DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in the Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque

HEALTHCARE INSPECTION | REPORT #20-00716-177 | JULY 8, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate an allegation that Community Care Service (Community Care) consults were completed in June 2018 without scanning and attaching available clinical results to patients' Veterans Health Administration (VHA) electronic health records (EHRs). Completion of the consults triggered notifications, known as view alerts, that consult results from community providers were available for review by ordering providers at the New Mexico VA Health Care System (facility) in Albuquerque, when, in fact, they were not available. It was further alleged that Veterans Integrated Service Network (VISN) 22 and facility leaders were aware of this practice and did not take action.

The OIG substantiated that in June 2018, Community Care nurses were completing consults without scanning and attaching clinical documentation to the patients' EHRs. Of the 255 consults reviewed by the OIG, 230 did not have clinical documentation scanned and attached to the consult in the patients' EHRs at the time of consult completion. However, providers who received incorrect view alerts developed work-arounds to obtain information necessary to care for the patients, and the OIG did not identify adverse clinical outcomes associated with the false view alerts for the patients reviewed.[1]

Nurses who were working in Community Care in 2016 reported this process reflected training they received by their peers at that time. Nurses within the program lacked a comprehensive orientation and training program to provide them with the required knowledge and skills to correctly perform their duties. In October 2019, nursing management staff developed a unit-specific standardized orientation and training program. However, there was no documentation to show full implementation of this program.

The Chief of Community Care assumed that procedures that were in place for completing Community Care consults were correct when accepting the position in 2016. The Chief of Community Care did not verify adherence to consult-related VHA requirements or conduct regular reviews and improvements for departmental performance deficiencies.

The OIG learned the Chief of Community Care had competing priories due to dual roles as surgeon and Chief of Community Care. As of May 2020, the Chief of Community Care continued to work in both roles. The staff from the VISN 22 Business Implementation Office indicated the position required dedicated leadership; however, the Chief of Community Care

[1] Merriam-Webster Dictionary, *definition of work-around,* accessed September 29, 2020, https://www.merriam-webster.com/dictionary/work-around. A work-around is a plan or method to circumvent a problem without eliminating it.

continued clinical duties and performed approximately one quarter of all surgeries at the facility. The Facility Director approved a position for a deputy to assist the Chief of Community Care with program management in October 2019; however, the position remained vacant as of February 2021.

The facility's Group Practice Manager and Consult and Access Management Steering Committee conducted monthly performance monitoring that addressed consult timeliness. For Community Care consults, performance monitoring addressed consult processes prior to patients receiving care, such as open consults, but did not address the consult completion process, and therefore did not identify the non-compliance with VHA policy prior to 2019. The OIG received conflicting information from facility staff about who was responsible and the expectations for this monitoring. VHA requires that the facility's Consult and Access Management Steering Committee assist the Facility Director in consult oversight. The Chief of Staff designated responsibility for monitoring to the facility's Group Practice Manager, who chairs the Consult and Access Management Steering Committee. However, the Group Practice Manager did not perform EHR audits.

The Chief of Community Care's misunderstanding of VHA requirements and lack of oversight led to a failure to recognize the problem with consult completions. Additionally, the failures by the facility to designate responsibilities for monitoring enabled the consult completion errors to continue for years. There continued to be a deficiency in monitoring as of June 2020. As of that date, the OIG found no evidence of oversight that consults were completed properly once the errors were identified, or for ongoing quality reviews.

The OIG made five recommendations to the Facility Director related to the Community Care consult completion process, nursing competencies and training, Consult and Access Management Steering Committee oversight and monitoring, facility leaders' oversight, and Community Care organizational structure and leaders' expertise.

Comments

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

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Abbreviations

COS	Chief of Staff
EHR	Electronic Health Record
GPM	Group Practice Manager
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate an allegation that Community Care Service (Community Care) consults were completed in June 2018 without scanning and attaching available clinical results to patients' Veterans Health Administration (VHA) electronic health records (EHRs).[1] Completion of the consults triggered notifications, known as view alerts, that consult results from community providers were available for review by ordering providers at the New Mexico VA Health Care System (facility) in Albuquerque, when, in fact, they were not available.[2] It was further alleged that Veterans Integrated Service Network (VISN) 22 and facility leaders were aware of this practice and did not take action.

Background

The facility is part of VISN 22 and includes a medical center with 13 community-based outpatient clinics. The facility provides primary and specialty care services as well as a 24-hour Emergency Department. From October 1, 2018, through September 30, 2019, the facility served 59,755 patients. The facility contracted with third-party administrators to provide patients with access to community care clinics throughout New Mexico and southwest Colorado.[3] The facility was affiliated with the University of New Mexico School of Medicine and approximately 70 other academic institutions for health training opportunities. The Veteran's Health Administration (VHA) classifies the facility as level 1b—high level complexity.[4]

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[1] Following a patient's community care visit, records from the community care provider are sent to VA. Upon receipt of the records, the documents are reviewed, scanned, and attached to the consult request. Community care consults are considered complete when consult results or clinical documentation provided by the community care provider are attached to a consult result note in the patient's VA EHR.

[2] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015. EHR-based notifications (view alerts) are related to test results. View alerts are "the most widely used VHA method for asynchronous communication of test results from diagnostic providers to ordering providers or designees."

[3] VA Patient-Centered Community Care—Information for Providers, accessed November 23, 2020, https://www.va.gov/COMMUNITYCARE/providers/info_PC3.asp. Third Party Administrators perform "certain functions on behalf of VA, such as scheduling appointments and paying claims."

[4] VHA Office of Productivity, Efficiency & Staffing, Facility Complexity Model, accessed November 19, 2019, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. The VHA Facility Complexity Model categorizes level 1b facilities as high level complexity. High-level complexity facilities are facilities with medium–high volume, high-risk patients, many complex clinical programs, and medium–large research and teaching programs.

