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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia

HEALTHCARE INSPECTION | REPORT #21-01724-84 | FEBRUARY 16, 2022

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Martinsburg VA Medical Center (facility) in West Virginia to assess allegations of failure to schedule a Care in the Community (CITC) COVID Priority 1 cardiology consult within Veterans Health Administration (VHA) time requirements and that inadequate CITC staffing caused delays in the processing and scheduling of CITC consults.[1]

Synopsis of Events

On a day in fall 2020 (day 1), a patient in their early 70s with a history of hypertension, coronary artery disease, coronary stents, and heart failure was seen by a facility cardiology physician assistant for ongoing chest pain, and further studies were planned to be completed at the facility.[2] On day 15, the patient was seen by a primary care provider for ongoing chest pain. The patient's primary care provider entered a COVID Priority 1 cardiology consult with a clinically indicated date (CID) of day 29 and included an additional comment to schedule as soon as possible.[3] A CITC clinical nurse approved the consult as a COVID 1 Priority on that same day. On day 57, a primary care registered nurse added a comment to the consult reiterating the request for immediate scheduling. On day 113, the patient was admitted to the facility for chest pain and discharged the next day after tests showed no acute heart issues. On day 116, the ordering provider entered a comment in the consult with a repeated request for immediate scheduling. At that time, CITC staff arranged a cardiology appointment for day 124 with a community provider.

Healthcare Inspection Results

The OIG substantiated that a COVID Priority 1 CITC cardiology consult was not scheduled in accordance with VHA requirements. The OIG determined the patient's CITC cardiology

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[1] "About COVID-19," Centers for Disease Control and Prevention, accessed May 5, 2021, https://www.cdc.gov/coronavirus/2019-ncov/cdcresponse/about-COVID-19.html. Coronavirus disease 2019 (COVID-19) is caused by a new coronavirus first identified in Wuhan, China, in December 2019. Because it is a new virus, scientists are learning more each day. Although most people who have COVID-19 have mild symptoms, COVID-19 can also cause severe illness and even death. Some groups, including older adults and people who have certain underlying medical conditions, are at increased risk of severe illness. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together. VHA Assistant Under Secretary for Health for Operations memo, "National Deployment of Consult Toolbox 1.9.0063, and 1.9.0066-COVID-19 Upgrades (VIEWS#02748457)," May 18, 2020. Priority 1—*Schedule despite COVID-19*; to be used when the ordering provider has concerns that scheduling delays may result in patient harm.

[2] The synopsis summarizes events described in the patient's electronic health record and OIG interviews with pertinent staff members. The OIG uses the singular form of they (their) in this instance for privacy purposes.

[3] VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures,* July 15, 2016, amended January 22, 2020. The CID 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.

appointment was scheduled greater than 30 days from the CID.[4] The failure of CITC staff to schedule the appointment in the required time frame resulted in a delay in patient care. Fortunately, the patient did not experience an adverse clinical outcome based on the scheduling delay. Through interviews with the CITC Chief and CITC and primary care staff, the OIG also learned of a backlog of approximately 5,000 CITC consults that warranted further review.

The OIG determined that the facility had a backlog of active CITC consults, including those designated as COVID Priority 1, spanning multiple specialty services. In assessing the circumstances surrounding the backlog, the OIG acknowledged decreased access to care due to COVID-19. Additionally, the OIG identified a failure by facility CITC staff to create action plans to improve failed metrics; maximize use of available reports to manage consults; conduct clinical reviews of delayed, unscheduled consults; and develop a process to review adverse events that may have occurred while patients awaited scheduling of CITC. The OIG also learned about confusion surrounding priority and urgency status categories. As a result, the OIG found that multiple departments created workarounds in an attempt to avoid further delays in patient care.

The OIG substantiated that inadequate staffing within the facility's CITC Service caused delays in the scheduling of CITC consults. Reported factors contributing to inadequate staffing included frequent staff turnover, outdated local processes and lack of training within the service, staff absences related to COVID-19, and a lack of alternative work options available to staff during the COVID-19 pandemic.

The OIG made one recommendation to the Veterans Integrated Service Network Director related to weekly calls with the facility about CITC Improvement Action Plans, monitoring progress, and reviewing timelines and next steps.

The OIG made seven recommendations to the Facility Director related to CITC Improvement Action Plans, review of COVID Priority 1 reports, implementation of a clinical review process for unscheduled COVID Priority 1 consults and for consults in which the patient died prior to being scheduled, evaluation of current backlog management strategies, review of appointment scheduling that occurs in departments outside CITC, and ensuring adequate CITC staffing levels.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with recommendations 2–7 and concurred in principle with recommendations 1 and 8. Acceptable

[4] VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures,* July 15, 2016, amended January 22, 2020. VHA's timeliness goal for consults specifies scheduling an appointment within 30 calendar days or less from the CID.

action plans were provided (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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Abbreviations

CID	clinically indicated date
CITC	Care in the Community
EHR	electronic health record
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 assess allegations related to the timeliness of scheduling Care in the Community (CITC) consults at the Martinsburg VA Medical Center (facility) in West Virginia.[1] The OIG identified additional concerns related to a backlog of active, unscheduled consults, and the consult management process during the COVID-19 pandemic.

Background

The facility is classified as a level 1c complexity facility and is part of Veterans Integrated Service Network (VISN) 5.[2] Situated in West Virginia's eastern panhandle, the facility serves veterans in surrounding areas of West Virginia, Maryland, Virginia, and Pennsylvania. The facility has 67 inpatient, 133 nursing home care unit, 259 domiciliary, and eight transitional care beds. The facility provides inpatient medical services as well as outpatient services such as primary care, surgical services, and specialty care, which includes cardiology, long-term care, rehabilitation, and domiciliary services. From October 1, 2019, through September 30, 2020, the facility provided care to 32,714 unique patients.

Community Care

The Veterans Health Administration (VHA) Community Care Program coordinates care for eligible patients by community providers. The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 explains that eligibility criteria for community care is met if a veteran[3]

- needs a service that is not offered at the VA,
- lives in a state or territory that does not have a full-service VA,
- qualifies under the "grandfather" provision, meaning the veteran was eligible under the distance criteria of the Veterans Choice Program and still lives in that location,

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] VHA Office of Productivity, Efficiency, and Staffing, "FY20 Facility Complexity Levels List," February 2, 2021. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b,1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex. A level 1c facility has medium risk patients, some complex clinical programs, medium-high volume, and medium research and training programs.

[3] VA Fact Sheet, "Veteran Community Care General Information," September 09, 2019, accessed February 9, 2021, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VHA-FS_MISSION-Act.pdf.

- meets specific standards for average drive or appointment wait times,
- agrees with the referring provider that community care is in their best medical interest, or
- needs care from a VA service that is not currently providing care in compliance with VA standards.

In June 2019, the Veterans Community Care Program was established, replacing the previous Veterans Choice Program, and simplifying the process for veteran community care. The program streamlined eligibility criteria and created a single Community Care Program to improve customer service.[4]

Consult Management Process

To initiate care in the community, a provider places a consult in a patient's electronic health record (EHR) and includes the clinically indicated date (CID) by which the patient needs to be seen based on the clinical status.[5] VHA defines two choices of urgency status for consults: (1) routine, patients should be seen in accordance with the CID; and (2) STAT, which indicates an immediate need and patients should be scheduled within 24 hours.[6] For consults other than STAT, VHA requires CITC staff to schedule the community care appointment within 30 days of the CID or the patient's preferred date.[7] Additionally, CITC staff are responsible for obtaining appointment records after care is provided.[8] All actions taken in the processing of a consult are documented within the body of the original consult, which sends an automatic electronic alert through the EHR to the requesting provider and CITC staff with updates or concerns related to the consult.[9]

[4] VA Fact Sheet, "Veteran Community Care General Information," September 9, 2019, accessed March 11, 2021, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VA-FS_CC-Eligibility.pdf#.

