US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Discontinued Consults Led to Patient Care Delays at the Oklahoma City VA Health Care System in Oklahoma

Healthcare Inspection | 23-01325-59 | February 1, 2024

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Oklahoma City VA Health Care System in Oklahoma (facility) to assess an allegation that the associate chief of staff of the Behavioral Health Service (program manager) denied behavioral health community care services for 32 identified patients.

The OIG substantiated that the program manager did not follow the consult management process and discontinued behavioral health community care consults for 29 of the 32 identified patients between early September and late October 2022. The OIG did not substantiate a denial of behavioral health care for the identified patients but did determine the discontinued consults resulted in a delay of care for seven patients. The OIG also determined that when the discontinued consults were identified, facility leaders initiated reviews and took timely action to ensure patients received the requested care.

The Veterans Health Administration (VHA) lists the consult status designations of *pending*, *active*, *scheduled*, *complete*, *discontinue*, and *cancel* to indicate the progress, timeliness of scheduling, and closing of a consult.[1] In 2021, VHA issued an updated requirement that stated, "the Discontinued (dc) action should no longer be used by consult receiving clinicians or staff responsible for consult management when the consult is no longer needed" and that "Cancel/Deny should be used in all instances when the consult is no longer needed and replaces the Discontinue action."[2] The *cancel* option allows a consult to be resubmitted if more information is received, whereas the *discontinue* option ends the consult process and does not allow any further actions to be taken.[3]

VHA also requires that facility schedulers review community care eligibility and offer patients who are eligible the choice to schedule an appointment in the community. If the patient chooses to set an appointment in the community, the facility scheduler will forward the consult to the facility community care office to coordinate care for the patient.

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[1] VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021. This directive was in place during the time of the events discussed in this report. It was replaced by VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022. Unless otherwise specified, the amended 2022 directive contains the same or similar language regarding consult management as the previous version. A consult is an electronic request for services for a patient. After a consult is entered, the receiving Service is responsible for changing the consult status from pending within two business days. The pending or active consult status is then changed to a consult status of scheduled, forwarded, completed, or canceled within three business days to ensure patients receive timely care. Consults for community care should additionally include a clinical review by the referral coordination team within two business days and must be forwarded to the community within three business days of the consult entry date.

[2] VHA Directive 1232(4).

[3] VHA Directive 1232(4).

The OIG learned that part of the role of the program manager's position was completing Service-level review for community care consults and that prior to the program manager's Service-level review, a Behavioral Health Service scheduler reviewed the consults to confirm eligibility for community care and ensure the patient had opted to receive care in the community.

The OIG found that the program manager reviewed each behavioral health community care consult, used an availability tool to identify open internal appointments, commented in the consult to schedule the patient for a specific open internal date and time, and discontinued the community care consult.[4] After the program manager had discontinued behavioral health community care consults, a Behavioral Health Service scheduler (scheduler) confirmed that the availability tool was not updating at regular intervals, and therefore, the internal appointment availability was incorrect. The scheduler notified the program manager. The scheduler also communicated to the program manager that the program manager's comments to schedule a patient in a specific date and time without speaking with the patient first could be considered a VHA prohibited practice called "blind scheduling."[5] During interviews, the program manager incorrectly identified the *discontinue* consult status as the option that allows further action to be taken and also reported not knowing about the prohibited practice of blind scheduling, despite having completed the required trainings for consult management.

The OIG determined the program manager lacked a working knowledge of the consult management and scheduling processes and took actions that delayed patients receiving behavioral health community care.

During the electronic health record review, the OIG found that Behavioral Health Service providers had to enter repeat consult requests for behavioral health community care services in 19 of the 29 consults discontinued by the program manager. VHA expects community care consults to be completed within 90 calendar days of the date an appointment is deemed clinically appropriate, also known as the clinically indicated date.[6] The OIG determined seven patients experienced delays between 122 to 199 calendar days that failed to meet the required 90-day time frame. Facility leaders reported that based on the review conducted by the Behavioral Health Service leaders, no adverse events were identified from the delays. The OIG concluded

[4] The VHA's multi-grid (MK) availability tool is a nationally available electronic dashboard that provides analysis on clinical provider availability. The availability tool is under development.