Community Care

Community care refers to care purchased by VHA for eligible patients based on criteria that include care or services are not available at a VA medical facility, the patient lives in an area where there is not a full service VA medical facility, the veteran is grandfathered in under the Veteran Choice Program for the distance criteria, the veteran meets specific access standards for appointment wait times, the veteran and the referring physician agrees that it is in the veteran's best medical interest, or the veteran needs care from a VA medical service line that is not providing care that complies with VA's quality standards.[5]

The Veterans Choice Program was started in 2014 and ended June 6, 2019. The Veterans Choice Program was established to assist patients who were unable to schedule an appointment within specific wait-time goals or their preferred or clinically necessary date, or who were unable to access VA health care based on distance from or physical barriers from their place of residence.[6]

In 2018, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act consolidated "seven VA community care programs into one streamlined program."[7] In response to the MISSION Act, the Veterans Choice Program was replaced by the Veterans Community Care Program in June 2019. This program simplified the process for veteran community care by streamlining eligibility criteria, creating a single Community Care Program, improving customer service, and providing a way for patients to seek emergency and in-network walk-in care without requiring prior authorization.[8]

Consult Process

A clinical consult is a request by a provider for input from an expert regarding evaluation or management of a specific patient problem. The consult process allows for two-way communication between the requesting provider and the responding provider, on behalf of the patient.[9]

VHA facilities use a consult software program to track and document Community Care consult information in patients' EHRs. Within a patient's EHR, a provider enters an order for a consultation. The receiving service reviews the request for services and accepts the consult. The appointment is then scheduled. Once a patient completes the appointment, the community-based

[5] VA Fact Sheet, *Veteran Community Care General Information*, September 09, 2019, accessed October 23, 2020, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VHA-FS_MISSION-Act.pdf#.

[6] VA Fact Sheet, *Veteran Community Care General Information*.

[7] U.S. Senate Committee on Veterans Affairs, *The VA Mission Act of 2018*, accessed June 16, 2020, https://www.veterans.senate.gov/imo/media/doc/One%20Pager_The%20VA%20MISSION%20Act%20of%202018.pdf. The Mission Act consolidated "seven VA community care programs into one streamlined program."

[8] VA Fact Sheet, *Veteran Community Care General Information*.

[9] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016.

provider sends the results of the consultation and recommendations back to the requesting facility. Documents may be in the form of paper or electronic files sent directly from the community provider, or documents may be brought in by the patient. The documentation is scanned into the patient's EHR and attached to the consult. When a consult status is updated to "complete," the ordering provider is notified electronically in the EHR in the form of a view alert.[10] A provider may use view alerts to review comments or results.[11] Requesting providers use consult results to determine a patient's need for continued care and treatment.

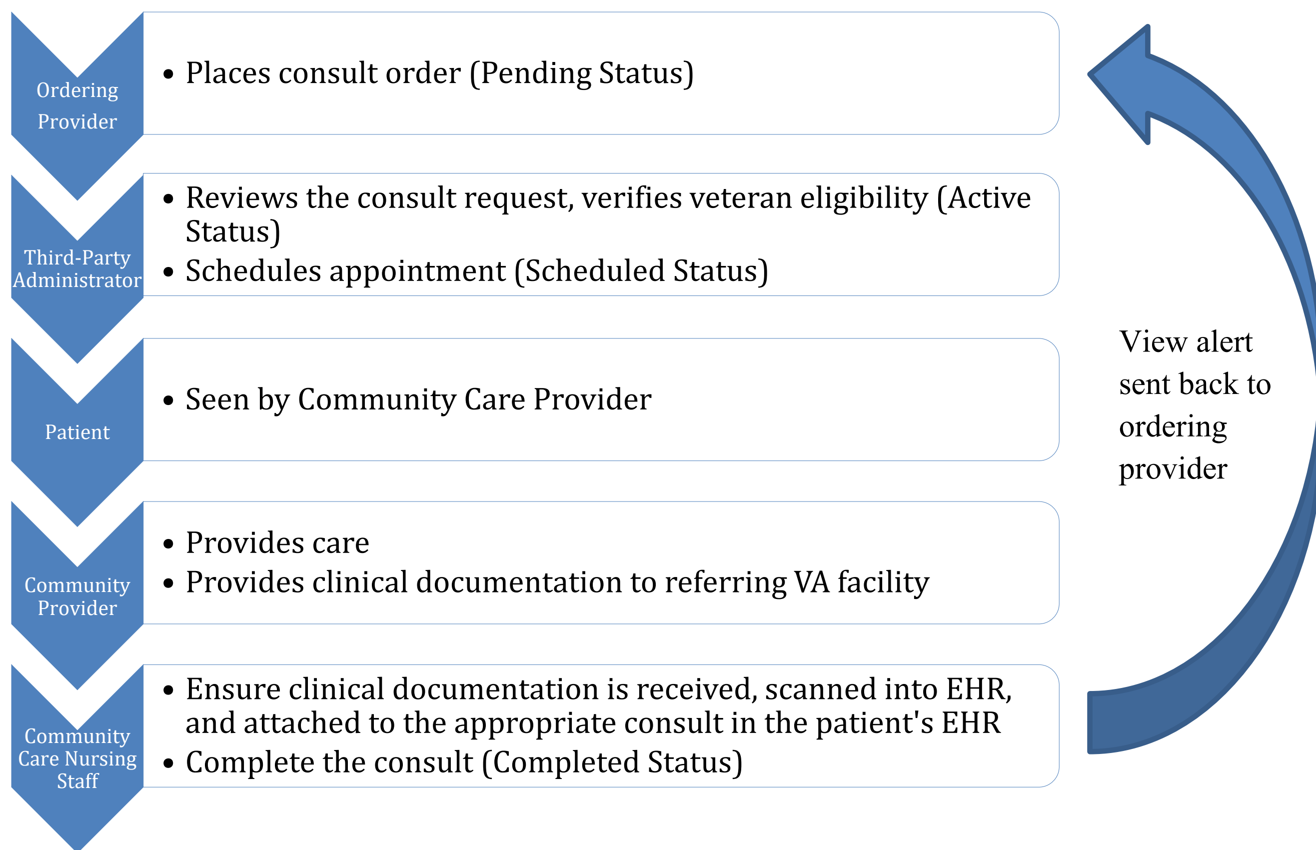

Figure 1. Overview of the Community Care Consult Process
Source: OIG analysis of VHA Directive 1232(2) and Government Accountabilities Office report, Management and Oversight of Consult Process Need Improvement, September 2014

[10] VHA Directive 1232(2).

[11] The Consult Package provides an interface with the EHR Order Entry, which permits clinicians to review consults within the EHR package.