[5] VHA Directive 1232 (2), *Consult Processes and Procedures*, August 24, 2016, amended June 28, 2019. The directive was further amended on April 5, 2021, and was renumbered 1232(3). This directive was issued after the OIG's inspection period of VHA operations discussed in this report. The amendment does not affect OIG findings or recommendations.

[6] VHA Directive 1232 (2).

[7] VHA Directive 1232 (2). VHA Directive 1230 (2), *Outpatient Scheduling Processes and Procedures,* July 15, 2016, amended January 22, 2020. The CID 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 CID.

[8] VHA Directive 1232 (2).

[9] VHA Directive 1232 (2).

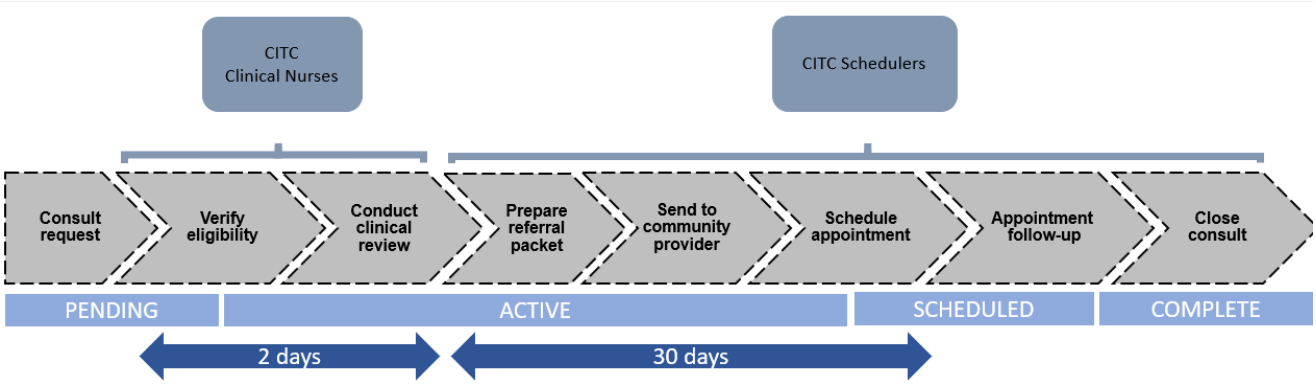

Figure 1. *Care Coordination Process for Routine Consults*
Source: The OIG Analysis of Office of Community Care Field Guidebook Chapter 3 (Care Coordination) [10]

VHA uses the consult status designations of *pending*, *active*, *scheduled*, *complete*, *discontinue*, and *cancel* to mark the progress, timeliness of scheduling, and closing of a consult appointment.[11] Through interviews with CITC staff, the OIG learned how the consult process was operationalized within CITC.

- *Pending*—Designates that the provider submitted a consult request in the EHR, but the consult is not yet acted on by a CITC clinical nurse who has the responsibility to review the consult as soon as possible and no later than two business days of the request receipt.
- *Active*—The consult has been received by a CITC clinical nurse. The consult remains unscheduled until further actions are made by the CITC scheduler who has the responsibility to schedule the consult.[12]
- *Scheduled*—The consult changes to scheduled when an appointment has been made and linked to the consult request by the CITC scheduler.
- *Complete*—The requested service has been provided.
- *Discontinue*—The consult may be discontinued when the sending or receiving provider determines a consult is no longer needed.
- *Cancel*—The receiving service returns a consult request to the sender due to insufficient information.

[10] VHA Office of Community Care Field Guidebook, chapter 3, "How to Perform Care Coordination," accessed March 17, 2021, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx.

[11] VHA Directive 1232 (2).

[12] Within the context of this report, the OIG considers schedulers to be the Medical Support Assistant and Program Support Assistant staff working within the CITC Service.

The Impact of COVID-19 on CITC Consult Management

The COVID-19 pandemic has compelled healthcare systems to adjust their approach for delivering health care. To reduce the risk associated with face-to-face healthcare visits, the Centers for Disease Control and Prevention recommended optimization of telehealth services whenever possible. In situations where telehealth was not appropriate or available, healthcare systems were guided to balance the need for clinical services with minimizing the risk of COVID-19 exposure to patients and healthcare staff by identifying and prioritizing patients who were at risk for complications from delayed care.[13]

Guidance provided by VHA on accessing care in the community states:

> In light of the COVID-19 Pandemic, the Veterans Health Administration (VHA) must take action to ensure the clinical needs of Veterans are met and that Veteran safety is protected to the greatest degree possible….Referral to the community for emergent or urgent clinical needs will continue, and VA will work to ensure care coordination and safety given the increased risk environment with COVID-19.[14]

VHA directed VA facilities to postpone or delay all elective and non-urgent visits, admissions, and procedures, and to prioritize urgent and emergent visits.[15] VHA introduced four priority categories to help providers determine which consults to reschedule for a later date and which to schedule despite the risk associated with COVID-19 for in-person visits.[16] The priority category most pertinent to this inspection is the COVID Priority 1 category, which identifies consults that should be scheduled despite the COVID-19 pandemic.[17] Consults for which providers had determined that delaying an appointment would "lead to harm" were to be categorized as

[13] "About COVID-19," Centers for Disease Control and Prevention, accessed May 5, 2021, https://www.cdc.gov/coronavirus/2019-ncov/cdcresponse/about-COVID-19.html. Coronavirus disease 2019 (COVID-19) is caused by a new coronavirus first identified in Wuhan, China, in December 2019. Because it is a new virus, scientists are learning more each day. Although most people who have COVID-19 have mild symptoms, COVID-19 can also cause severe illness and even death. Some groups, including older adults and people who have certain underlying medical conditions, are at increased risk of severe illness.

[14] VHA Deputy Under Secretary for Health for Operations and Management memo, "Guidance on Access Standards in Response to COVID-19," updated March 30, 2020.

[15] VHA Deputy Under Secretary memo, "Guidance on Access Standards in Response to COVID-19."

[16] VHA Assistant Under Secretary for Health for Operations memo, "National Deployment of Consult Toolbox 1.9.0063, and 1.9.0066-COVID-19 Upgrades (VIEWS#02748457)," May 18, 2020. Priority 1—*Schedule despite COVID-19*; to be used when the ordering provider has concerns that scheduling delays may result in patient harm. Priority 2—*Clinical Review*; to be used to indicate a clinical review is needed to determine whether scheduling should occur. Priorities 3 and 4—Optional; definition provided by a facility, if used.

[17] VHA Assistant Under Secretary memo.

COVID Priority 1.[18] On September 15, 2020, VHA guidance was amended to mandate all facilities use the consult toolbox to process CITC consults categorized as a COVID Priority 1 or 2.[19]

Allegations and Related Concerns

On January 19, 2021, the OIG received allegations and subsequently identified additional concerns related to a backlog of active consults and the management of CITC consults:

1. Allegation: Failure to schedule a CITC COVID Priority 1 cardiology consult within VHA time requirements.
2. Related Concern: Backlog and management of active CITC consults.
3. Allegation: Inadequate CITC staffing delaying processing and scheduling of CITC consults.[20]

Scope and Methodology

The OIG conducted a virtual site visit from April 26–29, 2021.

