



Report to the Chairman, Subcommittee
on Oversight & Investigations,
Committee on Veterans' Affairs, House
of Representatives

September 2014

VA HEALTH CARE

Management and
Oversight of Consult
Process Need
Improvement to Help
Ensure Veterans
Receive Timely
Outpatient Specialty
Care

GAO Highlights

Highlights of [GAO-14-808](#), a report to the Chairman, Subcommittee on Oversight & Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

There have been numerous reports of VAMCs failing to provide timely care to veterans, including specialty care. In some cases, delays have reportedly resulted in harm to patients. In 2012, VHA found that its consult data were not adequate to determine the extent to which veterans received timely outpatient specialty care. In May 2013, VHA launched an initiative to standardize aspects of the consult process at its 151 VAMCs and improve its ability to oversee consults.

GAO was asked to evaluate VHA's management of the consult process. This report evaluates (1) the extent to which VHA's consult process has ensured veterans' timely access to outpatient specialty care, and (2) how VHA oversees the consult process to ensure veterans are receiving outpatient specialty care in accordance with its timeliness guidelines. GAO reviewed documents and interviewed officials from VHA and from five VAMCs that varied based on size and location. GAO also reviewed a non-generalizable sample of 150 consults requested across the five VAMCs.

What GAO Recommends

GAO recommends that VHA take actions to improve its oversight of consults, including (1) routinely assess VAMCs' local consult processes, (2) require VAMCs to document rationales for closing unresolved consults, (3) develop a formal process for VAMCs to share consult management best practices, and (4) develop a policy for managing patient no-shows and cancelled appointments. VA concurred with all of GAO's recommendations and identified actions it is taking to implement them.

View [GAO-14-808](#). For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

September 2014

VA HEALTH CARE

Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care

What GAO Found

Based on its review of a non-generalizable sample of 150 consults requested from April 2013 through September 2013, GAO found that the Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) management of the consult process has not ensured that veterans always receive outpatient specialty care in a timely manner, if at all. Specifically, GAO found that for 122 of the 150 consults reviewed—requests for evaluation or management of a patient for a specific clinical concern—specialty care providers did not provide veterans with the requested care in accordance with VHA's 90-day timeliness guideline. For example, for 4 of the 10 physical therapy consults GAO reviewed for one VA medical center (VAMC), between 108 and 152 days elapsed with no apparent actions taken to schedule an appointment for the veteran. VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments among the factors that lead to delays and hinder their ability to meet VHA's timeliness guideline. Further, for all but 1 of the 28 consults for which VAMCs provided care within 90 days, an extended amount of time elapsed before specialty care providers properly documented in the consult system that the care was provided. As a result, the consults remained open in the system, making them appear as though the requested care was not provided within 90 days.

VHA's limited oversight of consults impedes its ability to ensure VAMCs provide timely access to specialty care. VHA officials reported overseeing the consult process primarily by reviewing data on the timeliness of consults; however, GAO found limitations in VHA's oversight, including oversight of its initiative designed to standardize aspects of the consult process. Specifically:

- VHA does not routinely assess how VAMCs are managing their local consult processes, and thus is limited in its ability to identify systemic underlying causes of delays.
- As part of its consult initiative, VHA required VAMCs to review a backlog of thousands of unresolved consults—those open more than 90 days—and if warranted to close them. However, VHA did not require VAMCs to document their rationales for closing them. As a result, questions remain about whether VAMCs appropriately closed these consults and if VHA's consult data accurately reflect whether veterans received the care needed in a timely manner, if at all.
- VHA does not have a formal process by which VAMCs can share best practices for managing consults. As a result, VAMCs may not be benefitting from the challenges and solutions other VAMCs have discovered regarding managing the consult process.
- VHA lacks a detailed system-wide policy for how VAMCs should manage patient no-shows and cancelled appointments for outpatient specialty care, making it difficult to compare timeliness in providing this care system-wide.

Consequently, concerns remain about the reliability of VHA's consult data, as well as VHA's oversight of the consult process.

Contents

Letter		1
	Background	6
	VHA's Consult Process Has Not Ensured Veterans Always Receive Outpatient Specialty Care in a Timely Manner, or at All	11
	VHA's Limited Oversight of Consults Impedes Its Ability to Ensure VAMCs Provide Timely Access to Specialty Care	16
	Conclusions	22
	Recommendations for Executive Action	23
	Agency Comments	24
Appendix I	Examples of Gastroenterology Consult Request Templates	25
Appendix II	Comments from the Department of Veterans Affairs	27
Appendix III	GAO Contact and Staff Acknowledgments	31
Tables		
	Table 1: Timeliness of Initial VA Medical Center (VAMC) Specialty Care Consult Reviews	12
	Table 2: Timeliness of Care Provided by VA Medical Centers (VAMC) to Veterans for Specialty Care Consults	12
	Table 3: VA Medical Center (VAMC) Strategies for Managing Future Care Consults	19
Figures		
	Figure 1: Veterans Health Administration's (VHA) Outpatient Consult Process	7
	Figure 2: Example of a Gastroenterology Consult Request Template for Abdominal Pain	8
	Figure 3: Example of a Gastroenterology Consult Request Template for Chronic Diarrhea	25
	Figure 4: Example of a Gastroenterology Consult Request Template for a Liver Condition	26

Abbreviations

VA	Department of Veterans Affairs
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture

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September 30, 2014

The Honorable Mike Coffman
Chairman
Subcommittee on Oversight & Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates one of the nation's largest health care systems. Its medical facilities include 151 VA medical centers (VAMC), which, in addition to providing inpatient care, also provide outpatient care through primary and specialty care clinics.¹ In recent years, VHA has faced a growing demand for providing outpatient medical appointments. From fiscal years 2005 through 2013, the number of annual outpatient medical appointments VHA provided through its medical facilities increased by approximately 50 percent, from 58 million to 86 million.²

Access to timely medical appointments is critical to ensuring that veterans obtain needed medical care, and problems with VHA's scheduling and management of outpatient medical appointments may contribute to delays in care, or care not being provided at all. Over the past few years, there have been numerous reports of VAMCs failing to provide timely care, including specialty care, and in some cases, the delays reportedly have resulted in harm to veterans.³ In December 2012, we reported that

¹Outpatient primary and specialty care clinics offer services to patients that do not require a hospital stay. VAMCs' primary care clinics address patients' routine health needs, while its specialty care clinics are focused on a specific specialty service such as cardiology.

²In addition, the number of patients VHA served increased from fiscal years 2005 to 2013 by approximately 22 percent, from 5.3 million to 6.5 million.

³See, for example, Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Gastroenterology Consult Delays, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina*, Report No. 12-04631-313. (Washington, D.C.: Sept. 6, 2013); and Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, Washington*, Report No. 12-01731-284. (Washington, D.C.: Sept. 25, 2012).