Prior OIG Reports

In the July 2019 report, *Concerns with Access and Delays in Outpatient Mental Health Care at the New Mexico VA Health Care System, Albuquerque, New Mexico,* the OIG determined that patients had limited access to outpatient mental health care, and patients experienced delays in care. However, none of the patients reviewed during the study time frame completed suicide. Patients with mental health consults were called but did not consistently receive face-to-face appointments. Consults were marked complete regardless of whether or not the patients were seen. These completed consults were not tracked through VHA appointment scheduling processes, may have been lost in the scheduling process, and patients may not have received consistent mental health care. The OIG made 12 recommendations.[12] Two of the 12 recommendations were open as of March 22, 2021.

In the August 2019 report, *Health Information Management Medical Documentation Backlog*, the OIG found that VHA medical staff did not consistently scan and enter medical documentation into patients' EHRs. Also, staff did not consistently perform appropriate reviews and monitoring to assess the quality and legibility of the scanned documents. The OIG made nine recommendations to the Under Secretary for Health of which seven remained open as of November 24, 2020.[13]

In the July 2020 report, *Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia,* the OIG confirmed that scheduling delays occurred for all patients' consults identified in the allegation but did not identify an increased risk of or adverse clinical outcome for these patients. The OIG determined that inconsistent scheduling processes and oversight, deficiencies with third-party administrator scheduling oversight, shortages of facility staff, and lack of training and supervision for facility Non-VA Care Coordination scheduling staff contributed to the delays. The OIG made six recommendations.[14] As of November 24, 2020, all recommendations remained open.

Allegations

On September 21, 2019, the OIG received an allegation from an anonymous complainant that Community Care consults were completed without scanning and attaching the available consult results in patients' EHRs in June 2018.

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[12] VA OIG, *Concerns with Access and Delays in Outpatient Mental Health Care at the New Mexico VA Health Care System, Albuquerque, New Mexico*, Report No. 17-05572-170, July 23, 2019.

[13] VA OIG, *Health Information Management Medical Documentation Backlog*, Report No. 18-01214-157, August 21, 2019.

[14] VA OIG, *Consult Delays at the Atlanta VA Health Care System in Decatur, Georgia*, Report No. 18-01622-207, July 21, 2020.

On November 18, 2019, the OIG opened a healthcare inspection to evaluate the following specific allegations:

1. A Chief of Community Care authorized staff to close consults without the community care clinical documents scanned into patients' EHRs, triggering false indications (view alerts) that consult results were available for review.
2. VISN and facility leaders were aware of the practice of closing Community Care consults without scanning consult results into the patients' EHRs and did not take action.

Scope and Methodology

The OIG opened a healthcare inspection on November 18, 2019, and conducted a virtual site visit from April 13–22, 2020. The OIG was cognizant of the facility's burden with COVID-19 issues and made allowances for this when scheduling staff interviews.[15] The virtual review was chosen due to *stay-at-home* restrictions that resulted from COVID-19.

The OIG evaluated the portion of the consult process that occurs from the receipt of clinical information from a community care provider through the completion of the consult and a subsequent view alert sent to the ordering provider.

The OIG interviewed VISN and facility Compliance and Business Officers, VISN and facility Group Practice Managers (GPMs), the VISN Business Implementation Manager and Associate Manager, and the VISN Chief Medical Officer. Additionally, the OIG interviewed facility leaders including the Facility Director, Chief of Staff (COS), Associate Director, Chief of Community Care, and the Acting Chief of Ambulatory Care. Other interviews conducted by the OIG included key staff in Community Care, Primary Care, Patient Safety, Health Information Management medical records supervisor and scanners, and members of the facility's Consult and Access Management Steering Committee (Steering Committee).[16]

The OIG team reviewed relevant VHA policies, Deputy Under Secretary for Health for Operations and Management memorandums, and facility policies on topics related to the process of completing consults and documenting clinical information from community providers.[17]

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[15] World Health Organization, *Naming the coronavirus disease (COVID-19) and the virus that causes it,* accessed September 29, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

[16] VHA Directive 1232(2). The Steering Committee assists facility leaders in the oversight and management of consult processes. Merriam-Webster, *Primary Care Definition*, accessed July 14, 2020, https://www.merriam-webster.com/dictionary/primary%20care#medicalDictionary. Primary Care is a term used for health care provided by a medical professional with whom the patient has initial contact.

[17] The Deputy Under Secretary for Health for Operations and Management oversees field operations and provides both specific and general operations direction and guidance to the 18 VISN Directors.

Other documents reviewed included

- Examples of completed consults including view alerts to providers,
- Reports of Consult Compliance Audits completed by VISN 22 and facility Compliance and Business Integrity Officers,
- Results and action plans from VISN 22 Business Implementation Manager site visits of the Community Care Program,
- Steering Committee meeting minutes reflecting consult data presentation and discussion, and
- Risk Management, Patient Safety, and Quality Management documents related to issues with consults and adverse events.

Using VHA Support Services Center data, the OIG identified 3,409 Community Care consults that closed in June 2018.[18] Of these 3,409, the OIG identified 411 consults for patients who died. The OIG reviewed all 411 of these consults. From the remaining 2,998 consults, duplicates, inpatient, and low-risk clinics were removed, as those were least likely to result in a patient's increased risk of or an adverse clinical outcome, leaving 999 completed consults.[19] The OIG then generated and reviewed a statistical sample of 200 consults. In total, the OIG reviewed the patients' EHRs of the 611 consults designated as complete to determine if medical documentation was scanned and attached to the medical record at the time of consult completion. The OIG also assessed patients' EHRs for indications of patients' increased risk of or adverse clinical outcomes.[20]

Upon further review of the consults, the OIG identified 211 that were incorrectly designated as complete that were discontinued or canceled. Discontinued or canceled consults are consults where the patient was not seen by a community provider; therefore, those consults were excluded from further review. Consults for transfers to nursing homes, community living centers, and hospice care were also excluded as those entities provided the patients' care. Consults where the community care provider did not return the clinical documentation were also removed as these

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[18] VHA Support Services Center Data Use Agreement. Closed consults have an EHR Status of canceled, complete, discontinued, and discontinued/edit.

[19] VHA Consult Standard Operating Procedure. VHA defined low-risk clinics to include physical therapy, occupational therapy, kinesiotherapy, acupuncture, smoking clinic, MOVE clinic, massage therapy, chiropractic care, and erectile dysfunction clinic.