The OIG reviewed EHRs, and VHA and facility policies and documents related to the processing and scheduling of CITC consults. In addition, the OIG reviewed facility CITC consult data, and facility documents related to CITC staffing during the COVID-19 pandemic from March 11, 2020, through March 10, 2021.

The OIG interviewed the complainant, the VISN CITC Program Manager, the Facility Director, the Chief of Staff, Service Chiefs of CITC and primary care, the CITC supervisors for program support assistants, CITC clinical nurses, and schedulers as well as the CITC Medical Officer, primary care staff, and the facility's Group Practice Manager.

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).

[18] VHA Assistant Under Secretary memo. Harm in this report is recognized as an adverse event defined as death, requirement for a higher level of care, worsening of related symptoms, or significant change in the status of a patient's disease that in the OIG's assessment, may have been preventable if the community care consult occurred within the time frame as requested by the ordering provider.

[19] VHA Assistant Under Secretary for Health for Operations memo, "Changes to Consult Referral Management During COVID-19," September 15, 2020.

[20] The OIG considered a delay to be the appointment for the consult was scheduled or completed beyond the requirement of 30 days of the CID, or the appointment had not been scheduled and was beyond 30 days of the CID.

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. 1101, 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.

Patient Case Summary

The patient was in their early 70s with a history of hypertension, coronary artery disease, three coronary stents, and heart failure.[21] On a day in fall 2020 (day 1), the facility's cardiology physician assistant examined the patient for ongoing chest pain and planned for further studies with an echocardiogram and nuclear stress testing to be completed at the facility. Due to the long distance that the patient had to drive from home to the facility, the cardiology physician assistant planned for the patient to follow-up with a local cardiologist once the heart studies were completed. On day 15, the patient's primary care provider completed a follow-up telephone appointment visit and entered a cardiology CITC consult with a CID of day 29. Additionally, the consult requested that the appointment be scheduled as soon as possible. The CITC clinical nurse approved the consult as a COVID Priority 1. On day 16, the patient completed the ordered cardiology studies at the facility. On day 32, the cardiology physician assistant entered an addendum to a clinical progress note from the visit on day 1, documenting the results of the nuclear stress test as normal and the echocardiogram indicating moderate aortic stenosis. The cardiology physician assistant called the patient and indicated that the aortic stenosis was not attributed as the cause of the chest pain. On day 57, a facility primary care registered nurse added a comment to the original cardiology CITC consult reiterating the request for the consult to be scheduled as soon as possible.

On day 113, the patient was admitted to the facility for chest pain and was discharged the next day after tests showed no acute heart issues. On day 116, the patient's primary care provider added a comment to the original cardiology CITC consult with a repeat request for the

[21] The OIG uses the singular form of they (their) in this instance for privacy purposes.

appointment to be scheduled as soon as possible. CITC staff coordinated a cardiology appointment for day 124.

Inspection Results

1. Allegation: Failure to Schedule a COVID Priority 1 CITC Cardiology Consult Within VHA Time Requirements

The OIG substantiated that a COVID Priority 1 CITC cardiology consult was not scheduled in accordance with VHA time requirements. The OIG determined the patient's CITC cardiology appointment was scheduled greater than 30 days from the CID; however, the patient did not experience an adverse clinical outcome based on the delay in scheduling the consult. The OIG also found that additional facility COVID Priority 1 CITC cardiology consults were delayed.

On day 15, the patient's primary care provider placed a CITC cardiology consult with a CID of day 29. Per VHA policy, CITC staff were to ensure that the patient had an appointment no later than day 59, 30 days from the CID.[22]

The OIG reviewed the patient's EHR and found the patient was scheduled to be seen by a community provider 65 days after day 59 (CID + 30 days). When interviewed by the OIG, CITC and primary care staff did not recall this specific consult and were unable to provide details related to the appointment scheduling delay.

Table 1. Timeline of Notable Consult Events

Date	Days Elapsed from CID +30	Consult Events
Day 15	Not Applicable	Patient's primary care provider submitted a CITC cardiology consult with a CID of day 29.
	Not Applicable	CITC clinical nurse received, processed, and approved the consult as a COVID Priority 1 with a CID of day 29, and forwarded the consult to the CITC scheduler.
Day 57	Not Applicable	Primary care registered nurse added comment, "Please schedule patient ASAP [as soon as possible]."

[22] VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 22, 2020.

Date	Days Elapsed from CID +30	Consult Events
Day 116	57	Primary care provider added comment, "THIS CONSULT WAS PLACED IN [Fall] 2020. VETERAN HAS NOW EXPERIENCED AN ACUTE MI [myocardial infarction]. THIS NEEDS TO BE SCHEDULED ASAP FORCOMMUNITY CARE."[23]
Day 121	62	The CITC clinical nurse added two comments; one to inform the CITC scheduling staff of the urgent need to schedule; the second to alert the CITC scheduling supervisor and the CITC nurse supervisor about the scheduling delay. The patient was notified of community care cardiology appointment scheduled for day 124 at 11:00 a.m.[24]

Source: VA OIG review of the patient's EHR

To understand if the delay experienced by the index patient was an anomaly or indication of a broader system issue, the OIG team analyzed 531 CITC COVID Priority 1 cardiology consults ordered from March 11, 2020, through March 10, 2021. The OIG found that 62 percent of the COVID Priority 1 cardiology consults during this time frame were scheduled more than 30 days beyond the CID. In addition, the OIG found 26 percent were scheduled within 30 days of the CID and 11 percent did not have a CID identified.

In interviews with the CITC Chief, and CITC and primary care staff, the OIG learned that the cardiology consults were a subset of approximately 5,000 active (unscheduled) CITC consults at the facility.[25]

Despite VHA scheduling requirements, CITC staff failed to schedule a COVID Priority 1 CITC cardiology consult within 30 days of the CID. The failure of CITC staff to schedule the appointment in the required time frame resulted in a delay in patient care. The patient was ultimately seen and assessed by a community care cardiologist. Furthermore, the OIG learned of a backlog of CITC consults warranting further review.

[23] On day 113, the patient presented to the facility's Emergency Department with chest pain and was admitted to rule-out a myocardial infarction. On day 114, the patient was diagnosed with costochondritis (an inflammation of the cartilage that connects a rib to the breastbone) and discharged.

[24] The patient did not see the community care cardiologist on day 124 as the patient requested to be seen by a different community care cardiologist who was familiar with the patient's care. The patient was seen by the preferred community provider on day 304.

[25] For this report, the OIG analyzed the facility's CITC specialty care active (unscheduled) consults as of May 25, 2021, to include those designated as COVID Priority 1.

2. Related Concern: Backlog and Management of Active CITC Consults

The OIG determined that the facility had a backlog of active CITC consults, including those designated as COVID Priority 1, spanning across multiple specialty services. In assessing the circumstances surrounding the backlog, the OIG acknowledged decreased access to care related to COVID-19. Additionally, the OIG identified a failure by facility CITC staff to create action plans to improve failed metrics; maximize use of available reports to manage consults; conduct clinical reviews of delayed, unscheduled consults; and develop a process to review adverse events that occurred while patients awaited scheduling of their CITC appointments. The OIG also learned about confusion surrounding priority and urgency status categories. As a result, the OIG found that multiple departments created workarounds in an attempt to avoid further delays in patient care.

Through interviews with the OIG, facility leaders confirmed that CITC had approximately 5,000 consults in active status waiting to be scheduled. The OIG examined a list of 5,442 active consults provided by the facility as of May 25, 2021, and found that 3,996 were COVID Priority 1 and 20 specialty services were represented, confirming that the backlog was widespread. Of the COVID Priority 1 consults, 2,913 consults were in active status, waiting to be scheduled, for more than 30 days beyond the CID.

