totals	**40**	**29 (73%)**	**11 (28%)**	**8 Days**	**17 Days**	**22 (55%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 28 summarizes results of the statistical sample review of veterans' health care through Choice.

Table 28. Sample Results—Choice Care

Appointment Type	Cases Reviewed*	Veterans Who Received Choice Care	Average Time to Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice Care
Specialty Care	30	29 (97%)	1 Days	26 Days	1 (3%)
Primary Care	16	12 (75%)	31 Days	59 Days	4 (25%)
Mental Health	19	11 (58%)	7 Days	38 Days	8 (42%)
Totals	**65**	**52 (80%)**	**10 Days**	**36 Days**	**13 (20%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

** The OIG reviewed all authorizations for strata with fewer than 30 valid authorizations during the sample period.*

Table 29 summarizes results of the statistical sample review of open specialty care consults that exceeded 30 days as of October 31, 2016.

Table 29. Sample Results—Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Consults Remain Open	Average Days Open (OIG)	Veterans' Consult Was Closed
30	17 (57%)	26 Days	9 (30%)	210 Days	4 (13%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of the review from January through May 2017

Table 30 summarizes results of the statistical sample review of discontinued and canceled consults.

Table 30. Sample Results—Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans' Care Not Affected
30	23 (77%)	7 (23%)	7	0	0

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of the review from January through May 2017

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of the review.*

Appendix G Summary Results - VA St. Louis Health Care System

The OIG conducted a site visit to the VA St. Louis Health Care System in St. Louis, Missouri, during the week of February 27, 2017. The OIG interviewed 31 employees and conducted scheduler observations in the Primary Care, Mental Health, and Specialty Care Clinics.

Table 31 summarizes results of the statistical sample review of new patient appointments.

Table 31. Sample Results—New Patient Appointments with Clinically Indicated Dates

Appointment Type	Cases Reviewed	Wait Time 30 Days or Less	Wait Time over 30 Days	Average Wait Time (VA)	Average Wait Time (OIG)	Number with Incorrect Date Used
Specialty Care	27	25 (93%)	2 (7%)	11 Days	13 Days	11 (41%)
Mental Health	8	8 (100%)	0 (0%)	2 Days	11 Days	5 (63%)
Totals	**35**	**33 (94%)**	**2 (6%)**	**9 Days**	**12 Days**	**16 (46%)**

Source: VA OIG analysis of statistically sampled new patient appointments

Table 32 summarizes results of the statistical sample review of veterans' health care through Choice.

Table 32. Sample Results—Choice Care

Appointment Type	Cases Reviewed*	Veterans Who Received Choice Care	Average Time to Authorize	Average Wait Time for Choice Care	Veterans Who Did Not Receive Choice
Specialty Care	30	29 (97%)	19 Days	46 Days	1 (3%)
Primary Care	30	21 (70%)	7 Days	30 Days	9 (30%)
Mental Health	21	17 (81%)	20 Days	42 Days	4 (19%)
Totals	**81**	**67 (83%)**	**15 Days**	**40 Days**	**14 (17%)**

Source: VA OIG analysis of statistically sampled Choice authorizations

** The OIG reviewed all authorizations for strata with fewer than 30 valid authorizations during the sample period.*

Table 33 summarizes results of the statistical sample review of open specialty care consults that exceeded 30 days as of October 31, 2016.

Table 33. Sample Results—Open Consults

Consults Reviewed	Veterans Received Care	Average Wait Time (OIG)	Consults Remain Open	Average Days Open (OIG)	Veterans' Consult Was Closed
30	27 (90%)	27 Days	0 (0%)	N/A	3 (10%)

Source: VA OIG analysis of statistically sampled open specialty care consults as of the time of the review from January through May 2017

Table 34 summarizes results of the statistical sample review of discontinued and canceled consults.

Table 34. Sample Results—Discontinued and Canceled Consults

Consults Reviewed	Appropriately Discontinued or Canceled	Inappropriately Discontinued or Canceled	Veterans Had Not Received Requested Care*	Veterans Received Delayed Care	Veterans' Care Not Affected**
30	20 (67%)	10 (23%)	6	3	1

Source: VA OIG analysis of statistically sampled discontinued and canceled specialty care consults as of the time of the review from January through May 2017

** Of the inappropriately discontinued or canceled consults, these veterans had not received the requested care at the time of the review.*

*** Of the inappropriately discontinued or canceled consults, these veterans refused care or received care through the Choice Program or another VA consult, or were treated without a new consult entered.*

Appendix H Background

Access to VA Medical Facility Care

It is VHA policy (VHA Directive 1230) that "Veterans' appointments are scheduled timely, accurately, and consistently." The goal is to schedule appointments "no more than 30 calendar days from the date an appointment is deemed clinically appropriate by a VA health care provider (Clinically Indicated Date), or, in the absence of a Clinically Indicated Date, 30 calendar days from the date the Veteran requests outpatient health care service (Preferred Date)."

VHA Directive 1230 states that VISN Directors are responsible for the oversight of the scheduling program and monitoring compliance with the directive. VA facility directors are responsible for "providing appropriate resources to adequately perform scheduling tasks," ensuring "continuous audit and improvement process of scheduling activities," ensuring an "ongoing review of access to care indicators," and "monitoring compliance" with the directive.

VHA Directive 1230 requires wait time be measured from the appointment's clinically indicated date, or in the absence of a clinically indicated date, the patient's preferred appointment date. In addition, if a patient cancels their appointment or does not show up for the appointment, the wait time resets and starts from the patient's new preferred appointment date. VHA calculates the wait time for the rescheduled appointments of clinic cancelations differently. In general, if the clinic needs to cancel appointments because it is unable to provide care to the patient at the original appointment time, staff must input the cancelation as a clinic cancelation and would continue to use the original appointment's clinically indicated date or preferred date for the rescheduled appointment.

Since 2014, VHA has made patient access data public on its website, and data are available for all VA medical centers and community based outpatient clinics. The patient access data include average wait times, number of patients waiting for a scheduled appointment, and the number of patients who cannot be scheduled for an appointment in 90 days or less. In April 2017, VHA created another public website showing patient access data called Access and Quality in VA Healthcare.[36] The website is aimed at providing veterans with an easy, understandable way of accessing wait times and quality of care data. The website includes data showing the average wait times at individual facilities. According to the website, the average wait times are based on appointments completed at VA facilities during the previous month. Similarly, the OIG's assessment of wait times for appointment at VA facilities in this report are also based on completed

[36] https://www.accesstocare.va.gov/

appointments. The appointments the OIG reviewed were prior to VA launching the Access and Quality in VA Healthcare website. As VA works to provide greater transparency in the timeliness of access to care, it is important that the data are reliable.

Access to Choice Care

The Veterans Access, Choice, and Accountability Act of 2014 requires VA to offer an authorization to receive non-VA care to veterans who are unable to secure an appointment at a VA medical facility within 30 days or who live more than 40 miles from a VA facility. VA facilities began providing Choice care to eligible veterans as of November 2014. Congress authorized Choice to continue until the date the Choice funds are exhausted.

Prior to Choice, VA facility staff reviewed VA physician requests for care in the community (consults) when the VA medical facility could not directly provide appropriate care and therefore could not offer the veteran an appointment. VA facility staff approved the care, created an authorization, and worked directly with the veteran and local care providers in the community to coordinate the care. VA facility staff used the consult to manage the veteran's care including arranging the appointment and communicating with the community provider.

Under Choice, VA medical facilities continued to use consults to manage Choice authorizations when a VA medical facility could not directly provide care. However, when VA medical facility staff schedule an appointment over 30 days in the future, there is no consult to identify the veteran as eligible for Choice care, so VA medical staff use the Veterans Choice List (VCL) to track these veterans' eligibility. Under Choice, eligible veterans can choose to have care provided by non-VA providers. If a veteran opts in, staff electronically provide the authorization and other related medical documents, via the contractor portal, to TriWest rather than coordinate the care directly with the provider in the community. After Choice care is authorized, VA facility staff must monitor the authorization by querying TriWest's online web portal. This process requires VA staff to continually monitor each authorization to address any issues that may affect VA's ability to coordinate the authorized care and ensure appropriate medical documentation is received timely.

Consult Management

VHA issued VHA Directive 1232 in August 2016 and amended it in September 2016. The directive provided criteria to VHA staff on appropriate consult management, standardized consult processes, and defined oversight responsibilities. This directive states that clinicians and non-clinicians may discontinue consults under certain circumstances and that facilities are required to document the reason for discontinuing a consult. The directive specifies that a clinician should review the consult prior to discontinuing it when the patient canceled or "no-showed" more than once or did not respond to the minimum scheduling efforts. The consult directive also differentiates between discontinuing and canceling consults, and states that consults may

only be canceled if the ordering provider did not ask an appropriate question or include sufficient information in the consult request, if consult pre-work was inadequate per the service care agreement, if service was not available, or to correct an obvious error.