[20] Within the context of this report, the OIG considers an adverse clinical outcome to be death, a change in diagnosis, a change in the course of treatment, or a significant change in the patient's level of care. The risk of an adverse clinical outcome associated with a premature consult closure is a function of both the potential severity of the referring medical condition and of the magnitude of the missing medical treatment information. The risk increases if the missing medical information affected the treatment plan, and the patient's disease process could progress to severe disability or death.

records were not available for review. Of the remaining consults with the designation of completed, 255 had clinical documentation returned to the facility. The 255 consults were analyzed to determine if clinical documents were scanned and attached to the consult at or before the time the consult was completed (see appendix A).

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, 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.

Inspection Results

1. Community Care Consults Were Completed Without Scanning and Attaching Clinical Information

The OIG substantiated that Community Care consults were completed without scanning and attaching the clinical information from community providers to patients' EHRs in June 2018. As a result of nursing staff marking consults as completed, ordering providers received view alerts that clinical information (consult results) was available for review and action. However, the consult results were not available, possibly placing patients at increased risk of or adverse clinical outcomes and compelling providers to develop work-arounds to coordinate patient care.[21]

Consult Completion

According to VHA policy, a consult is completed when clinical documentation is received from the community care provider and scanned into the EHR.[22] Further, VHA requires that appropriate checks and balances are in place to ensure clinical documentation from community providers is scanned and attached to the appropriate consult in the patient's EHR before the consult is completed.[23] "VHA, by statute, must maintain complete, accurate, timely, clinically-pertinent, and readily-accessible patient health records, which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education, research, and facilitate performance improvement processes and legal requirements."[24]

The Chief of Community Care and Community Care nurses reported that the prior direction was to complete consults with a note and send the documents for scanning. This created a time lapse between consult closures and scanning and attaching of clinical information from patients' community care visits. During facility staff interviews, the OIG was told of a backlog in scanning and the facility's efforts to improve this backlog. The OIG was unable to determine exactly when or why the practice was implemented because the prior Chief of Community Care was no longer employed by VHA and was unable to be contacted for interview.

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[21] The Consult package provides an interface with the EHR Order Entry, which permits clinicians to review consults within the EHR package. Merriam-Webster Dictionary, *definition of work-around,* accessed September 29, 2020, https://www.merriam-webster.com/dictionary/work-around. A work-around is a plan or method to circumvent a problem without eliminating it.

[22] VHA Directive 1232(2).

[23] VHA Directive 1232(2).

[24] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. Title 44 United States Code (U.S.C.) 3102(1).

The OIG found that 230 of the 255 (90 percent) reviewed consults did not have clinical documentation scanned and attached to the consult in the patients' EHRs at the time of consult completion. However, the OIG found no evidence that patients suffered increased risk of or adverse clinical outcomes related to staff's failure to scan and attach the clinical information to the EHR at the time of completion. Further, there were no adverse clinical outcomes reported by primary care providers, a primary care nurse, a patient safety staff member, or leaders interviewed by the OIG.

Scanning Work-Arounds and View Alerts

The OIG determined that the lack of scanned and attached clinical documentation contributed to the development of work-arounds by ordering providers and care teams to obtain clinical information. The OIG was told by a clinical leader that if the clinical information from the community care provider was not available in the EHR, it could be problematic. Incomplete EHRs can put patients at increased risk of or adverse clinical outcomes. Without the available information, the accuracy of medical diagnoses and timely treatment can be in jeopardy.

Primary Care Clinic staff reported spending one–two hours per week attempting to obtain the information. These work-arounds included

- Provider-to-provider inquiries by telephone,
- Nursing inquiries to community providers by telephone or fax and through collaboration with Community Care staff, and
- Instructing patients to bring the information back to the clinic.

When a Community Care consult is completed, the ordering provider receives a view alert in the EHR that the consult is complete indicating records are available for review and action on behalf of the patient. The lack of complete clinical documentation at the time of consult closure created the distribution of inaccurate view alerts to providers.

The OIG interviewed facility staff who said that issues with scanning and attachment of clinical consult documentation created a need for ordering providers to take time away from patient care to search for the information to make safe patient care decisions. Inaccurate view alerts made it difficult for an ordering provider to determine if the information was available. The ordering provider's perspective was that the process was inconsistent and delayed.

Inadequate Training and Competencies

The OIG determined that the process of completing consults without the attached documentation occurred because staff lacked training and guidance on VHA consult completion processes and requirements.

VHA policy on consult processes and procedures was available in 2016. This policy outlined the procedure to complete consults and remained in place at the time of the OIG inspection.[25] The facility has a consult management policy that is in alignment with VHA requirements.[26] However, the OIG found no evidence that either policy was used for the Community Care nurses' ongoing competencies.

A Community Care Nurse Manager stated that they were using the VHA Chief Business Office field guides for direction.[27] The OIG did not find evidence that the field guides were used for nurses' competencies. The Chief of Community Care and a prior Community Care nurse manager confirmed there were no Community Care-specific competencies for nursing staff. The prior Community Care nurse manager also reported that staff were trained by observing their peers.

The VHA Office of Community Care developed competencies for Community Care staff in August 2018. However, there was no documented evidence that these competencies were used at the facility to develop staff competencies until October 2019 when the newly hired Community Care nurse manager developed competencies that included staff knowledge of the relevant directives, laws, guidelines, and consult processes.

Community Care nurses stated they were oriented by senior Community Care nurses to complete consults and send documents to the Health Information Management department for scanning and attaching to the EHR.[28]

To improve the timeliness and availability of clinical information from community care providers, new procedures were developed in October 2019 that required Community Care nurses to learn the process for scanning and attaching community care documents. In March 2020, nursing staff began to process clinical documentation by reviewing and scanning to complete consults.[29]

The OIG was unable to determine when the incorrect process for completing community care consults began because of the lack of documented competencies. However, it is clear from staff

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[25] VHA Directive 1232(2).

[26] Facility Memorandum 11-20, *Consult Management,* February 24, 2017. Consults are completed upon receipt and scanning of supporting clinical documentation.

[27] VHA National Non-VA Medical Care Program Office, Chief Business Office, *VHA National Non-VA Medical Care Consult/Referral Management*, October 28, 2014, Version 1; This topic contains guidelines on managing Non-VA Medical Care Program Office Consult/Referral based on Non VA Care Consult Business Rules and Process and Standard Operating Procedures to facilitate Veteran-Centered Care Coordination.

[28] VHA Handbook 1907.07. Health Information Management staff manage all aspects of VHA health records maintenance including scanning community care clinical documents.