Failure to Meet Metrics

The OIG found the facility consistently failed to meet metrics set by VHA for consult management and did not take required steps to initiate action plans in response to consistently failed consult management metrics. Delays at any step of the consult process can lead to extended wait times for patients to receive CITC appointments.

VHA expects facility and VISN leaders to use three national metrics to help manage CITC consults. The two national metrics specific to this report are

- 90 percent of pending consults should be received and clinically reviewed within two days, and
- 90 percent of active consults should be scheduled within 30 days.[26]

[26] "Office of Community Care Field Guidebook," VHA Office of Community Care, accessed May 12, 2021, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. Metrics include consults in pending status no more than two business days from consult creation, consults in active status no greater that 30 days, and consults in scheduled status no greater than 90 days. Targets for all metrics are 90 percent compliance.

If these targets are not consistently met, facilities are required to develop an Improvement Action Plan and to review progress, timelines, and next steps weekly with facility and VISN leaders.[27]

While facility CITC consults were generally moved from pending to active within the expected time frame consistently, the benchmark for scheduling consults within 30 days was not met. This trend was identifiable since late 2018 but became even more pronounced with the onset of COVID-19.[28]

From January through April 2020, prior to the impact of the COVID-19 pandemic, the percentage of consults that remained in active status for less than 30 days were in the range of roughly 75 percent to 85 percent. In May 2020, that figure dropped to approximately 30 percent and despite reaching 50 percent in December 2020, stayed stagnant at around 30 percent from January through June 2021. Data extracted by the OIG showed that as of July 8, 2021, 37 percent of the facility's CITC consults were scheduled in less than 30 days.

Despite failing to meet the national metrics, the facility did not have an Improvement Action Plan. The Group Practice Manager, who was responsible for day-to-day scheduling processes and oversight, shared with the OIG that there were no action plans in progress related to CITC consult management, and as the Co-Chair of the Consult Management Committee, was not aware of the requirement to implement Improvement Action Plans as a result of poor performance on consult metrics.

CITC leaders and staff shared the strategy in use at the time of the OIG visit to address the backlog of unscheduled consults. On Tuesdays and Thursdays, CITC staff redirected their focus solely on the backlog of unscheduled consults and all other consults entered on these days, except those deemed urgent, were set aside to be processed on a later date. Outside of the dedicated days for addressing the backlog, CITC schedulers reported being urged to use a "work today's work today" approach to managing incoming consults, meaning any consults that were not addressed on a given day would go to the bottom of their list the following day once new consults came in.

The facility's CITC staff reported to the OIG that the lack of plans to address the ongoing failure to meet national expectations for scheduling active consults had a negative impact on CITC staff's outlook on their ability to meet the needs of the patients they were serving. The CITC nurse supervisor also told the OIG that CITC clinical nurses voiced concerns in staff meetings about unscheduled consults that were delayed after the CID. Other front-line staff reported that

[27] "Office of Community Care Field Guidebook," VHA Office of Community Care website. If targets are not met for four consecutive weeks, an improvement action plan is needed.

[28] The OIG did not independently validate fiscal year 2019 and fiscal year 2020 Community Care Consult Metrics provided by the facility.

the magnitude of the backlog caused them stress, as they felt they were failing patients because they were unable to complete their work.

The OIG found the facility consistently failed to meet VHA consult management standards and did not initiate action plans required as a result, contributing to delays in patient care. Not initiating action plans represents a missed opportunity by facility and CITC leaders to identify workflow gaps, implement process improvement strategies, and collaborate with VISN leaders to meet the VHA expectation of timely scheduling of consults.

Lack of Report Use

Based on information obtained through interviews, the OIG noted a lack of awareness and accountability related to the tracking and management of consults using available reports. With the implementation of COVID-19 consult Priority levels 1–4, VHA communicated the recommendation that COVID Priority 1 consult reports should be run and reviewed by CITC managers and staff daily.[29]

Through interviews with CITC supervisors and scheduling staff, the OIG learned that the COVID Priority 1 consult status report was not generated daily, but rather printed and shared inconsistently by supervisors. The supervisor of CITC schedulers reported being unaware of the recommendation that facility staff review COVID Priority 1 reports daily.

The facility's Group Practice Manager expressed concerns about the volume of consults that were not being addressed and the failure to utilize available reports. The Group Practice Manager reported recommending to CITC supervisors and facility leaders that they use consult reports on multiple occasions, and identified the lack of report use as a factor contributing to the volume of unaddressed consults.

The VISN CITC Program Manager identified the facility's greatest inefficiency in the consult process as a lack of documented processes for tracking consults and follow-up care. During a site visit in May 2021, the VISN CITC Program Manager provided recommendations to the facility for tracking processes and identified reports that would help redirect their course.

The OIG identified a lack of awareness and accountability related to the tracking and management of CITC consults using available reports, which was also noted by the facility's Group Practice Manager and the VISN CITC Program Manager. The VHA Office of Community Care offers reporting tools to monitor performance measures within CITC. If used, these reports may determine the effectiveness and efficiency of current options and help to identify areas with opportunities to improve processes.

[29] VHA Assistant Under Secretary memo, "National Deployment of Consult Toolbox 1.9.0063 and 1.9.0065-COVID-19 Upgrades (VIEWS#02748457)."

Failure to Conduct Clinical Reviews

The OIG determined that facility CITC staff failed to clinically review active consults that had not been scheduled within 30 days of the CID.

In December 2020, VHA's Office of Community Care issued guidance to facilities to perform reviews on unscheduled CITC consults to ensure care had not already occurred and that the unscheduled consults were not duplicates.[30] The guidance further stated that consults that had a file entry date of 90 days or greater were to be given priority and reviews were to be coordinated by the CITC Manager. Since the start of this inspection, the Office of Community Care Field Guidebook has been updated to include guidance that COVID Priority 1 consults should be reviewed clinically to ensure patient acuity has not changed while waiting to be scheduled. This clinical review is to be documented, and consults should continue to be reviewed administratively every seven days until scheduled.

With the large number of facility COVID Priority 1 CITC consults waiting to be scheduled, the OIG inquired about clinical reviews done to assess for changes in the acuity of the patient's status over time.

The OIG reviewed documentation from 2020 that was provided by the facility that acknowledged that consults that remained in active status for an extended period of time should be clinically reviewed for changes in urgency. In July 2020, the facility's Group Practice Manager alerted clinical services that they would be required to report on the status of clinical reviews; however, the OIG was told by a current CITC staff member that the Group Practice Manager left the facility in August 2020, and the subsequent Group Practice Manager did not follow up on this reporting requirement.