[5] VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.

[6] VHA, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022, updated January 13, 2022. The December 2022 SOP was in place during the time of the events discussed in this report. The updated SOP contains the same or similar language regarding completed community care consult timeliness as the original SOP. For this inspection, the OIG defined a delay of care as care received beyond 90 days of the clinically indicated date entered on the initial discontinued consult.

that the program manager introduced a vulnerability that caused a delay in the provision of behavioral health care and placed patients at risk for adverse clinical outcomes.[7]

The OIG determined that when Behavioral Health Service leaders and the patient safety manager reported that the program manager was discontinuing behavioral health community care consults, facility leaders took administrative actions by investigating the reports, involving the facility compliance office, and conducting quality reviews.

The OIG made one recommendation to the Facility Director to review community care consult management and appointment scheduling processes, identify deficiencies, and take action as warranted.

VA Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendation and provided an acceptable action plan (see appendixes A and B). The OIG will follow up on the planned action until it is completed.

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

[7] Within the context of this report, the OIG considered an adverse clinical outcome as a patient experiencing an inpatient hospitalization for psychiatric or substance use detoxification needs, an overdose or a suicide behavior reported through a Suicide Behavior and Overdose Report, or death, between submission and completion of consults for mental health services or, for incomplete consults, to the date of OIG review.

Contents

Abbreviations

CID	clinically indicated date
EHR	electronic health record
HRO	high reliability organization
JPSR	Joint Patient Safety Reporting
OIG	Office of Inspector General
RCI	Referral Coordination Initiative
RCT	referral coordination teams
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Oklahoma City VA Health Care System in Oklahoma (facility) to assess an allegation that the associate chief of staff of Behavioral Health Service (program manager) denied behavioral health community care services for 32 identified patients.

Background

The facility is designated as a Level 1b, high complexity facility and is part of Veterans Integrated Service Network (VISN) 19, the Rocky Mountain Network.[1] The facility operates 16 outpatient clinics. From October 1, 2021, through September 30, 2022, the facility served 72,478 unique patients and provided primary and specialty care, including surgery and behavioral health.

Community Care

In June 2019, the Veterans Community Care Program was established, replacing the previous Veterans Choice Program. The program streamlined eligibility criteria and created a single Community Care Program to improve customer service.[2] The Veterans Community Care Program "provides care to Veterans through community providers when VA cannot provide the care needed." Veterans who meet eligibility criteria may qualify to receive health care through a community provider.[3]

Allegation and Related Concern

On December 23, 2022, the OIG received an allegation that the program manager was not following the consult management process and was discontinuing consults, resulting in patients being denied behavioral health community care. The complainant provided a list of 32 patients allegedly affected by discontinued consults from September through November 2022. The OIG also evaluated a related concern regarding facility leaders' response to the allegation.

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[1] VHA Office of Productivity, Efficiency, & Staffing, "Facility Complexity Model Fact Sheet." The Facility Complexity Model categorizes 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 1b facility has "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs." The VA Oklahoma City Health Care System is located in Oklahoma City, Oklahoma, with VA clinics in Ada, Altus, Ardmore, Blackwell, Clinton, Enid, Lawton, Oklahoma City, and Stillwater, Oklahoma; Tinker Air Force Base in Oklahoma; and Wichita Falls, Texas.

[2] VA Fact Sheet, "Veteran Community Care General Information," September 09, 2019, accessed February 8, 2023, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VHA-FS_MISSION-Act.pdf.

[3] VA Fact Sheet, "Veteran Community Care General Information," September 09, 2019, accessed February 8, 2023, https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VHA-FS_MISSION-Act.pdf.

Scope and Methodology

The OIG initiated the inspection on February 6, 2023, and conducted an on-site visit March 20 through 23, 2023. The OIG also conducted virtual interviews between March and May 2023.

The OIG interviewed the complainant, facility leaders, and relevant providers and staff.[4] The OIG reviewed the electronic health records (EHRs) of the 32 patients identified by the complainant. The OIG reviewed pertinent Veterans Health Administration (VHA) and facility policies and procedures related to consult management and scheduling, facility committee charters and minutes, training records, audit records, email communications, action plans, quality reviews, and organizational charts.