[29] The OIG did not evaluate the impact of COVID-19 on Community Care staffing or workload; however, the OIG was told that the number of consults for Community Care were down and that gave Community Care staff a chance to work down the backlog of consults that did not have returned clinical information from the community.

interviews that the process was perpetuated by peer-to-peer training combined with a lack of standardized policy-based training. In October 2019, the facility began implementing VHA-developed standardized training materials to educate staff.

Process Monitoring

The practice of completing consults without scanning and attaching the clinical information continued until 2019 when the VHA Office of Compliance and Business Integrity released the National Compliance Audit Report to facility leaders identifying this practice was occurring at the facility and was not in alignment with VHA policy. The facility practice reportedly stopped at that time, and the roles and responsibilities of Community Care nurses changed accordingly. At the time of the OIG's inspection, details of quality oversight or monitoring of newly implemented processes were inconsistent. For example, the Chief of Community Care reported 100 percent of the consult completions were monitored for quality, while a nurse manager reported 40 percent. Although Community Care nurse managers said monitoring was done, they did not document the monitoring.

As of May 2020, the OIG was unable to determine the quality and efficacy of the monitoring process and corrective actions taken by the facility due to the lack of oversight consistency and documentation.[30]

2. Leaders' Inadequate Oversight

The OIG substantiated that the facility's Chief of Community Care was aware of the practice of staff completing Community Care consults without scanning and attaching clinical documentation from community providers to the patients' EHRs. However, other facility leaders stated they were not aware of the practice until 2019. The OIG found that failures in Community Care consult oversight and monitoring led to this lack of awareness.[31]

Chief of Community Care

The OIG substantiated the Chief of Community Care knew Community Care nurses were completing consults without scanning and attaching clinical documentation as required. The Chief of Community Care stated this practice was in place in January 2016 when accepting the position and assumed it was correct. The Chief of Community Care denied knowledge of a VHA policy that allowed nurses to complete consults in this manner.

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[30] Merriam-Webster Dictionary, *definition of efficacy*, accessed September 22, 2020, https://www.merriam-webster.com/dictionary/efficacy?src=search-dict-box, Efficacy is the power to produce and effect.

[31] Merriam-Webster Dictionary, *definition of oversight,* September 22, 2020, https://www.merriam-webster.com/dictionary/oversights. Oversight is watchful and responsible care and includes regulatory supervision.

VHA requires service and department clinical leaders be responsible for adherence to any consult-related national program office guidance.[32] In addition, leaders are responsible for regular review and improvement of departmental performance deficiencies.

Competing Priorities and Program Changes

The staff from the VISN 22 Business Implementation Office indicated the Chief of Community Care position required dedicated leadership; however, the Chief of Community Care continued clinical duties and performed approximately one quarter of all surgeries at the facility.

The Facility Director reported that the Chief of Community Care, who was a facility surgeon at the time of selection as Chief of Community Care, had not previously held a leadership position. After assuming the position, the Chief of Community Care reported maintaining a surgical workload of 25 percent in addition to the Community Care responsibilities.

The Facility Director stated being aware of gaps in the Chief of Community Care's leadership experience at the time of the selection for this position. The Facility Director further stated the COS was expected to assist with these challenges, including coaching, and assumed that was occurring.

The COS reported having an open-access policy for the Chief of Community Care but held no scheduled meetings. The COS defined a limited role in Community Care, with the job to make sure they had sufficient staff. The COS reported no concerns with the performance of the current Chief of Community Care. However, plans were to hire additional staff to support the Chief of Community Care.

The Chief of Community Care reported that there was a lack of a formal transition to the new role in Community Care, and it was a *trial by fire* as the prior Chief of Community Care was gone. The Chief of Community Care reported the program underwent multiple changes over the years. Staff reporting to the Chief of Community Care increased from 18 in 2017 to 101 approved positions by 2019. The approved positions included a Deputy Chief of Community Care and other supervisors; however, these positions were vacant at the time of the OIG review.

Program changes included modifications related to VHA's transition from the Choice Act to the MISSION Act, in which multiple community care programs were merged into one Community Care Program. In an email, the Chief of Community Care listed the numerous new responsibilities and tasks that were added to the clinical duties that came with this shift. Additionally, the administrative staff who managed the scheduling of appointments for Community Care were re-aligned under the Chief of Community Care.

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[32] VHA Directive 1232(2).

The OIG noted several factors that interfered with the Chief of Community Care's responsibility to evaluate the Community Care Program and ensure its adherence to any consult-related program guidance:

- Knowledge deficits of VHA requirements for consult completion
- New leadership position without formal transition to the role
- Concurrent surgeon activities
- VHA and facility program and service changes

Due to these competing priorities, the Chief of Community Care assumed the practice in place in 2016 was correct. This allowed errors in the Community Care consult completion practice to continue for three years. This may have placed patients at increased risk of or adverse clinical outcomes, and providers developed work-arounds to coordinate patient care.

Facility Leaders Failure to be Aware of Community Care Practices

The OIG found that facility leaders, except for the Chief of Community Care, were not aware of the practice of nursing staff completing Community Care consults without scanning and attaching clinical documentation into patients' EHRs until 2019.

VHA identifies a facility director's responsibilities as overseeing the facility consult policy and outcomes, monitoring and improvement of performance at least monthly, and ensuring adherence to VHA performance timeliness standards.[33] A facility's COS is responsible for "reviewing and improving facility consult performance and outcomes."[34]

The Facility Director reported awareness of challenges with consult processing and obtaining medical documentation from community providers. However, the Facility Director reported being unaware that Community Care consults were marked as complete without scanning and attaching the available clinical information prior to 2019. The COS also reported being unaware of this practice. Both leaders were notified of the discrepancies when the results of the VHA Office of Compliance and Business Integrity National Compliance Audit Report were issued in February 2019.

The Facility Director and COS routinely received reports on VHA timeliness metrics for consults. These reports, provided by the VISN Business Implementation Manager, noted the number of open consults in the various consult stages and consult timeliness performance metrics. The reports focused on how long the consult was in various stages such as pending,

[33] VHA Directive 1232(2).

[34] VHA Directive 1232(2).

active, and scheduled. However, the reports did not include monitoring of the completion process, specifically, attaching clinical documentation to the consults.

The OIG found that although the Facility Director and COS met their responsibilities for monitoring of performance of timeliness metrics on consults, they did not review the consult completion process.