VHA's medical appointment wait times were unreliable and VHA's inadequate oversight of the outpatient medical appointment scheduling processes contributed to VHA's problems with scheduling timely medical appointments.⁴ More recently, a report by VA's Office of Inspector General,⁵ as well as congressional hearings on VHA's delivery of medical care, have focused on delays in care and improper scheduling practices resulting in lengthy wait times at VHA facilities. Furthermore, a recent VA system-wide audit to identify the scope and magnitude of these issues confirmed questionable scheduling practices and other problems at many VHA facilities, and identified strategies, such as expanding outpatient clinic hours, VHA needed to implement to address immediate health care access issues for veterans.⁶

The problems identified in these reports include issues regarding VHA's management of consults for outpatient specialty care. When a physician or other provider determines that a veteran needs outpatient specialty care, the provider refers the veteran to a specialty care provider for an outpatient consult—a request for evaluation or management of a patient for a specific clinical concern, or for a specialty procedure such as a colonoscopy. VAMCs request, review, and manage consults using VHA's clinical consult process and electronic consult system, which retains information about each consult request and is part of VHA's Veterans Health Information Systems and Technology Architecture (VistA).⁷ One of VHA's timeliness guidelines is that consults should generally be

⁴GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, [GAO-13-130](#) (Washington, D.C.: Dec. 21, 2012).

⁵Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration Interim Report, Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System*, Report No. 14-02603-178. (Washington, D.C.: May 28, 2014).

⁶Department of Veterans Affairs, *Access Audit, System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014*.

⁷VistA is the single, integrated health information system used throughout VHA in all of its health care settings. It contains patients' electronic health records.

completed—care provided and documented in the consult system—within 90 days of being requested.⁸

Ideally, the consult system would contain timely and reliable information on the status and outcomes of consults, and would provide VHA information it needs to help VAMCs effectively manage the process. In 2012, however, VHA found that these system-wide consult data were not adequate to determine the extent to which veterans received timely outpatient specialty care. Specifically, VHA found at the time, approximately 2 million consults in its system were “unresolved” for more than 90 days—that is, for those consults, care had not been provided, care had been provided but not documented, or it had yet to be determined if care was still needed.⁹ Additionally, VHA determined that its consult data were inadequate to identify whether care had been provided in a timely manner or at all. In response, in May 2013, VHA launched the Consult Management Business Rules Initiative (referred to in this report as the “consult business rules initiative”) to standardize aspects of the consult process, with the goal of developing consistent and reliable consult data across all 151 VAMCs.

In light of the findings and conclusions raised in recent reports, including our December 2012 report on outpatient medical appointment wait times, you asked us to evaluate VHA’s management of the consult process. This report evaluates (1) the extent to which VHA’s consult process has ensured veterans’ timely access to outpatient specialty care, and (2) how VHA oversees the consult process to ensure veterans are receiving outpatient specialty care in accordance with its timeliness guidelines.

To determine the extent to which VHA’s consult process has ensured veterans’ timely access to outpatient specialty care, we reviewed documents and interviewed VHA central office officials about VHA’s

⁸According to the guideline, VAMCs are expected to complete consults within 90 days, but VHA officials told us that consults for urgent needs should be completed sooner, while other consults may be completed beyond 90 days when clinically appropriate. Also, according to VHA guidelines, the specialty care provider is expected to review and determine whether to accept a consult within 7 days of the request.

⁹Consults may be resolved in VHA’s electronic system by either providing the requested care and completing the consult in the electronic system, or by determining the consult is no longer needed (e.g., care is not needed, the patient refuses care, or the patient is deceased) and closing the consult in the electronic system.

policies and guidance for VAMCs to send, receive, and complete outpatient consults.¹⁰ We also reviewed VHA's policies for scheduling outpatient specialty care medical appointments, including VHA's timeliness guidelines for managing consults. As part of our review, we interviewed officials from five VAMCs selected for variation in volume of outpatient consults, complexity,¹¹ and location. These five VAMCs were located in Augusta, Maine; Denver, Colorado; Gainesville, Florida; Oklahoma City, Oklahoma; and Palo Alto, California. At each VAMC, we interviewed leadership, specialty care service chiefs, administrative staff, and providers from three high-volume, specialty care services—cardiology, gastroenterology, and physical therapy—regarding how they implemented the consult process at their respective VAMCs. Although VHA found that its consult data could not be used to determine the timeliness of outpatient specialty care system-wide, through interviews with VHA officials knowledgeable about the data, we determined that the data were sufficiently reliable for our use in selecting individual VAMCs and specialties to include in our review. We also obtained and reviewed any local policies or procedures governing the consult process.

Additionally, for each of the five VAMCs, we obtained data on outpatient consults that were requested by providers for the three specialties included in our review during the period April 1, 2013, through September 30, 2013. From these data, we identified those consults that took more than 90 days to complete or had been in process for more than 90 days at the time of our review, and selected a random sample of 150 outpatient consults, 30 from each VAMC included in our review (10 from each of the three specialties). We selected our sample of consults from those open for more than 90 days to identify factors that affected VAMCs' ability to meet VHA's timeliness guideline for consults to be completed within 90 days. For each of the 150 consults, we examined veterans' medical records to determine the history of actions taken on each of the outpatient consults included in our sample. From the consults data VHA originally provided, we asked VHA to identify those that were requested for veterans who were deceased as of March 2014. We then selected a

¹⁰Although VHA uses consults for both inpatient and outpatient specialty care, the scope of our review was limited to outpatient consults.

¹¹VHA categorizes VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity.

separate random sample of 50 of these consults (10 from each VAMC included in our review) to determine if veterans experienced any delays in care, and to identify the reported causes of their deaths. For all 200 of the consults we examined, we reviewed key data elements from the patients' medical records—such as dates the consults were requested, and dates they were completed, if applicable. Due to the small sample size and focus on consults open for more than 90 days, the results from our examination cannot be generalized to all consults at the VAMCs in our review, or to other VAMCs.

To determine how VHA oversees the consult process to ensure veterans are receiving outpatient specialty care in accordance with its timeliness guidelines, we reviewed documents and interviewed VHA central office officials about their efforts to oversee implementation of VHA's consult policies system-wide. We focused our review on VHA's oversight of the consult business rules initiative, as this initiative was specifically intended to help improve VHA's ability to oversee the consult process. We also interviewed officials at each of the five VAMCs we selected to identify the processes and mechanisms they have used to oversee consults at their facilities, and the extent to which they have implemented the tasks outlined in the consult business rules initiative. Further, we interviewed officials from each of the five Veterans Integrated Service Networks (VISN)¹² responsible for overseeing the VAMCs included in our review about the processes they have used to oversee consults and VAMCs' implementation of the consult business rules initiative. Finally, we assessed VHA's efforts to oversee consults within the context of federal internal control standards.¹³

We conducted this performance audit from July 2013 to September 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

¹²VHA's health care system is divided into 21 health care networks, referred to as VISNs, which serve as the basic budgetary and decision-making units for providing health care services to veterans within a given geographical area.