Information received regarding the facility process for clinical reviews of unscheduled consults was varied across all levels of staff and leadership and pointed to the lack of a well-managed process. The Facility Director shared that a periodic clinical review of unscheduled consults was to be done to identify potential changes in acuity, but the process was not as consistent as it should have been. The Chief of Staff reported that the facility had a process for periodic clinical review of consults in which scheduling was delayed; however, further added that there was not a lot of specifics to the process except that it was dependent on the specialty for which the consult was ordered and that the ordering providers were responsible, along with CITC staff, for

[30] "Consult Cancelled Appointment and Consults Management Initiative Process Guide," VHA Office of Community Care, accessed June 4, 2021, https://dvagov.sharepoint.com/sites/vacovha/DUSHCC/DC/DO/CI/FGB/FGB_Artifacts/Forms/AllItems.aspx?e=2%3ASD4pMt&at=9&id=%2Fsites%2Fvacovha%2FDUSHCC%2FDC%2FDO%2FCI%2FFGB%2FFGB%5FArtifacts%2FCACMI%2FOCC%20Unscheduled%20Consult%20Review%20Initiative%5F%20Process%20Guide%2012%2E16%2E2020%2Epdf&parent=%2Fsites%2Fvacovha%2FDUSHCC%2FDC%2FDO%2FCI%2FFGB%2FFGB%5FArtifacts%2FCACMI.

conducting the review. The CITC Chief reported primary care staff and specialty providers were assisting with reviewing lists to make sure time-sensitive consults were not overlooked. A CITC supervisor reported receiving guidance early in the pandemic that CITC nursing staff were to reach out to patients every 30 days to identify if there had been clinical changes during their wait for an appointment that would alter urgency or priority, but was unable to locate documentation outlining this expectation to provide to the OIG. A CITC clinical nurse reported the only time they were prompted to conduct a clinical review was when they were made aware of scheduling delays by a primary care provider or patient.

To determine what, if any, clinical reviews of unscheduled and pending consults were completed and documented, the OIG reviewed facility CITC cardiology consults as of March 25, 2021, and found 45 COVID Priority 1 cardiology consults in active status that were waiting longer than 120 days from the CID to be scheduled and found none had clinical reviews documented.[31] Likewise, there was no evidence of clinical review in the consult named in the original allegation that was scheduled 62 days after the CID.

The OIG determined that facility CITC staff failed to clinically review active consults that had not been scheduled within 30 days of the CID to ensure that there were no changes in patients' clinical need for care.

Failure to Review Adverse Events While Awaiting Scheduling

The OIG found the facility lacked a process to review and determine if a delay in scheduling a CITC appointment contributed to adverse events that occurred while patients awaited scheduling of their CITC consult.

VHA describes an adverse event as "untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility."[32] For the context of this report, the OIG defines adverse events due to delays in processing consults as untoward incidents such as death, hospitalization, or significant change in the status of a patient's disease that may have been preventable if the CITC consult was acted upon by the CID. VHA highlights the use of the Joint Patient Safety Reporting system as critical to ensuring patient safety events are recorded and investigated.[33]

[31] The OIG did not independently validate the information provided by the facility.

[32] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[33] "Office of Community Care Field Guidebook," VHA Office of Community Care website.

VHA requires CITC consults be clinically reviewed prior to administratively closing them out.[34] The administrative closure should include a reason for terminating the consult and identify the person authorizing the closure.[35]

In an interview with the CITC Chief, the OIG was informed that there have been consults in which CITC staff discovered that the patient died before an appointment with a CITC provider could be scheduled. When asked if the facility had a process in place to identify whether an adverse event related to the need for the pending consult had occurred, the CITC Chief reported being unaware of any process to assess such consults prior to administratively closing them. The facility's Risk Manager confirmed that the facility lacks a process as it relates to CITC consult delays and patient safety. The CITC Chief reported that when CITC staff discover that a patient died before a CITC appointment had been scheduled, the consult was discontinued; the Chief acknowledged that having a process to evaluate and determine if the delay in scheduling may have contributed to the patient's death would be imperative from the aspect of quality management.

The OIG reviewed a list of CITC cardiology consults in active, scheduled, and discontinued status from March 11, 2020, through March 10, 2021, and determined that in a total of 38 consults, the associated patients had died. Additionally, in 24 consults, patients did not yet have an appointment scheduled, whereas 14 consults had a scheduled appointment for the patients. Through further EHR review, the OIG determined that 30 patients died from conditions other than what was specified on the cardiology consults. In the remaining eight cases, due to a lack of documentation, the OIG was unable to determine the relationship between the cause of death and the condition specified in the consult. Therefore, the OIG could not identify delays as a factor that may have led to the eight deaths. There was no evidence of documentation by the facility of a patient safety review for any of the eight cases.

The OIG found that the facility lacked a formal process to determine if a delay in scheduling a CITC appointment may have contributed to an adverse event such as death. As such, the facility may miss opportunities to review each case to identify system issues in need of attention to improve patient safety, and identify the impact of scheduling delays.

Confusion Surrounding Priority and Urgency Status Categories

The OIG found the introduction of COVID Priority categories for consults created confusion and misuse of the COVID Priority 1 category. Furthermore, in a failed attempt to triage and prioritize the backlog of COVID Priority 1 consults, the facility's use of "urgent or emergent" category added more confusion to an already complex process.

[34] VHA Directive 1232(2).
[35] VHA Directive 1232(2).

There are only two urgency status categories in the VHA consult management process. When placing a consult, providers select an urgency of either routine, patients to be seen in accordance with the CID; or STAT, patients to be seen immediately and the consult completed within 24 hours.[36] During the COVID-19 pandemic, VHA introduced four COVID-19 Priority categories requiring providers to indicate which consults needed to be scheduled, despite the COVID-19 pandemic, and which could wait.[37] Providers were tasked with determining urgency, as well as COVID-19 Priority categories, for each consult.

CITC staff told the OIG team that some providers selected the COVID Priority 1 category for consults that did not meet the definition of this designation and some entered CIDs earlier than one would expect for the given clinical scenario. CITC staff opined that this was done to expedite scheduling. A CITC clinical nurse and the facility's Group Practice Manager also reported that some consults were submitted without a COVID Priority. As a result, CITC staff had a large volume of consults to process without a clear delineation as to which should be addressed first.

The OIG learned through an interview with a CITC nurse that a guideline, created by CITC supervisors in late March 2020, was given to CITC staff that instructed nurses to "review for level of urgency and/or time sensitivity based on the nature of the consult prioritizing only urgent and emergent consults. For questions regarding urgency, the nurse will reach out to the appropriate provider." However, in an interview with the OIG, the CITC Chief reported that local guidance related to expected or best practices on how to prioritize level of urgency was not shared with CITC nurses.

In March 2021, as an attempt to address the backlog of COVID Priority 1 consults, facility CITC leaders created an additional urgency category called "urgent" that is undefined by VHA. To streamline scheduling, CITC supervisors implemented a process whereby consults designated as COVID Priority 1 with the "urgent or emergent" category assigned would be identified and CITC clinical nurses would print the electronic consults and place them in a box located outside the supervisors' offices. Supervisors then took these paper consults and dispersed them to schedulers for action.[38]

The OIG was informed by CITC staff that providers, as well as CITC clinical nurses triaging consults, could use this category in verbal or written communication with CITC schedulers;

[36] VHA Directive 1232(2).

[37] VHA Assistant Under Secretary memo, "National Deployment of Consult Toolbox 1.9.0063, and 1.9.0065-COVID-19 Upgrades (VIEWS#02748457)."

[38] Upon inquiry from the OIG regarding access to the CITC office and personally identifiable information, the CITC nurse manager reported that the current CITC office is located behind a locked door with secured access. Additionally, once appointments are scheduled, CITC staff are to dispose of the paper consults using shredders within the CITC office space.

however, it was neither VHA approved nor embedded in the design of the electronic consult management process. Based on interviews with CITC staff, the OIG learned that use of the urgent category meant scheduling needed to occur within 7–10 days of consult receipt. The urgent time frame did not seem to be known throughout the facility. One primary care provider shared with the OIG that the definition of "urgent" was a patient who needed to be seen within 15 days.

As a result of staff confusion with COVID Priority categories and the use of "urgent or emergent" categories, CITC staff had the responsibility to prioritize consults without a formal process or guidance, which overwhelmed staff and ultimately had a negative impact on the consult management process, contributing to delays in patient care.