Recurring Issues

During the past decade, OIG, GAO, VA, and other organizations have issued numerous reports regarding issues with access to VA care, veteran wait times, scheduling practices, consult management, and more recently, Choice care. Furthermore, since 2014, OIG and VA continued to review and identify inappropriate scheduling practices at VA facilities across the country. In May and June 2014, VA conducted a system-wide Access Audit to ensure a full understanding of VA's policy among scheduling staff, identify inappropriate scheduling practices, and review wait list management. The VA Access Audit flagged 112 facilities because of concerns that indicated inappropriate scheduling practices or because of staff who indicated they received instructions to modify scheduling dates.

Previous OIG Reports

Since 2014, the OIG has issued numerous reports that identified inappropriate scheduling practices at VA facilities across the country. The following highlight recently published OIG reports related to access to VA care, Choice, and consult management.

In March 2017, OIG issued a report titled *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6*.[37] The audit found that "VISN 6 did not consistently provide timely access to health care for new patients at its VA medical facilities and through Choice during the" first quarter of FY 2016. The audit estimated that "36 percent of the appointments for new patients at facilities within VISN 6 during the relevant time period had wait times longer than 30 days," which "was notably higher" than the 10 percent "that VHA's electronic scheduling system showed." The OIG estimated "the average wait time for this 36 percent was 59 days." The overall average wait time identified in VISN 6 included an assessment of primary care appointments. The audit estimated that 16 percent of mental health appointments had wait times greater than 30 days, and 39 percent of specialty care appointments had wait times greater than 30 days. VISN 6 "also did not have accurate wait time data." The OIG's "assessment of wait times for new patient appointments shows a significant difference when compared to wait time data captured in VHA's electronic scheduling system." This occurred at VISN 6 because "staff entered preferred dates that resulted in inaccurate wait times for an estimated

[37] Report No. 16-02618-424: Although it covered a different period of time, the methodology of this audit was generally the same as the OIG's earlier audit of VISN 6, and provided a comparison between VISNs. Sample estimates between VISN 6 and VISN 15 were statistically significant and unlikely due to sampling error.

74 percent of appointments." Applying VHA's new scheduling policy,[38] Directive 1230, to the VISN 6 results, OIG "still found that staff entered preferred dates resulting in inaccurate wait times for an estimated 59 percent of appointments." OIG found that VISN 6 facility management provided inconsistent guidance on the use of the clinically indicated date. More specifically "VISN 6 facility management—such as facility directors (two), associate and assistant directors (two), and chiefs of staff (two)— disagreed with VHA's guidance related to using the referring provider's clinically indicated date. In these instances, management disagreed because it felt that receiving providers should determine the clinically indicated date; however, this conflicted with VHA's scheduling guidance."

The audit found "inaccurate wait time data resulted in a significant number of veterans not being eligible for treatment through Choice." As a result, the OIG concluded that "VHA and VISN 6 leaders relied on wait time data that did not accurately represent how long veterans were waiting for care."

With respect to VISN 6 patients who received their care through Choice, the audit estimated that 82 percent had wait times longer than 30 days. The OIG "estimated that the average wait time for those who received their care through Choice was 84 days." The 84 days included "an average of 42 days for VA staff to provide the authorization to Health Net[39] and 42 days for Health Net to provide the service." OIG found that the issues in VISN 6 occurred "primarily because staffing resources were not sufficient" to effectively manage the increased workload. Based on the sample review of open specialty care consults in VISN 6, OIG "found that staff inappropriately discontinued or canceled consults an estimated 26 percent of the time" during the first quarter of FY 2016. VISN 6 facility staff "were unaware of specific consult management procedures regarding discontinuing or canceling consults." In addition, some VISN 6 clinicians "disagreed with VHA guidance that requires at least two patient cancelations or no-shows before discontinuing a consult." This report included 10 recommendations in which the then Under Secretary for Health concurred or concurred in principle.

In January 2017, the OIG issued a report titled *Review of the Implementation of the Veterans Choice Program* (Report No. 15-04673-

[38] During the audit of VISN 6, the OIG assessed the accuracy of the patient preferred dates entered in the electronic data field based on VHA guidance in place during the scope of the audit, which included that the desired date should be entered in the appointment comments. VHA's new scheduling policy, Directive 1230, requires schedulers to use the documented clinically indicated date when scheduling patient appointment, but does not require additional documentation to support a veteran's preferred date.

[39] Health Net Federal Services LLC is the contractor VISN 6 used to coordinate veterans' Choice appointments.

333). OIG conducted this review at the request of the Chairman of the Senate Committee on Veterans' Affairs, "who expressed concerns about the implementation of the Veterans Choice Program and, more specifically, about the barriers facing veterans trying to access it." "The observations expressed in this report reflected the barriers faced by veterans during the period after VA struggled to meet a 90-day implementation timeline mandated by the Veterans Access, Choice, and Accountability Act of 2014." OIG made six recommendations to the Under Secretary of Health. The Under Secretary for Health concurred with the findings.

In addition to these recent reports, OIG issued other reports related to access to care since 2015, including the following.

- *Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post-Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System* (Report No. 17-00414-376, November 16, 2017)
- *Audit of VHA's Imaging Service Scheduling Practices at the South Texas Veterans Health Care System* (Report No. 16-00597-279, August 17, 2017)
- *Review of Alleged Delay of Care and Scheduling Issues at the VA Medical Center in West Palm Beach, Florida* (Report No. 15-02583-256, August 9, 2017)
- *Audit of Alleged Inappropriate Scheduling of Electromyography Consults at the Memphis VA Medical Center* (Report No. 16-02468-281, July 20, 2017)
- *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System* (Report No. 15-04672-342, October 4, 2016)
- *Review of Alleged Patient Scheduling Issues at VA Medical Center Tampa, Florida* (Report No. 15-03026-101, February 5, 2016)
- *Review of Alleged Untimely Care at the Community Based Outpatient Clinic Colorado Springs, CO* (Report 15-02472-46, February 4, 2016)
- *Review of Allegations of Inappropriately Completed Consults and Inappropriate Bonuses at the St. Louis VA Health Care System* (Report No. 14-03434-530, September 29, 2015)
- *Review of Alleged Mishandling of Ophthalmology Consults at the Oklahoma City, OK, VA Medical Center* (Report No. 15-02397-494, August 31, 2015)

Appendix I Scope and Methodology

Scope

The OIG conducted its audit work from January through December 2017 to assess veterans' access to care within VISN 15. Specifically, the OIG assessed access to care at VISN 15 medical facilities, access to care through Choice, and appropriate consult management. The OIG analyzed completed VA appointments, created Choice authorizations, and discontinued and canceled consults. In addition, the OIG analyzed consults that were open greater than 30 days as of October 31, 2016. Appendix J provides details on the specific scope for each statistical sampling population.

During the audit, the OIG conducted site visits to the main VA medical facilities in VISN 15 during February and March 2017.

Table 35. VISN 15 VA Medical Centers and Health Care Centers

VA Medical Facility	Location
Harry S. Truman Memorial Veterans' Hospital	Columbia, MO
John J. Pershing VAMC	Poplar Bluff, MO
Kansas City VAMC	Kansas City, MO
Marion VAMC	Marion, IL
Robert J. Dole VAMC	Wichita, KS
VA Eastern Kansas Health Care System	Leavenworth, KS Topeka, KS
VA St. Louis Health Care System	St. Louis, MO

Source: VA OIG

Methodology

To address the audit objectives, the OIG reviewed applicable laws, regulations, policies, procedures, and guidelines. The audit of VISN 15 included the following actions.

- The OIG interviewed over 250 staff, most with direct knowledge and responsibility for patient scheduling and consult management. This included scheduling staff, supervisors, administrative officers, clinicians, chiefs of staff, and management staff. The OIG also conducted interviews with VHA officials and VISN 15 staff.
- The OIG observed staff schedule over 80 appointments.

- The OIG reviewed statistical samples of completed VA appointments, Choice authorizations, and consults from VISN 15 medical facilities. Specifically, the OIG reviewed new patient completed appointments in the Primary Care, Mental Health, and 12 Specialty Care Clinics.[40] In addition, the OIG reviewed patients authorized for Choice in primary care, mental health, and specialty care. The OIG reviewed open consults (greater than 30 days), and discontinued and canceled consults in 12 Specialty Care Clinics. During site visits, the OIG discussed sample review results with medical facility staff assigned to assist us, whereby the OIG received clarification on questions and potential issues.

- The OIG reviewed prior reports relevant to the audit objectives.

- The audit team referred 83 patient cases from the sample appointments and consults to OIG's OHI for review. The audit team referred these cases because the patients were deceased or had experienced significant delays in care. The audit team referred the medical records for these veterans to OHI to determine whether inappropriate or untimely care resulted in any adverse clinical impact to the veteran.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators by taking actions such as:

- Performing an assessment to identify fraud indicators and the likelihood of their occurrence

- Interviewing VA medical facility staff concerning potential fraudulent activities within the scope of the objectives

The OIG did not identify any instances of fraud during this audit.