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, as amended, 5 U.S.C. §§ 401–424. 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

The OIG substantiated that the program manager did not follow the consult management process and discontinued behavioral health community care consults for 29 of the 32 identified patients. Although the OIG did not substantiate a denial of behavioral health care for the identified

[4] The OIG interviewed the Facility Director; Chief of Staff; Deputy Chief of Staff; executive assistant; the program manager; chief and assistant chief of psychology; a psychologist; a social worker; three Behavioral Health Service schedulers; the chief nurse of community care; a nurse practitioner; a registered nurse; two program support assistants in community care; the director of quality, safety, and value; a patient safety officer; and a clinical applications coordinator.

patients, the OIG determined a delay of care for seven patients.[5] The OIG identified deficiencies in the program manager's knowledge of the consult management process that contributed to the discontinued consults and delays in patient care. The OIG determined that when the discontinued consults were identified, facility leaders initiated reviews and took timely action to ensure patients received the requested care.

1. Failure of the Program Manager to Follow VHA Consult Management Process

VHA established standard scheduling and referral coordination to improve the consult management process.[6] VHA lists the consult status designations of *pending*, *active*, *scheduled*, *complete*, *discontinue*, and *cancel* to indicate the progress, timeliness of scheduling, and closing of a consult.[7] In 2021, VHA issued an updated requirement that stated, "the Discontinued (dc) action should no longer be used by consult receiving clinicians or staff responsible for consult management when the consult is no longer needed" and that "Cancel/Deny should be used in all instances when the consult is no longer needed and replaces the Discontinue action."[8] The *cancel* option allows a consult to be resubmitted if more information is received, whereas the *discontinue* option ends the consult process and does not allow any further actions to be taken.[9]

VHA requires that facility schedulers complete annual training, which includes relevant updates to consult management and scheduling procedures, such as changes in the use of *cancel* and *discontinue* consult status designations. VHA also requires that facility schedulers review community care eligibility and offer patients who are eligible the choice to schedule an appointment in the community.[10] If a patient chooses to set an appointment in the community,

[5] The VHA's multi-grid (MK) availability tool is a nationally available electronic dashboard that provides analysis on clinical provider availability. The availability tool is under development.

[6] VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021. This directive was in place during the time of the events discussed in this report. It was replaced by VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022. Unless otherwise specified, the amended 2022 directive contains the same or similar language regarding consult management as the previous version.

[7] VHA Directive 1232(4); Standard Operating Procedure, *Consult Timeliness*, December 1, 2022. After a consult is entered, the receiving service is responsible for changing the consult status from pending within two business days. The pending or active consult status is then changed to a consult status of scheduled, forwarded, completed, or canceled within three business days to ensure patients receive timely care. Consults for community care should include a clinical review by the referral coordination team within two business days. Consults for Community Care must be forwarded within three business days of the consult entry date.

[8] VHA Directive 1232(4).

[9] VHA Directive 1232(4).

[10] VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.

the facility scheduler will forward the consult to the facility community care office to coordinate care for the patient.[11]

Further, when scheduling a patient, facility schedulers are required to have a discussion with the patient to negotiate the appointment date and time. Failure to include the patient in the appointment scheduling process is considered "blind scheduling" and is prohibited.[12] To further improve consult management processes by incorporating community care eligibility requirements and patient preference, VHA mandated implementation of the Referral Coordination Initiative (RCI).[13] The RCI established referral coordination teams (RCTs), that include administrative and clinical staff, tasked with triaging the consult submitted by the ordering provider, contacting the patient to discuss eligibilities, and scheduling for an internal facility appointment or forwarding to community care.[14] The OIG found through document review that the facility RCT training also included information on the processes required to review consults, including the use of the canceled consult status designation, and that the facility leaders completed implementation of the RCI process within Behavioral Health Service in November 2021.[15]

During an interview with a facility Behavioral Health Service leader, the OIG learned that part of the role of the program manager's position was completing Service-level reviews for community care consults. Additionally, the OIG learned that prior to the program manager's Service-level review, a Behavioral Health Service scheduler also reviewed consults to confirm patients' eligibility for community care and ensure patients had opted to receive care in the community. The program manager told the OIG during an interview of being the Service-level approver for each behavioral health community care consult.

