DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia

HEALTHCARE INSPECTION | REPORT #18-01622-207 | JULY 21, 2020

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Atlanta VA Health Care System, Decatur, Georgia (facility), to review allegations and concerns of delays in care related to three patients' consult appointments. The first patient had orthopedic/hand consults for a facility outpatient clinic that were subsequently replaced with a non-VA community care (NVCC) consult.[1] The second and third patients had colonoscopy and allergy/immunology NVCC consults, respectively.[2]

The OIG requested and received responses from the facility regarding the allegations. The OIG confirmed the facility's substantiation that the scheduling of the Veterans Health Administration (VHA) consult and NVCC consult appointments for the three patients were delayed. The OIG did not identify adverse clinical outcomes or increased risk for the three patients.[3] To evaluate if delays were widespread in scheduling NVCC consult appointments and whether patients experienced risks of or adverse clinical outcomes from those delays, the OIG expanded the review to include NVCC orthopedic/hand, colonoscopy, and allergy/immunology consults ordered by facility providers July 1–September 30, 2018. The OIG identified and reviewed 221 NVCC consults during the specified timeframe:[4]

- One hundred fifty-nine of the 221 NVCC consults reviewed did not meet the VHA requirement to schedule appointments within 30 days or less of the patient indicated date.[5]
- Two of the 221 patients had increased risks of adverse clinical outcomes related to the delays but did not experience adverse clinical outcomes.

[1] This OIG inspection relates to events that took place prior to implementation of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) act and the transition from the term NVCC to Community Care. The OIG uses the term NVCC in this report.

[2] The orthopedic/hand patient had two facility outpatient clinic consults that were discontinued and subsequently replaced with an NVCC consult. Based upon the issues reported, the focus of the OIG review was NVCC consults.

[3] Within the context of this report, the OIG considered adverse clinical outcomes to be changes in the patient's condition including worsening symptoms that required emergency care, hospitalization, and/or caused death.

[4] The 221 NVCC consults included 13 orthopedic/hand, 196 colonoscopy, and 12 allergy/immunology consults but did not include the three patients specified in the original allegations.

[5] VHA Memorandum, *Scheduling and Consult Policy* Update (VAIQ#7798804) June 5, 2017. VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. The patient indicated date is the date an appointment is deemed clinically appropriate. It is based upon the needs of the patient and should be at the soonest appropriate date. VHA's timeliness goal for consults specifies scheduling an appointment within 30 calendar days or less from the patient indicated date.

- Forty-four of the 221 consults lacked either an appointment for the consult or documentation from a consult appointment.

The OIG requested and received updates on three occasions from the facility for the 44 patients who did not have an appointment or documentation of an appointment. The most recent update in August 2019 indicated

- Twenty-two patients had consults completed with appointment documentation received and scanned into record;
- Eight patients had consult appointments, but documentation, though requested, had not yet been received;
- Six patients had consults in progress and partially completed;
- Six patients had consults discontinued when scheduling efforts failed; and
- Two patients had consults discontinued when the veteran declined the appointment.[6]

Several factors affected the processing, scheduling, and timeliness of NVCC consults. These factors included, but were not limited to, inconsistent scheduling processes, inconsistent oversight as evidenced by lack of documentation of leaders' oversight and program performance improvement actions, deficiencies with third-party administrator scheduling oversight, shortages of facility NVCC staff, and training and supervision deficiencies as evidenced by lack of documentation for facility NVCC scheduling staff.[7]

According to an interviewee, facility leaders were informed in August 2018 that there were 18,000 open NVCC consults, and although no specific action plan was outlined, facility staff worked after hours and weekends to decrease the backlog. The OIG determined that contributing factors for this backlog may have been scheduling-staff shortages, the loss of the third-party administrator, lack of leadership and oversight of scheduling processes, and deficiencies in scheduling staff training. The OIG requested an update on July 26, 2019, and received a response from the facility on August 2, 2019, that open consults had decreased to 13,740. Although no specific action plan was presented with this update, leaders stated that NVCC staff continued to work on assisting patients in the NVCC scheduling process.[8]

The OIG reviewed consult timeframes to close and schedule appointments and found that delays primarily occurred during the active status (consult has been authorized but appointment has not

[6] This information was provided by the facility, and the OIG inserted the definition of consult completion to be consistent with the completed definition from the VHA directive.

[7] A third-party administrator is a non-VA contractor who performs management duties, such as appointment scheduling, for the VA CHOICE program.

[8] The 18,000 open consults included all NVCC consults whether patients' appointments were scheduled or not. The 13,740 consults also reflected all open consults within the NVCC program.

been scheduled) of the NVCC consult process.[9] According to facility staff, delays occurred due to disjointed and inconsistent processes; specifically, scheduling staff would not finish the scheduling process for one patient before moving to the next patient request.

VHA Directive 1232 requires facilities to "outline the necessary steps to be taken to complete the Non-VA Care consult if no clinical documentation is obtained." To accomplish this task, consults that are closed due to lack of documentation from non-VA providers must be distinguished from those closed for other reasons. The facility's Standard Operating Procedure did not include the necessary steps to identify NVCC consults closed due to lack of results documentation.[10]

Six recommendations were made to the Facility Director related to the open NVCC consults backlog, oversight of non-VA consult management, NVCC consult performance measurements, NVCC staff hiring, documentation of NVCC scheduler training and supervision, patient case reviews, and identification of consults that are administratively closed without relevant medical documentation.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes C and D). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

[9] VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016. VHA uses *status* designations to track the progression of a consult through the scheduling process (emphasis added). The progression statuses are pending (automatic when consult order is written); active (received by schedulers and efforts are underway to schedule an appointment. For non-VA care, appointment schedulers must also check for veteran eligibility and review the consult before beginning the tasks of scheduling an appointment); scheduled (appointment is scheduled but has not occurred); completed (appointment has occurred and tasks performed), discontinued (closed for reasons other than completion); and canceled (additional information is needed to complete the consult, consult may be edited).

[10] VHA Directive 1232(1).

Contents

Abbreviations

Choice	Veterans Choice Program
ECMS	Executive Committee of the Medical Staff
EHR	electronic health record
NVCC	Non-VA Community Care
OIG	Office of Inspector General
PID	patient indicated date
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Atlanta VA Health Care System, Decatur, Georgia (facility), to review allegations and concerns of delays in care related to three patients' consult appointments. The first patient had orthopedic/hand consults for a Veterans Health Administration (VHA) outpatient clinic and a non-VA community care (NVCC) consult. The second and third patients had colonoscopy and allergy/immunology NVCC consults, respectively.[1]

Background

The facility is part of Veterans Integrated Service Network (VISN) 7. It operates seven community-based outpatient clinics. VA classifies the facility as Level 1a–high complexity.[2]

From October 1, 2017, through September 30, 2018, the facility served 115,785 patients and had a total of 371 hospital operating beds, including 192 inpatient beds, 107 community living center beds, 61 domiciliary beds, and 11 Compensated Work Therapy/Transitional Residents beds.

Consults

A consult is a request for clinical services on behalf of a patient. VHA consult requests are made through an electronic documentation communication process that allows an interaction between a sending provider and a receiving provider.[3]

VHA facilities use a consult software program to enter, approve, schedule, and document consult information in patients' electronic health records (EHRs). This software generates an automatic notification (alert) in the EHR to notify the requesting provider of updates, including when a consult is canceled or discontinued.[4]

---

[1] The orthopedic/hand patient had two facility outpatient clinic consults that were discontinued and subsequently replaced with an NVCC consult. Based upon the issues reported, the focus of the OIG review was NVCC consults.

[2] The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex, http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx. (The website was accessed on March 6, 2019.)

[3] VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

[4] VA Office of Information and Technology, *Consult/Request Tracking User Manual,* August 2018.

Clinical Consults

Clinical consults are "two-way communications on behalf of a patient" between a sending provider and a receiving provider. The sending provider requests or is seeking an opinion, advice, or expertise regarding the evaluation or management of a patient-specific problem from the receiving provider, who responds to the request. The process applies to consults sent to providers within VHA and consults sent to providers in the community.[5]

Clinical consults include a patient indicated date (PID), which is the date an appointment is deemed clinically appropriate.[6] The PID is based upon the needs of the patient and should be at the soonest appropriate date. VHA's timeliness goal for consults specifies scheduling an appointment within 30 calendar days from the PID.[7] See figure 1 for the clinical consult process.

[5] VHA Directive 1232(1).

[6] VHA Memorandum, *Scheduling and Consult Policy Update* (VAIQ#7798804) June 5, 2017. VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016. PID includes earlier definitions of the clinically indicated date (CID) and preferred date (PD). The PID is determined by the date the provider requests an appointment for a patient or by the date when the provider decides an appointment is clinically appropriate. Within the context of this report, the OIG uses the term PID to represent all three terms: PID, CID, and PD.

[7] VHA Directive 1230.

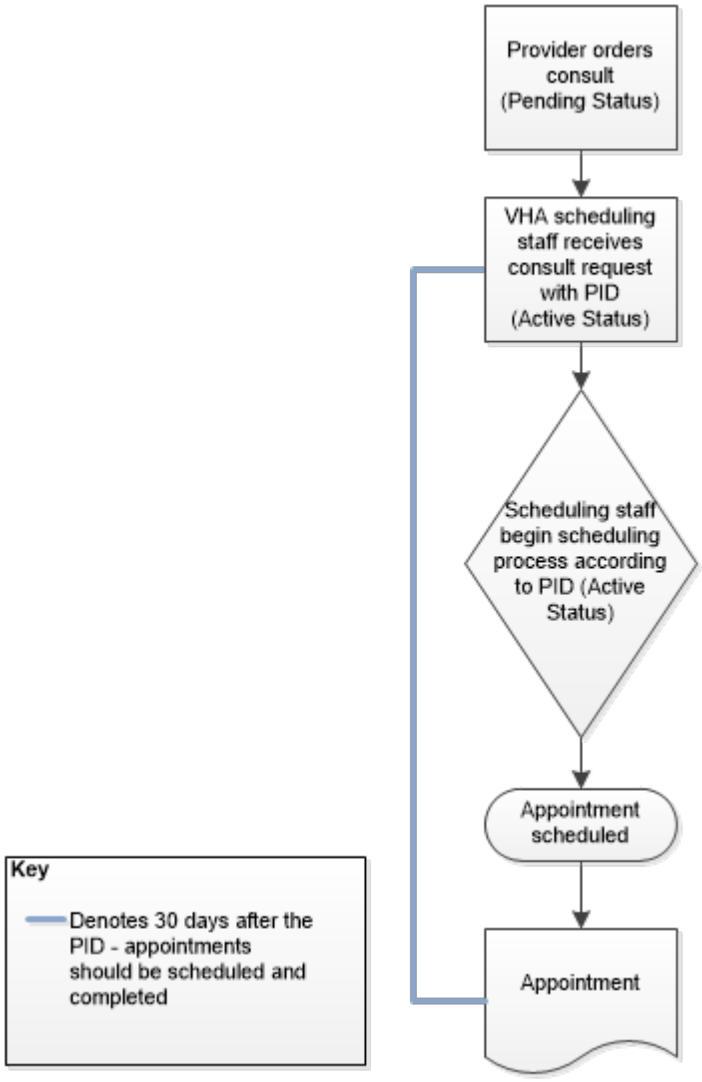

Figure 1. Clinical consult appointment scheduling process
Source: OIG Analysis of VHA Directive 1232(1) and VHA Directive 1230

NVCC Consults

NVCC refers to clinical consults made to non-VA providers by VHA providers; additional steps must be taken to complete this consult process. Non-VA care for veterans is purchased by VHA and may be utilized by eligible veterans when VHA facilities cannot provide care and services; a patient cannot safely travel due to medical reasons; care cannot be provided in a timely manner; or care cannot be provided due to geographic inaccessibility.[8] A consult and pre-authorization

[8] VHA Directive 1232(1). VHA Directive 1601A.02, *Eligibility Determination*, June 7, 2017, amended July 27, 2017.

