



# Department of Veterans Affairs Office of Inspector General

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## Healthcare Inspection

### Consultation Mismanagement and Care Delays Spokane VA Medical Center, Spokane, Washington

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## Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections reviewed allegations of inappropriate consultation cancellation causing delays in care and potential harm to patients, poor communication between consultants and primary care providers (PCPs) and patients, and inappropriate requests for PCPs to order tests for consultants at the Spokane VA Medical Center, Spokane, WA. The purpose of the review was to determine whether the allegations had merit.

We substantiated that requests for consultations were inappropriately cancelled or discontinued, and that patients consequently had unnecessary delays in the amelioration of symptoms. We found that the facility did not have a comprehensive policy or process in place for consult management.

We substantiated that there was poor communication between consultants and PCPs that resulted in requests for consultations being discontinued or cancelled. We found evidence of poor communication both in PCP and consultant documentation. Non-productive interactions between PCPs and consultants contributed to poor communication, which in turn had a negative impact on the consultation process.

We did not substantiate that consultants inappropriately asked PCPs to order tests. However, we noted opportunities for improvement, such as the use of service agreements to define workflow processes and expedite efficient patient care.

We recommended that the Medical Center Director: (1) ensure that there is a comprehensive consultation process in place and that staff are educated on the process, (2) ensure that all requests for consultations be appropriately generated, tracked to completion, and that consultation completion data is shared with clinical staff, and (3) ensure that staff conflicts and communication issues are appropriately addressed and resolved. The Veterans Integrated Service Network and Medical Center Directors agreed with the findings and recommendations and provided acceptable action plans.



**DEPARTMENT OF VETERANS AFFAIRS**  
**Office of Inspector General**  
**Washington, DC 20420**

**TO:** Director, Northwest Network (10N20)

**SUBJECT:** Healthcare Inspection –Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, Washington

### **Purpose**

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed allegations of inappropriate consultation cancellation causing delays in care and potential harm to patients, poor communication between consultants and primary care providers (PCPs) and patients, and inappropriate requests for PCPs to order tests for consultants. The purpose of the review was to determine whether the allegations had merit.

### **Background**

The Spokane VA Medical Center (SVAMC), Spokane, WA, the Portland VA Medical Center (PVAMC), Portland, OR, and the VA Puget Sound Health Care System (VAPSHCS), Seattle, WA, are part of Veterans Integrated Service Network (VISN) 20. The SVAMC provides primary and secondary care, with emphasis on preventive health and chronic disease management. VAPSHCS and the PVAMC are tertiary care centers offering specialty care services not provided in Spokane.

### **Allegations**

On February 07, 2012, a complainant contacted the OIG hotline and alleged that mismanagement of consultations was causing delays in care and possible harm to patients. Specifically, the complainant alleged that:

- SVAMC consultants inappropriately cancelled or discontinued requests for consultations causing delays in care and potential harm to patients.

- SVAMC consultants cancelled or discontinued requests for consultations without communicating with the ordering PCP and/or patient.
- SVAMC consultants inappropriately asked PCPs to order tests.

## Scope and Methodology

We reviewed information provided by the complainant, the electronic health record (EHR), Veterans Health Administration (VHA) policies and procedures, facility consultation completion data, and other pertinent documents. We conducted a site visit March 27-29, 2012. We interviewed PCPs and consultants, as well as leadership and administrative staff. For the purpose of this review, requests for consultations are considered to have had an appropriate response if the patient was seen or scheduled to be seen within 30 days.

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

## Inspection Results

### **Issue 1: Alleged cancellation or discontinuation of requests for consultations causing delays in care and potential harm to patients.**

We substantiated that requests for consultations were inappropriately cancelled or discontinued, and that patients consequently had unnecessary delays in the amelioration of symptoms.

According to VHA consult policy, “a clear and solid consultation process is vital to patient care.”<sup>1</sup> Requests for specialty consultation are made using the electronic health record (EHR), and can be scheduled, cancelled, or discontinued. A scheduled status indicates that the request for consultation has been accepted and that an appointment has been scheduled. A cancelled status indicates that the request for consultation has been closed without the consulting service seeing the patient. A discontinued status indicates that the PCP who requested the specialty care no longer requests consultation. A request for consultation in scheduled status will change to completed status when the consulting service has seen and evaluated the patient and written a progress note in the patient’s EHR linked to the consultation request. A non-visit request for consultation is used when clinical consultations can be resolved without a face-to-face patient encounter. Non-visit requests for consultations are answered electronically and the consultation process is completed without scheduling an appointment.

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<sup>1</sup> VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.

We found that the facility did not have a comprehensive policy or process in place for consult management, and that providers were unsure about the appropriate disposition of requests for consultation (schedule, cancel, and discontinue).