GPM and Steering Committee Inadequate Oversight

The OIG found that the facility's GPM and Steering Committee failed to assist the Facility Director and COS in oversight of the facility's consult processes. As a result, facility leaders were unaware of the consult process used by Community Care that allowed nurses to complete consults without attaching the clinical documentation to the EHR. This process was not in alignment with VHA policy and while the OIG did not find evidence of adverse clinical outcomes for the patients reviewed, the non-adherent practice had the potential to place patients at increased risk of or adverse clinical outcomes.

The GPM is responsible for maintaining standardized consult processes that are consistent with VA policy.[35] The COS reported an expectation that the GPM audits facility consult processes. In an interview with the OIG, the GPM discussed oversight of access to care, wait times, and provider productivity. The GPM monitors the numbers of open consults but does not request EHRs for auditing, and stated that consult auditing was done by the facility's Compliance and Business Integrity Officer.[36]

The facility's Steering Committee, chaired by the GPM, is responsible for "assisting the Facility Director and COS in oversight, management, implementation, and improvement of the facility's consult processes."[37] The responsibilities of the Steering Committee are defined by VHA directive and the facility's Steering Committee charter.[38] According to the GPM, the Steering Committee met monthly with a few exceptions and reviewed consult data obtained from the VHA Support Service Center that was analyzed by the GPM.[39] The consult data presented are for open consults only and did not include closed consults. The OIG found that there were deficiencies and inconsistencies between VHA policy and the facility's charter (see table 1).

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[35] VA Deputy Under Secretary for Health for Operations and Management (10N), Memorandum, *Supplemental Guidance for Clinic Access Management Training Announcement (VACAA Section 103),* December 22, 2014. This memorandum provides guidance on development of organizational structure that incorporates a GPM.

[36] Merriam Webster Dictionary, *definition of Audit*, accessed September 22, 2020, https://www.merriam-webster.com/dictionary/audit. Audit is a methodological examination and review.

[37] VHA Directive 1232(2).

[38] VHA Directive 1232(2).

[39] VHA Support Service Center provides a healthcare data tool used for quality evaluation, accessed February 12, 2020, https://vssc.med.va.gov/VSSCMainApp/. (This is an internal VHA website and not accessible to the public.)

Table 1. Steering Committee Responsibilities

VHA Oversight Requirement-Directive 1232(2)	Facility Steering Committee Charter	Steering Committee Activities and Deficiencies
Assisting the Facility Director and COS in the oversight, management, implementation, and improvement of the facility consult process to include all consult services	Oversee compliance with established consult management processes	Results of the VHA audit conducted by the facility Compliance and Business Integrity Officer were not documented as discussed in this committee. No documentation that reflected oversight of consult completion process compliance with VHA Directive.
	Coordinate the assessment, implementation, and management of consult management	Coordinates audits of scheduling processes but no audits regarding consult completions. Of 20 sets of meeting minutes reviewed, 19 had agenda items of audits for scheduling processes. The Chair (GPM) coordinated, reviewed, or developed an action plan based on the outcome of audits.
	Monitor, analyze, and address all aspects of consult and access management for the purpose of meeting the facility's mission and commitment to timeliness and continuity of care	Timeliness and other data on consults from electronic database, monthly data reported on open consults. There was no monitoring of completed consults noted in the minutes.
Working collaboratively with national level consult work groups and performance improvement efforts	Develop consult management performance metrics or measures and monitor approved measures	Timeliness Metric of Stat Consults; Open Consults; Scheduling; Wait times; Access developed nationally. There was no monitoring of completed consults noted in the minutes.
	Develop consult management quality measures	No documentation of quality assurance measures used to identify problems with the consult completion process[40]

[40] Merriam-Webster, *Definition of quality assurance,* accessed September 22, 2020, https://www.merriam-webster.com/dictionary/quality%20assurance. Quality assurance is a method used for the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met.

VHA Oversight Requirement-Directive 1232(2)	Facility Steering Committee Charter	Steering Committee Activities and Deficiencies
Reporting its findings or concerns to the facility or VISN Compliance and Business Integrity Committee as appropriate	Report and make recommendations regarding the consult process for the facility	No concerns identified, no concerns reported.

Source: OIG comparative analysis of VHA Directive 1232(2), the facility's Steering Committee charter, and Steering Committee Minutes

The Steering Committee's charter did not address who was responsible for assisting the Facility Director and COS in the oversight, management, implementation, and improvement of the facility consult process that includes all consult services as outlined in VHA policy. However, according to the GPM, the role of the Steering Committee is to ensure the facility follows VHA Directives 1231(1) and 1232(2).[41]

The OIG found Steering Committee deficiencies in responsibility that included the following areas:

- Assisting the Facility Director and COS with oversight, management, implementation and improvement of the facility consult process to include all consult services.
- Overseeing compliance with established consult management processes.
- Monitoring, analyzing, and addressing all aspects of consult and access management.

The GPM and the COS had differences of opinion about the GPM's responsibilities for oversight and monitoring. The COS expected the GPM to audit facility consult processes. The GPM monitored consult processes prior to the patient's visit. However, once the care was received, the GPM and the Steering Committee did not monitor the consult completion process.

VHA and VISN Leaders Met Oversight Responsibilities

The OIG found that VHA and VISN leaders' oversight of consults met responsibilities as outlined in VHA policy. In a 2019 report, the VHA Office of Compliance and Business Integrity issued results of a 2018 audit that found deficiencies in the facility's consult completion process.

VHA developed the audit criteria and required facilities' staff to perform audits on specific topics.[42] The VISN Compliance and Business Integrity Officer is responsible for monitoring

[41] VHA Directive 1231(1), *Outpatient Scheduling Process Procedures,* Amended July 12, 2019. VHA Directive 1232(2).

[42] VHA Compliance Audits were placed on hold in 2019 until facilities had fully implemented the MISSION Act.

compliance audits performed at each facility within a VISN and evaluating facility-based audits for VISN-wide issues, trends, and consult documentation accuracy.[43]

The purpose of this audit of the facility's outpatient consult management was to evaluate the use of VHA's standardized clinical consultation processes.[44] The audit reviewed consult documentation to evaluate consult actions, such as status changes like consult completions.[45] The facility results showed that completed Community Care consults had documentation discrepancies. Clinical documents from the community were not scanned into EHRs when the consults were completed. VISN staff stated they were unaware of the facility's practice of completing consults without the attachment of clinical documents to the EHR. The facility's Compliance and Business Integrity Officer sent an email on February 5, 2019, to the Facility Director, COS, and the compliance email group. The VISN Compliance and Business Integrity Officer sent the compliance report to the VISN 22 Community Care, GPM, and Compliance email groups that included the facility's Chief of Community Care and GPM. The VHA Office of Compliance and Business Integrity recommendations included reporting to the facility's Steering Committee and GPM for development of corrective action plans. The GPM and the facility's Compliance and Business Integrity Officer developed an action plan; however, it did not include specific actions to correct the facility's practice of completing consults without attaching clinical documentation.