(which includes checking whether the veteran is eligible and wants non-VA services) for non-VA treatment are required for services rendered through NVCC.[9]

At the time of this review, NVCC purchased care included two methods to purchase care though consults in the community: Veterans Choice Program (Choice) and traditional non-VA care.[10] Choice care appointments were generally coordinated and scheduled using a third-party administrator, traditional non-VA care was purchased from non-VA providers without the involvement of a third-party administrator. (See figure 2 for explanation of both processes and appendix A for discussion of new legislation that replaced Choice in June 2019.)[11]

[9] VHA Directive 1232(1).

[10] At the time of the OIG review, VA offered a variety of healthcare and services for veterans through non-VA healthcare providers and other partners outside of VA. These services were provided to veterans based on certain conditions and eligibility requirements, and in consideration of a veteran's specific needs and circumstances and may be scheduled through a non-VA third-party service or directly through VA schedulers. https://www.va.gov/COMMUNITYCARE/programs/veterans/General_Care.asp. (The website was accessed on March 6, 2019.) Choice was established by the Veterans Access, Choice, and Accountability Act of 2014. Under Choice, VA contracted with a third-party administrator to purchase care from certain non-VA providers. VHA Directive 1700.

[11] Veterans Choice Program. https://www.va.gov/COMMUNITYCARE/programs/veterans/VCP/index.asp. (The website was accessed on March 6, 2019.) https://www.hnfs.com/content/hnfs/home/va/veteran.html. (The website was accessed on February 22, 2019.) VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013.

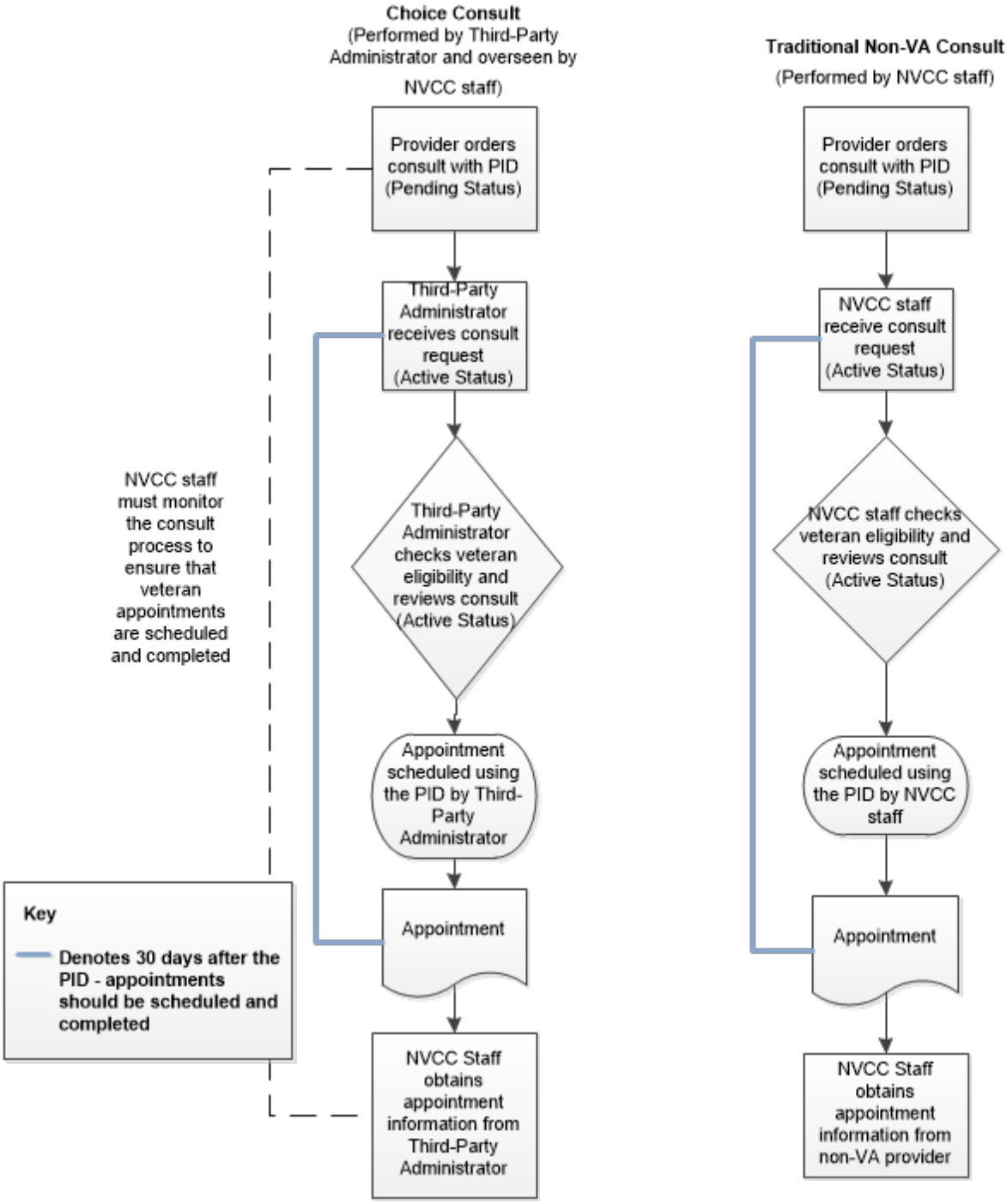

Figure 2. Choice and traditional non-VA care clinical consult appointment scheduling processes
Source: OIG analysis of VHA Directive 1232(1), and on-line descriptions of third-party and VA appointment schedulers https://www.va.gov/COMMUNITYCARE/programs/veterans/General_Care.asp. (The website was accessed on March 6, 2019.)

Once the consult appointment is performed by a non-VA provider, a note with the results is sent back to the VHA sending provider and is scanned into the patient's EHR.[12] Consults discussed in this report include a VHA outpatient clinic consult and NVCC consults.

Allegations and Related Concerns

The OIG received allegations related to delays in scheduling consult appointments, and care experienced by three patients whose consult appointments were not scheduled timely.

The OIG requested and received responses from the facility for the allegations. Facility leaders substantiated the delays in scheduling appointments; however, they confirmed that appointments had been made for the three patients. Although the OIG agreed with the facility's substantiation and actions to schedule consult appointments for these patients, the responses did not allay the OIG concerns about the facility's consult processes, including the timeliness of scheduling consult appointments.[13]

A hotline inspection was opened on September 27, 2018, to address the OIG's concerns with scheduling timeliness of the three patients' consult appointments. The first patient had two orthopedic/hand consults for the facility's outpatient clinic and an NVCC consult. The second and third patients had colonoscopy and allergy/immunology NVCC consults, respectively. The OIG reviewed the patients' EHRs for possible increased risk of and/or adverse clinical outcomes resulting from those delays.[14]

After initially reviewing the VHA consult and the three patients' consult appointments and substantiating the delays, the OIG expanded the review to include NVCC orthopedic/hand, colonoscopy, and allergy/immunology consults ordered by facility providers from July 1 through September 30, 2018, to evaluate if delays were widespread in scheduling NVCC consult appointments and if patients experienced risk of or adverse clinical outcomes from delays. The

[12] VHA Directive 1232(1).

[13] The OIG identified a concern with one patient's outpatient consult urgency designation (marked routine instead of STAT) that should have been reviewed initially by the first provider ordering the consult to appropriately schedule the consult; however, the OIG did not identify an increased risk of, or adverse clinical outcome related to the urgency designation.

[14] Medline Plus, *Orthopedic services.* Orthopedic services are diagnostic tests and treatments that involve the musculoskeletal system including bones, joints, ligaments, tendons and muscles. https://medlineplus.gov/ency/article/007455.htm. Medline Plus, *Colonoscopies.* Colonoscopies are procedures performed by a provider to view the larger intestines using a scope with a small camera attached to the end that is inserted into the bowel. The procedure allows the provider to view inflamed tissue, abnormal growths and ulcers. https://medlineplus.gov/colonoscopy.html. American College of Physicians, *Allergy and Immunology.* Allergy and immunology services involve the management by providers of disorders related to the immune system. Conditions include allergy reactions to food and other items, and symptoms include respiratory issues such as sneezing, and cessation of breathing, and skin reactions such as rashes and inflammation. https://www.acponline.org/about-acp/about-internal-medicine/subspecialties/allergy-and-immunology. (The websites were accessed on February 25, 2019.)

OIG identified and reviewed 221 NVCC consults during the specified timeframe. The 221 NVCC consults included 13 orthopedic/hand, 196 colonoscopy, and 12 allergy/immunology consults but did not include the three patients named in the original allegations.

The OIG also identified possible deficiencies in the facility's consult process and evaluated factors that may have contributed to the delays.

Scope and Methodology

The OIG conducted a site visit November 26–30, 2018. Interviewees included the Acting Facility Director, Acting Chief of Staff, Chief of Medicine, Acting Chief of Primary Care, Chief of Surgical Services, NVCC coordinator, and other key staff. Additionally, the OIG interviewed facility front-line staff involved in the process of scheduling non-VA care.

The OIG team reviewed relevant VHA and facility policies, facility procedures and processes, committee minutes, NVCC consult scheduler training and audits, the quality assurance plan of the third-party administrator, and other pertinent documents. The review also included analysis of NVCC consult performance data collected from the VHA Corporate Data Warehouse.[15]

The EHR review included an evaluation of consults for the three patients provided to the OIG in the allegations.[16] The OIG assessed the facility's outpatient clinic consult and NVCC consults for scheduling timeliness or delays.[17] The OIG also examined whether patients were at risk of, or experienced, adverse clinical outcomes.[18] The NVCC consults were reviewed for consult date, status designation, and PID date.

The OIG expanded the scope of the EHR review to include the scheduling timeliness and processes for an additional 221 NVCC orthopedic/hand, colonoscopy, and allergy/immunology consults occurring from July 1 through September 30, 2018.

[15] The VHA Corporate Data Warehouse collects and contains historical data beginning in fiscal year 1999; data are updated daily from the VHA system patient EHR and other healthcare data. Data extracted from the VHA Corporate Data Warehouse also contains demographic, and clinical characteristics and healthcare utilization.