¹³GAO, *Internal Control: Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

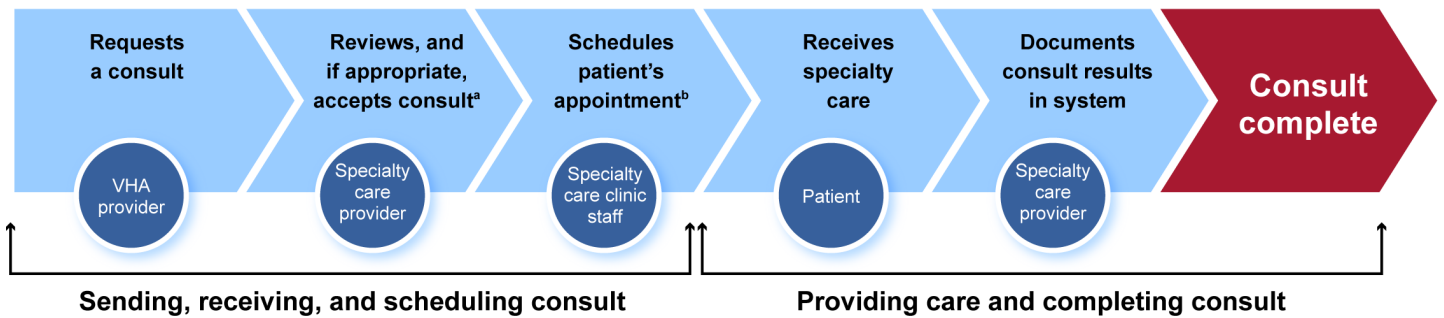
VHA's outpatient consult process is governed by a national policy¹⁴ that outlines the use of an electronic system for requesting and managing consults and delineates oversight responsibilities at the national, VISN, and VAMC level.

Outpatient Consult Process

Outpatient consults include requests by physicians or other providers for both clinical consultations and procedures. A clinical consultation is a request seeking an opinion, advice, or expertise regarding evaluation or management of a patient's specific clinical concern, whereas a procedure request is for a specialty care procedure, such as a colonoscopy. The consult process—displayed in figure 1—is governed by VHA's national consult policy, which requires VAMCs to manage consults using a national electronic consult system, and to provide timely and appropriate care to veterans.

¹⁴Department of Veterans Affairs, Veterans Health Administration, *VHA Consult Policy*, VHA Directive 2008-056, (Washington, D.C.: Sept. 16, 2008).

Figure 1: Veterans Health Administration's (VHA) Outpatient Consult Process



Source: GAO analysis of VHA documents. | GAO-14-808

Note: According to VHA's consult policy, each step of the consult process is to be documented in the electronic consult system.

^aIf the specialty care clinic does not accept the consult, the consult is either closed or sent back to the requesting provider to obtain additional information for resubmission.

^bSome consults, referred to as "e-consults," do not require in-person appointments with patients; and instead may be addressed electronically through the consult system. In these cases, an appointment would not be scheduled; instead, the specialty care clinic would review the information submitted in the patient's medical record by the requesting provider and document recommendations in the consult system.

Outpatient consults typically are requested by a veteran's primary care provider using VHA's electronic consult system. To send a consult request, providers log on to the system and complete an electronic consult request template that may be customized by the VAMC's applicable specialty care clinic. The template requires the requesting provider to provide specific information, such as a diagnosis and a reason why the specialty care is needed, and may require additional information as determined by the specialty care clinic.¹⁵ For example, a gastroenterology template for abdominal pain used at one VAMC asked the requesting provider whether the treatment should be provided in person, reminded the provider about specific lab tests to be completed, and asked the provider to provide a brief history of the patient's symptoms. (See fig. 2.) This specialty care clinic had specific templates depending on the patient's symptoms. (See appendix I for examples of other templates used by the gastroenterology clinic at this VAMC.) After completing the template, the requesting provider electronically submits the consult for the specialty care provider to review.

¹⁵According to VA, information can automatically be pulled into consult request templates, and thus providers do not always have to input information.

Figure 2: Example of a Gastroenterology Consult Request Template for Abdominal Pain

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GI Clinic consult for Abdominal Pain.

Please select Preferred method of consult completion:
*
 Phone consult: For urgent questions
 E-consult: Peer-to-peer consult
 SCAN: Present this patient to one or more specialists for help with management
 Face-to-face visit: Traditional in person visit

Symptom-appropriate imaging and labs should be ordered prior to referral.
Here are some hints for symptom appropriate images.....

If you suspect:                Then order this imaging study:
-----
Gall Bladder Dx/Stones.....Abdominal Ultra sound
Biliary Colic.....CT of the Abdomen
Pancreatitis.....CT with Pancreatic Protocol
Small Bowel Obstruction.....Small Bowel Follow Through

Appropriate imaging and labs completed? *  Yes  No
* If "No," then please order the appropriate images from the menu that
follows the consult.
* If "Yes," then please ignore the menu that follows the consult.

Brief History: *


NO VAMC IMAGING PROCEDURES WITHIN LAST YEAR

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Source: One of the VA medical centers in our review. | GAO-14-808

According to VHA’s guideline, the specialty care provider is to review and determine whether to accept a consult within 7 days of the request. Typically, the provider’s review involves determining whether to accept the consult—that the consult is needed and appropriate—and if the consult is accepted, determining its relative urgency—a process known as triaging. When reviewing a consult request, a specialty care provider may decide not to accept it, and will send the consult back to the requesting provider. This is referred to as discontinuing the consult, which a specialty care provider may decide to do for several reasons, including that the care is not needed, the patient refuses care, or the patient is deceased.¹⁶ In other cases the specialty care provider may determine that additional information is needed before accepting the consult; in such cases, the specialty care provider will send the consult back to the requesting provider, who can resubmit it with the needed information.

¹⁶When a provider discontinues a consult, action on the consult is stopped, and a new consult request must be initiated by the requesting provider for the veteran to obtain the specialty care.

If the provider accepts the consult, an attempt is made to contact the patient and schedule an appointment.¹⁷ Appointments resulting from outpatient consults, like other outpatient medical appointments, are subject to VHA's scheduling policy.¹⁸ This policy is designed to help VAMCs meet their commitment of scheduling medical appointments with no undue waits or delays for patients. According to VHA officials, the scheduler is to take into account the relative urgency of the consult, that is, the result of the reviewing specialty provider's triage decision, when attempting to schedule the appointment.

If an appointment resulting from a consult is scheduled and held, VHA's policy requires the specialty care provider to appropriately document the results in the consult system, which would then close out the consult as completed. To do so, the provider updates the consult with the results of the appointment by entering a clinical progress note in the consult system. If the provider does not perform this step, or does not perform it appropriately, the consult remains open in the consult system. If an appointment is not held, specialty care clinic staff members are to document why they were unable to complete the consult.

VHA National Consult Policy and Initiative to Improve Consult Data

According to VHA's national consult policy, VHA central office officials have overall oversight responsibility for the consult process, including the measurement and monitoring of ongoing performance. The policy also requires VISN leadership to oversee the consult processes for VAMCs in their networks, and requires each VAMC to manage individual consults consistent with VHA's timeliness guidelines.

To evaluate the timeliness of resolving consults across VAMCs, in September 2012, VHA created a national consult database from the information contained in its electronic consult system. After reviewing these data, VHA determined that they were inadequate for monitoring consults, because they had not been entered in the consult system in a consistent, standard manner, among other issues. For example, in

¹⁷Some consults, referred to as "e-consults," do not require an in-person appointment with the patient and instead may be addressed by the specialty care provider electronically through the consult system.