Consult Management Workarounds During the Pandemic

Through interviews, the OIG learned of various workarounds created by individual staff members in multiple services to avoid consult scheduling delays.

Primary care and CITC clinical nursing staff reported creating lists of patients they were concerned about, to monitor and ensure their appointments were scheduled. After the COVID-19 pandemic began, primary care staff and managers saw an increase in delayed consults and started using an email group to send a message to CITC staff when they identified patients who were not scheduled as indicated by the provider.

Through interviews with the OIG, a primary care provider and the Women's Health Program Manager reported that staff in these services assumed different levels of responsibilities intended to be completed by CITC staff during the COVID-19 pandemic in an attempt to avoid consult processing delays. A primary care provider informed the OIG of having made appointments for time-sensitive cardiology and pulmonology consults to make sure care was not delayed. Women's Health staff implemented a process in which the facility temporarily adapted the Women's Healthcare Navigator's roles and responsibilities to allow for full-time tracking of active mammography consults and direct scheduling of mammography appointments outside of the typical CITC consult scheduling process, a task which is designated to CITC schedulers, to decrease delays. Once an appointment was made, the Women's Healthcare Navigator forwarded details of the appointment to CITC staff to complete the consult scheduling process. The Women Veteran Program Manager reported that some of the mammogram appointments made by the facility's Women's Healthcare Navigator had been waiting up to eight months to be scheduled. In an effort to avoid delays in care, Women's Health staff decided to collect their own mammography results from community providers, independent of the consult management process.

The OIG found that the strategy adopted by CITC leaders for managing their workload ultimately became part of the backlog problem. In the absence of a facility plan, informal

processes and workarounds were created by individual staff members in CITC as well as specialty services to avoid further consult scheduling delays.

Pandemic-Related External Factors

A facility provider and CITC leaders and staff reported the most significant factor outside the facility's control impacting the scheduling of consults was decreased healthcare access during the COVID-19 pandemic. CITC staff referred to a period when the facility was closed to non-emergent patients, resulting in facility providers entering CITC consults and increasing the overall volume of CITC consults and contributing to challenges in scheduling. Similarly, CITC leaders reported through OIG interviews that specialty care in the community within Martinsburg and surrounding areas experienced some level of access challenges, further complicating scheduling.

A CITC scheduler explained, through an OIG interview, that because of the COVID-19 pandemic, many of the administrative staff in community provider offices started teleworking and only went to their offices periodically to collect faxes and other information required to schedule appointments, contributing to the delay in scheduling.

3. Allegation: Inadequate Staffing Caused Delays in Community Care Consult Management

The OIG substantiated that inadequate staffing within the facility's CITC Service caused delays in the scheduling of CITC consults. Factors contributing to inadequate staffing included reports of frequent staff turnover, outdated local processes and lack of training within the service, staff absences related to COVID-19, and a lack of alternative work options available to staff during the COVID-19 pandemic.

VHA guidance requires facility directors to oversee a facility's consult management processes and allocate sufficient resources to ensure timely delivery of care.[39] To assist with forecasting clinical and administrative staffing needs, VHA released a staffing tool in May 2017, requiring facility directors to complete an initial CITC staffing assessment prior to May 23, 2017.[40] In 2019, the staffing instrument underwent revisions to incorporate updates related to the MISSION Act of 2018.[41] In March 2021, VHA issued a memorandum requiring facilities to complete a CITC staffing assessment by March 15, 2021, and every 90 days after that.[42]

[39] VHA Directive 1232(2).

[40] VHA Deputy Under Secretary for Health for Operations and Management memo, "National Deployment of the Community Care Operating and Coordination Models (VAIQ 7794358)," May 11, 2017.

[41] Office of Community Care, "Update Office of Community Care Staffing Tool Release and Training," n.d.

[42] VHA Assistant Under Secretary for Health for Operations memo, "National Implementation of the Community Care Operating Model Staffing Tool," March 1, 2021.

As directed by VHA, in March 2021, the facility completed the Office of Community Care staffing tool. The tool required the facility to self-report data on average task times, workload, available staffing resources, leave coverage, and other factors to estimate the number of clinical and administrative staff needed for their CITC Service.[43] The results from the 2021 staffing tool estimated that the facility's CITC Service needed 23 schedulers and 11 clinical full-time employee equivalents to meet workload demands, but only had 10 scheduling and four clinical staff as of March 2021.

Documentation received from the facility stated that, as of June 2021, six schedulers had been hired, and the facility was recruiting additional scheduling staff. Despite gaps in staffing, clinical nursing staff were able to consistently perform consult reviews within the time frame prescribed by VHA.[44]

Through interviews with CITC staff in various roles, the OIG heard of frequent staff turnover in the CITC Service. The VISN Program Manager described the staffing turnover experienced by the CITC Service as significant, while the Facility Director and a CITC scheduler referred to staffing as a revolving door. Another CITC scheduling staff member reported staffing was challenging before the COVID-19 pandemic because employees left every month with staffing getting worse as more employees left. The Facility Director stated that ongoing staffing losses created personnel shortages and significantly impacted the scheduling of patients' CITC appointments.

As of March 2021, the service had multiple inexperienced team members with limited knowledge of the consult scheduling process. The CITC Chief acknowledged the loss of experienced staff created knowledge gaps within the service that placed an undue burden on employees who did not fully know how to carry out scheduling tasks. The CITC Chief and a CITC supervisor explained that the consult scheduling process was complex and involved multiple steps and software systems to complete each consult. To manage the complicated process, staff within CITC had designated roles and responsibilities. CITC staff included qualified clinical professionals with delegated authority to review CITC consult requests and schedulers specifically trained to authorize, schedule, and ensure closure of consults. Through interviews with the OIG, CITC staff reported that the facility had obsolete standard operating procedures outlining local processes and procedures related to the scheduling of consults. Employees applied on-the-job training methods including turning to experienced staff or the CITC SharePoint site for guidance and referring to VHA's Office of Community Care Guidebook to answer questions about the scheduling process. A CITC supervisor reported that the facility used a training packet, which staff refer to as "The Journey," that was outdated and

[43] VHA Deputy Under Secretary memo, "National Deployment of the Community Care Operating and Coordination Models (VAIQ 7794358)."

[44] The OIG did not independently validate the information provided by the facility.

difficult to maintain due to rapid process changes. The same supervisor reported that while there are plans to update the training packet, doing so will require the input of several staff members to ensure accuracy and avoid missing steps. In an interview, the CITC Chief reported that there was a total of nine scheduling staff with three having been "here greater than 3 years" and the rest "less than a month." A lead scheduler, a new position for CITC, was hired in December 2020 with a primary role to train new and current scheduling staff. Highlighting the need for training, the CITC Chief told the OIG that the new lead position would focus on CITC staff training.

A staff member in CITC shared accounts of how the COVID-19 pandemic impacted CITC staffing due to multiple callouts and unexpected absences related to illness or exposure. The CITC Chief reported to the OIG that COVID-19 caused strains on staffing. The CITC nurse manager described having to take two or three weeks to orient two staff nurses unfamiliar with CITC processes sent to replace two regular CITC clinical nurses that were reassigned to direct patient care during the COVID-19 pandemic. A CITC clinical nurse told the OIG that sometimes clinical staff worked with only one or two nurses, half of the available clinical team, due to multiple staff simultaneously being diagnosed with COVID-19. When this occurred, clinical staff addressed COVID Priority 1 urgent consults first and tried to address as many of the remaining pending consults as possible when teammates were out.