Data Reliability

The OIG relied on computer-processed data from VHA's Veteran Support Service Center (VSSC) Completed Cube, VA's Corporate Data Warehouse, VHA's VSSC VCL Report, VHA's VSSC Consult Cube, and the Scheduling Audit Tool, located within the Group Practice Management/Supervisory Appointment Tools Business Intelligence Service Line.

- To assess the reliability of VSSC Completed Cube data, the OIG compared details of the completed appointment data reported in the Completed Cube with completed appointment data of individual patient records in VHA's Computerized Patient Record System and VistA.

[40] The 12 Specialty Care Clinics reviewed in this audit were physical therapy, cardiology, audiology, dermatology, podiatry, optometry, orthopedics, gastroenterology, physical medicine and rehabilitation service, urology, ophthalmology, and general surgery.

- To assess the reliability of the Corporate Data Warehouse and TriWest's data, the OIG compared details of the Choice authorizations reported in the Corporate Data Warehouse and TriWest's data with Choice data of individual patient records in VHA's Computerized Patient Record System, TriWest, and the VCL.
- To assess the reliability of VSSC Consult Cube data, the OIG compared details of the consult data reported in the Consult Cube with consult data of individual patient records in VHA's Computerized Patient Record System.
- To assess the reliability of VSSC VCL data, the OIG compared details of the VCL data in the VCL report with VCL data of individual patient records in VistA.
- To assess the reliability of the Scheduling Audit Tool data, the OIG compared details of the data in the Scheduler Audit Detail report and the Scheduling Audit by Service Section report to audit data provided by the site as well as appointment data from the Corporate Data Warehouse.

The OIG concluded that the data obtained and relied upon were sufficiently reliable for the purposes of this audit.

Government Standards

Our assessment of internal controls focused on those controls relating to our audit objectives. The OIG conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix J Statistical Sampling Methodology

To determine whether VISN 15 provided veterans with timely access to health care, the OIG selected a statistical sample of:

- New patient appointments
- Choice Authorizations
- Open consults
- Discontinued and canceled consults

Figures and percentages have been rounded for reporting purposes. As a result, totals may not always sum due to rounding.

New Patient Appointments

Population

To determine whether VISN 15 provided timely access to health care at its medical facilities, the OIG selected a statistical sample of completed new patient appointments for primary care, mental health care, and specialty care. The population consisted of 4,374 primary care appointments, 1,737 mental health care appointments, and 18,405 specialty care appointments completed in the first quarter of FY 2017.

The scope included only scheduled outpatient care; the OIG excluded any care associated with Compensation and Pension exams because those types of appointments are used for veterans' benefits claims versus a request for new care. The OIG also excluded appointments within group clinics because the focus was on care for individual veterans.

Sampling Design

For new patient appointments, the OIG used a stratified random sample. From the population, the OIG sampled 216 primary care appointments, 223 specialty care appointments, and 214 mental health appointments. Of the 653 sampled appointments, the OIG assessed 275 appointments with clinically indicated dates, which included two primary care appointments, 115 mental health care appointments, and 158 specialty care appointments. All records had a known chance of selection. This allowed us to make estimates over the entire population and by stratum.

Weights

The OIG calculated estimates in this report using weighted sample data. Sampling weights were computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG repeated this audit with multiple samples, the estimates and confidence intervals would differ for each sample, but the confidence intervals would include the true population value 90 percent of the time.

Table 36 presents the estimates over the sample population, including the sample results, estimate, margin of error, lower 90 percent value, and upper 90 percent value.

Table 36. Statistical Projections–New Patient Care

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total Number of New Patient Appointments for Primary Care, Mental Health Care, and Specialty Care with a Clinically Indicated Date	275	13,857 (56.5%)	945 (3.9%)	12,911 (52.7%)	14,802 (60.4%)
For the above, Average OIG Wait Time	275	18	3	16	21
For the above, Average VHA Wait Time	275	13	2	10	15
Total Number of New Appointments with a Clinically Indicated Date Where OIG Wait Time Is over 30 Days	50	2,517 (18.2%)	695 (4.9%)	1,823 (13.3%)	3,212 (23.1%)
For the above, Average Wait Time	50	53	10	43	64
For the above with an OIG Wait over 30 Days, Total Number VHA Wait Shows 30 Days or Less	30	1185 (47.1%)	511 (15.8%)	674 (31.3%)	1696 (62.8%)
For the above Where OIG Wait Is over 30 Days and VHA Wait Is 30 Days or Less , Total That Should Have Been Added to the VCL but Were Not	26	973 (82.1%)	477 (16.5%)	496 (65.6%)	1449 (98.6%)
Total Number of New Appointments with a Clinically Indicated Date Where VHA Wait Is Greater Than 30 Days	20	1,332 (9.6%)	526 (3.7%)	806 (5.9%)	1,858 (13.3%)
Number of Appointments with a Clinically Indicated Date and VHA Did Not Use the Clinically Indicated Date	112	5,320 (38.4%)	904 (6.1%)	4,417 (32.3%)	6,224 (44.5%)
For the above, Average OIG Wait Time	112	24	6	18	31
For the above, Average VHA Wait Time	112	9	3	6	12

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
For the above, Average Difference between OIG and VHA Wait Time	112	15	6	9	22
Total Number of Mental Health Appointments with a Clinically Indicated Date	115	784 (45.1%)	103 (5.9%)	681 (39.2%)	887 (51.1%)
For the above, Average OIG Wait Time	115	17	2	14	19
For the above, Average VHA Wait Time	115	5	2	4	7
Out of the Total Mental Health Appointments with a Clinically Indicated Date, Number of Mental Health Appointments with an OIG Wait over 30 Days	21	150 (19.1%)	55 (6.7%)	95 (12.4%)	204 (25.8%)
For the above, Average OIG Wait Time	21	42	4	38	46
Out of the Total Mental Health Appointments with a Clinically Indicated Date, Number of Mental Health Appointments with a VHA Wait over 30 Days	3	27 (3.4%)	29 (3.6%)	-2 (-0.2%)	55 (7%)
Out of the above, Total Number of Mental Health Appointments with a Clinically Indicated Date and VHA Did Not Use the Clinically Indicated Date	58	409 (52.2%)	81 (8%)	329 (44.2%)	490 (60.2%)
For the above, Average OIG Wait Time	58	24	4	20	27
For the above, Average VHA Wait Time	58	2	1	1	3
For the above, Average Difference between OIG and VHA Wait Time	58	22	4	18	26

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total Number of Specialty Care Appointments with a Clinically Indicated Date	158	13,026 (70.8%)	938 (5.1%)	12,088 (65.7%)	13,964 (75.9%)
For the above, Average OIG Wait Time	158	19	3	15	22
For the above, Average VHA Wait Time	158	13	2	11	15
Out of the Total Specialty Care Appointments with a Clinically Indicated Date, Number of Specialty Care Appointments with an OIG Wait over 30 Days	29	2,367 (18.2%)	692 (5.2%)	1,675 (13%)	3,060 (23.4%)
For the above, Average OIG Wait Time	29	54	11	43	65
Out of the Total Specialty Care Appointments with a Clinically Indicated Date, Number of Specialty Care Appointments with a VHA Wait over 30 Days	17	1,305 (10%)	525 (4%)	780 (6.1%)	1,830 (14%)
Out of the above, Total Number of Specialty Care Appointments with a Clinically Indicated Date and VHA Did Not Use the Clinically Indicated Date	53	4,885 (37.5%)	899 (6.4%)	3,986 (31.1%)	5,784 (43.9%)
For the above, Average OIG Wait Time	53	24	7	18	31
For the above, Average VHA Wait Time	53	10	3	6	13
For the above, Average Difference between OIG and VHA Wait Time	53	15	7	8	22
Average VHA Wait for Total Number of New Patient Appointments for Primary Care, Mental Health Care, and Specialty Care with a Preferred Date	378	9	2	7	11

Source: VA OIG analysis of statistical sample results projected over the sample population

Choice Authorizations

Population

To determine whether VISN 15 provided timely access to Choice care, the OIG selected a statistical sample of Choice authorizations for primary care, mental health care, and specialty care. The population consisted of 260 primary care authorizations, 177 mental health care authorizations, and 21,763 specialty care authorizations created August 1 through October 31, 2016.

Sampling Design

For Choice authorizations, the OIG used a stratified random sample based on the three types of care—primary care, mental health care, and specialty care—to select samples for each stratum. The OIG reviewed only sample cases where veterans qualified for Choice based on having a wait of greater than 30 days or the need for services a VA medical facility cannot directly provide. The OIG did not include in the review authorizations for Choice care for those who qualified based on the 40-mile criteria. The OIG removed authorizations, such as those for an incorrect facility or those for continuing service, from the sample, and randomly replaced these authorizations when additional items were available in the population, resulting in an adjusted universe of about 22,200 authorizations. The OIG reviewed 79 primary care authorizations, 133 mental health care authorizations, and 210 specialty care authorizations. All records had a known chance of selection. This allowed us to make estimates over the entire population and by stratum.

Weights

The OIG calculated estimates in this report using weighted sample data. Sampling weights were computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG repeated this audit with multiple samples, the estimates and confidence intervals would differ for each sample, but the confidence intervals would include the true population value 90 percent of the time.