Non-existent or poor communication between PCPs and consultants was a source of frustration. PCPs generated requests for consultation with the expectation that their patients would be seen and evaluated in person by the consultant. In some cases, consultants reviewed requests, determined that a non-visit consultation was appropriate, and provided management recommendations without seeing the patient. In breach of VHA Handbook 1907.01,<sup>2</sup> PCPs often expressed dissatisfaction with this process by writing inappropriate comments in consult notes. Consultants, in turn, sometimes responded with unprofessional comments.

We found that requests for consultations were resubmitted by PCPs for the same patient with the same condition without following consultant recommendations. Some PCPs reported sending requests for consultations to tertiary care centers in order to avoid using local consultants.

The facility provided data about rates of cancellation, discontinuation, and completion for consult requests to specialty areas. However, PCPs were not aware of this data and the data was not routinely used to manage practice. We reviewed 15 EHRs of patients whose names were provided to us by the complainant and by facility patient advocates. We substantiated that delays in care occurred for 8 of the 15 patients reviewed and we determined that in 7 of the 8 cases, patients suffered a delay in amelioration of symptoms.

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<sup>2</sup> VHA Handbook 1907.01, *Health Information Management & Health Records*, August 25, 2006.

## Case Summaries

Patient	Delay in Care	Adverse Patient Outcome	Comments
1	Yes	Yes	PCP requested VAPSHCS Pain Clinic consultation. VAPSHCS recommended patient be fee based to the University of Washington (UW) because VAPSHCS Pain Clinic closed. Patient not seen at UW, but enrolled in VAPSHCS Pain Clinic when it reopened 10 months after the initial request for consultation.
2	Yes	Yes	PCP requested SVAMC neurology consultation for management of migraine. Consultant provided non-visit consultation on medication management six weeks after initial request.
3	Yes	Yes	PCP requested consultation to PVAMC neurosurgery for management of degenerative disc disease. <sup>3</sup> Patient seen eight weeks after the initial request.
4	Yes	Yes	PCP requested PVAMC neurosurgery consultation for evaluation of neck pain. Patient seen 10 weeks after initial request.
5	Yes	Yes	PCP requested SVAMC Spine Clinic consultation for low back pain. Patient seen 4 months and treatment begun 11 months after request.
6	Yes	Yes	PCP requested PVAMC neurosurgery consultation for chronic head, neck, and back pain. Patient seen eight weeks later and placed on wait list for surgery.
7	Yes	Yes	PCP requested orthopedic consultation for shoulder pain. Consultant requested MRI <sup>4</sup> and CT <sup>5</sup> before seeing the patient. Six weeks later patient seen by SVAMC consultant and VAPSHCS consultation requested. Consultation cancelled by VAPSHCS and patient received care at SVAMC eight weeks after initial request.

<sup>3</sup> Degeneration of the intervertebral disc of the spine.

<sup>4</sup> Magnetic Resonance, the use of nuclear magnetic resonance to produce images of the molecules that make up a substance, especially the soft tissue of the human body.

<sup>5</sup> Computerized Axial Tomography, an imaging method in which a cross-sectional image of the structures in a body plane is reconstructed by a computer program from the x-ray absorption of beams projected through the body in the image plane.

Patient	Delay in Care	Adverse Patient Outcome	Comments
8	Yes	No	Patient complained of chest pain from shrapnel from old injury. PCP requested SVAMC surgical consultation. Consultant declined to remove shrapnel because of location in chest. PCP requested VAPSHCS thoracic surgery consultation, but request cancelled by VAPSHCS because of long wait times.
9	No	No	PCP requested neurology consultation for patient with multiple sclerosis who is followed by non-VA provider. VA Neurologist requested non-VA MRI results. PCP unable to provide documentation and neurologist requested PCP to begin work-up. PCP cancelled the consultation request after testing revealed no abnormality.
10	No	No	PCP requested pulmonary consultation for evaluation of a lung mass. Consultant provided non-visit recommendations for a fee basis CT/PET Scan. <sup>6</sup> Lipoma <sup>7</sup> removed by SVAMC surgeon.
11	No	No	PCP requested VAPSHCS otolaryngology <sup>8</sup> consultation for evaluation of sinus symptoms. An appointment was scheduled, but the patient cancelled the appointment.
12	No	No	PCP requested SVAMC pulmonary consultation for management of asthma. Consultant provided non-visit recommendations to PCP on the day of consultation. PCP chose not to institute the recommendations.
13	No	No	PCP requested SVAMC pulmonary consultation for pulmonary function tests <sup>9</sup> . The tests were completed within 30 days.
14	No	No	Patient with laryngeal cancer was treated at two VA and multiple non-VA facilities. No definite delays in care were identified.
15	No	No	PCP requested SVAMC pulmonary consultation for pulmonary function tests. The tests were completed within 30 days.