[16] The original patient is included in these three patient's NVCC consults. Based upon the issues reported and OIG review of the system responses to the issues, the focus of the OIG review was NVCC consults.

[17] The OIG considered a delay to be the appointment for the consult was scheduled or completed beyond the requirement of 30 days of the PID, or the appointment had not been scheduled and was beyond 30 days of the PID. The OIG examined the delays as of December 3, 2018. Data were collected and filtered using NVCC, and orthopedic/hand, colonoscopy, and allergy/immunology diagnostic and procedural codes.

[18] Within the context of this report, the OIG defined an adverse clinical outcome to be changes in the patient's condition including worsening symptoms that required emergency care, hospitalization, and/or caused death. The risk of an adverse clinical outcome was considered to be the increased likelihood of an adverse clinical outcome related to noncompliance with VA policy regarding scheduling time frames. The degree of risk associated with scheduling delays was a function of an individual patient's overall clinical circumstances, including the potential severity and stability of the patient's condition, and the length of the delay.

To determine if these patients experienced an increased risk of or adverse clinical outcomes, the OIG reviewed the EHRs for patients who

- Died more than 30 days beyond the PID,
- Were hospitalized more than 30 days beyond the PID,
- Had diagnosis(es) of cancer, sepsis, or bacteremia, and
- Had emergency department visit(s) more than 30 days beyond the PID.

Patients who the OIG initially identified as having an increased risk of or adverse clinical outcomes received additional reviews of the initial consult, addendums to the consult, pertinent medical notes, pertinent laboratory and diagnostic test results, and scanned documents from NVCC providers to determine if patients had an increased risk or an adverse clinical outcome. The OIG could not make an assessment of risk of or adverse clinical outcomes for 44 of the 221 patients who had NVCC consult delays because either the patient had not received an appointment, or the consult lacked results documentation. The OIG contacted the facility for additional information regarding these 44 patients on three occasions.[19]

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[19] The 44 patients included 43 patients with colonoscopy consults and one patient with an allergy/immunology consult.

Inspection Results

1. Allegation: Consult Scheduling Delays

The OIG confirmed the facility's substantiation of scheduling delays for the three patients identified in the allegations. However, the OIG did not identify increased risk of or adverse clinical outcomes for the orthopedic/hand, colonoscopy, or the allergy/immunology consult patients.[30]

Outpatient Clinic and NVCC Orthopedic/Hand Consult Delay

The patient's initial facility outpatient orthopedic/hand consult was placed in fall 2017, with a PID of the same day (see appendix B, Patient Case Summaries).

The facility outpatient clinic consult was discontinued within 30 days of the initial PID. The OIG concluded the patient experienced a delay, because the patient was not actually seen until 80 days after the original PID. Although the patient experienced a delay in care, there was no increased clinical risk. See figure 3 for a timeline of events illustrating a delay in the consult appointment.

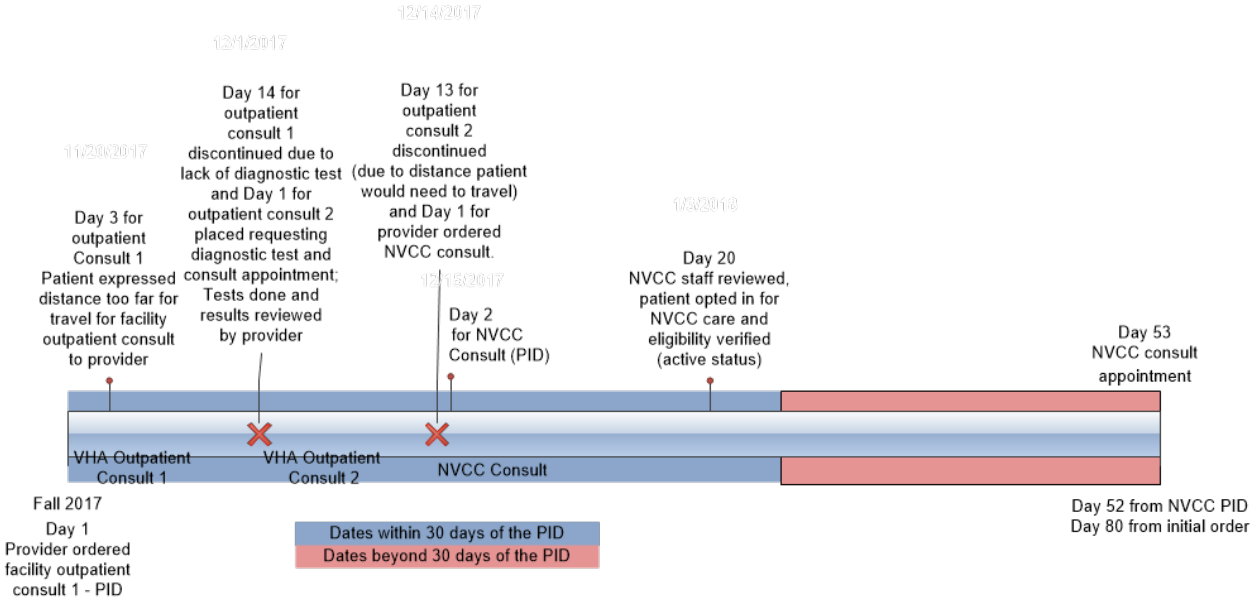

Figure 3. Timeline and consult appointment delay
Note: Day 30 from the NVCC PID was in early 2018.
Source: OIG Analysis

[30] The orthopedic/hand patient had two facility outpatient clinic consults, which were discontinued and subsequently replaced with an NVCC consult. The colonoscopy and allergy/immunology patients had NVCC consults. Based upon the issues reported, the focus of the OIG review was NVCC consults.

NVCC Colonoscopy Consult Delay

The OIG found that this patient waited 238 days for the colonoscopy. Although biopsy results were not immediately scanned into the patient's EHR, the patient did not experience a risk of or an adverse clinical outcome.

According to the EHR, the PID for this patient was fall 2017. NVCC staff documented discussion with the patient that the third-party administrator would make contact for scheduling and placed the consult into an active status in late 2017 (see figure 4 for a timeline of events illustrating a delay in the consult appointment).

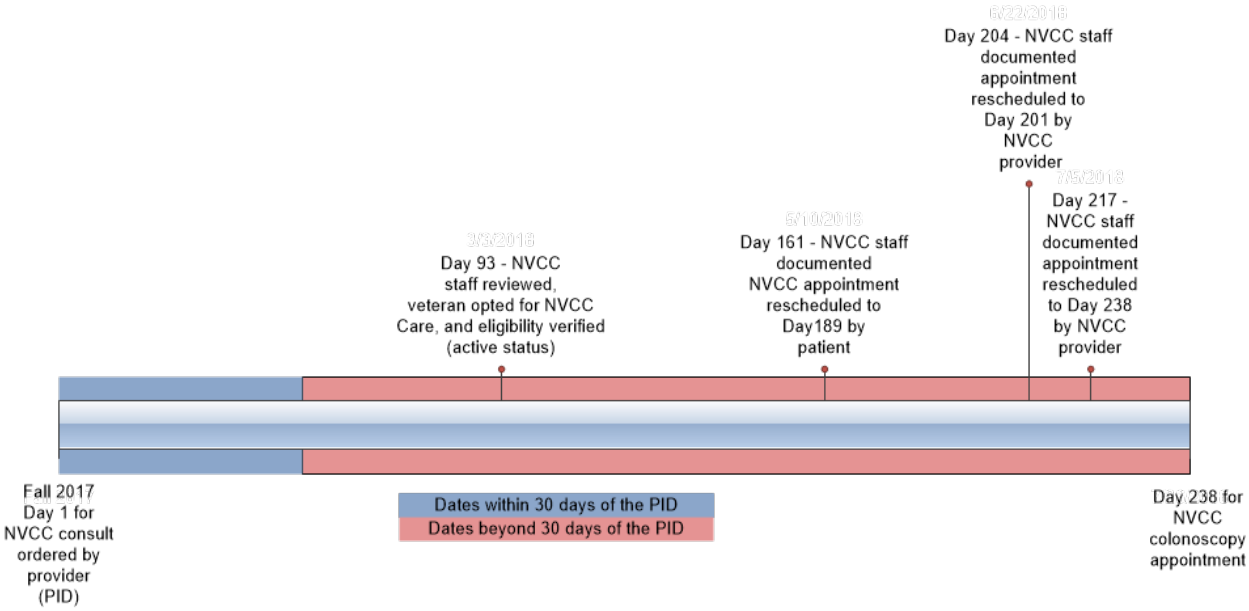

Figure 4. Timeline and consult appointment delay
Note: Day 30 from the PID was in late 2017.
Source: OIG Analysis

According to the patient's EHR, the procedure report was scanned into the patient's EHR in late summer 2018, and the pathology results of the colonoscopy were scanned into the patient's EHR in early 2019. The procedure report noted that the patient had indicators of diverticulitis and that a polyp (in the colon), discovered during the procedure, was sent for biopsy. The procedure report further indicated that the timing of a repeat colonoscopy recommendation was dependent on the biopsy results.[31] A progress note in early summer 2019, noted the biopsy results as

[31] Mayo Clinic, *Diverticulosis and diverticulitis*. Diverticulosis is a condition of having small outpouchings from the large intestine and can occur in any area of the large intestine. The outpouching can become inflamed and infected. https://www.mayoclinic.org/diseases-conditions/diverticulitis/multimedia/diverticulosis-and-diverticulitis/img-20006098. (The website was accessed on October 31, 2019.)

hyperplastic polyps and recommended, based upon those results, that a follow-up procedure be done in 10 years.[32]

NVCC Allergy/Immunology Consult Delay

While this patient experienced a delay in the scheduling of an allergy/immunology NVCC consult, the OIG did not identify an increased risk of or adverse clinical outcome.

According to the EHR, in early 2018, NVCC staff documented telling the patient that the third-party administrator would make contact for scheduling the same day and then placed the consult into an active status three days later (see figure 5 for a timeline of events illustrating a delay in the consult appointment).