Table 37 presents estimates over the sample population, including the sample results, estimate, margin of error, lower 90 percent value, and upper 90 percent value.

Table 37. Statistical Projections–Choice Authorizations

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total Number of Choice Authorizations, Specialty, Primary, and Mental Health Care	422	22,196	N/A	N/A	N/A
Total Number of Choice Authorizations, Specialty Care	210	21,763	N/A	N/A	N/A
Total Number of Choice Authorizations, Primary Care	79	256	N/A	N/A	N/A
Total Number of Choice Authorizations, Mental Health Care	133	177	N/A	N/A	N/A
Total Number of Choice Authorizations with Scheduled Appointment	351	20,316 (91.5%)	683 (3.1%)	19,633 (88.5%)	21,000 (94.6%)
Average Days to Receive Care through VA or Other Non-Choice Provider	51	83	38	46	121
Average Days to Choice Appointment from Clinically Indicated Date Total	351	31.5	3.6	28.0	35.1
Average Days to Choice Appointment from Clinically Indicated Date Specialty Care	193	31.5	3.7	27.8	35.1
Average Days to Choice Appointment from Clinically Indicated Date Primary Care	58	41.2	9.3	31.9	50.5
Average Days to Choice Appointment from Clinically Indicated Date Mental Health Care	100	28.8	4.1	24.7	33.0
Total Did Not Receive Choice Appointment within 30 days of Clinically Indicated Date	150	8,347 (41.1%)	1,165 (5.7%)	7,182 (35.4%)	9,513 (46.7%)
Average Days to Receive a Choice Appointment If Not within 30 Days	150	58.5	5.1	53.4	63.5

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total Received a Choice Appointment within 30 Days of Clinically Indicated Date	201	11,969	1,236	10,733	13,205
Average Days to Refer to TriWest from Clinically Indicated Date	422	6.2	3.0	3.3	9.2
Average Days Scheduled Appointment Occurred after VA Provided Referral	351	25.7	2.5	23.2	28.1
Total over Seven Days to Refer to TriWest, from Clinically Indicated Date	123	6,593	1,060	5,533	7,654
Total under Seven Days to Refer to TriWest, from Clinically Indicated Date	228	13,723	1,162	12,561	14,885
For Those over Seven days to Refer to TriWest, Total Number Over 30 Days from Clinically Indicated Date to Choice Appointment	91	4,909 (74.5%)	986 (8.9%)	3,923 (65.5%)	5,896 (83.4%)
For Those under Seven Days to Refer to TriWest, Total Number over 30 Days from Clinically Indicated Date to Appointment	59	3,438 (25.1%)	894 (6.2%)	2,544 (18.9%)	4,332 (31.3%)
Total over 30 Days to Refer to TriWest, Total Number over 30 Days from Clinically Indicated Date to Appointment	96	6,246	1,120	5,126	7,366
Total Number of Choice Authorizations for Which VA Did Not Have Documentation at the Time of the Site Visit	110	4,373 (19.7%)	973 (4.4%)	3,399 (15.3%)	5,346 (24.1%)
Total Number of Choice Authorizations for Which VA Provided Documentation at the Time of the Site Visits	80	4,958 (22.3%)	1,009 (4.6%)	3,949 (17.8%)	5,966 (26.9%)
Total Number of Choice Authorizations for Which TriWest Provided Documentation at the Time of the Site Visits	161	10,986 (49.5%)	1,236 (5.6%)	9,750 (43.9%)	12,221 (55.1%)
Care Provided by VA or Non-VA Provider Other Than Choice	51	797 (6.4%)	434 (3.5%)	363 (2.9%)	1,230 (9.9%)

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Percent of Specialty Care Appointments over 30 Days from the Five Specialties: Dermatology, Neurology, Orthopedics, Radiology, and Sleep Studies	26	49.6	11.5	38.1	61.1

Source: VA OIG analysis of statistical sample results projected over the sample population

Open Consults

Population

To determine whether VISN 15 timely completed consults for new patients' appointments at its medical facilities, the OIG selected a statistical sample of open specialty care consults. The population consisted of 3,905 open specialty care consults that were greater than 30 days old, as of October 31, 2016.

Sampling Design

The OIG used a stratified random sample to select specialty care consults for review. From the population, the OIG reviewed 209 specialty care consults. All records had a known chance of selection. This allowed us to make estimates over the entire population.

Weights

The OIG calculated estimates in this report using weighted sample data. Sampling weights were computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG repeated this audit with multiple samples, the estimates and confidence intervals would differ for each sample, but the confidence intervals would include the true population value 90 percent of the time.

Table 38 presents an estimate over the entire population, including the sample results, estimate, margin of error, lower 90 percent value, and upper 90 percent value.

Table 38. Statistical Projections–Open Consults

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total Number of Open Consults That Were Greater Than 30 Days Old, as of October 31, 2016	209	3,905	0	3,905	3,905
Total Number of Open Consults Where Patients Received the Requested Care	151	2,878 (73.7%)	216 (5.5%)	2,662 (68.2%)	3,094 (79.2%)
For the above, Average OIG-Determined Wait Time	151	34.0 days	5.0	29.0	39.0
Total Number of Open Consults That Remain Open	11	213 (5.5%)	99 (2.5%)	115 (2.9%)	312 (8.0%)
For the above, Average OIG-Determined Are Still Open	11	198.0 days	42.0	156.0	240.0
Total Number of Open Consults That Were Discontinued or Canceled at the Time of the Review	47	814 (20.8%)	202 (5.2%)	612 (15.7%)	1,016 (26.0%)
For the above, Average Time to Close Consult	47	86.0 days	18.0	68.0	104.0
Total Number of Open Consults Where Staff Entered a Different Date Other Than the Referring Provider's Clinically Indicated Date	39	662 (39.5%)	183 (9.2%)	479 (30.3%)	845 (48.7%)
For the above, Average Days Beyond the Referring Provider's Clinically Indicated Date	39	36.0 days	10.0	25.0	46.0
Average Days to Act upon the Received Consults	209	3.0 days	1.0	1.0	4.0
Average Days to Schedule the Received Consults	197	16.0 days	4.0	12.0	20.0

Source: VA OIG analysis of statistical sample results projected over the population

Discontinued and Canceled Consults

Population

To determine whether VISN 15 staff appropriately managed consults, the OIG selected a statistical sample of discontinued and canceled specialty care consults. The population consisted of 15,897 specialty care consults that staff discontinued or canceled during the first quarter of FY 2017.

Sampling Design

The OIG used a stratified random sample to select discontinued and canceled specialty care consults for review. From the population, the OIG reviewed 210 discontinued and canceled consults. All records had a known chance of selection. This allowed us to make estimates over the entire population.

Weights

The OIG calculated estimates in this report using weighted sample data. Sampling weights were computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG repeated this audit with multiple samples, the estimates and confidence intervals would differ for each sample, but the confidence intervals would include the true population value 90 percent of the time.

Table 39 presents an estimate over the entire population, including the sample results, estimate, margin of error, lower 90 percent value, and upper 90 percent value.

Table 39. Statistical Projections–Closed Consults

Results	Sample Results	Estimate	Margin of Error	Lower 90%	Upper 90%
Total Number of Consults That Were Discontinued or Canceled during the First Quarter of FY 2016	210	15,897	0	15,897	15,897
Total Number of Consults That Were Inappropriately Discontinued or Canceled	51	4,293 (27.0%)	942 (5.9%)	3,351 (21.1%)	5,235 (32.9%)
Of Those Consults Inappropriately Discontinued or Canceled, Total Number of Patients Who Had Not Received the Requested Care as of the Review	29	2,706 (63.0%)	813 (13.7%)	1,893 (49.3%)	3,518 (76.7%)
Of Those Consults Inappropriately Discontinued or Canceled, Total Number of Patients Who Later Received the Requested Care, but Experienced Additional Delays	15	1,059 (24.7%)	571 (12.5%)	488 (12.2%)	1,630 (37.2%)
Of Those Consults Inappropriately Discontinued or Canceled in Which Patients Later Received the Requested Care, Average Additional Days Waited	15	51.0 days	12.0	38.0	63.0
Of Those Consults Inappropriately Discontinued or Canceled, Total Number of Patients Whose Care Was Not Affected	7	529 (12.3%)	375 (8.3%)	153 (4.0%)	904 (20.6%)

Source: VA OIG analysis of statistical sample results projected over the population

Appendix K Management Comments – Executive in Charge, Office of the Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: January 11, 2018

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15 (7862932)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15. I concur with recommendations 2, 6 and 7 and provide action plans to address these recommendations. The Director, Veterans Integrated Service Network (VISN) 15, will provide action plans to address the remaining recommendations.