<sup>6</sup> Positron emission tomography (PET), a nuclear medicine imaging method similar to computed tomography, except that the image shows the tissue concentration of a positron-emitting radioisotope.

<sup>7</sup> Lipoma, a benign tumor composed chiefly of fat cells.

<sup>8</sup> Otolaryngology, the branch of medicine dealing with disease of the ear, nose, and throat.

<sup>9</sup> Pulmonary function tests are a group of procedures that measure the function of the lungs, revealing problems in the way a patient breathes. The tests can determine the cause of shortness of breath and may help confirm lung diseases, such as asthma, bronchitis, or emphysema.



**Issue 2: Alleged cancellation of requests for consultations without communicating with the PCP or patient.**

We substantiated that there was poor communication between consultants and PCPs that resulted in requests for consultations being discontinued or cancelled. We found evidence of poor communication both in PCP and consultant documentation. Non-productive interactions between PCPs and consultants contributed to poor communication, which in turn had a negative impact on the consultation process.

PCPs did not telephone consultants or visit them in person to discuss their concerns or expectations. PCPs and consultants alike used consultation notes to express dissatisfaction with the consultation process, and leaders took no action to address persistent staff conflicts.

In the absence of a local policy on the use of service agreements and types of consultations available, PCPs made repeated requests for consultations for the same patient with the same condition. Consultants reported that some PCPs submitted requests before completing an appropriate initial assessment.

Communication between leadership and clinicians was identified as a problem. Changes to programs were made without consulting stakeholders. For example, the facility hired two hand surgeons with the goal of becoming the hand surgery referral facility for the VISN. This decision was made without the involvement of the Physical Medicine & Rehabilitation Department even though this decision would have a significant impact on this service. A second example of poor communication involves the development of an orthopedic consultation process that required PCPs to follow an ordering guideline before their patients could be evaluated by a SVAMC orthopedist. The algorithm involved a series of physical therapy sessions over a prescribed period of time regardless of the patient's diagnosis. This process was developed without the involvement of the orthopedic provider or the Physical Therapy department.

Local policy requires that the consultation process be tracked through to completion and monitored by the Clinical Executive Board. Although the facility had consultation completion data available, it was not consistently tracked and was not shared with the stakeholders (i.e., PCPs and consultants).

**Issue 3: Alleged inappropriate requests of PCPs to order tests for consultants.**

We did not substantiate this allegation. However, we noted opportunities for improvement such as the use of service agreements to define workflow processes and expedite efficient patient care.

VHA Directive<sup>10</sup> places the responsibility for meeting the health care needs of an assigned panel of patients with the PCP, either through their own scope of practice or by referral to specialty services.

Physicians, nurse practitioners, and physician assistants comprise the range of clinicians who provide comprehensive primary care to a panel of assigned patients.<sup>11</sup> We interviewed PCPs, including those working at the facility for over 10 years as well as PCPs who had been there less than 2 years, to discuss their role in the ordering of tests for their patients prior to sending them to consultants. We also interviewed consultants from four specialty services to discuss their expectation of what tests needed to be ordered, and by whom, prior to patients being referred for specialty care.

We found PCPs with varied levels of understanding and comfort regarding their responsibility when ordering, interpreting, and managing tests results. A PCP mentioned that his responsibility for coordinating care of his patient was to order the requested tests and then ensure the results were directed to the consultant, whereas another PCP stated that interpretation of test results was the responsibility of the clinician who ordered the test. The consultants we interviewed stated that they did not expect PCPs to interpret tests that they requested prior to consultations. For example, a PCP may be asked to order an EEG but was not expected to interpret the results or decide next clinical steps based on the test results. Rather, the expectation of the consultant was that those test results would be part of the pre-consultation work up.

A number of PCPs and consultants reported that they did not, nor were they requested to, order tests outside their current scope of practice or privileges. We reviewed EHRs and did not find any examples of tests ordered that were inappropriate or outside of the PCPs' scope of practice or privileges.

In order for the consultation process to be effective, relationships need to be established between sending and receiving services with well-defined workflow rules. VHA policy<sup>12</sup> sets an expectation for the use of service agreements to facilitate mutual understanding between services and better coordination of care. In order for consultation templates and service agreements to be well received and used in clinical practice, all affected parties need to be part of the development process and agree to the final product. Establishing in advance which clinical tests are needed by consultants to allow them to complete a request for consultation expedites patient care.

We found the organization had limited examples of consultation templates or service agreements. We were provided only one service agreement between primary care and a consultant service (cardiology). The relationship between primary care and cardiology was consistently reported to be very good. We found an example of ordering guidelines

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<sup>10</sup> VHA Directive 2006-031, *Primary Care Standards*, May 17, 2006.

<sup>11</sup> VHA Handbook 1101.2, *Primary Care Management Module (PCMM)*, April 21, 2009.