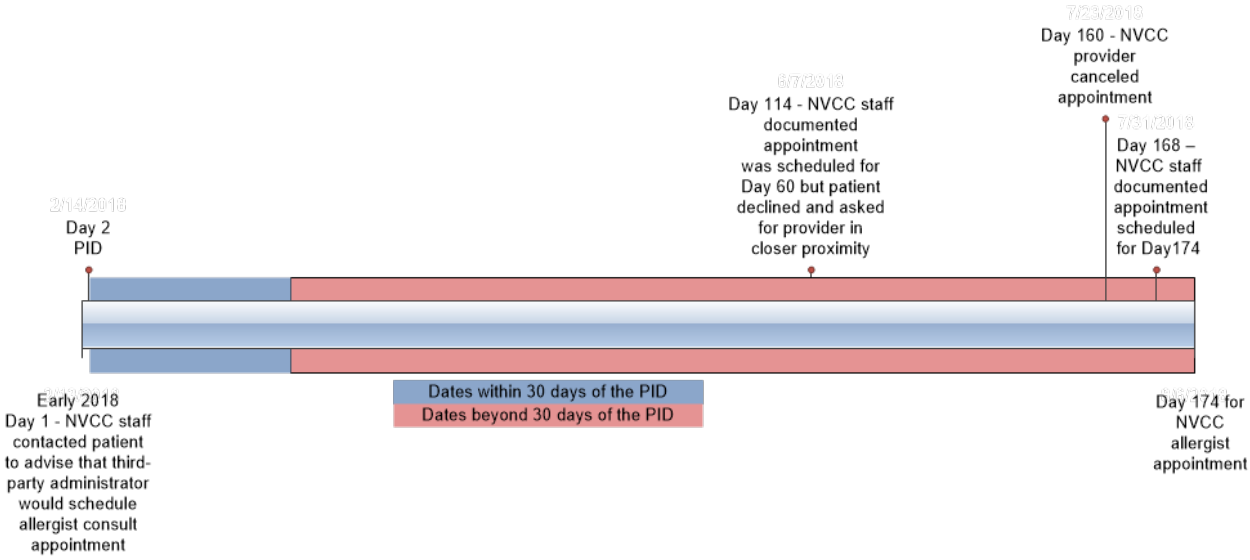

Figure 5. Timeline and consult appointment delay
Note: Day 30 from the PID was in early spring 2018.
Source: OIG Analysis

2. Related Concerns: Facility NVCC Consult Scheduling Delays

To identify if delays occurred for other facility patients, the OIG evaluated consults from the three NVCC clinical areas identified in the allegations; orthopedic/hand, colonoscopy, and allergy/immunology. The OIG reviewed data for facility NVCC consults that occurred from July 1, 2018, through September 30, 2018.

OIG determined that delays occurred for this set of orthopedic/hand, colonoscopy, and allergy/immunology patients.

[32] Mayo Clinic, *Colon polyps*. A colon polyp is a small clump of cells that forms on the lining of the colon or large intestine that can be harmless. But over time, some can develop into cancer. Hyperplastic polyps are considered benign (not cancerous) and generally are not a cause for concern. https://www.mayoclinic.org/diseases-conditions/colon-polyps/symptoms-causes/syc-20352875. (The website was accessed on October 31, 2019.)

The OIG identified and reviewed 221 NVCC consults during the specified timeframe. The 221 NVCC consults included 13 orthopedic/hand, 196 colonoscopy, and 12 allergy/immunology consults but did not include the three patients named in the original allegations.

- One hundred and fifty-nine (72 percent) of the 221 NVCC consults reviewed did not meet the VHA requirement to schedule an appointment within 30 days or less of the patient indicated date (range of 3 to 158 days).
- Two (1 percent) of the 221 patients had increased risk of adverse clinical outcomes related to the delays.
- Forty-four (20 percent) of the 221 consults lacked consult result documentation.

In the next three sections, the OIG outlines the data related to the 221 delayed consults according to NVCC consult type.

NVCC Orthopedic/Hand Consults

After reviewing 13 additional orthopedic/hand NVCC consults from July 1 through September 30, 2018, the OIG identified 10 of 13 (77 percent) consults that were beyond 30 days of the PID with a delay of 26 to 110 days.

The OIG did not identify risk of or adverse clinical outcomes for the one patient referred for review.

NVCC Colonoscopy Consults

After reviewing 196 additional colonoscopy NVCC consults from July 1 through September 30, 2018, the OIG identified 140 of 196 (71 percent) consults that were beyond 30 days from the PID with a delay of 2 to 158 days (beyond 30 days).

The OIG found that 79 of the 140 consults needed further review and determined that 43 of the 79 consults did not have sufficient information, such as documented pathology or procedure results or a scheduled appointment, to determine patient risk.[33]

The OIG sent the list of the 43 colonoscopy patients to the facility for review on February 12, 2019, and the facility responded on February 20.[34] On July 26, the OIG asked for further updates for the 43 colonoscopy patients and the facility responded with the following information on August 2, 2019:

- Twenty-one patients had consults completed with appointment documentation received and scanned into the EHR;

[33] VHA Directive 1230.

[34] A total of 44 consults were sent to the facility: 43 colonoscopy and one allergy/immunology consult. This section discusses the 43 colonoscopies; the remaining allergy/immunology consult is discussed in a separate report section (see NVCC Allergy/Immunology Consults).

- Eight patients had consult appointments; documentation, though requested, had not yet been received;
- Six patients had consults in progress and partially completed;
- Six patients had consults discontinued when scheduling efforts failed; and
- Two patients had consults discontinued when the veteran declined the appointment.

Increased Risk of Adverse Clinical Outcomes

Of the remaining 36 patient consults, the OIG identified two patients who were at risk of an adverse clinical outcome as indicated by the delay in scheduling the appointments and overall clinical symptoms.

Both patients received appointments and care, and although at risk, did not experience an adverse clinical outcome. Delays were 84 and 116 days after the PID. One of the patients arranged for and received care from non-VA providers without using the facility's NVCC process (see appendix B, Patient Case Summaries).

NVCC Allergy/Immunology Consults

After reviewing 12 additional allergy/immunology NVCC consults from July 1 through September 30, 2018, the OIG identified 9 of 12 (75 percent) consults that were beyond 30 days of the PID with a delay of 8 to 125 days (beyond 30 days).[35]

Four of the 12 patients required additional review, and the OIG found no risk of or adverse clinical outcome for three of the four patients. Clinical documentation of the consult visit results was not available for the fourth patient (whose medical care was not urgent). The OIG added this patient to the 43 colonoscopy patients (total of 44 patients) provided to the facility for review.[36]

According to facility NVCC staff and leaders, a shortage of NVCC staff, the lack of a third-party administrator to assist with scheduling, and the loss of a colonoscopy non-VA provider practice caused delays in scheduling appointments for the NVCC consults discussed above.[37]

3. Contributing Factors Affecting NVCC Consult Delays and Processes

The OIG identified several contributing factors or reasons that the NVCC consults may have been delayed including inconsistent scheduling processes; inconsistent leadership involvement

[35] VHA Directive 1230.

[36] Per the facility's response, this patient's consult was completed, and documentation received from the NVCC provider and uploaded to the patient's EHR.

[37] Prior to September 30, 2018, a third-party administrator assisted in coordination and scheduling of appointments. Once a patient's eligibility was determined, the third-party administrator communicated with the patient to schedule an appointment. https://www.hnfs.com/content/hnfs/home/va/veteran.html. (The website was accessed on February 22, 2019.)

and actions reflected by a lack of documentation; deficiencies with facility oversight of the third-party administrator consult scheduling processes; shortages of facility NVCC staff; and training and supervision deficiencies of facility NVCC scheduling staff as evidenced by lack of documentation.

Inconsistent Scheduling Processes

Data reviewed by the OIG identified that the predominant delay in the scheduling process occurred after the consult had been given to NVCC staff and scheduling activities started, such as confirming the veteran's eligibility, but before an appointment had been made. This phase is named the active status. Once the appointment has been made, the consult is in the scheduled status (see appendix A for details of consult statuses).

The OIG used VHA consult timeliness goals to evaluate the facility's consult process:

- Delayed consults are open greater than 90 days of the PID.
- Delayed appointments are scheduled greater than 30 days of the PID.

The expected VHA compliance rate for appointment scheduling timeliness is 90 percent.[38] According to a review of NVCC orthopedic/hand, colonoscopy, and allergy/immunology consults from July 1, 2018, through September 30, 2018, the OIG determined that 74 of 221 (33 percent) consults were open beyond 90 days (range of 91 to 188 days beyond the PID). In addition, 71 of the 221 (32 percent) consults were delayed between the active and scheduling phase of the NVCC consult process, which meant that 71 patients did not have appointments scheduled within 30 days of the PID.

Facility staff described the scheduling process as disjointed and inconsistent. Rather than processing consults from pending to active to scheduled status, facility staff stated supervisors gave them a consult patient list to move and process patients' consults from pending to active status every few days. Once this list was completed, rather than following the same patients through to the next step of the process (appointment scheduling), staff received a different list of active status patients that could be a few months old. The facility NVCC schedulers were tasked to move the older active consults to a scheduled status. This affected the process by increasing the numbers of active status patients who were waiting for appointments to be scheduled.

Inconsistent Leadership Oversight and Program Performance Improvement Action

The OIG determined that facility leaders and managers were aware of and communicated about identified NVCC consult timeliness concerns during formal committee meetings; however, facility leaders did not seek additional discussion or analysis of the high number of open NVCC consults or implement a clinical or an administrative process or both, or plan for performance

[38] VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

improvement. Reasons for the lack of leadership oversight and action plans were unclear, but the acting Facility Director and other NVCC leadership staff had not been in their positions very long (in some cases, three weeks).

VHA policy specifies the facility director is responsible for "oversight of the facility consult policy, processes, and outcomes" including "regular monitoring and improvement of facility consult performance" and "allocating sufficient resources to enable management of consultations and timely delivery of care."[39]

VHA suggests one function of a facility consult steering committee is to assist the "facility Director and Chief of Staff in the oversight, management, implementation and improvement of the facility consult process to include all consult services." According to its charter, the Consult Management Committee is responsible for formulating, recommending, and implementing consult management policies; overseeing compliance with consult management processes; and reporting on compliance with facility consult management policies. The facility committee reports to the Executive Committee of the Medical Staff (ECMS). The Consult Management Committee must meet regularly and include NVCC representation.[40]

In addition to the Consult Management Committee and ECMS, two other facility committees oversee the NVCC consult process: the NVCC Oversight Committee, and the Leadership Council. Initially the NVCC Oversight Committee and the Consult Management Committee reported to the ECMS that reports to the Leadership Council; however, the NVCC Oversight Committee now reports to the Facility Director who is on the Leadership Council (see figure 6 for the reporting responsibilities of each committee).[41]

[39] VHA Directive 1232(1).

[40] VHA Directive 1232(1). VHA Office of Community Care, *Community Care Consult/Referral Management*, Version 2, June 30, 2017.

[41] According to the facility's VA Community Care Oversight Committee policy, the NVCC Oversight Committee is "responsible for analyzing and reviewing data and implementing programs and procedures to most effectively utilize internal and community services." According to the facility's ECMS structure memorandum and chart as of July 5, 2018, the ECMS provides oversight for clinical service lines. The Facility Director is part of the Leadership Council that functions as the principal operating body for the facility. The OIG was informed that the committee structure changed in August 2018, and the NVCC Oversight Committee began reporting to the Facility Director and the Leadership Council.