2. The Veterans Health Administration (VHA) remains committed to continually improving access to ensure that every Veteran receives timely care. Since the time of this OIG review, VHA has made steady progress in ensuring the accuracy and timeliness of Veteran appointments. Specific examples of this progress include the following:

    a. VHA broadened and modernized the content and delivery of scheduler training. All existing and new staff scheduling appointments in 2017, more than 30,000, completed nationally standardized face-to-face training.

    b. VHA developed and implemented a nationally standardized scheduling audit cycle process and reporting tool. As of October 1, 2017, VHA finished the first 6-month audit cycle (April 1 – September 30, 2017) with a national compliance rate of completing 98 percent of the required audits. Of note, VISN 15 is on target to completed 100 percent of the required scheduling audits for the current audit cycle.

    c. Since April 2017, VHA measures wait times for all new patient appointments as the elapsed time between the date the patient requests an appointment (the appointment create date) to the date when the patient is seen (completed appointment). The starting point for this measurement is automatically generated when the appointment is scheduled and cannot be altered. This method of measurement ensures that wait times for new patient appointments are reliable.

    d. VHA developed and is in the process of implementing a new process to ensure the reliability for wait time calculations for follow-up appointments. This process automates the Patient Indicated Date (PID), also known as the Clinically Indicated Date, to ensure the clinician documented return to clinic date is automatically downloaded into VHA's scheduling system as the PID. Once completed, this process is expected to markedly decrease or eliminate errors in transcribing the PID from the order into a follow-up appointment record. This long awaited improvement is a big step in improving the reliability of waiting times, scheduling and trust in VA.

    e. VA remains committed to transparently publishing wait times, patient satisfaction scores and quality data for Veterans, their families and the public. The Access and Quality in VA Healthcare website launched in April 2017 at www.accesstocare.va.gov provides helpful information for every VA medical center and clinic to assist Veterans as they make decisions about where and when to receive care. This degree of transparency does not exist in private sector medicine.

f. VHA continues to prioritize Veterans with urgent care needs. As of December 31, 2017, VHA now provides same day services in Primary Care and Mental Health for urgent care needs in 100 percent of the over 1,000 community based outpatient clinics and other stand-alone clinics across the country.

g. In FY 2017, the average wait times for new patient appointments in Primary Care, Mental Health, Specialty Care, and All Clinics Combined were 21.8 days, 11.2 days, 20.7 days and 17.1 days, respectively. Since FY 2014, these wait times have improved respectively by 2.5 days, 0.2 days, 2.8 days and 2.0 days. VA staff continues to strive to further reduce wait times.

h. VA also measures the percentage of Veterans new to Primary Care and Mental Health whose appointments were completed the same day as the request for an appointment. For FY 2018, to date, VA completed 14.4 percent and 31.5 percent the same day, respectively. Both of these have improved when compared with data from FY 2014, when the numbers were 11.7 percent and 26.4 percent, respectively.

3. VHA has established and implemented monitoring procedures and controls to ensure that all Veterans Choice Program (VCP) contract performance standards and requirements are met. During FY 2017, VHA's Quality Assurance Surveillance Plan (QASP) activities identified and addressed performance issues specifically related to TriWest's performance for routine appointment scheduling and medical appointment completion. Remedial actions were taken and as of July 2017, the performance standards of 90 percent were being met and sustained for both measures.

4. Similarly during FY 2017, VHA identified issues with the timeliness of TriWest's medical documentation returns. Remedial actions were identified and TriWest is in the process of implementing these. While there has been continued and overall improvement in this timeliness since January 2017, VHA anticipates that TriWest will not fully achieve the performance standard until July 2018. VHA will continue to monitor TPA performance.

5. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(Original signed by:)

Carolyn M. Clancy, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15

Date of Draft Report: December 8, 2017

Recommendations/ Actions	Status	Completion Date

Recommendation 2: We recommended the Veterans Health Administration Executive in Charge initiate a process to automate the use of the clinically indicated date, when applicable, when scheduling appointments.

VHA Comments: Concur

The Veterans Health Administration (VHA) completed implementation of VistA Scheduling Enhancement (VSE) software that includes the process for automatically populating the clinically indicated date in the scheduling software. The VSE software was released in the summer of 2017 and as of January 2018, 97 percent of sites report schedulers are using VSE to schedule appointments. The data field in the VSE software containing the clinically indicated date is named "PID."

When the clinician sends a consult for specialty care or other health services, the clinician enters the clinically indicated date into the electronic consult request. VSE automatically populates the clinician's clinically indicated date into the scheduler's software. In other words, the "PID" data field is the same in the consult software as in the scheduling software. No staff are able to change the automatically populated clinically indicated date; even schedulers are not able to change the automatically populated clinically indicated date.

Status	Completion Date
Completed	January 2018

Recommendation 6: We recommended the Veterans Health Administration Executive in Charge implement standard monitoring procedures to ensure medical appointment timeliness standards are met as required under Choice contracts.

VHA Comments: Concur

VHA established and implemented standard monitoring procedures and controls to ensure all Veterans Choice Program (VCP) contract performance standards and requirements, including those standards for medical appointment timeliness, are met. The VCP Quality Assurance Surveillance Plan (QASP), pursuant to the requirements listed in the VCP contract's performance work statement, sets forth the procedures and guidelines VHA uses to ensure the required performance standards and service levels are achieved by the VCP Third Party Administrators (TPA). VHA's implemented procedures also include controls to ensure that VCP performance-related data is reported by the TPAs in a timely and consistent manner and is analyzed monthly by both TPA and VHA staff. The VCP QASP oversight processes have helped improve TPA performance over the life of the contract and have led to positive improvements in medical appointment timeliness.

VHA monitors TPA performance against VCP contract standards and requirements in the following ways:

- VHA Contracting Officer Representatives (COR) receive performance-related data from the TPAs by the 10th of each month. This information is assessed and discussed by both VHA and TPA staff. Regular review of performance data provides timely opportunities to address existing or emerging deficiencies as well as to initiate research on anomalies that require further discovery on their root cause.
- In-person Performance Management Reviews (PMR) are held on a quarterly basis to review overall and location-specific performance for the quarter. These formal reviews are a key part of VHA's activities for monitoring TPA performance and performance trends. They provide an opportunity to discuss solutions to specific issues, convey status of remedial actions being taken to address performance deficiencies and create a forum to collaborate with the TPA on a way ahead.
- When performance deficiencies are identified, VHA issues a Letter of Correction (LOC) and the TPA must respond to it by submitting a formal Corrective Action Plan (CAP) for the deficiencies. VHA reviews the CAP and approves or disapproves. If approved, VHA tracks the actions to completion and verifies through collected performance data that the deficiencies are corrected in line with the contract standard and/or performance requirement.

It should also be noted that VHA annually reports on TPA performance, including for medical appointment and scheduling timeliness, to the Naval Sea Logistics Center's Contractor Performance Assessment Reporting System (CPARS). The Administrator of the Office of Federal Procurement Policy has identified CPARS as the single Federal Government-wide information system for processing and collecting contractor performance data. The data is used by Federal government source selection officials when evaluating contract/order bids.

VHA has been routinely and regularly monitoring medical appointment timeliness, including the timeliness performance for routine care:

1) Scheduling of routine appointments within 15 business days of clinically indicated date or Veteran preferred date (QASP 1a performance standard 90 percent).
2) Completion of appointment within 30 business days of clinically indicated date or Veteran preferred date (QASP 12 performance standard 90 percent).

In fiscal year (FY) 2017, two LOCs were issued to TriWest related to their timeliness performance (January 2017 and July 2017). TriWest responded with appropriate Corrective Action Plans (CAP) which VHA accepted. TriWest's overall performance since January 2017, has reflected a continued improvement for both routine care timeliness measures. The scheduling performance standard was achieved in June 2017 (98 percent) and in July 2017, TriWest achieved a 91 percent performance level for appointment completion. Both measures have been sustained at the appropriate performance level since then.

VHA considers that appropriate actions have been implemented to ensure VCP performance standards are being met and actively monitored. VHA will continue to work with the TPAs to address VCP contract performance issues and will keep the communications and conversations with them on this matter open and on-going.

The following supporting documentation is evidence of VHA's completed actions and will be provided electronically to the Office of the Inspector General (OIG):

- VCP QASP – Oversight for Medical Appointment Timeliness
- VCP QASP performance data for medical appointment timeliness (TriWest, performance trend Jan – Oct 2017)

Status	Completion Date
Complete	October 2017

Recommendation 7: We recommended the Veterans Health Administration Executive in Charge implement controls to ensure Choice medical documentation is received timely in accordance with Choice contracts.

VHA Comments: Concur

VHA established and implemented standard monitoring procedures and controls to ensure that all VCP contract performance standards and requirements, including those for submission of medical documentation, are met. These are incorporated in the VCP contract's QASP. The prompt return of medical documentation is critical to Veteran care. It allows VA medical staff to ensure the Veteran received the requested care, evaluate whether the care was appropriate, and to coordinate future medical care for the Veteran. Timely receipt of medical documentation is also important to support the verification and auditing of billing activities and their accuracy.