¹⁸VHA medical appointment scheduling policy is documented in Department of Veterans Affairs, Veterans Health Administration, *VHA Outpatient Scheduling Processes and Procedures*, VHA Directive 2010-027, (Washington, D.C.: June 9, 2010).

addition to requesting consults for clinical concerns, VHA found that VAMCs also were using the consult system to request and manage a variety of administrative tasks, such as arranging patient travel to appointments. Additionally, VHA could not accurately determine whether patients actually received the care they needed, or if they received the care in a timely fashion. VHA found that this was due, in part, to the fact that data in the consult system included consults for both care that was clinically appropriate to be open for more than 90 days—known as future care consults¹⁹—as well as those for care that was needed within 90 days. At the time of the database’s creation, according to VHA officials, approximately 2 million consults (both clinical and administrative) were unresolved for more than 90 days.

Subsequently, in October 2012, a task force convened by VA’s Under Secretary for Health began addressing several issues, including those regarding VHA’s consult system. In response to the task force recommendations, in May 2013, VHA launched the consult business rules initiative to standardize aspects of the consult process and develop consistent and reliable information on consults across all VAMCs. For example, the consult business rules initiative required that VAMCs limit their use of the consult system to requesting consults for care expected within 90 days, and distinguish between administrative and clinical consults in the consult system. As part of this initiative, VAMCs were required to complete four tasks between July 1, 2013, and May 1, 2014:

- Review and properly assign codes to consistently record consult requests in the consult system.
- Assign distinct identifiers in the electronic consult system to differentiate between clinical and administrative consults.
- Develop and implement strategies for managing requests for future care consults that are not needed within 90 days.
- Conduct a clinical review, as warranted, to determine if care has been provided or is still needed for unresolved consults—those open more than 90 days.

¹⁹According to VHA officials, it is clinically appropriate to request future care consults for certain types of care that will not be needed for more than 90 days, such as a routine, follow-up colonoscopy.

After the initial implementation of these tasks, VHA required VAMCs to maintain adherence to the consult business rules initiative when processing consults. VHA was updating its national consult policy to incorporate aspects of the consult business rules initiative and expected to have a draft policy by September 2014.

VHA's Consult Process Has Not Ensured Veterans Always Receive Outpatient Specialty Care in a Timely Manner, or at All

Our review of a sample of consults at five VAMCs found that veterans did not always receive outpatient specialty care in a timely manner, if at all. We found consults that were not processed in accordance with VHA timeliness guidelines—for example, consults that were not reviewed within 7 days or not completed within 90 days. We also found consults for which veterans did not receive the outpatient specialty care requested—64 of the 150 consults in our sample (43 percent)²⁰—and those for which the requested specialty care was provided, but the consults were not properly closed in the consult system.

We found that specialty care providers at the five VAMCs we examined were not always able to make their initial consult reviews within VHA's 7-day guideline. Specifically, we found that for 31 of the 150 consults in our sample (21 percent), specialty care providers did not meet the 7-day guideline, but they were able to meet the guideline for 119 of the consults (79 percent). (See table 1.) For one VAMC, nearly half the consults were not reviewed and triaged within 7 days, and for some consults, we found it took several weeks before the specialty care providers took action. Officials at this VAMC cited a shortage of providers needed to review and triage the consults in a timely manner.

²⁰In these cases, the veterans did not receive care related to the specific consults in our review, but may have received the care requested under a separate consult at a later date.

Table 1: Timeliness of Initial VA Medical Center (VAMC) Specialty Care Consult Reviews

VAMC	Total consults in sample	Number for which specialty care providers did not review within 7 days (percentage of total)	Number for which specialty care providers reviewed within 7 days (percentage of total)
A	30	3 (10%)	27 (90%)
B	30	4 (13)	26 (87)
C	30	6 (20)	24 (80)
D	30	14 (47)	16 (53)
E	30	4 (13)	26 (87)
Total	150	31 (21%)	119 (79%)

Source: Sample of patient medical records from the five VAMCs in our review. | GAO-14-808

Note: The Veterans Health Administration's guideline is for specialty care providers to review and determine whether to accept a consult within 7 days.

We also found that for the majority of the 150 consults in our sample, veterans did not receive care within 90 days of the date the consult was requested, in accordance with VHA's guideline. Specifically, veterans did not receive care within 90 days for 122 of the 150 consults we examined (81 percent). (See table 2.)

Table 2: Timeliness of Care Provided by VA Medical Centers (VAMC) to Veterans for Specialty Care Consults

VAMC	Total consults in sample	Number of consults for which veterans did not receive care within 90 days (percentage of total)	Number of consults for which veterans received care within 90 days (percentage of total)
A	30	26 (87%)	4 (13%)
B	30	27 (90)	3 (10)
C	30	17 (57)	13 (43)
D	30	24 (80)	6 (20)
E	30	28 (93)	2 (7)
Total	150	122 (81%)	28 (19%)

Source: Sample of patient medical records from the five VAMCs in our review. | GAO-14-808

Note: According to the Veterans Health Administration's (VHA) timeliness guideline, VAMCs are expected to complete consults within 90 days of being requested. However, consults for urgent needs should be completed sooner, while other consults may be completed beyond 90 days when clinically appropriate, according to VHA officials.

We also found that for the 28 consults in our sample for which VAMCs provided care to veterans within 90 days, an extended amount of time elapsed before specialty care providers completed all but 1 of them in the consult system. As a result, the consults remained open in the system, making them appear as though the requested care was not provided within 90 days. Although 1 consult remained open for only 8 days from when the care was provided, for the remaining 27 consults, it took between 29 and 149 days from the time care was provided until the consults were completed in the system. In addition, of the 28 consults, we found that specialty care providers at one VAMC did not properly document the results of all 10 cardiology consults we reviewed, in order to close them in the system.

Officials from four of the five VAMCs told us that specialty care providers often do not properly document that consults are complete, which requires the selection of the correct clinical progress note that corresponds to the patient's consult. Officials attributed this ongoing issue in part to the use of medical residents who rotate in and out of specialty care clinics after a few months, and lack experience with completing consults. Officials from one VAMC told us such rotations require VAMC leadership to ensure new residents are continually trained on how to properly complete consults. To help ensure that specialty care providers consistently choose the correct clinical progress note, this VAMC activated a technical solution consisting of a prompt in its consult system that instructs providers to choose the correct clinical progress note needed to complete consults. Officials stated that this has resulted in providers more frequently choosing the correct notes needed to complete consults.

Examples of consults that were not completed in 90 days, or were closed without the veterans being seen, included:

- For 3 of 10 gastroenterology consults we examined for one VAMC, we found that between 140 and 210 days elapsed from the dates the consults were requested to when the veterans received care. For the consult that took 210 days, an appointment was not available and the veteran was placed on a waiting list before having a screening colonoscopy.
- For 4 of the 10 physical therapy consults we examined for one VAMC, we found that between 108 and 152 days elapsed, with no apparent actions taken to schedule appointments for the veterans for whom consults were requested. The veterans' medical records indicated that

due to resource constraints, the clinic was not accepting consults for non-service-connected physical therapy evaluations.²¹ For 1 of these consults, several months passed before the veteran was referred to non-VA care, and was seen 252 days after the initial consult request. The other 3 consults were sent back to the requesting providers without the veterans receiving care.