The program manager also reported during an interview with the OIG of using an availability tool to determine available clinic appointments and adding consult comments notifying the scheduler of a specific open appointment date and time. The OIG learned during interviews with a facility leader and Behavioral Health Service staff members, that the availability tool was introduced by the facility's group practice manager in August 2022 at a facility consult management meeting. The OIG independently accessed the availability tool on the national site and noted it was listed as being "still under development." In an interview with the OIG, a

[11] VHA Office of Integrated Veteran Care, *Referral Coordination Initiative (RCI) Guidebook*, May 2022.

[12] VHA Directive 1230.

[13] VHA Office of Integrated Veteran Care, *Referral Coordination Initiative (RCI) Guidebook*. Community care eligibility is based on six criteria, two of which are the patient's drive time and wait time for the requested care. For the purposes of this report, a referral is the same as a consult.

[14] VHA Office of Integrated Veteran Care, *Referral Coordination Initiative (RCI) Guidebook*. The Referral Coordination Team completes the review to ensure the appropriateness of care requested, determines eligibility for referral to community care, and determines internal availability for appointments.

[15] The Referral Coordination Initiative (RCI) Guidebook is continuously updated. The OIG used the version from May 2022.

Behavioral Health Service scheduler reported noticing that the availability tool was not updating and informed the program manager about the appointments in the availability tool being inaccurate. Further, the program manager told the OIG during an interview that a Behavioral Health Service scheduler had notified the program manager that entering an appointment date and time as a comment on the consult could be interpreted as blind scheduling. The program manager also told the OIG of being unaware the consult comments could be interpreted as blind scheduling before the Behavioral Health Service scheduler provided that information.

The OIG reviewed the EHRs of the 32 identified patients and determined that the program manager discontinued 29 of the 32 community care consults between early September 2022 and late October 2022.[16] Discontinuing the community care consults meant the Behavioral Health Service staff could not take any further actions on the care requested in the 29 consults. During the same EHR review, the OIG found the program manager documented that facility appointments were available in 23 of 29 discontinued consults. Furthermore, in 5 of the 29 discontinued consults, the OIG found the program manager documented comments in the consults that instructed facility schedulers to schedule a patient into a specific appointment date and time. However, the OIG found no documented evidence that the program manager discussed the scheduling of appointments with patients prior to entering a comment to schedule a specific date and clinic.[17]

During interviews, the OIG learned that in early October 2022 a Behavioral Health Service leader identified then communicated to another Behavioral Health Service leader that the program manager was discontinuing behavioral health community care consults. The same day, the Behavioral Health Service leader also reported communicating to the program manager in writing that discontinuing a consult did not allow any further action to be taken on the consult and did not ensure the patient received the requested service. The OIG further discovered through interviews that although the program manager had acknowledged understanding of the impact of discontinuing consults, the program manager resumed discontinuing the consults the next day and continued doing so for approximately three weeks. The OIG learned that Behavioral Health Service leaders and staff also notified facility leaders through face-to-face and written communication that the program manager was discontinuing behavioral health community care consults.

During an interview with the OIG, the program manager denied a pattern of discontinuing consults. However, when the OIG provided examples of consults the program manager had discontinued, the program manager acknowledged discontinuing the consults but did not provide

[16] The remaining three consults were canceled by another staff member.

[17] The OIG's review of the 29 discontinued consults found that consults were discontinued for the following reasons: internal appointment availability (23 consults), internal service availability (5 consults), and patient already engaged in care (1 consult). For this report, *specific appointment* is defined as an appointment with a specific provider or clinic with a date and time.

an explanation for failing to follow the consult management process. When questioned by the OIG, the program manager reported not understanding the difference between the actions of using *canceled* and *discontinued*. The program manager stated discontinued consults, instead of canceled consults, could be returned to an active status. When the OIG asked if the program manager had sought clarification about the use of *discontinue* and *cancel* for consult status designation, the program manager did not report any attempt to seek clarification. The program manager also reported not receiving training on the RCI process or consult management. However, the OIG, through document review, found that the program manager completed RCI training in July 2021 and completed the required national training for facility schedulers in September 2021.[18] Facility leaders and staff reported VHA prohibited discontinuing consults at least a year prior to the documented instances of discontinued community care consults in September and October, 2022.