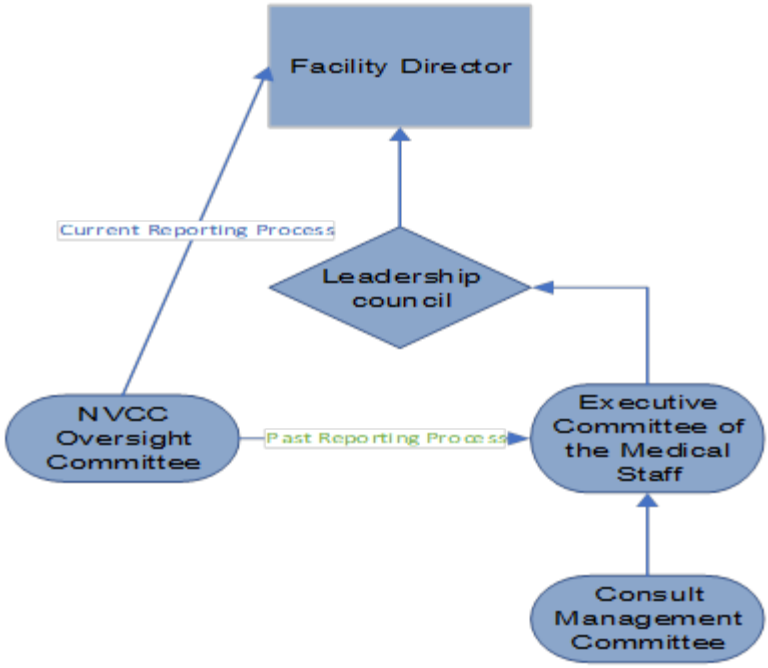

Figure 6. Hierarchy of committees with NVCC oversight responsibility reporting structure
Source: Facility committee organization chart and leadership interviews

NVCC Oversight Committee

Although the NVCC Oversight Committee charter was not approved until July 2018, the NVCC coordinator, chair of the committee, reported that the committee met eight times from October 1, 2017, through September 30, 2018; however, committee members did not take minutes, and the OIG was unable to determine the extent or sufficiency of oversight activities. According to an interviewee, on August 31, 2018, the NVCC coordinator presented information to facility leaders that indicated NVCC staff identified over 18,000 open consults.

Although no specific action plans for addressing the open consults or improving the processes were reported, the NVCC coordinator noted that facility staff were working beyond designated hours and weekends, and more staff had been hired to assist with scheduling NVCC consults that were not processed through third-party administrators. The OIG received updated facility information on August 2, 2019, indicating that the number of open consults had decreased to 13,740. Although no specific plan or process was presented with this update, NVCC staff continued to assist patients with the scheduling processes.

Consult Management Committee

The facility's Consult Management Committee is responsible for overseeing consults including NVCC consults. The Chief of Staff is the chair of the committee and members include but are

not limited to chairs of other standing subcommittees.[42] Although committee meeting minutes from January through August 2018 reflected that membership included the NVCC Chief and/or the Coordinator, both were marked absent for every meeting they were scheduled to attend. Committee meeting minutes in April identified that the facility had some of the highest numbers of open consults both within the VISN and nationally. During a discussion of open NVCC consults in June 2018, it was noted that a model to reduce the number of consults was available but no NVCC representatives were present during the meeting when the model was discussed, and no action plan was presented.

Executive Committee of the Medical Staff

From October 1, 2017, through September 30, 2018, the ECMS met every month and was chaired by the facility's Chief of Staff. The committee membership includes medical and surgical service chiefs, is responsible for communications between all service lines, and makes recommendations regarding staff membership and performance improvement.[43] During the April 10 meeting, the committee minutes reflected that the facility had over 6,000 open consults greater than 90 days, and that the ECMS would be receiving quarterly updates. No action plan to address this issue was described in the minutes.

Leadership Council

The facility Leadership Council was comprised of the Facility Director, Associate Director, Chief of Staff, Associate Director of Nursing, and the Assistant Director. Responsibilities included surveys, reviews, reports, programs and minutes (including ECMS minutes) for facility operations.[44] The May 2018 meeting minutes reflected 16,153 open NVCC consults with 4,888 over 90 days. Meeting minutes continued to reflect that access to care targets/goals were unmet, and in July 2018, the meeting minutes noted that 8,868 NVCC consults were open beyond 90 days. In August, the NVCC coordinator updated the Council regarding the continued high number of open NVCC consults (estimated 18,000 open consults). The OIG received updated facility information on August 2, 2019, and the number of open consults had decreased to 13,740. Although no specific plan was presented, NVCC staff continued to work on reducing the number of open consults and assisted patients with the scheduling process.

When interviewed on November 27, 2018, the Acting Facility Director discussed two primary concerns with NVCC: consult volume and backlog.[45] Related to this was a large volume (over 4,000) of unpaid non-VA providers as well as the loss of a contract with a gastroenterology provider who performed many of the facility's colonoscopies. In addition, the Acting Facility

[42] Facility Consult Management Committee Charter, December 20, 2013.

[43] Facility Memorandum 00-13, *Executive Committee Structure*, August 6, 2015.

[44] Facility Memorandum 00-13.

[45] The Acting Director started at the facility in November 2018.

Director indicated that delays in scheduling were often reviewed retrospectively, the facility's human resources department did not use a physician recruiter, gaps in market pay existed, and the facility was transitioning from one third-party administrator contract to another, and at the time of the interview, there were no third-party administrators to assist with scheduling.[46]

An NVCC scheduling staff member, who had been with scheduling for four years, stated that the facility always had a backlog. Another staff member stated that when and because they stopped using the third-party administrator in June 2018, the number of open consults increased by 5,000. The facility had a persistent backlog made worse by the loss of the third-party administrator's scheduling.

The OIG determined that contributing factors for this backlog may have been scheduling staff shortages, the loss of the third-part administrator, lack of leadership and oversight of scheduling processes, and deficiencies in scheduling staff training. Without more effective oversight by leaders and leadership committees with discussions on accountability, and specific action plans to address the backlog of open consults, access to care, and delays in care may continue.

Consult Oversight Deficiencies of Third-Party Administrator

The OIG determined that facility NVCC staff did not consistently perform daily oversight of consults being scheduled by a third-party administrator.[47]

At the time of the events under discussion, facility NVCC staff had the responsibility to check the consult status and appointment tracker daily to ascertain if the appointments assigned to the third-party administrator had been made and then follow-up with the third part administrator.[48]

The OIG identified an issue involving the lack of daily oversight by facility NVCC staff to ensure patient appointments were made by the third-party administrator; however, OIG staff could not ascertain why the oversight was not performed. An example of this occurred with the NVCC allergy/immunology consult patient previously discussed. NVCC staff placed the patient's consult into the third-party administrator's issue tracker in early 2018, after the consult had been authorized. Daily monitoring of the issue tracker by facility NVCC staff would have revealed that an appointment was made by the third-party administrator two months later. However, NVCC staff did not note this appointment in the patient's EHR in a timely manner suggesting the lack of daily monitoring. The patient declined this appointment (requested another provider closer to home) and the third-party administrator made another appointment for the patient closer to home for a date in mid-summer 2018. Facility NVCC staff did not document the

[46] At the time of the OIG site visit to the facility, scheduling via the third-party administrator had been discontinued and scheduling tasks were absorbed by facility NVCC staff.

[47] After the MISSION Act was signed into law in June 2018, VHA began to prepare for the transition from the Choice program to a new community care program (full implementation of the MISSION Act was set for June 2019). VHA's transition plans included the use of a third-party administrator for tasks other than scheduling.

[48] Chief Business Office, VHA National Non-VA Medical Care Program Office, *Non-VA Medical Care Consult/Referral Managemen*t, October 28, 2014. VHA Choice First Standard Operating Procedure, July 30, 2015.

information about the earlier canceled appointment nor the mid-summer 2018 appointment in the patient's EHR until early summer 2018.

NVCC Staff Shortage

The OIG identified a shortage of facility NVCC staff.

The VHA Office of Community Care promotes a "clinic within a clinic" model that emphasizes calculating staffing needs that align with NVCC processes including responsive customer service and consistent processes to meet patients' needs and increase staff efficiency.[49]

According to the facility's human resources department, from October 1, 2017, through December 31, 2018, facility NVCC managers requested 59 staffing positions; 45 were approved and the others were pending approval. However, only 11 positions were filled. The remaining positions were in various stages ranging from pending approval and acceptance of the position to onboarding. Staffing requests included consult schedulers and advanced or lead schedulers, registered nurses, and management staff (management staff tasks may include scheduling and supervision of NVCC schedulers). As of December 31, 2018, 48 of 59 (81 percent) requested staff were still not available to assist with scheduling or supervision tasks.

This was further supported by the NVCC coordinator who said that a lack of staff contributed to the backlog of consults reported to leaders in August 2018. In addition, the coordinator indicated the increase in the number of consults due to the return of patients from the third-party administrator in August–September 2018 also increased the burden on the current NVCC scheduling staff to arrange appointments and follow VHA scheduling requirements.

NVCC Scheduling Staff Training and Supervision

The OIG was unable to confirm that facility NVCC schedulers had completed all required training for patient scheduling processes due to a lack of documentation of such training. In addition, although facility NVCC staff performed scheduling activities, facility and VISN leaders decided that the VHA policy on audits for scheduling staff did not apply and that audits of staff were completed according to a facility-defined process. Additionally, NVCC scheduling staff did not consistently receive supervisory audits as required by the facility's process.[50]

According to the NVCC coordinator, who had been in this position only a year, NVCC scheduling staff lacked training, oversight, and supervision. The coordinator reported hiring and training more schedulers and scheduling supervisors, and continuing to work on a timelier audit process.

---

[49] VA Community Care Operating Model Fact Sheet, May 12, 2017. https://vaww.vha.vaco.portal.va.gov/DUSHCC/DC/DO/CI/S/OM/default.aspx. (The website was accessed on February 8, 2019.)

[50] According to the data provided by the facility, scheduling activities were performed by medical or program support assistants.

NVCC Scheduler Training

VHA requires staff who schedule appointments to successfully finish required training within 120 days of the date they have access to the scheduling menu options and that evidence of the completion is documented. Facilities may defer training to a time when there is a minimum of five or more staff for attendance. The required training courses included several patient scheduling modules.[51]

The VHA Office of Community Care promotes implementing and completing appropriate staff training and providing responsive customer service.[52]

The facility scheduling staff consisted of 38 scheduling staff including four supervising or lead staff. At the time of the OIG site visit, 19 staff members were identified as new and still in basic training. This group was not considered in the OIG's analysis of staff who should have completed training. Of the remaining 19, two completed their basic training, and 17 staff members who should have completed basic scheduler training did not have documentation that it was completed.

NVCC Supervision

VHA requires supervisory audits for scheduling staff to be performed every six months and does not differentiate between VHA outpatient and NVCC consult schedulers.[53] The audits must include "all active schedulers regardless of position or title" performing "scheduling activities" and a review of at least 10 scheduled appointments per scheduler.[54] Scheduling supervisors must evaluate the timeliness and appropriateness of scheduling actions such as using consult status designations.[55]

Facility NVCC staff acknowledged performing scheduling activities such as contacting patients about appointments, moving patients to different consult scheduling status designations according to VHA timeframes, and making sure that provider documentation was linked to the consult. However, according to a facility nursing manager and a member of the VISN management staff, the VHA policy for auditing/supervising schedulers did not apply to NVCC

[51] VHA Directive 1230. Deputy Under Secretary for Health for Operations and Management Memorandum, *Enhancements to the Veterans Choice Program Referral Processes*, January 13, 2017.