- For all 10 of the cardiology consults we examined for one VAMC, we found that staff initially scheduled veterans for appointments between 33 and 90 days after the request, but medical records for those patients indicated that the veterans either cancelled or did not show for their initial appointments. In several instances, medical records indicated the veterans cancelled multiple times. For 4 of the consults, VAMC staff closed the consults without the veterans being seen; for the other 6 consults, VAMC staff rescheduled the appointments for times that exceeded VHA's 90-day guideline.²²

VAMC officials cited increased demand for services, patient no-shows, and cancelled appointments, among the factors that hinder specialty care providers' ability to meet VHA's guideline for completing consults within 90 days. Several VAMC officials also noted a growing demand for both gastroenterology procedures, such as colonoscopies, as well as consultations for physical therapy evaluations, combined with a difficulty in hiring and retaining specialty care providers for these two clinical areas, as causes of periodic backlogs in providing these services. Officials at these VAMCs indicated that they try to mitigate backlogs by referring veterans to non-VA providers for care.

Although officials indicated that use of non-VA care can help mitigate backlogs, several officials also indicated that this requires more coordination between the VAMC, the patient, and the non-VA provider; can require additional approvals for the care; and also may increase the

²¹A non-service-connected disability is an injury or illness that was not incurred or aggravated during active military service. According to VHA's medical appointment scheduling policy (VHA Directive 2010-027), VHA is mandated to provide priority, non-emergent care for veterans with certain service-connected disabilities and certain service-connected conditions.

²²As we previously reported, scheduling practices at some VAMCs could result in miscommunication with veterans, which causes or contributes to them missing medical appointments. In addition, outdated or incorrect veteran contact information may also affect patient no-shows and cancelled appointments. See [GAO-13-130](#).

amount of time it takes a VAMC specialty care provider to obtain the results (such as diagnoses, clinical findings and treatment plans) of medical appointments or procedures. Officials acknowledged that using non-VA care does not always prevent delays in veterans receiving timely care or in specialty care providers completing consults.²³

Additionally, we identified one consult for which the patient experienced delays in obtaining non-VA care and died prior to obtaining needed care. In this case, the patient needed endovascular surgery to repair two aneurysms—an abdominal aortic aneurysm and an iliac aneurysm. According to the patient's medical record, the timeline of events surrounding this consult was:

- September 2013 – Patient was diagnosed with two aneurysms.
- October 2013 – VAMC scheduled patient for surgery in November, but subsequently cancelled the scheduled surgery due to staffing issues.²⁴
- December 2013 – VAMC approved non-VA care and referred the patient to a local hospital for surgery.
- Late December 2013 – After the patient followed up with the specialty care clinic, it was discovered that the non-VA provider lost the patient's information. The specialty care clinic staff resubmitted the patient's information to the non-VA provider.
- February 2014 – The consult was closed because the patient died prior to the surgery scheduled by the non-VA provider.²⁵

According to VAMC officials, they conducted an investigation of this case. They found that the non-VA provider planned to perform the surgery on February 14, 2014, but the patient died the previous day. Additionally, they stated that according to the coroner, the patient died of cardiac disease and hypertension, and that the aneurysms remained intact.

²³We have previously reported on VA's use of non-VA providers for care. See GAO, *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement*, [GAO-13-441](#) (Washington, D.C.: May 31, 2013).

²⁴Officials indicated that, in October 2013, the VAMC temporarily suspended the endovascular surgeon that conducts these surgeries.

²⁵We have referred this case to VA's Office of Inspector General for further review.

VHA's Limited Oversight of Consults Impedes Its Ability to Ensure VAMCs Provide Timely Access to Specialty Care

Since launching the consult business rules initiative in May 2013, VHA officials reported overseeing the consult process system-wide primarily by reviewing consult reports created from its national database to monitor VAMCs' progress in meeting VHA's timeliness guidelines. However, we found limitations in VHA's system-wide oversight, as well as in the oversight provided by the five VISNs included in our review. These limitations have affected the reliability of VHA's consult data and consequently VHA's ability to effectively assess VAMC performance in managing consults.

VHA and VISNs do not routinely assess VAMCs' management of consults. Although VHA officials reported using system-wide consult data to help ensure that VAMCs are meeting VHA timeliness guidelines, and the five VISNs included in our review reported using consult data to monitor VAMCs they oversee, neither routinely assesses how VAMCs are actually managing consults. According to federal internal control standards, managers should perform ongoing monitoring, including independent assessments of performance.²⁶ Such assessments are important to help VHA identify the underlying causes of delays and to help ensure that its consult data reliably reflects the number of, and length of time, veterans are waiting for care. VHA and VISN officials reported that they do not routinely audit consults to assess whether VAMC providers have been appropriately requesting, reviewing, and resolving consults in accordance with VHA's consult policy. Instead, VHA and VISN officials reported their oversight primarily relies on monitoring reports that track VAMCs' progress in reducing the number of consults unresolved for more than 90 days. VHA officials stated that they delegate oversight of unresolved consults to VAMCs and as such, do not conduct assessments of individual consults. Further, several VISN officials stated that they did not see the need for such assessments and that ongoing monitoring of consult data has been sufficient.

Although VHA and the five VISNs included in our review do not routinely conduct such assessments, our work at five VAMCs found such reviews may help provide insights into the underlying causes of delays. Our examination of a sample of consults revealed several issues with VAMCs' specialty care clinics' management of consults, including delays in reviewing and scheduling consults, incorrectly discontinuing consults, and

²⁶See [GAO/AIMD-00-21.3.1](#).

in some cases incorrectly closing a consult as complete even though care had not been provided. We discussed these issues with officials at the five VAMCs included in our review. Officials from two VAMCs stated that in responding to our questions, they researched the actions taken on each consult and learned about some of the root causes contributing to consult delays. For example, one VAMC found that its process for managing consults requested from other VAMCs was not clear to providers and needed to be improved to mitigate delays in processing such consults. Additionally, for a few of the consults for which we identified that care had not been provided, VAMC officials stated that, as a result of our findings, they contacted the veterans to schedule appointments when care was still needed. In addition, VHA officials stated that independent assessments of consults may be helpful and that they would consider conducting them in the future. By primarily relying on reviewing data and not routinely conducting an assessment of VAMCs' management of consults, VHA and VISN officials may be limited in identifying systemic issues affecting VAMCs' ability to provide veterans with timely access to care.

VHA lacks documentation of how VAMCs addressed unresolved consults. One task under the consult business rules initiative required VAMCs to resolve consults that had been open for more than 90 days. VHA provided system-wide guidance outlining how to appropriately complete this task. VAMCs were to conduct clinical reviews of all non-administrative consults and determine whether the consult should be completed or discontinued—thus closing them in the consult system. However, VHA did not require VAMCs to document these decisions or the processes by which they were made, only to self-certify the task had been completed. Further, VHA did not require VISNs to independently verify that the task was completed appropriately. VAMC officials told us their reviews indicated that for many of the consults, care had been provided, but an incorrect clinical progress note was used. Therefore, officials had to select the correct note that corresponded to each consult, which completed the consult in the system. In addition, officials also told us that they discontinued many other consults because they found that patients were deceased or that patients had repeatedly cancelled appointments and thus, they determined that care was no longer needed. However, none of the five VAMCs in our review were able to provide us with specific documentation of these decisions and rationales. At one VAMC, for example, we found that a specialty care clinic discontinued 18 consults the same day that a task for addressing unresolved consults was due. Three of these 18 consults were part of our random sample, and we found no indication that a clinical review was conducted prior to the

consults being discontinued. The lack of documentation is not consistent with federal internal control standards, which indicate that all transactions and other significant events need to be clearly documented and stress the importance of the creation and maintenance of related records, which provide evidence of execution of these activities.²⁷

In addition to monitoring VAMC performance in completing the consult business rules initiative tasks, VHA officials told us they are continuing to monitor VAMCs' performance in addressing unresolved consults. In 2012, VHA estimated that approximately 2 million consults in its system were unresolved for more than 90 days. According to a VHA June 2014 consult tracking report, 285,877 consults were unresolved.²⁸ VHA officials attributed this reduction in the number of unresolved consults to implementation of the consult business rules initiative and their continued monitoring of VAMC performance in meeting VHA's consult timeliness guideline. Given the thousands of consults that have been closed by VAMCs, the lack of documentation and independent verification of how VAMCs addressed these unresolved consults raises questions about the reliability of VHA consult data and whether the data accurately reflects whether patients received the care needed in a timely manner, if at all.