VHA monitors TPA performance against VCP contract standards and requirements in the following ways:

- VHA CORs receive performance-related data from the TPAs by the 10th of each month. This information is assessed and discussed by both VHA and TPA staff. Regular review of performance data provides timely opportunities to address existing or emerging deficiencies as well as to initiate research on anomalies that require further discovery on their root cause.
- In-person PMRs are held on a quarterly basis to review overall and location-specific performance for the quarter. These formal reviews are a key part of VHA's activities for monitoring TPA performance and performance trends. They provide an opportunity to discuss solutions to specific issues, convey status of remedial actions being taken to address performance deficiencies and create a forum to collaborate with the TPA on a way ahead.
- When performance deficiencies are identified, VHA issues a LOC and the TPA must CAP for the deficiencies. VHA reviews the CAP and approves or disapproves. If approved, VHA tracks the actions to completion and verifies through collected performance data that the deficiencies are corrected in line with the contract standard and/or performance requirement.

It should also be noted that VHA annually reports on TPA performance, including medical appointments and scheduling timeliness, to the Naval Sea Logistics Center's CPARS. The Administrator of the Office of Federal Procurement Policy has identified CPARS as the single Federal Government-wide information system for processing and collecting contractor performance data. The data is used by Federal government source selection officials when evaluating contract/order bids.

VHA has worked aggressively since the start of the VCP contract to address specific issues affected by untimely medical documentation returns. VHA has been routinely and regularly monitoring two timeliness standards for return of medical documentation:

- QASP 2b – Inpatient medical documentation will be returned within 30 days of patient discharge with a performance standard of 95 percent.
- QASP 2a – Outpatient medical documentation will be returned within 75 days of the completion of the episode of care with a performance standard of 90 percent.

In addition, special requirements apply to urgent reports and critical findings.

VHA has noted an overall positive trend in TriWest's performance for both measures since January 2017. However, two LOCs were issued to TriWest related to their timeliness performance (January 2017, October 2017). TriWest responded with appropriate action plans which VHA has accepted. The plans include a provision for a provider portal to streamline and better support TriWest providers in complying with medical documentation submission requirements and timeliness standards. Completion of CAP actions was originally anticipated for January 2018, but recently revised to reflect a June 2018 completion. VHA anticipates TriWest compliance with the timeliness standards by July 2018.

VHA considers that appropriate controls and monitoring activities have been implemented to oversee medical documentation timeliness in accordance with the VCP contracts. VHA will continue to monitor TriWest's performance and improvement progress in this regard. VHA will request closure of this recommendation when TriWest has achieved performance at the 90/95 percent standard levels. This will provide an additional indication of the controls and monitoring processes focused on addressing this performance concern.

VHA will provide the following documentation to OIG to demonstrate closure of this recommendation:

- VCP QASP – Oversight for Medical Documentation Timeliness
- VCP QASP performance data for medical documentation timeliness (TriWest, performance trend Jan 2017 – July 2018)

Status	Target Completion Date
In Progress	August 2018

For accessibility, the format of the original documents in this appendix has been modified to fit in this document to comply with Section 508 of the Americans with Disabilities Act.

Appendix L Management Comments – Director, Veterans Integrated Service Network 15

Department of Veterans Affairs Memorandum

Date: December 22, 2017

From: Director, VA Heartland Network (10N15)

Subj: Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15

To: Assistant Inspector General for Audits and Evaluations (52)

Appointment scheduling is a necessary and critical function in healthcare. In a system as large and complex as the Veterans Healthcare Administration (VHA), scheduling assumes an even more critical role than in most medical organizations. This report by the VA Office of Inspector General documents the successes, challenges, and opportunities in scheduling function for the VA Heartland Network, VISN 15, and for VHA as a system.

The OIG determined that new patients with a clinically indicated date waited an average of 18 days. This value is well below, by almost 2 weeks, the VHA expectation of a no longer than a 30 day wait. In support of this finding by the OIG, 82% of new patients with a clinically indicated date were scheduled in 30 days or less. These results compare favorably with our experience in arranging care in the community through the traditional fee basis program. Outcomes such as these reflect the efforts of the Business Implementation and Systems Redesign staff at both the VISN and medical centers.

Scheduling practices in VHA represent a degree of complexity not seen in the rest of American medicine. Medical Support Assistants (MSA) who schedule in the VHA system must account for a Clinically Indicated Date or a Preferred Date while balancing these factors against clinic slot availability and whether the Veteran can or should be referred to the community, mostly through the Choice Program, and documenting these decisions correctly. The OIG determined that VISN 15 facilities overall did not record accurate wait times thirty eight percent of time. This error is concerning as it might reflect performance incorrectly and potentially impact resource allocation.

Despite the fact that the OIG did not include those Veterans whose wait time was measured on the Patient Indicated Date in this audit, the average wait time was only 18 days. A survey of private sector wait times done by Merritt Hawkins in 2017 found that family medicine wait times average 29.3 days. (*2017 Survey of Physician Appointment Wait Times and Medicare Acceptance Rates, Merritt Hawkins*).

Although VISN 15 was challenged to record wait times correctly, data from the OIG's report demonstrates in VISN 15 over 93% of Veterans either received care in less than 30 days or were referred to the community through the Choice Program. Even though the VA Calculated Wait Time differed significantly from the OIG Determined Wait Time, the more stringent measure by the OIG documented that VISN 15 met the 30 day wait time by almost two weeks. Thus, even though VISN 15 can and should improve its scheduling practices through enhancing training and feedback, the bottom line is that Veterans received timely care.

The Choice Program is designed to provide timely or more convenient care. The OIG audit documented that Veterans in VISN 15 waited an average of 32 days to receive healthcare through the Choice Program. While staff in VISN 15 provided an authorization to TriWest on an average of six days (one day less than the standard for in-house consult requests), TriWest required 26 days to complete the consult. The results achieved by VISN 15 occurred due to proactive establishment of a Choice Steering Committee designed to facilitate care through Choice. This committee continues to meet the challenges of assuring care is provided to Veterans in as timely and convenient manner possible.

VISN 15 achieved access through scheduler training and auditing. As noted in the OIG report, improvements are possible. In Fiscal Year 2016, VISN 15 did not meet the standard for auditing. However, in Fiscal Year 2017, VISN 15 exceeded the requirement of 10 appointments audited biannually. The biannual requirement is defined as *10 audits twice a year* as opposed to semi-annually (every six months). The OIG audit team only examined six months in Fiscal Year 2017; we provide the full year data to document compliance with the *biannual* requirement.

The OIG provided recommendations to VISN 15 and to VHA to improve scheduling practices, wait times, Choice management, and consult management. Our responses to each recommendation and plans to improve follow.

VISN Response to Findings and Recommendations

Finding 1: VISN 15 Medical Facilities Did Not Record Accurate Wait Times for an Estimated 38 Percent of New Mental Health or Specialty Care Appointments

Per the OIG estimates, more than 93% of Veterans (12,930 of 13,900 Veterans) were appropriately marked as having a wait less than 30 days based on the CID. Veterans are given the benefit to opt into the Choice program when the wait time is greater than 30 days. VISN 15 was compliant in seeing Veteran in less than 30 days or appropriately identifying the Veteran as being eligible for the Choice program.

Though CID/PID error was the #1 reason for an incorrect appointment, during the 1st half of FY17 VISN 15 only saw between 15% to 20% of its audits as incorrect due to CID/PID error. In the second half of FY17, VISN 15 saw a decrease in these errors. As a VISN, the CID/PID error rate was somewhere between 6% to 9% of the total audits. The OIG's finding that 38% of new MH and SC appointments had an incorrect CID/PID was higher than our audit results.

Finding 2: Veterans in VISN 15 Waited an Average of 32 days To Receive Health Care Through the Veterans Choice Program

The OIG report confirms VISN 15 efforts to ensure Veterans receive timely and seamless care through the Choice Program. Key figures from the report include:

- The average wait time for Veterans authorized for the Choice Program was 32 days. This included:
  - 6 days for the VAMC to upload the authorization to the national contractor. This time frames includes:
    - Opting the Veteran into the Choice program
    - Clinical eligibility review
    - Administrative eligibility review
    - Development of the community care plan
    - Packaging of relevant medical documentation
    - Completion of the authorization
    - Uploading documents successfully to the TPA Portal
  - 26 days from the time the national contractor received the authorization to the appointment date
  - Approximately 50% of those Veterans who were not seen in 30 days were for services in high demand in the community, including:
    - Dermatology

- Neurology
- Orthopedics
- Radiology
- Sleep studies

- Based on a review, for which 98% of the authorizations were scheduled more than 75 days prior to the review, the TPA provided medical records for approximately 49% (11,000 of 22,220).
  - The VAMC collected an estimated 5,000 missing medical records form Choice Vendors.