The COS reported that once the error was realized, of closing the consults before scanning and attaching clinical documents from the community care provider, the practice was corrected and now nurses are scanning clinical documents before closing consults. The COS reported the GPM had been working on this process. When asked, the GPM denied performing an audit of the consult process. However, the OIG did not find evidence in Steering Committee meeting minutes that the erroneous practice had stopped, nor did interviews with the COS or GPM validate that this practice had stopped. Further, the GPM reported no responsibility for Community Care.

Community Care nurses reported a newly implemented consult completion process, which began in May 2020, with nurses conducting quality reviews. Although Community Care nurse managers said monitoring was done, they did not document this monitoring. Details of quality

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[43] VHA Directive 1232(2).

[44] VHA Office of Compliance and Business Integrity audit reports address VA's response to routinely audit facilities to ensure use of VHA's standardized consultation processes, U.S. Government Accountability Office Report, *VA Health Care Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care*. *Report-14-808*, recommendation number two, the Office of Compliance and Business Integrity designed, developed, and implemented a consult management audit protocol to determine whether facilities adhered to standardized consult processes for outpatient specialty care.

[45] VHA Office of Compliance and Business Integrity, *Outpatient Specialty Care Consult Management Compliance Audit Protocol*, March 2018.

oversight or monitoring were inconsistent. One staff member reported they audited 100 percent of the nurse consult completion process while another staff member reported 40 percent.

The OIG concluded that facility leaders failed to take responsibility for oversight and monitoring processes. This failure contributed to facility leaders' lack of information and assumption that consult processes were done correctly.

Conclusion

The OIG substantiated that in June 2018, Community Care nurses were completing consults without scanning and attaching clinical documentation to patients' EHRs. Nurses who were working in Community Care as early as 2016 reported this was the accepted process for completing consults and reflected the peer training they received at that time. Nurses within the program lacked a comprehensive orientation and training program to provide them with the required knowledge and skills to correctly perform their duties. In 2019, the facility developed a program-specific standardized orientation and training program.

The Chief of Community Care assumed the procedures that were in place for completing Community Care consults were correct when accepting the position in 2016. The Chief of Community Care did not verify staff adherence to consult-related VHA policy or conduct regular reviews. As of June 2020, there continued to be a lack of monitoring.

The OIG learned the Chief of Community Care had competing priorities due to the dual roles as surgeon and Chief of Community Care. As of May 2020, the Chief of Community Care continued to work in both roles. A vacancy also remained open for a Deputy Chief of Community Care to assist with program management.

Monthly performance data, reviewed by VISN and facility leaders, the facility's GPM, and Steering Committee, were structured to identify issues with timeliness; however, consult processes alignment with VHA policy, such as the consult completion process, was not monitored. The Steering Committee failed to assist the Facility Director and COS with oversight of the facility consult process. The lack of monitoring for all aspects of consult management contributed to the erroneous processes used in Community Care to complete consults. The lack of a clear designation of expectations for auditing of consults should be addressed. The facility's Steering Committee charter was lacking key responsibilities as outlined in VHA policy and needs revision to clarify these expectations.

The Chief of Community Care's deficiencies in understanding VHA requirements and failure to monitor and provide oversight enabled the consult completion errors to continue for years. There continued to be a deficiency in monitoring after the erroneous consult completion process was discovered. This practice may place patients at an increased risk of or adverse clinical outcomes.

Recommendations 1–5

1. The New Mexico VA Health Care System Director verifies monitoring is in place to ensure that clinical documentation is obtained from non-VA providers, scanned into the electronic health record, and attached to the applicable consult prior to completion of the consult.
2. The New Mexico VA Health Care System Director evaluates program effectiveness and monitors the Chief of Community Care's implementation of the competency and training program for Community Care Service nurses.
3. The New Mexico VA Health Care System Director confirms the Consult and Access Management Steering Committee updates its charter and oversees all aspects of the consult process as required by the Veterans Health Administration consult management policy.
4. The New Mexico VA Health Care System Director determines that staff responsible for monitoring and oversight, as identified by the Chief of Staff and the Consult and Access Management Steering Committee, develop and implement a process to evaluate Community Care consult processes and procedures for consistency with Veterans Health Administration policies.
5. The New Mexico VA Health Care System Director reviews the organizational structure of the facility's Community Care Department, including available positions, evaluates the expertise of leaders and supervisory staff to ensure effective management and oversight, and takes action as necessary.