The OIG concluded that the program manager failed to follow required consult management and scheduling processes by discontinuing behavioral health community care consults. Although the program manager completed required trainings, the OIG found the program manager lacked a working knowledge of the consult management and scheduling processes, subsequently delaying behavioral health community care for the affected patients.

Discontinued Behavioral Health Community Care Consults Led to Delays in Care

The OIG found that seven patients experienced delays in receiving requested care when the program manager failed to follow consult management processes and discontinued behavioral health community care consults.

VHA expects community care consults to be completed within 90 calendar days of the date the appointment is deemed clinically appropriate, also known as the clinically indicated date (CID).[19]

During the EHR review, the OIG found that Behavioral Health Service providers had to enter repeat consult requests for behavioral health community care services in 19 of the 29 consults discontinued by the program manager. In an interview with the OIG, a Community Care

[18] The RCI training included instructions on how to review and disposition consults, as well as the scheduling processes for consult status changes. National training for scheduling appointments specifically identified to cancel the consult instead of using the discontinued option because the cancel option allows the consults to be restored to an active status.

[19] VHA Directive 1230, *Outpatient Scheduling Management,* June 1, 2022; VHA Directive 1234(4); VHA Directive 1234(5); VHA, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022, updated January 13, 2022. The December 2022 SOP was in place during the time of the events discussed in this report. The updated SOP contains the same or similar language regarding completed community care consult timeliness as the original SOP. For this inspection, the OIG defined a delay of care as care received beyond 90 days of the CID entered on the initial discontinued consult.

Program program support assistant responsible for scheduling reported that behavioral health community care consults were worked from oldest to newest. The OIG determined that if a provider had to enter a repeat consult because the initial consult was discontinued, the patient's repeat consult would have a later entry date, and the patient could potentially wait longer for the requested care.

In interviews with the OIG, facility and Behavioral Health Service leaders reported that some patients experienced delays in care due to the program manager discontinuing consults. Through document review, the OIG determined delays ranged from 122 to 199 calendar days. Ultimately, the OIG found that 7 of the 29 consults discontinued by the program manager did not receive behavioral health community care within 90 calendar days, as required, when measured from the original CID.[20] Facility leaders reported that based on the review conducted by Behavioral Health Service leaders, no adverse events were identified from the delays.[21]

The OIG concluded that the program manager's failure to follow consult management practices resulted in behavioral health providers having to resubmit consult requests for 19 of the 29 discontinued consults. The program manager introduced a vulnerability that caused a delay of behavioral health care and placed patients at risk for adverse clinical outcomes.

2. Facility Leaders' Timely and Efficient Response

The OIG determined that Behavioral Health Service leaders and the patient safety manager reported concerns related to the program manager discontinuing behavioral health community care consults to facility leaders. Facility leaders took administrative actions and conducted quality reviews in response to the reported concerns.

VHA requires facility leaders to be aware of safety events occurring in the facility so that actions can be taken to prevent patient harm.[22] VHA states facility leaders have the responsibility to

[20] VHA, "Consult Timeliness Standard Operating Procedure (SOP)." The remaining 22 of 29 consult showed 12 patients were seen within 90 days of the CID entered on the initial consults, five patients declined services, three patients failed mandated scheduling efforts, one patient moved, and one patient established behavioral health care through a consult unrelated to this review.

[21] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Within the context of this report, the OIG considered an adverse clinical outcome as a patient experiencing an inpatient hospitalization for psychiatric or substance use detoxification needs, an overdose or a suicide behavior reported through a Suicide Behavior and Overdose Report, or death, between submission and completion of consults for mental health services or, for incomplete consults, to the date of OIG review.