Finding 3: VISN 15 Did Not Consistently Manage Specialty Care Consults in Accordance With Policy

The OIG audit scope included the appropriate management of discontinued and canceled consults. VHA Directive 1232, Consult Processes and Procedures, dated August 24, 2016 and amended September 23, 2016, provides the guidance on consult management, standardize consult processes, and oversight responsibilities. The following are national consult status definitions for discontinued and cancel/Deny:

- Discontinue (dc). This status is used by the sending or receiving provider to discontinue a consult no longer wanted or needed. If the sender discontinues a consult an alert may be sent to the receiving service. If a receiving provider discontinues a consult an alert must be sent to the sending service. The Consult Resolution notification pathway must be set to mandatory so that a notification will be sent.
- Cancel/Deny (x). This status is selected by the receiving service to return a consult request to the sender. Cancel/Deny is used if the ordering provider did not ask an appropriate consult question or provide sufficient information. This status may also be used to correct an obvious error in the consult order (e.g., Future Care Consult with CID of Today). Selection of this status sends an alert to the sending provider. Canceled consults are never to be resubmitted if they are more than 90 calendar days old.

The findings from the OIG audit concluded VISN 15 staff used the discontinue and cancel consult statuses inappropriately. Staff members used the discontinue option when the cancel option should have been used and vice versa. Field staff have voiced their confusion and concern discontinue and cancel consult statues to national program directors. Facility Chiefs of Staff and VISN Chief Medical Officers have requested a change to the discontinue and cancel options or the elimination of one. The multiple national consult business rules associated with each of the consult statuses is challenging for providers and staff to recall or remember, especially when the consult menu options are not intuitive related to the final consult disposition.

Recommendation 1: OIG recommends VISN 15 Director ensure that staff at all network facilities use the clinically indicated date, when available, when scheduling new patient appointments.

Concur

Target Date for Completion: Request Closure

VISN 15 proactively established a VISN Scheduling Taskforce in December 2016 to promote compliance that all with VHA Scheduling Directive 1230. The Scheduling Taskforce oversees the scheduling program, completion of training of scheduling staff, and internal monitors are set up and reviewed at the VISN and Facility level.

VISN 15 has seen an improvement with scheduling accuracy pertaining to the use of the Clinically Indicated Date (CID) / Patient Indicated Date (PID). In the absence of national benchmarks, the VISN 15 director set a goal of 10% accuracy for the network. We expect with the rollout of the VSE which automates the determination of CID/PID that this will be solved.

(See Table 2 of Audits of Scheduling Accuracy)

Audits - Scheduling Accuracy												
CID or PID NOT USED (INCORRECT) / TOTAL AUDITS	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
VISN	**19.91%**	**14.63%**	**11.31%**	**15.35%**	**14.08%**	**12.08%**	**6.59%**	**7.57%**	**6.78%**	**6.70%**	**9.98%**	**9.92%**
*Lower is better												

Based on this data, we recommend closure of this recommendation.

Recommendation 3: We recommended the VISN Director ensure network facilities appropriately manage the scheduler audit tool in order to conduct the required scheduler audits, communicate specific audit results to scheduling staff, and take corrective actions as needed based on audit results.

Concur.

Target Date for Completion: Request Closure

By the end of FY17, the Office of Veteran Access to Care confirmed VISN 15 has met and completed the National Audit Requirement. (see Table 1 of Audits completed monthly by each facility). In addition, as of September 2017, all facilities have a full-time Scheduling Auditor on board. Every facility Scheduling Auditor has a process in place to ensure communication of audit results happen at the local level. The VISN Scheduling Taskforce is the main forum where audit results are communicated.

Also, the Facility CBI Office reports the audits to the Facility Director or a Facility Access Committee either weekly or monthly. Communicating audit results has significantly improved scheduling accuracy in VISN 15.

VISN 15												
	October	November	December	January	February	March	April	May	June	July	August	September
Accuracy Rate	75.64%	82.49%	80.31%	71.44%	72.00%	80.96%	86.85%	86.68%	92.83%	92.80%	88.87%	88.82%

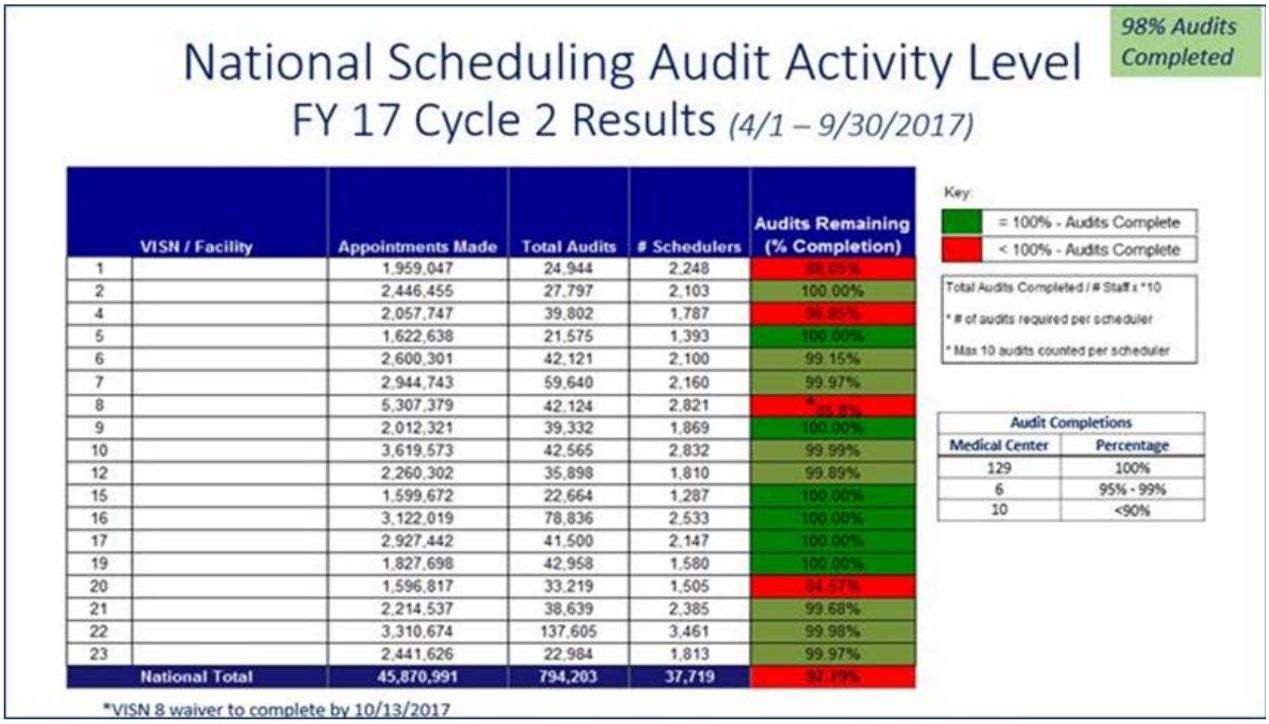
Each facility will document communication of Audit results in the appropriate committee minutes. Those minutes will be reviewed by the VISN. Target is all hospitals have 4 months of compliant minutes.

The tables below show the successful completion of the National Audit Requirement in FY 17.

Table from OIG Audit of Access to Care in V15 [OIG Note: last column added by VISN 15]

Table 5. VISN 15 Facility Scheduler Audits Completed in FY 2017 (October 2016 – March 2017) Facility	Schedulers	Schedulers Audited on 10 or More Appointments	Compliance by End of FY 2017
Harry S. Truman Memorial Veterans' Hospital	186	13 (7%)	100%
John J. Pershing VAMC	75	61 (81%)	100%
Kansas City VAMC	299	149 (50%)	100%
Marion VAMC	163	13 (8%)	100%
Robert J. Dole VAMC	214	106 (50%)	100%
VA Eastern Kansas Health Care System	291	256 (88%)	100%
VA St. Louis Health Care System	412	290 (70%)	100%

BISL Data from Office of Veterans Access to Care (OVAC):



Recommendation 4. We recommended the Veterans Integrated Service Network 15 Director examine processes to improve monitoring and tracking for timely surveillance colonoscopies.

Concur

Target Date for Completion: June 30, 2018

VHA has developed a Colorectal Cancer Screening Surveillance System that is being rolled out across the country. VISN 15 is included in Phase 2 of the roll out of the system. Phase 2 started on 12/13/2017. This system, based on clinical reminders will allow tracking future care needs. Once we have implemented the system, we will develop ongoing reports on completion that will be reported regularly to VISN leadership.

Recommendation 5: OIG recommends the VISN 15 Director implement additional standard monitoring procedures sufficient to enable network facility staff to accurately manage the aging of all referrals for eligible Veterans for Choice care.

Concur

Target Date for Implementation: March 2, 2018

VISN 15 has implemented the use of the Consult Toolbox to improve documentation of actions for community care consults. VISN 15 will continue to provide training to staff on how to utilize the Consult Toolbox reports to improve operations. The consult toolbox management reports will be implemented at all sites and in effect by March 2, 2018.

Recommendation 8: OIG recommends the VISN 15 Director communicate specific audit results of VHA's audit of consults to all network facility staff involved in consult management, implement specific training, and ensure corrective action is taken as needed.