[52] Veteran Community Care General Information Fact Sheet, September 9, 2019. https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VHA-FS_MISSION-Act.pdf# and VHA Office of Community Care–Community Care Hub Home. https://vaww.va.gov/communitycare/cchub.asp (The website was accessed on December 10, 2019.)

[53] VHA Directive 1230.

[54] VHA Directive 1230. Deputy Under Secretary for Health for Operations and Management Memorandum, *Scheduling Audit*, March 10, 2017.

[55] VHA Directive 1230.

scheduling staff as they did not directly schedule appointments because at that time, scheduling was performed by third-party administrators.

According to the Assistant Nurse Executive, facility NVCC scheduling supervisors audited 10 percent of the facility NVCC schedulers each week to assess how well the schedulers worked with NVCC consults and their compliance with VHA procedures.[56] NVCC scheduling supervisors rotated this process each week so another 10 percent of schedulers were audited the next week. This process allowed different schedulers to be audited each week.

Facility managers reported 34 NVCC schedulers who worked October 1, 2017–September 30, 2018, (review time frame), were subject to the facility audit process. There were four additional supervisory/lead schedulers who may have helped with scheduling activities, but they were not included in the audit process. Of the 34 schedulers, 19 were new to NVCC who had hiring dates ranging from August 16 through December 12, 2018, and who had not undergone an audit. Of the remaining 15 schedulers, audits for the time frame under review varied from 1 to 10 for each scheduler. Given the facility process and 15 employees who were not new, the OIG determined that the expectation would be an audit for each NVCC scheduler approximately every eight weeks or six to seven times per year. However, data showed that 5 of the 15 staff members were audited less than six times during the review period. The facility process for audits was not consistently followed.

The NVCC coordinator reported a lack of auditing and oversight for the schedulers and was continuing to work on a timelier audit process.

4. Other Finding: VHA Consult Process Requirement

Although the facility's Standard Operating Procedure addressed several VHA requirements to administratively close an NVCC consult, it did not include a process to identify consults that still required clinical documentation from the non-VA provider who provided care to the patient.[57] The OIG determined that the reasons for this process deficiency may be attributed to inconsistent leadership involvement and oversight.

VHA policy requires that a facility consult policy address the necessary steps to be taken to close an NVCC consult if the consult has no clinical documentation from the non-VA provider. If the consult is greater than 90 days beyond the care provided by the non-VA provider and is still without clinical documentation from the non-VA provider, the consult may be designated as administratively complete; however, staff must document why the consult is being closed and upon whose authority.[58]

[56] Facility NVCC staff scheduled non-VA consults that did not go through Choice third-party administrators.

[57] Facility Standard Operating Procedure, *Administrative Closure of Community Care Consults*, March 13, 2018.

[58] VHA Directive 1232(1). For NVCC, this process is used when NVCC consults are without clinical documentation and are more than 90 days from the date of the completed NVCC care.

In March 2018, VHA added criteria to clarify the required process to administratively close an NVCC consult. If clinical documentation is not received within 30 days of completion of the first appointment, facility NVCC staff must document three attempts on separate days to acquire the documentation and must confirm that the veteran actually received the requested non-VA care. In addition. once consults are administratively closed after 90 days due to a lack of clinical documentation from the non-VA provider, the facility must have a process to easily identify those consults that still need clinical documentation.[59]

The facility implemented a written Standard Operating Procedure outlining the process to administratively close NVCC consults and address VHA requirements; however, the procedure did not address how NVCC consults would be identifiable when the consults had been administratively completed/closed but still required medical documentation from a non-VA consult provider.[60] This process deficiency could impact patient care and treatment planning.

[59] VHA Memorandum, *Clarification of Administrative Closure of Community Care Consults* (VAIQ# 7880748), March 6, 2018.

[60] Facility Standard Operating Procedure, *Administrative Closure of Community Care Consults*, March 13, 2018.

Conclusion

The OIG confirmed the facility's substantiation that the orthopedic/hand consult patient identified in the allegation experienced a delay in the scheduling of a facility outpatient orthopedic consult appointment. The OIG did not identify an increase in risk of or an adverse clinical outcome for this patient.

The OIG confirmed the facility's substantiation that scheduling delays occurred for all three patients' NVCC consults identified in the allegation. The OIG did not identify increased risk of or an adverse clinical outcome for the three patients.

The OIG performed an expanded review of 221 NVCC orthopedic/hand, colonoscopy, and allergy/immunology consults submitted from July 2018 through August 2018 and found that delays occurred. The OIG did not identify risks of or adverse clinical outcomes for the orthopedic/hand and allergy/immunology consult patients; however, from the colonoscopy consults, the OIG determined that two patients had increased risks of an adverse clinical outcome due to delays in scheduling their appointments. Although the delays placed patients at increased risk, both patients received care and neither patient experienced an adverse clinical outcome.

The OIG determined that several factors affected the backlog and deficiencies in processing, scheduling, and timeliness of NVCC consults. These contributory factors included, but were not limited to, inconsistent scheduling processes, inconsistent oversight as evidenced by lack of documentation of leaders' oversight and program performance improvement actions; deficiencies with third-party administrator scheduling oversight; shortages of facility NVCC staff; and lack of training and supervision for facility NVCC scheduling staff as evidenced by a lack of documentation.

Scheduling processes for orthopedic/hand, colonoscopy, and allergy NVCC consult reviews demonstrated that the predominant consult delay occurred during the active to scheduled status timeframe. According to facility staff, this occurred due to disjointed and inconsistent processes; specifically, scheduling staff would not finish the scheduling process for one patient before moving to the next patient request.

In addition, although facility NVCC staff performed scheduling activities for NVCC that did not involve third-party administrators, facility and VISN leaders decided that VHA policy on supervisory audits for scheduling staff did not apply, and that audits of staff were required instead, as defined by the facility's process. However, the facility did not consistently meet facility process requirements for scheduling audits. The failure to conduct consistent audits did not allow the facility to identify and take action on scheduling issues.

The OIG also identified that facility consult procedures lacked a process to identify consults that were missing documentation after they were administratively closed.

The OIG requested the facility follow up on identified patient consults that lacked consult documentation or appointments. The facility provided additional information concerning the consults on August 2, 2019.

Recommendations 1–6

1. The Atlanta VA Health Care System Director reviews the process for non-VA community care consult performance measurements, evaluates compliance with Veterans Health Administration policy, and implements an action plan as needed.

2. The Atlanta VA Health Care System Director ensures managers review the backlog of open non-VA community care consults and implements an action plan as needed.

3. The Atlanta VA Health Care System Director verifies that managers develop a process to analyze and confirm non-VA community care staff compliance with daily monitoring according to Veterans Health Administration policy.

4 The Atlanta VA Health Care System Director evaluates the process for the hiring, training, and supervision of non-VA community care staff, and implements an action plan as needed.

5. The Atlanta VA Health Care System Director ensures that managers review the patient cases referred to the Atlanta VA Health Care System by the Office of Inspector General, assesses these patients for adverse clinical outcomes, and implements action plans as needed.

6. The Atlanta VA Health Care System Director makes certain that managers develop a policy to identify non-VA Community Care consults that are administratively closed but do not have relevant medical documentation, and implements an action plan as needed to be in alignment with Veterans Health Administration policy.

Appendix A: Consult Management Background

Consult Statuses

VHA uses status designations, pending, active, scheduled, completed, discontinued, and canceled, to mark the progress and timeliness of scheduling and closing a consult appointment:[61]

- Pending status is automatic when the consult is written by the provider. NVCC consults must be moved to the active status within seven days.
- Active status means the consult has been received by schedulers and efforts are underway to fulfill/schedule the consult. NVCC consults should be moved to the scheduled status within 30 days.
- Scheduled status means the consult appointment has been made.
- Complete status means the requested service has been performed and the consult is closed.
- Discontinued status means the consult has been closed for reasons other than complete, such as death and a duplicate request.
- Canceled status is used when the consult needs additional information; at this point the consult can be edited and resubmitted or closed.

New NVCC Legislation

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act was signed into law on June 6, 2018. The intent of the VA MISSION Act is to streamline VA's NVCC programs, improve VA healthcare delivery, expand veterans' access to caregivers and information technology, and replace the Veterans Choice Program.[62]

NVCC Consult Timeliness Performance

The OIG adopted VHA definitions and targets outlined in two NVCC consult timeliness reports, the VHA closed consult report, and top metric report for the consults in the active status, to evaluate data from the facility, and identify specific timeliness issues with the consult process.

VHA measures success with consult timeliness and process management using snapshot groups of data reports that reflect specific indicators for NVCC consults.[63] Performance measurements

---

[61] VHA Directive 1230. VHA Directive 1232(1). *VSSC Consult Cube V2.* https://vssc.med.va.gov/VSSCMainApp/Defaultrsg.aspx. (The website was accessed on February 3, 2019). This is an internal VA website and not available to the general public. Closed consults include status designations of complete, discontinued, and canceled.

[62]The *VA MISSION Act* of 2018. https://www.veterans.senate.gov/imo/media/doc/One%20Pager_The%20VA%20MISSION%20Act%20of%202018.pdf. (The website was accessed on February 20, 2019.)

[63] Snapshot refers to a date when a report is pulled that is based only on the data available on that date.

or indicators are based upon the consult status designations and the time required to move from one status to another. Data from VHA facilities are collected, stored, and organized in a national repository. Reports developed from this process are available to VHA medical facilities to assess and monitor consult programs.

Two measures commonly used to evaluate performance are the NVCC Open/Closed Consult report and the top performance metrics report.

NVCC Open/Closed Consult Reports

Data collected from each VHA medical center/system, region and nationally for this report are provided as a snapshot in time for NVCC consults and are updated daily. Report measurement definitions were updated May 2017.

Aggregate consult measurements include

- Closed Consults—Consults include status designations of canceled, complete, and discontinued; and
- Open Consults—Consults include status designations of active, pending, and scheduled.

The reports are based upon having open consults greater than 30, 60, and 90 days of the PID and are measured using these data points.

NVCC Top Performance Metrics Report

To ascertain the timeliness and success of scheduling NVCC consult patients, VHA developed an additional snapshot report, based on status designations, that was deployed on July 11, 2018, and summarized specific performance measures and goals related to the success of the facility's NVCC program and allowing comparison to other facilities. The measurement indicators include

- Consults in Pending status less than or equal to (≤) 7 days;
- Consults in Active status ≤ 30 days; and
- Consults in Scheduled status (not complete, canceled or discontinued so appointment may be scheduled but at or beyond 90 days) ≤ 90 days.

The VHA goal is to achieve 90 percent or higher compliance with these indicators.

Appendix B: Patient Case Summaries

Facility Outpatient and NVCC Orthopedic/Hand Consult Patient

This patient was in their 50s and had a history of diabetes with diabetic neuropathy, coronary artery disease, and hypertension.[64]

In fall 2017, the patient sustained a laceration and crush injury to the left index finger. The patient went to a non-VA Emergency Department on the day of injury to address the wound and again the following day for a recheck, where the Emergency Department staff instructed the patient to obtain an orthopedic evaluation.