VHA has not independently verified VAMCs' strategies for managing future care consults. Another task under the consult business rules initiative required VAMCs to develop and implement strategies for managing future care consults—those that are not needed within 90 days.²⁹ Similar to the other tasks, VHA relied on self-certification with no independent verification that this task was completed. VHA approved specific strategies for VAMCs to use to manage future care consults—namely that they could develop markers to identify them in the consult system, or use existing mechanisms outside of the consult system such as electronic wait lists. Although each VAMC in our review self-certified

²⁷See [GAO/AIMD-00-21.3.1](#).

²⁸VHA officials told us that this number changes daily and expects it to continue to decline as VAMCs continue to resolve consults open more than 90 days.

²⁹VAMCs were instructed to track future care consults either by developing markers so such consults could be identified in the consult system, or by using existing mechanisms outside of the consult system such as an electronic wait list. The electronic wait list is a component of the VistA scheduling system designed for recording, tracking, and reporting veterans waiting for medical appointments.

completing this task, we found that each of the five VAMCs initially implemented strategies for managing future care consults that were, wholly or in part, non-approved VHA options. For example, one VAMC reported to us that initially its staff entered consult requests for future care into the consult system without the use of a future care flag, and subsequently discontinued these consults if they reached the 90-day threshold. Discontinuing future care consults closed them in the consult system, and thus prevented the consults from being monitored, which may have increased the risk of the VAMC losing track of these requests for specialty care. Further, during the course of our work, officials from three VAMCs reported revising their initial strategies for managing future care consults. (See table 3.) Some of these VAMCs continued to implement strategies that were non-approved VHA options and could have resulted in consult data that failed to distinguish future care consults from those that were truly delayed.

Table 3: VA Medical Center (VAMC) Strategies for Managing Future Care Consults

VAMC	Initial VAMC strategies ^a			Updated VAMC strategies ^a		
	Approved strategy		Non-approved strategy	Approved strategy		Non-approved strategy
	Implement future care flags in consult system	Use existing mechanism outside of consult system	Enter consults in consult system without future care flags	Implement future care flags in consult system	Use existing mechanism outside of consult system	Enter consults in consult system without future care flags
A			X		X	
B			X			X
C	X		X ^b	X		X ^b
D			X		X	
E		X	X	X		

Source: Five VAMCs in our review. | GAO-14-808

Note: To manage future care consults, the Veterans Health Administration approved specific strategies for VAMCs to use: either developing markers so they could be identified in the consult system, or using existing mechanisms outside of the consult system to keep track of these requests, such as an electronic wait list. The electronic wait list is a component of the VistA scheduling system designed for recording, tracking, and reporting veterans waiting for medical appointments.

^aVAMCs reported their initial strategies for managing future care consults to us during interviews conducted between November 2013 and February 2014. VAMCs reported their updated strategies to us during interviews conducted between May and June 2014.

^bOfficials from this VAMC stated that they developed future care flags only for those specialty care clinics that routinely requested care beyond 90 days. Specialty care clinics that did not routinely request consults beyond 90 days entered them into the consult system regardless of when care was needed without identifying them as future care consults.

According to federal internal control standards, managers should perform ongoing monitoring, including independent assessments of performance.³⁰ However, because VHA officials relied on self-certifications submitted by VAMCs, they were not aware of the extent to which VAMCs implemented strategies that were not one of VHA's approved options, nor would they be aware of the extent to which VAMCs have since changed their strategies. As of June 2014, VHA officials told us they did not have detailed information on the various strategies VAMCs have implemented to manage future care consults, and they acknowledged that they had not conducted a system-wide review of VAMCs' strategies.

Furthermore, VHA does not have a formal process by which VAMCs could share best practices system-wide.³¹ According to federal internal control standards, identifying and sharing information is an essential part of ensuring effective and efficient use of resources.³² We found that VAMCs may not be benefiting from the challenges and solutions other VAMCs discovered when implementing strategies for managing future care consults. For example, during our review, we found that one VAMC revised its initial strategy in a way that another VAMC had already found ineffective. Officials at that VAMC stated that they were implementing a new strategy to manage future care consults in a separate electronic system. However, another VAMC opted not to use a similar electronic system it piloted after finding that it confused providers and required extensive training; that VAMC opted instead to use future care markers in its consult system. A more systematic identification and sharing of best practices for managing future care consults would enable VAMCs to more efficiently implement effective strategies for managing specialty care consults.

VHA lacks a detailed system-wide policy for managing patient no-shows and cancelled appointments. Although VHA's consult business rules initiative was intended to create consistency in VAMCs' consult data, we found variation in how VAMCs are managing patient no shows and cancelled appointments, which could impact VHA's ability to obtain

³⁰See [GAO/AIMD-00-21.3.1](#).

³¹Officials from VAMCs in our review described sharing best practices with colleagues at other VAMCs in their VISN on an ad hoc basis.

³²See [GAO/AIMD-00-21.3.1](#).

standardized data needed for conducting oversight. Additionally, according to federal internal control standards, management is responsible for developing the detailed policies, procedures, and practices to fit their agency's operations and to ensure that they are built into, and an integral part of, operations.³³

However, we found that VHA has not developed a detailed, system-wide policy on how to address patient no-shows and cancelled appointments, two frequently noted causes of delays in providing care. Instead, VHA policies provide general guidance that state that after a patient does not show for or cancels an appointment, the specialty care clinic staff should review the consult and determine whether or not to reschedule the appointment.³⁴ VHA officials told us that they allow each VAMC to determine its own approach to managing these occurrences. However, such variations in no-show and cancellation policies are reflected in the consult data, and as a result, this variation may make it difficult to assess and compare VAMCs' performance. For example, if a specialty care clinic allows a patient to cancel multiple specialty care appointments, the consult would remain open and could inaccurately suggest delays in care where none might exist. In contrast, if the specialty care clinic limited the number of patient cancellations, the consult would be closed after the allowed number and would not appear as a delay in care, even if a delay had occurred.

Officials from the five VAMCs in our review stated that they had adopted various strategies for managing patient no-shows and cancelled appointments. For example, one VAMC developed a rule, referred to as the "1-1-30" rule, which states that a patient must receive at least 1 letter and 1 phone call, and be granted 30 days to contact the VAMC to schedule a specialty care appointment.³⁵ In addition, this VAMC's consult policy limits a patient to a combination of two no-shows or cancelled appointments after which the specialty care provider may discontinue the consult. The other four VAMCs in our review had some type of policy addressing patient no-shows and cancelled appointments, each of which

³³See [GAO/AIMD-00-21.3.1](#).