Concur

Target Date for Completion: May 31, 2018

VISN 15 Compliance performs biannual consult audits in accordance with VHA Directive 1232. The monitoring activities related to consult audits include a corrective compliance action plan (CCAP) for compliance audit rates below 95%. The results of the consult audits are presented at the VISN 15 Consult Workgroup meeting. The workgroup membership includes site representatives involved in consult management at the respective facilities. In addition to biannual consult audits, random out of cycle focused audits are conducted for the appropriate use of the discontinue and cancel consult statuses.

A fact to be aware of is the VISN 15 Compliance audit consult report for FY17Q1 was not released until after the conclusion of the OIG audit. The raw data was available, but was not authorized to be released to the field until the National CBI office completed the quality checks. Making note of this does not imply sole reliance on national audit results for monitoring activities, but it does provide the necessary data needed to assess and address wide-spread systematic problems. This data is critical in the determining corrective actions or focused training that may be needed on a large scale.

The Office of Compliance and Business Integrity published the Outpatient Specialty Care Consult Management Compliance Audit on April 28, 2017. The VISN level documentation error rates are 5% or less. This means that VISN 15 has a 95% or better compliance rate in all categories.

Taken from CBI Consult Audit Report								
	Provisional Diagnosis not documented	Reason for Request Not Documented	Veterans Choice Option Not Offered	Documentation Does Not Support Status Changes	Discontinued Consult Non-Compliant	Minimum Scheduling Efforts Not Documented	Cancelled Consult Non-Compliant	Completed Consult Inappropriately
V15	0%	1%	2%	3%	4%	1%	5%	4%
Rank	1 of 18	2 of 18 (tied)	3 of 18 (tied)	5 of 18 (tied)	8 of 18 (tied)	1 of 18 (tied)	11 of 18 (tied)	6 of 18 (tied)

VISN 15 will ensure consult audits results are communicated to facilities compliance officers and VISN 15 consult workgroup members. Compliance minutes will document that communication.

Recommendation 9: OIG recommends the VISN 15 Director ensure network facilities manage consults that are clinically indicated for the future in accordance with VHA's consult policy.

Concur in principle

Target date for Completion: Request Closure

The finding associated with the recommendation was based on an isolated occurrence at the Kansas City VAMC with the GI consult process and was not deemed to be a systemic issue throughout VISN 15 facilities. Bearing in mind this fact and considering VISN 15 is committed to maintaining a highly reliable system, VISN 15 will ensure all facilities adhere to the consult processes and procedures for future care consults as outlined in VHA Directive 1232.

VHA Directive 1232, Consult Processes and Procedures, dated August 24, 2016 and amended September 23, 2016, provides the guidance on consult management, standardize consult processes, and oversight responsibilities. Definition: Future Care Consults. Requests for care where the earliest appropriate date/clinically indicated date is more than 90 days from consult initiation. Future care consults should not be used to address issues of access or availability. Future care appointments may be managed within the consult package using consult titles with the words "future care" or "FC" and with the earliest appropriate date/clinically indicated date field completed by the sending provider. Future care consults may remain in a pending or active status and be scheduled closer to when the appointment is needed.

The findings from the OIG audit concluded the Kansas City VAMC inappropriately discontinued GI future care consults and alternative methods were used to track the resubmission of the GI consult at a date closer to the timeframe the service was needed.

- Action taken: The Kansas City VAMC re-instated the use of future care consults for the GI consult service on 4/18/17.

Recommendation 10: OIG recommends the VISN 15 Director ensure network facilities implement contingency plans in accordance with VHAs outpatient clinic practice management policy and communicate to providers regarding how to process consults when a service becomes unavailable.

Concur in principle

Target Date for Completion: February 16, 2018

The finding associated with the recommendation was based solely on an isolated occurrence at the Poplar Bluff VAMC Pain consult service and was not deemed to be a systemic issue throughout VISN 15 facilities. Bearing in mind this fact and considering VISN 15 is committed to maintaining a highly reliable system, VISN 15 will ensure all facilities establish a local process for the deactivation of a consult service when no longer available.

- VISN 15 will ensure all facility create standard operating procedures for the deactivation of consult services when the service is no longer available by January 31, 2018.
- VISN 15 will facilities communicate the consult service deactivation and notification process to referring providers by February 16, 2018.

Recommendation 11. We recommended the Veterans Integrated Service Network 15 Director ensure the care of patients identified in the patient summaries of this report are evaluated, take action, if appropriate, and confer with Regional Counsel regarding the appropriateness of disclosures to patients and families.

Concur and request closure.

The OIG actually reviewed 1,494 appointments during the course of this audit. Of those 1,494, they referred 83 cases to the OIG OHI for review. This means that 95 percent did not have any potential issues identified. Only 6 of the 1,494 were found to have possible issues, which means that 99.6% of the cases reviewed did not have any issues. Of the six cases identified in this report, only 1 case needed follow up for disclosure, which means that 99.94% needed no follow up.

All patients identified in this report have had their care evaluated. The summaries of the results of those evaluations and the plans are below.

Patient 1:

This case was evaluated by a board-certified Gastroenterologist. The 2005 colonoscopy was done at a VAMC in a different VISN. The patient was at this VAMC until 2006, and no further action was taken at that hospital. According to the Gastroenterologist who reviewed this record, the findings of that colonoscopy were common findings, and not significant. This Veteran had multiple significant co-morbidities including age which would make having a colonoscopy a greater risk. Because of the significant risk associated with having a colonoscopy, when the Veteran had a positive FIT, a CT colonography was completed which identified the cancer. The Gastroenterologist noted that it is highly improbable that a significant premalignant lesion was present in the cecum, that was not visualized during the 2005 colonoscopy. That ultimately was the initiating lesion leading to this cancer more than a decade later. No further action is necessary. No clinical intervention was recommended by outside physician reviewer.

Patient 2:

The colonoscopy in 2005 showed no polyps. It is a supposition that if next colonoscopy was done sooner there would be fewer polyps. Although there were polyps found, none were cancerous, so there was no clinical significance to length of time between colonoscopies. This case was reviewed by a board-certified Gastroenterologist who found “Based on the most recent guidelines published in 2012, patients who have low risk adenomas as presumably noted on this patient in 2001 and found to have no polyps on 5 year surveillance can be followed in 10 years for colon polyp surveillance without increased risk of CRC. The guidelines summarize this issue on Table 10 of the guidelines. More importantly colonoscopy with polypectomy does not reduce the risk of developing metachronous polyps as the etiology of polyp development is not altered by colonoscopy. The use of Aspirin or NSAIDs has however been shown to reduce the risk of metachronous development of polyps”. No clinical intervention was recommended by outside physician reviewer.

Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer, Lieberman et al, GASTROENTEROLOGY 2012;143:844–857.

Patient 3:

Consult documentation shows that the patient did not want the consult. He did not show for one appointment, and cancelled a second appointment. During a follow-up primary care appointment 6 months after the last consult contact, the Primary Care Provider asked the patient about seeing urology. Again the patient refused to see urology. The staff completed all required steps to ensure the patient received care. Veterans have the right to refuse care (VHA Handbook 1004.01 INFORMED CONSENT FOR CLINICAL TREATMENTS AND PROCEDURES). No clinical intervention was recommended by outside physician reviewer.

Patient 4:

The Choice report was provided to the OIG OHI with essentially negative results. The gastroenterologist did not recommend any further follow up or screening colonoscopies. The six-month wait was not clinically significant. No clinical intervention was recommended by outside physician reviewer.

Patient 5:

The Medical Center completed a review of this patient's care and an institutional disclosure was completed on January 8, 2018.

Patient 6:

The provider, after the patient refused a foot exam during that appointment, requested podiatry in November. Patient was admitted in early November with infected foot so appointment in November wouldn't have prevented that. If patient would have kept his scheduled podiatry appointments earlier in the year, there could have been better monitoring of his foot.

From 2015 to 2017, the patient had 9 scheduled appointments, and either no-showed or cancelled 5 of them.

3/5/15 – no-show

11/12/15 – kept appointment

12/14/15 – cancelled by patient

1/4/16 – no-show

2/10/17 – no-show

8/21/17 – kept appointment

8/29/17 – kept appointment

9/13/17 – cancelled by patient

11/13/17 – kept appointment

The delay in scheduling of the September consult did not lead to his hospitalization. Upon evaluation, the difference between September primary care appointment and the hospitalization in early November did not impact the care of the Veteran and no disclosure is needed. No clinical intervention was recommended by outside physician reviewer.

(Original signed by:)

Dr. William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

For accessibility, the format of the original documents in this appendix has been modified to fit in this document to comply with Section 508 of the Americans with Disabilities Act.

Appendix M OIG Contact and Staff Acknowledgments

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Acknowledgments	Daniel Morris, Director Maria Afamasaga Kalli Anello John Bertolino, MD Matthew Byrne Katherine Clay Glenn Dawkins Kevin Day Marisa Fantasia Michael Fleak Lee Giesbrecht Timothy Halpin Eileen Keenan Barry Johnson Jennifer Leonard Meredith Majerle Sonia Melwani, DO Karen Myers David Orfalea Nilda Ortega Carla Reid Victor Rhee Brock Sittinger Keila Tugwell-Core Debra Zamora

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