<sup>12</sup> VHA Directive 2006-031.

that some staff referred to as a service agreement. In direct opposition to the process for developing service agreements, these guidelines had been implemented without the input of the affected clinical services thereby resulting in confusion, dissatisfaction, and questionable use of available resources.

## Conclusions

We substantiated delays in care both within the facility as well as with the tertiary care centers. In the course of our review, we became aware of significant delays for PVAMC neurosurgery. We did not substantiate that the consultants were inappropriately cancelling or discontinuing requests for consultations, but we did identify several factors that contributed to a breakdown in the consultation process. Delays in care did result in the adverse patient outcomes of increased or unrelieved pain or an exacerbation of symptoms.

We substantiated that requests for consultation were cancelled and that communication was poor between consultants and PCPs. Contributing factors included an unclear local consultation policy, lack of service agreements, inadequate oversight of the consultation process by management, and an adversarial PCP/consultant relationship.

We did not substantiate that SVAMC consultants inappropriately asked PCPs to order tests. We found that the organization did not have systems in place, such as consultation templates or service agreements, that outlined expectations for pre-consultation testing.

## Recommendations

**Recommendation 1.** We recommended that the Medical Center Director ensure that there is a comprehensive consultation process in place and that staff are educated on the process.

**Recommendation 2.** We recommended that the Medical Center Director ensure that all requests for consultations be appropriately generated, tracked to completion, and that consultation completion data is shared with clinical staff.

**Recommendation 3.** We recommended that the Medical Center Director ensure that staff conflicts and communication issues are appropriately addressed and resolved.

## Comments

The VISN and Medical Center Directors concurred with our recommendation and provided acceptable action plans. (See Appendixes A and B, pages 10-13 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** August 23, 2012

**From:** Acting Network Director, VISN 20 (10N20)

**Subject:** **Healthcare Inspection – Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, WA**

**To:** Director, Management Review Service (VACO 10AR MRS)  
Director, Seattle Regional Office of Healthcare Inspections (54SE)

1. Thank you for the opportunity to provide comments on the Draft Report: Consultation Mismanagement and Care Delays, Spokane VA Medical Center.
2. Attached please find the facility comments to each of the recommendations from the review.
3. If you have additional questions or need further information, please contact Susan Gilbert, Survey Coordinator, VISN 20 at (360) 567-4678.

*(original signed by:)*  
Michael W. Fisher

## Facility Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** August 16, 2012

**From:** Director, Spokane VA Medical Center

**Subject:** **Healthcare Inspection – Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, WA**

**To:** Director, VA Northwest Network (10N20)

The following information is provided per your instructions.  
Questions can be referred to Dr. William Nelson, Spokane VAMC, Chief of Staff.

*(original signed by:)*  
Linda K. Reynolds, MA, FACHE  
Medical Center Director

## **Director's Comments to Office of Inspector General's Report**

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

### **OIG Recommendations**

**Recommendation 1. We recommended that the Medical Center Director ensure that there is a comprehensive consultation process in place and that staff are educated on the process.**

Concur

VHA Directive 2008-056, "Consult Policy," was reviewed with all clinical service chiefs including a discussion on the consult process. Most of the chiefs then discussed the consultation process with their staff. A task force comprised of all clinical service chiefs and their administrative officers was chartered on May 21, 2012, to review the consultation process and to make recommendations to improve the process. Planned actions:

- (1) Update the local policy to clarify the consultation process that includes the definition of each consult status. Target date: October 1, 2012.
- (2) Educate staff on the consultation process by December 1, 2012.
- (3) Develop service agreements and implement by December 1, 2012.

**Recommendation 2. We recommended that the Medical Center Director ensure that all requests for consultations be appropriately generated, tracked to completion, and that consultation completion data is shared with clinical staff.**

Concur

Implemented weekly review of outstanding consults. Planned actions:

- (1) Review disposition of all consults monthly at the Clinical Executive Council. Take corrective action to ensure proper completion. Implement in September 2012.
- (2) Provide service specific data to staff when corrections are needed. Implement in August 2012.

**Recommendation 3. We recommended that the Medical Center Director ensure that staff conflicts and communication issues are appropriately addressed and resolved.**

Concur

Expectations of appropriate communication were given in the Clinical Executive Council on January 4, 2012, March 7, 2012, and July 11, 2012 meetings. Actions planned:

Medical Records department monitors comments in the medical records and consults. When inappropriate or unprofessional documentation is discovered, staff will be counseled and corrective action taken when indicated. Implement in August 2012.



## OIG Contact and Staff Acknowledgments

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OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Gail Bozzelli, RN, Project Leader Sami O'Neill, MA, Team Leader Jerome E. Herbers Jr., MD, Physician Consultant Susan Tostenrude, MS Marc Lainhart, BS, Management and Program Analyst
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