³⁴See VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010) and VHA Directive 2008-056, *VHA Consult Policy* (Sept. 16, 2008).

³⁵According to VAMC officials, the 1-1-30 rule provides a minimum standard for specialty care providers to follow in scheduling medical appointments.

varied in its requirements.³⁶ For the 150 consults included in our sample, we found that specialty care providers had scheduled appointments for 127 of the consults, and that patient no-shows and cancelled appointments were among the factors contributing to delays in providing timely care for 66 of these consults (52 percent).

Conclusions

Providing our nation's veterans with timely access to medical care, including outpatient specialty care, is a crucial responsibility of VHA. We and others have identified problems with VHA's consult process used to manage the outpatient specialty care needs of veterans. Our review of a sample of consults found that VAMCs did not always provide veterans with requested specialty care in a timely manner, if at all. In other cases, VAMCs were able to provide the needed care on a timely basis, but specialty care providers failed to properly complete or document the consults, making it appear as though care for veterans was delayed, even when it was not.

Limitations in VHA's oversight of the consult process have affected the reliability of VHA's consult data and its usefulness for oversight. Although VHA officials cited VAMCs' progress in reducing the backlog of consults unresolved for more than 90 days, they have not independently verified that VAMCs appropriately closed these consults, calling into question the accuracy of these data. Due to their lack of oversight, VHA officials are not aware of the various strategies VAMCs implemented to manage future care consults, and thus when monitoring consult data, cannot adequately determine if future care consults are distinguishable from those that are truly delayed. Additionally, VHA has not developed a system-wide process for identifying and sharing VAMCs' best practices for managing future care and other types of consults; thus, VAMCs may be implementing strategies that others already have found ineffective or may be unaware of strategies that others have successfully implemented. Further, VHA's decentralized approach for handling patient no-shows and cancelled appointments, as well as other issues, makes it difficult to compare timeliness of providing outpatient specialty care system-wide.

³⁶One of the VAMCs allowed for a maximum of two no-shows for all specialty care appointments, with consideration given to the patient's medical needs. Two of the VAMCs' policies stated that specialty care providers should reassess the patient's needs after one no-show and may or may not reschedule the appointment. Another VAMC's policy did not include a limit to the number of no-shows allowed for specialty care appointments.

Ultimately, this decentralized approach may further limit the usefulness of the data and VHA's and VISNs' ability to assess VAMCs' performance in managing consults and providing timely care to our nation's veterans.

Recommendations for Executive Action

To improve VHA's ability to effectively oversee the consult process, and help ensure VAMCs are providing veterans with timely access to outpatient specialty care, we recommend that the Secretary of Veterans Affairs direct the Interim Under Secretary for Health to take the following six actions:

- Assess the extent to which specialty care providers across all VAMCs, including residents who may be serving on a temporary basis, are using the correct clinical progress notes to complete consults in a timely manner, and, as warranted, develop and implement system-wide solutions such as technical enhancements, to ensure this is done appropriately.
- Enhance oversight of VAMCs by routinely conducting independent assessments of how VAMCs are managing the consult process, including whether they are appropriately resolving consults. This oversight could be accomplished, for example, by VISN officials periodically conducting reviews of a random sample of consults as we did in the review we conducted.
- Require specialty care providers to clearly document in the electronic consult system their rationale for resolving a consult when care has not been provided.
- Identify and assess the various strategies that all VAMCs have implemented for managing future care consults; including determining the potential effects these strategies may have on the reliability of consult data; and identifying and implementing measures for managing future care consults that will ensure the consistency of consult data.
- Establish a system-wide process for identifying and sharing VAMCs' best practices for managing consults that may have broader applicability throughout VHA, including future care consults.
- Develop a national policy for VAMCs to manage patient no-shows and cancelled appointments that will ensure standardized data needed for effective oversight of consults.

Agency Comments

We provided VA with a draft of this report for its review and comment. VA provided written comments, which are reprinted in appendix II. In its written comments, VA concurred with all six of the report's recommendations. To implement five of the recommendations, VA indicated that the VHA Deputy Under Secretary for Health for Operations and Management will take a number of actions, such as chartering a workgroup to develop clear standard operating procedures for completing and managing consults. VA indicated that target completion dates for implementing these recommendations range from December 2014 through December 2015. For the sixth recommendation, VA indicated that, by December 2014, VHA will establish a system-wide process that facilitates identifying and disseminating VAMC best practices for managing consults. VA also provided technical comments, which we have incorporated as appropriate.

As arranged with your office, unless you publicly disclose the contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies of this report to the Secretary of Veterans Affairs and interested congressional committees. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.

Sincerely yours,



Debra A. Draper
Director, Health Care

Appendix I: Examples of Gastroenterology Consult Request Templates

To send a consult request, providers log on to the consult system and complete an electronic consult request template developed by the VA medical center's specialty care clinic. As shown in figures 3 and 4 below, the information requested in these templates may vary depending on the patient's symptoms. After completing the template, the requesting provider electronically submits the consult for the specialty care provider to review.

Figure 3: Example of a Gastroenterology Consult Request Template for Chronic Diarrhea

```
Chronic Diarrhea

Please select Preferred method of consult completion:
*
 Phone consult: For urgent questions
 E-consult: Peer-to-peer consult
 SCAN: Present this patient to one or more specialists for help with management
 Face-to-face visit: Traditional in person visit

Diet and medications should be reviewed prior to consultation. Your
review should include recent diet change, lactose and sucrose in the diet,
and over the counter medications. Labs below should be ordered prior to
referral. If patient has weight loss, consider checking fecal fat.

Diet and medications reviewed? *  Yes  No
No ZZ-Cryptosporidium/Isospora Smear (LC) in the last 6

Giardia: GIARDIA BY IA - NONE FOUND
C-Diff: C.DIFF TOXIN/C.DIFF CULTURE ** - INVALID TEST NAME

* If Labs above read "No _____ in last 6m," then please order them on
the menu that follows the consult. GI will interpret the results if
needed.  Acknowledged.

* If the results are listed above, disregard the menu that follows the
consult.  Acknowledged.

Brief History: *
```

Source: One of the VA medical centers in our review. | GAO-14-808

Appendix I: Examples of Gastroenterology
Consult Request Templates

Figure 4: Example of a Gastroenterology Consult Request Template for a Liver Condition

Elevated liver enzymes:

Please select Preferred method of consult completion:

*

Phone consult: For urgent questions

E-consult: Peer-to-peer consult

SCAN: Present this patient to one or more specialists for help with management

Face-to-face visit: Traditional in person visit

Patients with persistent elevations (>3 months) should be referred after the following tests are ordered and drawn/performed (GI will interpret the results, if necessary): RUQ U/S, HCV Ab; HBV sAg and sAb; serum iron, ferritin and TIBC; AST, ALT, bilirubin, albumin, alk phos, ANA, and INR.

Symptomatic patients or those with 5-fold increased enzymes should be referred urgently. (Change the urgency drop down box from ROUTINE to WITHIN 1 WEEK.)