[22] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was in place during the time of the events discussed in this report. It was replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The updated directive states "Continuous quality management strengthens high reliability practices to build accountability, transparency, inclusion and standardization to prevent harm, promote continuous learning and improve the quality of care and services delivered."

promote and encourage staff to report adverse events and close calls.[23] A patient safety manager then evaluates events and determines appropriate next steps.[24] A patient safety manager is also responsible for ensuring timely investigation of reports entered by staff into the Joint Patient Safety Reporting (JPSR) system.[25]

In March 2020, VHA initiated "enterprise-wide HRO [high reliability organization] implementation" noting that improving safety and reliability requires transparency where errors and close calls are regarded as opportunities to improve processes that may cause harm.[26] VHA further states that high reliability requires an environment where "employees at every level of our organization are empowered to speak up for safety and effect positive change."[27] The OIG learned during an interview that high reliability was a driver that led to submitting safety concerns into the JPSR system and direct communication of concerns to the Facility Director and Chief of Staff.

Facility leaders and Behavioral Health Service leaders reported during interviews with the OIG that they took actions to evaluate concerns that the program manager was discontinuing consults. The Facility Director and Chief of Staff told the OIG that they initially spoke with the program manager about discontinuing behavioral health consults in October 2022 but the program manager denied there were any issues. The OIG was told during interviews that in early October 2022, multiple Behavioral Health Service staff members notified facility leaders, through face-to-face and written communication, that the program manager had discontinued additional behavioral health community care consults. The Facility Director told the OIG of responding to the discontinued consults by again discussing concerns with the program manager, who reported no problems with discontinued consults and was reviewing access issues. The Facility Director allowed the program manager to continue to provide oversight on the issue.

In mid-October 2022, a JPSR event was submitted, alerting the patient safety manager that behavioral health community care consults were being discontinued. Patient safety staff responded to the JPSR two weeks later by assigning an investigator and alerting facility leaders. Through an interview and document review, the OIG found that the patient safety manager

[23] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was in place during the time of the events discussed in this report. It was replaced by VHA Directive 1050.01, *Quality and Patient Safety Programs*, March 24, 2023. Unless otherwise specified, the rescinded 2011 handbook contains the same or similar language regarding reporting of adverse events as the 2023 directive.

[24] VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021. The JPSR system is used to report patient incidents in real time and capture real-time reporting data from all VHA care sites.

[25] VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*.

[26] VA, *VHA High Reliability Organization (HRO) Reference Guide*, April 2023, "High reliability means evidence-based, high-quality care is consistently delivered for every patient, every time, at any facility across VHA."

[27] VA, *VHA High Reliability Organization (HRO) Reference Guide*.

received four JPSRs that were related to the program manager discontinuing behavioral health community care consults.

The OIG determined that the patient safety manager responded to each JPSR as required by assigning investigators and informing the Facility Director. Additionally, through document reviews, the OIG found that at the end of November 2022, a Behavioral Health Service leader forwarded the Facility Director a list of patients who needed consults to be resubmitted as a result of the program manager discontinuing the consults.

The Facility Director told the OIG about initiating a review with the facility compliance office the following day.

At the end of January 2023, through document reviews, the OIG learned that a member of the compliance office emailed a human resources specialist and the Facility Director stating the program manager was not following acceptable scheduling practices. The OIG learned the Facility Director responded by initiating an Administrative Investigation Board one week later. In early June 2023, the OIG learned through written communication from the Facility Director that recommendations from the Administrative Investigation Board were being addressed through various approaches, including training. During the course of the inspection, the OIG received and reviewed additional documentation that a Behavioral Health Service leader completed follow-up reviews of the patients affected by the program manager discontinuing consults, ensuring the identified patients' consults were monitored until the care that had been requested was completed. Behavioral Health Service leaders told the OIG about completing EHR reviews for the identified patients and determining there were no adverse events.

During interviews with the OIG, the Facility Director reported chartering an Administrative Investigation Board to review the program manager's consult management practices.[28] The OIG learned through document review that the Administrative Investigation Board was chartered in January 2023 and completed in April 2023, and the Administrative Investigation Board substantiated the program manager improperly managed consults and that discontinuing the community care consults violated VHA requirements for consult practices and outpatient scheduling management. Further, the results of the Administrative Investigation Board included recommendations to ensure Behavioral Health Service staff involved in consult management and scheduling processes complete training as required by VHA, and that facility compliance office staff conduct ongoing audits of the behavioral health consult management and scheduling process.