The next day, the patient called the facility and spoke with a nurse in the primary care provider's office. The patient told the nurse about a need for an orthopedist evaluation as the patient had gone to a non-VA Emergency Department and was instructed to see an orthopedist. The nurse documented the information in the patient's EHR.

On the following day, the patient's VA primary care provider acknowledged the nurse's telephone note and instructed another nurse to obtain the patient's records. The primary care provider also entered an orthopedic/hand consult for evaluation of a crush injury to the finger and deemed the level of urgency as routine.

Three days later, the nurse acknowledged the primary care provider's request to obtain the patient's Emergency Department records and called the patient, who told the nurse that the patient was at risk for losing the finger if the injury was not fixed. This nurse documented the patient's response, "going to Atlanta ER [facility's Emergency Department] was not an option, I am 100 miles away and something needs to be done." The nurse sent this information to the primary care provider who co-signed the notation the same day.

---

[64] The OIG uses the singular form of they (their) in this circumstance for the purpose of patient privacy. U.S. Department of Health and Human Services, *National Institute of Health, National Institute of Diabetes and Digestive and Kidney Disease*. "Diabetes is a disease that occurs when blood glucose (also called blood sugar) is too high." https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes. Mayo Clinic, *Diabetic neuropathy*. "Diabetic neuropathy is a type of nerve damage that can occur if "a person has diabetes." High blood sugar (glucose) can injure nerves throughout the body. Diabetic neuropathy most often damages nerves in the legs and feet." https://www.mayoclinic.org/diseases-conditions/diabetic-neuropathy/symptoms-causes/syc-20371580. Mayo Clinic. *Coronary artery disease.* "Coronary artery disease develops when the major blood vessels that supply the heart with blood, oxygen and nutrients (coronary arteries) become damaged or diseased. Cholesterol-containing deposits (plaque) in the arteries and inflammation are usually to blame for coronary artery disease." https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/symptoms-causes/syc-20350613. (The websites were accessed on January 20, 2020.) Mayo Clinic, *High blood pressure (hypertension).* Blood pressure is "determined both by the amount of blood the heart pumps and the amount of resistance to blood flow in arteries. The more blood the heart pumps and the narrower the arteries, the higher the blood pressure." https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410. (The websites were accessed on February 11, 2019.)

The next day, a surgical physician assistant entered instructions to schedule the patient into an orthopedic clinic and nine days later, another surgical physician assistant discontinued the consult and documented the reason as incomplete workup. Later that day, the patient called the facility and requested a re-submission of the orthopedic/hand consult as the process was completed to transfer the Emergency Department records.

A day later, the primary care provider acknowledged the re-consult request and instructed the nurse to call the patient to obtain a new x-ray and a primary care exam. Later that day, the primary care provider examined the patient, obtained the x-ray, and submitted another orthopedic/hand consult request with the urgency marked as routine. That same day, the surgical physician assistant received the consult and requested scheduling the patient into clinic within a week and could overbook if needed.

The patient's x-ray showed a fracture extending to the distal tip of the distal phalanx of the left second (index) finger with associated soft tissue swelling. The radiologist documented that the fracture did not suggest significant displacement or angulation.

Six days later, the patient called the facility to ask about an NVCC referral for orthopedics. On the following day, the primary care provider acknowledged the telephone note and requested the patient call the facility's orthopedic clinic to request the NVCC non-Choice referral.

The next day, the scheduler attempted to clarify which orthopedic clinic to assign the patient. Five days later, the surgical physician assistant discontinued the orthopedic/hand consult and documented the explanation for discontinuation was the patient could not easily travel to the facility as travel distance was 100 miles and that an NVCC consult would be placed for the patient.

That same day, a facility orthopedic physician assistant canceled the outpatient orthopedic/hand consult request and entered an NVCC referral for orthopedics and listed it as routine urgency. The consult was approved and sent to NVCC staff to complete.

Approximately three weeks later, NVCC staff entered an addendum to the consult verifying eligibility and that documents were sent via fax to the NVCC provider. Twenty days later, NVCC staff entered another addendum to the consult and documented that documents were re-sent (faxed) to the NVCC provider and the fax number was verified.

Thirteen days later, a community orthopedist evaluated the patient's injury and deemed the finger to be stable and recommended follow-up only as needed.

NVCC Colonoscopy Consult Patient

The patient was in their 60s and had a history of hypertension, hyperlipidemia, and seizures.[65]

In fall 2017, the patient's primary care provider entered an NVCC non-Choice routine screening colonoscopy consult, and nine days later, NVCC staff contacted the patient and said the community provider will call for scheduling.

Over a three-week period in early 2018, NVCC staff documented four addendums to the original consult and that an appointment for a community provider, a gastroenterologist, was scheduled for the next month.[66]

Seventeen days later, NVCC staff documented that the patient had rescheduled the appointment to the next month. Additional entries documented the colonoscopy was rescheduled for two dates later that month.

In mid-summer 2018, the patient had the colonoscopy, and according to the procedure note, the community provider found a polyp that was removed and sent to pathology for further analysis. The community provider documented the pathology results were pending and recommended a colonoscopy reevaluation in five years if the polyp was confirmed as an adenoma and 10 years if the tissue was benign.

In early 2019, the final pathology report was uploaded to the patient's EHR and indicated the polyp was benign (hyperplastic not an adenoma). In mid-summer 2019, a clinical reminder entry in the EHR recommended a reevaluation in 10 years.

Two Colonoscopy Patients with Increased Risk of Adverse Clinical Outcomes

Patient 1

The patient was in their 40s and presented to the facility's Emergency Department in mid-summer 2018. The patient complained of abdominal pain with blood and mucous in the stool and informed the Emergency Department provider of loose stools since early 2018 with weight loss

[65] Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410. (The website was accessed on February 11, 2019.) Heart.org. *Prevention and Treatment of High Cholesterol (Hyperlipidemia). Hyperlipidemia* is a condition of a high level of lipids (fat) in the blood. https://www.heart.org/en/health-topics/cholesterol/prevention-and-treatment-of-high-cholesterol-hyperlipidemia, (The website was accessed on January 7, 2020.) Mayo Clinic, *Seizure*. "A seizure is a sudden, uncontrolled electrical disturbance in the brain." https://www.mayoclinic.org/diseases-conditions/seizure/symptoms-causes/syc-20365711. (The website was accessed on February 11, 2019.)

[66] American College of Gastroenterology, *What is a Gastroenterologist*? A gastroenterologist is a physician who received training in performing endoscopy, which "is the use of narrow, flexible lighted tubes with built-in video cameras, to visualize the inside of the intestinal tract." https://patients.gi.org/what-is-a-gastroenterologist. (The website was accessed on February 12, 2019.)

of about five pounds over the past month. The Emergency Department provider suspected that the patient had inflammatory bowel disease and entered a consult for a diagnostic colonoscopy with a PID of mid-summer 2018. The patient was discharged home in stable condition.

Approximately a week later, NVCC staff contacted the patient to schedule a colonoscopy in the community. About a month later, an addendum to the consult verified the patient's eligibility, and in two weeks, a gastrointestinal appointment was scheduled for mid-fall 2018.

About two weeks after the scheduled appointment, the patient underwent a colonoscopy, and the results confirmed colitis with visual confirmation of moderate inflammation that involved the anus through the descending colon. The gastroenterologist biopsied the inflamed tissue and initiated a medication to treat ulcerative colitis. The results of the biopsy confirmed ulcerative colitis.[67]

Although the patient's diagnosis was delayed, which incurred the risk of more severe symptoms in the interim, the patient was diagnosed and treated, and did not experience an adverse clinical outcome.

Patient 2

The patient was in their 70s and had a history of chronic obstructive pulmonary disease, myocardial infarction, previous tobacco use of 55 pack years, and daily alcohol consumption.[68]

In early fall 2018, a VA pulmonary provider saw the patient for a routine follow-up regarding a main complaint of shortness of breath on exertion. The patient reported a weight loss of 20 pounds over three months, a change of taste and smell, and trouble with swallowing solids. The patient also complained of choking on food and intermittent pain upon swallowing. The patient's weight was 181 pounds, a decrease of 17 pounds over the previous five months.

Based on a recommendation from the pulmonary provider, the patient's primary care provider entered a gastrointestinal consult five days later with a PID of the same day. The NVCC gastrointestinal consult was approved four days later. In mid-fall 2018, an addendum to the consult documented that the patient agreed to non-VA gastrointestinal care.

---

[67] Mayo Clinic, *Ulcerative colitis.* "Ulcerative colitis is an inflammatory bowel disease that causes long-lasting inflammation and ulcers in the digestive tract." https://www.mayoclinic.org/diseases-conditions/ulcerative-colitis/symptoms-causes/syc-20353326. (The website was accessed on February 11, 2019.)

[68] verywellhealth. *Calculating Pack Years of Smoking and Health Risks*. One pack-year of smoking equals to smoking a package of cigarettes (20 cigarettes) daily for one year. https://www.verywellhealth.com/definition-of-pack-years-of-smoking-2249140. (The website was accessed on November 20, 2019.) World Health Organization, *COPD: Definition.* "Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible." https://www.who.int/respiratory/copd/definition/en. Cleveland Clinic, *Heart Attack (Myocardial Infarction). "*A heart attack or myocardial infarction is permanent damage to the heart muscle… tissue due to lack of blood supply." https://my.clevelandclinic.org/health/diseases/16818-heart-attack-myocardial-infarction. (The websites were accessed on February 11, 2019.)

In late 2018, a primary care provider evaluated the patient for a routine follow-up but did not document the patient's swallowing issues, comment on the weight issue, or reference the pending NVCC gastrointestinal consult.

According to the OIG's review of the patient's EHR, the facility's NVCC staff contacted the patient two months later to verify information. The patient's spouse informed staff that tests and care were requested with non-VA providers (not contacted through NVCC) in early 2019.

The same day NCVCC staff contacted the patient, the facility attempted to obtain the test results and discontinued the consult. The OIG found no procedure or biopsy results from the non-VA providers but found a VHA provider's note from early summer 2019 indicating that the tests performed earlier that year were to assess whether the patient's difficulty swallowing was due to scleroderma, and, although negative for scleroderma, the tests showed eosinophilic esophagitis.

Care was provided by non-VA providers and, as of mid-summer 2019, although the patient was at increased risk for an adverse clinical outcome due to weight loss and swallowing issues, the OIG found no additional notes, information, or indicators of an actual adverse clinical outcome.[69]

NVCC Allergy/Immunology Consult Patient

The patient was in their 50s and had a history of asthma, gastroesophageal reflux disease, and hypertension.[70]

In early 2018, the patient emailed a primary care provider and requested help for continuing non-VA weekly allergy injections that was originally approved through an NVCC consult placed in late summer 2017. In the patient's email, it was indicated the NVCC provider would not continue the patient's weekly injections due to delayed payments from VA. The primary care provider forwarded the email to NVCC staff to assist the patient. The staff provider, reviewing the primary care provider's email, stated that in the past, NVCC care could be approved for up to 52 weeks and suggested a new referral for the patient.