The last contributing factor related to staffing centered on concerns voiced by CITC staff about a lack of alternative work options available during COVID-19. Per the Facility Director, authorization to telework is at the discretion of facility leaders as determined by operational needs. Both the Facility Director and CITC Chief reported that positions within the CITC Service were not authorized to telework. Per the CITC Chief, the lack of approved telework during the COVID-19 pandemic negatively affected morale and resulted in some staff finding employment elsewhere.

The OIG determined staffing levels within the CITC Service were below those identified through the Office of Community Care staffing assessment tool. As a result, the facility lacked staffing to schedule consults timely. In addition to insufficient staffing levels, the OIG noted several factors further exacerbated the staffing challenges and contributed to inefficient consult management that contributed to the delays in patient care.

Conclusion

The OIG substantiated that facility CITC staff failed to schedule a COVID Priority 1 CITC cardiology consult in accordance with VHA requirements. CITC staff did not schedule the COVID Priority 1 CITC cardiology consult within 30 days of the CID; however, the patient did not experience an adverse clinical outcome based on the delay in scheduling the consult. A review of the patient's EHR determined that the patient was scheduled to be seen by a community cardiology provider 95 days after the CID of day 29.

The patient's CITC cardiology consult was among a backlog of CITC consults in active, unscheduled, status. The OIG determined that the backlog consisted of approximately 3,996 COVID Priority 1 CITC consults in active status waiting to be scheduled. Multiple specialty services, including Cardiology, had CITC consults in active status that were waiting more than 30 days beyond the CID.

The OIG determined several factors that contributed to the facility's backlog and mismanagement of the consult process. The facility consistently failed to meet 90 percent of active consults scheduled within 30 days, one of the national metrics used to help manage CITC consults. Despite failing to meet this metric, the facility did not have an Improvement Action Plan in place as required by the Office of Community Care. In addition, facility CITC staff lacked awareness and did not make use of available reports to track and manage consults. Furthermore, the OIG determined that facility CITC staff failed to conduct clinical reviews on active CITC consults to ensure that care had not already occurred and that there was no duplication of consults. The OIG received various accounts of the facility process for clinical reviews from CITC leaders and staff, leading the OIG to determine that the facility lacked an effective process to clinically review consults. Subsequently, the OIG found that CITC staff discontinued consults upon learning that a patient died prior to being seen for care in the community. In doing so, facility staff were unable to determine if a delay in scheduling a CITC appointment was a contributing factor for an adverse event, such as death.

In response to the increased volume of CITC consults and high demands to schedule CITC appointments urgently, the facility created several workarounds in an attempt to meet expectations. The workarounds, which included the misuse of COVID Priority 1 designation, and the use of unstandardized guidelines created by CITC supervisors, created more confusion with an already complicated process.

The OIG substantiated that inadequate staffing within the CITC Service caused delays in the scheduling of CITC consults. The facility had frequent staff turnover, which may have been attributed to lack of appropriate training and lack of alternative work options during the COVID-19 pandemic.

Recommendations 1–8

1. The Veterans Integrated Service Network Director confirms that weekly calls with facility and Veterans Integrated Service Network leaders are held to discuss active Improvement Action Plans, progress made, timelines, and next steps.

2. The Martinsburg VA Medical Center Director verifies that Improvement Action Plans, identifying areas of improvement and outlining recommendations, are in place for unmet national Care in the Community performance metrics.

3. The Martinsburg VA Medical Center Director ensures COVID Priority 1 consults are run and reviewed by Care in the Community managers and staff daily.

4. The Martinsburg VA Medical Center Director confirms that clinical reviews of COVID Priority 1 active consults are completed and documented, monitors compliance, and takes action as warranted.

5. The Martinsburg VA Medical Center Director ensures a process is in place to review and address consults for patients who died prior to being scheduled or seen by a community care provider to determine if an adverse event occurred as a result of a delay in processing a patient's consult.

6. The Martinsburg VA Medical Center Director evaluates the effectiveness of strategies to manage the backlog of active consults and the use of *urgent* and *emergent* to prioritize consults for scheduling, determines if changes in practice are warranted, and documents the agreed upon process.

7. The Martinsburg VA Medical Center Director conducts a review to determine who, outside Care in the Community staff, is facilitating appointment scheduling and evaluates if the scheduling assistance of other services is an effective use of resources, and establishes a standardized process to align practices.

8. The Martinsburg VA Medical Center Director ensures Care in the Community staffing levels are adequate to support the processing of consults according to time frames set by the Veterans Health Administration.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 13, 2022

From: Director, VA Capitol Health Care Network (10N5)

Subj: Healthcare Inspection—Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia

To: Director, Office of Healthcare Inspections (54HL05)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG's) draft report entitled - Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia.

2. I have reviewed the attached comments provided by the Medical Center Director, Martinsburg VA Medical Center and concur with the submitted actions for recommendations #2, 3, 4, 5, 6, 7, and 8.

3. Furthermore, actions for recommendation #1 assigned to the VISN are included and will remain open and ongoing.

4. Should you require any additional information please contact VISN 5 network office.

(*Original signed by*:)

Robert M. Walton, FACHE
Director, VA Capitol Health Care Network (10N5)

VISN Director Response

Recommendation 1

The Veterans Integrated Service Network Director confirms that weekly calls with facility and Veterans Integrated Service Network leaders are held to discuss active Improvement Action Plans, progress made, timelines, and next steps.

Concur in principle.

Target date for completion: July 1, 2022

Director Comments

The VISN Quality Management Officer and the VISN Chief Business Officer will ensure that all current and required related action plans are monitored and are captured in the VISN Care in the Community (CITC) Oversight Committee minutes.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: January 10, 2022

From: Director, Martinsburg VA Medical Center (613)

Subj: Healthcare Inspection—Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia

To: Director, VA Capitol Health Care Network (10N5)

1. I have reviewed the findings and recommendations from this report. Thank you for the opportunity to further strengthen our processes.

2. The facility Quality Management Service Chief and I are available for questions regarding the facility response and continuous process improvement.

(*Original signed by*:)

Kenneth W. Allensworth, FACHE
Medical Center Director/CEO

Facility Director Response

Recommendation 2

The Martinsburg VA Medical Center Director verifies that Improvement Action Plans, identifying areas of improvement and outlining recommendations, are in place for unmet national Care in the Community performance metrics.

Concur.

Target date for completion: July 1, 2022

Director Comments

Community Care Service Chief and Quality Management Analyst will ensure that all current and identified action plans will be in place and captured in the facility Care in the Community (CITC) Oversight Committee minutes.

Recommendation 3

The Martinsburg VA Medical Center Director ensures COVID Priority 1 consults are run and reviewed by Care in the Community managers and staff daily.

Concur.

Target date for completion: July 1, 2022

Director Comments

Community Care Service Chief will ensure that Priority 1 consults will be reviewed by the next business day. Chief of Staff and Deputy Chief of Staff retain authority to approve Priority 1 consults for care that is needed before the next business day.

Recommendation 4

The Martinsburg VA Medical Center Director confirms that clinical reviews of COVID Priority 1 active consults are completed and documented, monitors compliance, and takes action as warranted.

Concur.

Target date for completion: July 1, 2022

Director Comments

Community Care Service Chief will ensure that Priority 1 consults will be reviewed by the next business day. Chief of Staff and Deputy Chief of Staff retain authority to approve Priority 1 consults for care that is needed before the next business day.

Community Care Service Chief will monitor compliance and timeliness of completed reviews and documentation of these consults. These results will be captured in the facility Care in the Community (CITC) Oversight Committee minutes.