The OIG found that when facility staff and providers reported the concerns regarding the program manager discontinuing behavioral health community care consults, facility leaders

[28] VA Directive 0700, *Administrative Investigation Boards and Factfindings*, August 10, 2021. An Administrative Investigation Board is a type of administrative investigations using a systemic process for collecting evidence, ascertaining facts regarding matters of interest to VA.

reviewed the submitted concerns and took actions as required. The OIG found that facility leaders' commitment to high reliability empowered staff to speak up and positively impact patient care within the Behavioral Health Service.

Conclusion

The OIG substantiated that the program manager failed to follow VHA-required consult management processes by discontinuing behavioral health community care consults and found the program manager lacked a working knowledge of the consult management and scheduling processes. Once the behavioral health community care consults were discontinued, community care and Behavioral Health Service staff could not continue to coordinate the requested service for the patients. While patients were not denied behavioral health community care services, seven patients experienced delays in care because referring providers had to resubmit community care consults. The resubmitted behavioral health community care consults moved the patients further back from the original requested service date. Although the OIG found no documented evidence that the delays in care resulted in adverse events, the program manager introduced a vulnerability that caused delays in care and placed patients at risk for adverse clinical outcomes.

Facility leaders and the patient safety manager initiated clinical and administrative reviews and took action to review patient care after becoming aware that the program manager was discontinuing behavioral health community care consults. The OIG found that the facility leaders' commitment to high reliability empowered staff to speak up and report concerns regarding the program manager's consult management practices.

Recommendation

The Oklahoma City VA Health Care System Director, in conjunction with Behavioral Health Service leaders, reviews the community care consult management and appointment scheduling processes, identifies deficiencies, and takes action as warranted.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 27, 2023

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Discontinued Consults Led to Patient Care Delays at the Oklahoma City VA Health Care System in Oklahoma

To: Director, Office of Healthcare Inspections (54HL02)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) report, Discontinued Consults Led to Patient Care Delays at the Oklahoma City VA Health Care System in Oklahoma.

2. Based on the thorough review of the report by VISN 19 Leadership, I concur with the recommendation and submitted action plan of Oklahoma City VA Health Care System.

3. If there are any questions regarding the response or additional information required, please contact the VISN 19 Quality Management Officer.

(Original signed by:)

Sunaina Kumar-Giebel, MHA
Director, VA Rocky Mountain Network (10N19)

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 19, 2023

From: Director, Oklahoma City VA Health Care System (635)

Subj: Healthcare Inspection—Discontinued Consults Led to Patient Care Delays at the Oklahoma City VA Health Care System in Oklahoma

To: Director, Rocky Mountain Network (10N19)

1. Thank you for the opportunity to provide a response to the recommendation from the Healthcare Inspection—Discontinued Consults Led to Patient Care Delays at the Oklahoma City VA Health Care System in Oklahoma.
2. I concur with the findings and recommendation. Processes to correct the recommendation and monitor the corrective actions are in place.

(Original signed by:)

Wade Vlosich
Director, Oklahoma City VA Health Care System

Facility Director Response

Recommendation

The Oklahoma City VA Health Care System Director, in conjunction with the Behavioral Health Service leaders, reviews the community care consult management and appointment scheduling processes, identify deficiencies, and takes action as warranted.

_X_ Concur

____Nonconcur

Target date for completion: Request Closure

Director Comments

Oklahoma City VA Health Care System Director and Behavioral Health services reviewed the community care consult management and appointment scheduling processes. Ongoing monitoring was initiated in March 2023. Audits for June were not completed as the process for auditing the consults changed. The Compliance Office currently pulls a list of consults from 2 months prior. Thirty consults are randomly audited per month. Results of the audits indicate all consults reviewed were appropriately dispositioned and closed within 90 days.

OIG Comments

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Sami Cave, MA, Director Shelby Assad, LCSW Sherry Becker, MSN-Ed, RN-BC Hanna Lin, LCSW Vanessa Masullo, MD Jennifer Nalley, AuD Andrew Waghorn, JD
Other Contributors	Josephine Biley Andrion, MHA, BSN Limin Clegg, PhD Margaret Fox, RDN Reynelda Garoutte, MHA, BSN Stephanie Long, MSW, LCSW Natalie Sadow, MBA Jarvis Yu, MS

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