---

[69] Scleroderma Foundation. Scleroderma is a disease associated with an overactive immune system and involves the body's connective tissue. It may cause thickened skin, scarring blood vessel problems, and varying degrees of inflammation and pain. https://www.scleroderma.org/site/SPageNavigator/patients_whatis.html?NONCE_TOKEN=832F48D4A4E25EC558FA2D4B0D867399#.XdXALExFzg8. (The website was accessed on November 20, 2019.) Mayo Clinic. *Eosinophilic esophagitis* is an inflammation of the esophagus (tube from mouth to the stomach) whereby white blood cells build up in the esophagus (buildup is caused by a reaction to foods, allergens or acid reflux), which can lead to difficulty swallowing and tissue inflammation or injury. https://www.mayoclinic.org/diseases-conditions/eosinophilic-esophagitis/symptoms-causes/syc-2037219. (The website was accessed on July 29, 2019).

[70] Mayo Clinic. *Asthma.* "Asthma is a condition in which airways narrow and swell and produce extra mucus. This can make breathing difficult and trigger coughing, wheezing and shortness of breath." https://www.mayoclinic.org/diseases-conditions/asthma/symptoms-causes/syc-20369653. (The website was accessed on February 11, 2019.)

The next day, the primary care provider entered a new allergy consult, and NVCC staff approved the request the following day and forwarded the referral to the third-party administrator. Ten days later, NVCC staff contacted the patient and communicated that an appointment would be scheduled with another allergist. The NVCC staff also entered the patient's case into the third-party administrator's issue tracker.

In early summer 2018, NVCC staff documented an appointment was scheduled; however, the patient declined this appointment and requested an allergist closer to home. Twelve days later, NVCC staff documented that another non-VA allergist was scheduled for four days later. On two occasions in the previous month, the patient emailed the primary care provider and complained that the current inhalers were not effective in controlling the patient's asthma. In the second email, the patient suggested the symptoms may have been caused by the lack of allergy injections while waiting for another allergist.

The same day as the appointment was scheduled, the allergist canceled the patient's appointment. Two days later, the patient requested a different and specific non-VA allergist, and six days later, NVCC staff documented the patient was scheduled for this allergist the following month.

From four days after the patient's appointment through the next month, NVCC staff documented three attempts to obtain the records from the patient's non-VA allergy visit. In early fall 2018, NVCC staff administratively closed the consult after noting the three unsuccessful attempts to obtain the records.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 5, 2020

From: Network Director, VA Southeast Network (10N7)

Subj: Healthcare Inspection—Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia

To: Director, Office of Healthcare Inspections (54HL04)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I have had the opportunity to review the Draft Report: Healthcare Inspection of the Consult Delays, Atlanta VA Health Care System in Decatur, GA.
2. Atlanta VA Health Care System and VISN 7 submits concurrence to recommendations 1-6.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(*Original signed by*:)
Scott R. Isaacks, FACHE

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 29, 2020

From: Director, Atlanta VA Health Care System (508/00)

Subj: Healthcare Inspection—Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia

To: Director, VA Southeast Network (10N7)

1. I would like to express my appreciation to the Office of Inspector General (OIG) Health Care Inspection team for their professional and comprehensive review of the community care processes at the Atlanta VA Health Care System.
2. I have reviewed the draft report and acknowledge the identified opportunities for improvement in the delivery of community care services provided to our Veterans. I have reviewed and concur with the corrective actions and completion dates.
3. If you have any additional questions or require further information, please contact the Office of Quality Management.

(*Original signed by*:)
Ann R. Brown, FACHE
Director

Facility Director Response

Recommendation 1

The Atlanta VA Health Care System Director reviews the process for non-VA community care consult performance measurements, evaluates compliance with Veterans Health Administration policy, and implements an action plan as needed.

Concur.

Target date for completion: April 30, 2020

Director Comments

In accordance with VHA Directive 1232(2), Consult Processes and Procedures, the Atlanta VA Health Care System Director has required the facility's Office of VA Community Care to report on the facility's consult performance every morning with the Executive Leadership Team. The facility Community Care team is evaluated based upon the guidelines set forth from National and VISN level leadership for consult management. The Health Care System Director communicates regularly with VISN leadership on areas of concern and when necessary, action plans are developed and tracked with facility and VISN leadership. Community Care's action plan is reviewed with the Deputy Chief of Staff weekly and with the Executive Leadership Team every two (2) weeks.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The Atlanta VA Health Care System Director ensures managers review the backlog of open non-VA community care consults and implements an action plan as needed.

Concur.

Target date for completion: April 30, 2020

Director Comments

The Atlanta VA Health Care System Director has required the facility's Office of VA Community Care to brief the status of non-VA community care consults daily to the Executive Leadership Team during the facility's morning report and report on daily activity (e.g. consult movement) as well as provide a report on overall consult trends. This includes consults received from providers within the Atlanta VA Health Care System, and consults worked to completion

by the VA Community Care staff. This permits the Executive Leadership Team the opportunity to not only evaluate Community Care workflow, but the amount of care being sent to the community by each VA Clinical Service Line to determine if more emphasis for "in house" care is necessary. Community Care's action plan is reviewed with the Deputy Chief of Staff weekly and with the Executive Leadership Team every two (2) weeks.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The Atlanta VA Health Care System Director verifies that managers develop a process to analyze and confirm non-VA community care staff compliance with daily monitoring according to Veterans Health Administration policy.

Concur.

Target date for completion: April 30, 2020

Director Comments

The VA Community Care (VACC) utilizes and reports data daily which is monitored by facility and VISN leadership. A physician was recently assigned to serve as the Associate Chief of Staff for VA Community Care and is onsite in Community Care to evaluate performance as it relates to VHA policy. On a daily basis, the VACC Analyst team provides reports that evaluate pending, active and scheduled consults to ensure workflow is following VHA policy and discusses this data during VACC's leadership huddle.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 4

The Atlanta VA Health Care System Director evaluates the process for the hiring, training, and supervision of non-VA community care staff, and implements an action plan as needed.

Concur.

Target date for completion: September 30, 2020

Director Comments

The Atlanta VA Health Care System Director recognizes the staffing needs of VA Community Care (VACC) and has informed Community Care and Human Resources Leadership that achieving and maintaining approved staffing levels is a top priority.

The Office of VA Community Care at the Atlanta VA Health Care System (VAHCS) has had an increasing workload without a corresponding increase in staff. In Fiscal Year 2020, VACC's ceiling for staffing increased to 139.25 Full Time Employee Equivalent (FTEE) positions, but not all vacancies have been filled. As of May 12, 2020, VACC has received 41,407 consults and is on pace to exceed the number of consults received and processed during the previous fiscal year. Even with current staffing vacancies, VACC has procedures in place to manage consults for high risk care as a priority over consults for low risk care to reduce any potential harm to Veterans.

Fiscal Year	# Authorized FTEEs	# VACC Consults	Comment
2017	55	32,209	
2018	49	52,229	
2019	103	62,962	
2020	139.25	41,407	as of May 12, 2020

A supportable staffing model is being developed to meet the demands of reducing the backlog and addressing the demands of today's community care consults in a timely manner. The Atlanta VAHCS leadership is also looking at other approaches to reduce facility wait times and return care back to the health care system, thereby reducing the need to refer patients to community care.

Staffing and the status of vacancies within VACC are reviewed weekly with Human Resources (HR). Community Care's staffing plan is reviewed weekly with the Deputy Chief of Staff and with the Executive Leadership Team every two (2) weeks. VACC is collaborating with the HR department to hire a nurse educator and Medical Support Assistant (MSA) trainer to support the training of non-VA community care staff. In the interim, the VACC leadership team is utilizing online and virtual training recommended by the VISN and the National Office of Community Care. VACC's action plan includes monitoring of training to ensure any gaps are identified and addressed.

Recommendation 5

The Atlanta VA Health Care System Director ensures that managers review the patient cases referred to the Atlanta VA Health Care System by the Office of Inspector General, assesses these patients for adverse clinical outcomes, and implements action plans as needed.

Concur.

Target date for completion: June 30, 2020

Director Comments

The Atlanta VA Health Care System has completed a review of the 46 patient cases referred by the Office of the Inspector General, and there have been no identified adverse clinical outcomes. The status of those cases, as of May 15, 2020, is as follows:

- 34 patients had consults completed with appointment documentation received and scanned into the electronic health record.
- 6 patients had consults discontinued after scheduling efforts failed.
- 4 patient had consults discontinued after the Veteran declined the appointment.
- 1 patient had a consult appointment; the supporting documentation was requested but was not received.
- 1 patient received care outside of the original consult; supporting documentation not available.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 6

The Atlanta VA Health Care System Director makes certain that managers develop a policy to identify non-VA Community Care consults that are administratively closed but do not have relevant medical documentation, and implements an action plan as needed to be in alignment with Veterans Health Administration policy.

Concur.

Target date for completion: September 30, 2020

Director Comments

The Atlanta VA Health Care System's Office of VA Community Care (VACC) follows the current national policy which permits any consult to be administratively completed, without records, if VACC staff can confirm the Veteran was seen for their appointment and an initial request for records was made. VACC staff utilizes a report to ensure that "high-risk" consults receive at least three attempts to obtain the non-VA community care records, even if the consult was administratively completed.

A recent review conducted by a VACC Program Analyst identified consults that had been "Administratively Completed without Records," when in fact records were attached. It was identified that the report pulls data directly from the Computerized Patient Record System (CPRS) Consult Toolbox (CTB) and does not view the actual records. In order to correct this, when outside records are received and attached to the consult, an employee must go into CTB and click on Records Received (RR) which will then populate both the consult in CPRS as well as the CTB data pull and thereby removing those from the list. VACC leadership is developing an action plan to address this observation.

At the time of the healthcare inspection in October 2018, VHA Directive 1232 (1) did not contain follow-up action at the time of the review. Since that time, additional guidance was added to the Field Guidebook, Chapter 4, section 4.3 "*How to Run the Administrative Closure Report.*" The VACC Analyst team uses the report listed to pull the data on a weekly basis. The data is sent to the VACC staff to continue attempts to retrieve medical records for high risk consults. VACC created a Standard Operating Procedure (SOP) for the administrative closure of consults.

Community Care's action plan is reviewed with the Deputy Chief of Staff weekly and with the Executive Leadership Team every two (2) weeks.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Elaine Kahigian, RN, JD Kelli Brice, MPT Katherine Gemmell, MPH, LCSW James Seitz, RN, MBA Sandra Vassell, MBA, RN Thomas Wong, MD
Other Contributors	Katharine Brown, JD Alicia Castillo-Flores, MBA, MPH Laura Dulcie, BSEE Natalie Sadow, MBA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Southeast Network (10N7)
Director, Atlanta VA Health Care System (508/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kelly Loeffler, David Perdue
U.S. House of Representatives: Rick Allen, Sanford D. Bishop, Jr., Buddy Carter, Doug Collins, Drew Ferguson, Tom Graves, Jody Hice, Hank Johnson, John Lewis, Barry Loudermilk, Lucy McBath, Austin Scott, David Scott, Rob Woodall

OIG reports are available at www.va.gov/oig