Recommendation 5

The Martinsburg VA Medical Center Director ensures a process is in place to review and address consults for patients who died prior to being scheduled or seen by a community care provider to determine if an adverse event occurred as a result of a delay in processing a patient's consult.

Concur.

Target date for completion: March 15, 2022

Director Comments

Quality Management Service Chief will review existing facility decedent affairs policy for medical records administration and risk management processes, and to ensure that CITC consults are included in this policy.

Recommendation 6

The Martinsburg VA Medical Center Director evaluates the effectiveness of strategies to manage the backlog of active consults and the use of *urgent* and *emergent* to prioritize consults for scheduling, determines if changes in practice are warranted, and documents the agreed upon process.

Concur.

Target date for completion: July 1, 2022

Director Comments

Community Care Service Chief and Deputy Chief of Staff will review current facility process of further prioritizing COVID Priority 1 consults for continued viability.

Community Care Service Chief will ensure that Priority 1 consults will be reviewed by the next business day. Chief of Staff and Deputy Chief of Staff retain authority to approve Priority 1 consults for care that is needed before the next business day.

Community Care Service Chief will monitor compliance and timeliness of completed reviews and documentation of these consults. These results will be captured in the facility Care in the Community (CITC) Oversight Committee minutes.

Recommendation 7

The Martinsburg VA Medical Center Director conducts a review to determine who, outside Care in the Community staff, is facilitating appointment scheduling and evaluates if the scheduling assistance of other services is an effective use of resources, and establishes a standardized process to align practices.

Concur.

Target date for completion: March 15, 2022

Director Comments

Community Care Service Chief and Deputy Chief of Staff will review current facility process of decentralized scheduling for select categories of care for continued viability. Community Care Service Chief will ensure that if continued, competencies and delegations of authority are appropriately documented and that respective staff members are trained on these tasks.

Recommendation 8

The Martinsburg VA Medical Center Director ensures Care in the Community staffing levels are adequate to support the processing of consults according to time frames set by the Veterans Health Administration.

Concur in principle.

Target date for completion: September 15, 2022

Director Comments

Community Care Service Chief will continue to recruit as vacancies occur. Medical Center Director will continue to augment this team with additional permanent and term appointments to meet current and projected needs. Medical Center Director will implement additional recruitment authorities as authorized to identify and hire highly qualified candidates.

Community Care Service Chief will continue to monitor market capacity and will report any access standard gaps through the facility CITC Oversight Committee to the VISN CITC Oversight Committee and the Third-Party Administrator.

Community Care Service Chief will continue to monitor the timely receipt of medical records for CITC episodes of care and will report any timeliness delays through the facility CITC Oversight Committee to the VISN CITC Oversight Committee and the Third-Party Administrator.

Glossary

To go back, press "alt" and "left arrow" keys.

acute. Having a sudden onset, sharp rise, and short course of an illness.[1]

aortic stenosis. A condition in which the heart valve connecting to the main artery of the heart (aorta) narrows reducing and blocking blood flow from the heart to the rest of the body.[2]

backlog. An accumulation of tasks unperformed or materials not processed.[3]

cardiology. The study of the heart, its action, and associated diseases.[4]

consult. Submitted by a provider on behalf of a patient to request a specific service. In VHA, consult requests are made through the EHR to the service being requested.[5]

consult toolbox. Established through the Office of Community Care, the consult toolbox software is used "to manage the process of consult management".[6]

coronary artery disease. A term frequently used to refer to plaque that has developed in the arteries of the heart limiting the flow of blood to the heart muscle and potentially leading to a heart attack.[7]

coronary stents. "A small, metal mesh tube that acts as a scaffold to provide support inside the artery within the heart."[8]

costochondritis. "An inflammation of the cartilage that connects a rib to the breastbone (sternum). Pain caused by costochondritis might mimic that of a heart attack or other heart conditions."[9]

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[1] *Merriam-Webster.com Dictionary*, "acute," accessed July 1, 2021, https://www.merriam-webster.com/dictionary/acute.

[2] Mayo Clinic, "Aortic Valve Stenosis," accessed July 1, 2021, https://www.mayoclinic.org/diseases-conditions/aortic-stenosis/symptoms-causes/syc-20353139.

[3] *Merriam-Webster.com Dictionary*, "backlog," accessed July 6, 2021, https://www.merriam-webster.com/dictionary/backlog.

[4] *Merriam-Webster.com Dictionary*, "cardiology," accessed June 1, 2021, https://www.merriam-webster.com/dictionary/cardiology.

[5] VHA Directive 1232, Consult Processes and Procedures.

[6] VHA, Consult Tool Box Software Version 1.9.0076 User Guide, accessed June 6, 2021, https://vaww.portal.oig.va.gov/directorates/54/Hotlines/2021-01724-HI-1162/Work%20Papers/VHA,%20Consult%20Tool%20Box%20Software%20Version%201.0.0076%20User%20Guide,%20Consult%20tool%20Box%20Definition.pdf.

[7] American Heart Association, *Coronary Artery Disease*, accessed July 1, 2021, https://www.heart.org/en/health-topics/consumer-healthcare/what-is-cardiovascular-disease/coronary-artery-disease.

[8] Cleveland Clinic, Cardiac Catherization & Coronary Angioplasty and Stent Interventional Procedures, accessed July 1, 2021, https://my.clevelandclinic.org/health/treatments/16833-cardiac-catheterization--coronary-angioplasty-and-stent-interventional-procedures.

[9] Mayo Clinic, "Costochondritis Overview," accessed June 1, 2021, https://www.mayoclinic.org/diseases-conditions/costochondritis/symptoms-causes/syc-20371175.

echocardiogram. A test that uses sound waves to take images of the heart. The test allows doctors to see if the heart is beating and pumping blood.[10]

heart failure. A medical condition in which the heart is too weak to pump enough blood to the rest of the body.[11]

hypertension. Also known as high blood pressure, "is when [the] blood pressure, the force of [the] blood pushing against the walls of [the] blood vessels, is consistently too high."[12]

myocardial infarction. Also known as a heart attack that occur when the amount of blood getting to the heart is insufficient.[13]

nuclear stress test. A diagnostic test to identify areas within the heart with poor blood flow while at rest and upon exertion.[14]

telehealth. Providing virtual health care through technological applications to facilitate access to clinical care under circumstances where being in person is not feasible.[15]

telework. "A work flexibility arrangement under which an employee performs the duties and responsibilities of his/her position and other authorized activities, from an approved worksite other than the location from which the employee would otherwise work."[16]

workaround. A plan or method to temporarily fix a problem without resolving it.[17]

[10] Mayo Clinic, "Echocardiogram," accessed July 1, 2021, https://www.mayoclinic.org/tests-procedures/echocardiogram/about/pac-20393856.

[11] National Heart, Lung, and Blood Institute, *Heart Failure,* accessed July 1, 2021, https://www.nhlbi.nih.gov/health-topics/heart-failure.

[12] American Heart Association, *What is high blood pressure*, accessed July 1, 2021, https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure/what-is-high-blood-pressure.

[13] Centers for Disease Control and Prevention, *Heart Attack Symptoms, Risk, and Recovery*, accessed June 1, 2021, https://www.cdc.gov/heartdisease/heart_attack.htm.

[14] Mayo Clinic, "Nuclear Stress Test," accessed July 1, 2021, https://www.mayoclinic.org/tests-procedures/nuclear-stress-test/about/pac-20385231.

[15] "About Us," VHA Telehealth Services.

[16] VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020.

[17] *Merriam-Webster.com Dictionary*, "Work-around," accessed June 29, 2021, https://www.merriam-webster.com/dictionary/work-around.

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