Appendix A: Data Selection Workflow

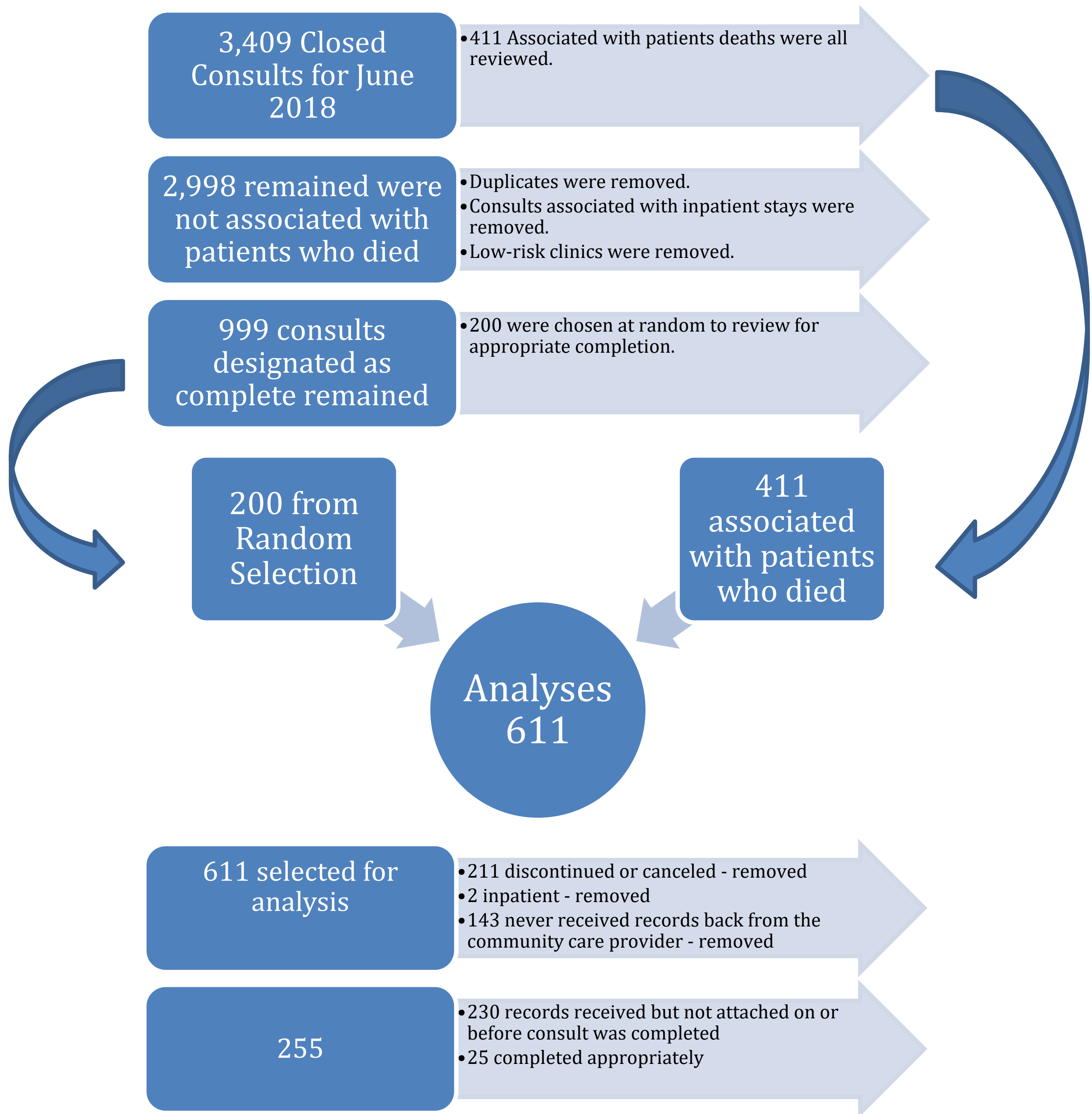

Figure A.1. Data Selection Workflow
Source: OIG analysis of VHA consult data.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 11, 2021

From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Deficiencies in Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque, New Mexico

To: Director, Office of Healthcare Inspections (54HL00)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed and concur with Albuquerque's actions and recommendations on Healthcare Inspection—Deficiencies in Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque, New Mexico.
2. If you have any additional questions, please contact me. Thank you.

(Original signed by:)

Michael W. Fisher
VISN 22 Network Director (10N22)
VA Desert Pacific Healthcare Network

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 11, 2021

From: Director, New Mexico VA Health Care System (501/00)

Subj: Healthcare Inspection—Deficiencies in Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque.

To: Director, Desert Pacific Healthcare Network (10N22)

1. We appreciate the Office of Inspector General's review of the allegations of deficiencies of Community Care Consults and leader's oversight.
2. The requested concurrence and corrective action plans are attached.
3. If any additional information is required, please contact the Chief of Quality, Safety and Value.

(*Original signed by*:)

Andrew M. Welch
Director

Facility Director Response

Recommendation 1

The New Mexico VA Health Care System Director verifies monitoring is in place to ensure that clinical documentation is obtained from non-VA providers, scanned into the electronic health record, and attached to the applicable consult prior to completion of the consult.

Concur.

Target date for completion: August 2021

Director Comments

The New Mexico VA Health Care System Community Care Service and Health Information Management Section (HIMS) reviewed their process and has monitoring in place to ensure that clinical documentation is obtained from non-VA providers, scanned into the electronic health record and attached to the applicable consult prior to completion of the consult. HIMS has assumed responsibility for the processes of scanning, consult closure and sending a view alert to the ordering provider. Starting in March 2021, HIMS will audit 20 closed consults per week to ensure they have been closed appropriately. This will be reported and tracked monthly in the Consult and Access Management Steering Committee and in the Quality Board.

Recommendation 2

The New Mexico VA Health Care System Director evaluates program effectiveness and monitors the Chief of Community Care's implementation of the competency and training program for Community Care Service nurses.

Concur.

Target date for completion: March 2021

Director Comments

The Community Care program effectiveness was evaluated, and Community Care Leadership developed an orientation program for new nurses. In addition, a comprehensive competency checklist was developed and completed for 100% of Community Care Nurses.

OIG Comment

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

Recommendation 3

The New Mexico VA Health Care System Director confirms the Consult and Access Management Steering Committee updates its charter and oversees all aspects of the consult process as required by the Veterans Health Administration consult management policy.

Concur.

Target date for completion: April 2021

Director Comments

The Consult and Access Management Committee charter was updated in August 2020 and the Committee oversees all aspects of the consult process. The charter will be revised to include the Facility Compliance and Business Integrity (CBI) Officer who will report on the required twice yearly audits of consult management activities as directed by the National CBI Office.

OIG Comment

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

Recommendation 4

The New Mexico VA Health Care System Director determines that staff responsible for monitoring and oversight, as identified by the Chief of Staff and the Consult and Access Management Steering Committee, develop and implement a process to evaluate Community Care consult processes and procedures for consistency with Veterans Health Administration policies.

Concur.

Target date for completion: August 2021

Director Comments

The Consult and Access Management Committee has developed and implemented a process to evaluate the Community Care consult process. The Consult and Access Management Committee will monitor the Community Care Consult processes to ensure consistency with VHA policy. In addition to the Consult and Access Management Committee, Community Care Consult monitoring will be reported and tracked in the Quality Board.

Recommendation 5

The New Mexico VA Health Care System Director reviews the organizational structure of the facility's Community Care Department, including available positions, evaluates the expertise of

leaders and supervisory staff to ensure effective management and oversight, and takes action as necessary.

Concur.

Target date for completion: May 2021

Director Comments

The New Mexico VA Health Care System Director and Chief of Staff reviewed the organizational structure of the Community Care Department, to include available positions, expertise of leaders and supervisory staff. A plan was developed to ensure effective management and oversight of the program.

OIG Comment

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

OIG Contact and Staff Acknowledgments

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