ALBUMIN - NONE FOUND
No ALKALINE PHOSPHATASE in the last 6M
SGPT - NONE FOUND
SGOT - NONE FOUND
No ANA (DVAMC) in the last 6M
No BILIRUB.,TOT in the last 6M
PROTHROMBIN TIME - NONE FOUND
No INR in the last 1Y
TIBC - NONE FOUND
No FERRITIN in the last 6M
No IRON in the last 6M
No HEPATITIS B SURFACE AG in the last 6M
No HEPATITIS B SURFACE AB in the last 10Y
06/08/2011 HEPATITIS C AB Negative

If any of the above labs state "No _____ in the last 6M," then you must order them from the next menu. Failure to order appropriate labs will result in consult refusal. * Acknowledged.

If the patient has not had a RUQ U/S or Abd CT (see below) then you must order the Ultra Sound using the next menu. * Acknowledged.

* If all of the above requirements are met, please disregard the menu that follows the consult. *

NO VAMC IMAGING PROCEDURES WITHIN LAST YEAR

Source: One of the VA medical centers in our review. | GAO-14-808

Appendix II: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

September 12, 2014

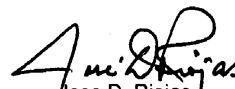
Ms. Debra A. Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA HEALTH CARE: Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care**" (GAO-14-808). VA generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure specifically addresses GAO's recommendations and provides technical comments in the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,


Jose D. Riojas
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**"VA HEALTH CARE: Management and Oversight of Consult Process Need
Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care"**
(GAO-14-808)

GAO Recommendation: To improve VHA's ability to effectively oversee the consult process, and help ensure VAMCs are providing veterans with timely access to outpatient specialty care, GAO recommends that the Secretary of Veterans Affairs direct the Interim Under Secretary for Health to take the following six actions:

Recommendation 1: Assess the extent to which specialty care providers across all VAMCs, including residents who may be serving on a temporary basis, are using the correct clinical progress notes to complete consults in a timely manner, and as warranted, develop and implement system-wide solutions such as technical enhancements, to ensure this is done appropriately.

VA Comment: Concur. To address variation in clinical progress note use, the Veterans Health Administration (VHA) Deputy Under Secretary for Health for Operations and Management (DUSHOM) will charter a workgroup to assess and develop a single set of clear standard operating procedures for requesting and completing consults. The workgroup will collaborate with VA Learning University (VALU) to develop a Talent Management System (TMS) educational tool to provide proper orientation for physicians, mid-level providers, and resident trainees on the use of the consult package. The standard operating procedures will specifically address rules related to the cancellation and denial of consults, as well as the appropriate process for completing and closing consults.

- Clarification of the standard operating procedures for requesting and completing consults; development of TMS programs to educate physicians, mid-levels providers, and resident trainees. Target Completion Date: December 31, 2014.
- Completion of training for all providers. Target Completion Date: March 31, 2015.
- Validation of ongoing training, including assurance that all new residents and providers are trained. Target Completion Date: December 31, 2015.

Recommendation 2: Enhance oversight of VAMCs by routinely conducting independent assessments of how VAMCs are managing the consult process, including whether they are appropriately resolving consults. This oversight could be accomplished, for example, by VISN officials periodically conducting reviews of a random sample of consults as GAO did in the review GAO conducted.

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA HEALTH CARE: Management and Oversight of Consult Process Need
Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care”***
(GAO-14-808)

VA Comment: Concur. The DUSHOM-charged workgroup will develop a clear set of standard operating procedures for tracking and monitoring consults at the provider, clinic, service line, facility, and Veterans Integrated Service Network (VISN) level. As part of the standard operating procedures, the workgroup will develop recommendations and instructions for generating a standard set of management tools. The facility will be responsible for using these tools to manage the consult process at the requestor and consultant level. Oversight of these processes will occur at the VA medical center (VAMC), VISN, and VHA levels. Clinical leadership at VAMCs will regularly review and monitor the consult process. In addition, VISNs will be responsible for reviewing the facility audit process. Lastly, VHA's Office of Compliance and Business Integrity will routinely audit facilities to ensure use of VHA's standardized consultation process and to identify causes of delays.

- Development of standard operating procedures for tracking and monitoring consults. Target Completion Date: December 31, 2014.
- Implementation of facility/VISN auditing process. Target Completion Date: March 31, 2015.

Recommendation 3: Require specialty care providers to clearly document in the electronic consult system their rationale for resolving a consult when care has not been provided.

VA Comment: Concur. The DUSHOM-charged workgroup will develop a clear set of standard operating procedures for the management of consults. The workgroup will collaborate with VALU to develop a TMS educational tool to provide proper orientation for physicians, mid-level providers, and resident trainees on the use of the consult package. These tools will specifically address rules related to the cancellation and denial of consults, as well as exploring options for the development of a template to indicate and track the reasons for cancellation and denial of consults.

- Clarification of the standard operating procedures for the cancellation and denial of consults; development of TMS programs to educate physicians, mid-level providers, and resident trainees; explore options for development of a template to standardize indications for cancellation and denial of consults. Target Completion Date: December 31, 2014.
- Completion of training for all providers; implementation and use of template for cancellation and denial of consults. Target Completion Date: March 31, 2015.
- Validation of ongoing training. Target Completion Date: December 31, 2015.

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA HEALTH CARE: Management and Oversight of Consult Process Need
Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care”***
(GAO-14-808)

Recommendation 4: Identify and assess the various strategies that all VAMCs have implemented for managing future care consults; including determining the potential effects these strategies may have on the reliability of consult data; and identifying and implementing measures for managing future care consults that will ensure the consistency of consult data.

VA Comment: Concur. The DUSHOM-charged workgroup will assess local strategies for managing future care consults, including the effects of the reliability of consult data. The DUSHOM, through the National Consult Steering Committee, will review workgroup findings and recommendations to reassess policy and practices for management of future consults. The DUSHOM will determine whether modifications to current measures are needed and will implement necessary changes. Target Completion Date: December 31, 2014.

Recommendation 5: Establish a system-wide process for identifying and sharing VAMCs' best practices for managing consults that may have broader applicability throughout VHA, including future care consults.

VA Comment: Concur. VHA will establish a system-wide process that facilitates the identification and dissemination of VAMC best practices for managing consults. Regular conference calls will be scheduled between representatives of local consult steering committees. The calls will include identification and discussion of best practices, including management of future care consults. Best practices that have broader applicability will be shared through posting on VHA's existing electronic consults switchboard and communicated to appropriate groups. The electronic consults switchboard is a system-wide tool that VISNs and facilities currently use to review national data on consults. This switchboard will be VHA's depository for best practices for managing consults. Target Completion Date: December 31, 2014.

Recommendation 6: Develop a national policy for VAMCs' to manage patient no-shows and cancelled appointments that will ensure standardized data needed for effective oversight of consults.

VA Comment: Concur. In the short term, the DUSHOM will issue clarification to all VISNs and facilities regarding management of no-shows and cancellations while developing national policy documents. Target Completion Date: December 31, 2014.

In the long term, the DUSHOM will establish requirements for managing no-shows and canceled appointments in national policy. Target Completion Date: March 31, 2015.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Janina Austin, Assistant Director; Jennie F. Apter; Jacquelyn Hamilton; David Lichtenfeld; Brienne Tierney; and Ann Tynan made key contributions to this report.

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