



# Department of Veterans Affairs Office of Inspector General

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## Healthcare Inspection

### Delays for Outpatient Specialty Procedures VA North Texas Health Care System Dallas, Texas

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## **Executive Summary**

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding patient care delays at the VA North Texas Health Care System, Dallas, TX. A complainant alleged that a dialysis patient waited more than 4 months for permanent vascular access and that ambulatory monitoring for a cardiac patient was delayed 3 months.

We substantiated that these and other patients experienced excessive wait times. For 5 recent referrals for vascular access, the time from referral to completion of a procedure was 89–138 days. For 213 patients scheduled for ambulatory cardiac monitoring, the average wait time was 68 days.

We also found that clinicians did not review referral requests, consultation reports were not linked to requests in the electronic health record as required, and that appointment dates requested by patients for vascular and cardiac procedures were incorrectly recorded by scheduling staff.

We recommended that the Facility Director ensure that patients receive timely vascular and cardiac care, that providers document review of consults in the electronic health record and link results to consult requests and that staff comply with Veterans Health Administration policy for scheduling outpatient appointments.

The Veterans Integrated Service Network and Facility Directors agreed with our findings and recommendations and provided acceptable improvement plans.



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

**TO:** Director, VA Heart of Texas Health Care Network (10N17)

**SUBJECT:** Healthcare Inspection – Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas

## **Purpose**

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding patient care delays at the VA North Texas Health Care System (facility) in Dallas, TX.

## **Background**

The facility, which is part of Veterans Integrated Service Network (VISN) 17, provides a broad range of inpatient and outpatient healthcare services to nearly 500,000 veterans in 40 counties in north Texas and southern Oklahoma. The facility has 613 hospital beds and 240 Community Living Center beds.

Veterans Health Administration (VHA) policy defines the management of clinical consultations and requires facilities to ensure that service agreements and well-defined communication processes are developed.<sup>1</sup> Consultation results are required to be attached to consultation requests in the Computerized Patient Record System consult package to ensure that the results are readily available.

VHA monitors the timeliness of access to care in the top 50 major clinical areas, using times requested by patients.<sup>2</sup> Requesting providers can specify timeframes, but dates requested by patients are used to measure timeliness.<sup>3</sup> VHA's goal is to schedule 98 percent of all specialty care appointments within 14 days of patients' desired appointment dates.

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

<sup>2</sup> *FY2012 Electronic Technical Manual*, VHA Office of Analytics and Business Intelligence website, <http://vaww.oqp.med.va.gov/programs/pm/pmPolicyTechManual.aspx>, accessed July 18, 2012.

<sup>3</sup> VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

In July 2012, a complainant contacted the OIG's Hotline Division with allegations of patient care delays at the facility. Specifically, the complainant alleged that:

- A dialysis patient needing permanent dialysis access had a request initiated in April 2012, but vein mapping could not be done until September 2012.
- A cardiac patient was referred for Holter monitoring in June 2012, but could not be scheduled until September 2012.

Dialysis treats patients with poor kidney function by filtering waste and excess water from the blood.<sup>4</sup> In the most common type of dialysis, blood flows from the patient's bloodstream through a hemodialysis machine. For chronic kidney failure, dialysis treatments 3 days each week require access to the bloodstream by an arteriovenous (AV) fistula<sup>5</sup> or graft.<sup>6</sup> Vascular access is ideally prepared weeks or months before a patient starts dialysis to allow easier and more efficient dialysis with fewer complications.<sup>7</sup> In planning for access placement, surgeons identify large veins in the arms using vein mapping.

A Holter monitor is a portable device used to measure the electrical activity of the heart over a period of at least 24 hours. The monitor, which is typically carried using a belt or strap, records signals from electrodes attached to the patient's chest. At the end of the recording period, information collected by the monitor is retrieved and analyzed.

## Scope and Methodology

We interviewed employees with knowledge of the issues raised by the allegations on August 14, 2012. We reviewed policies and procedures and electronic health records (EHRs). We evaluated patient appointments made in cardiology and vascular surgery clinics using data available through VHA Support Service Center<sup>8</sup> (VSSC) for June and/or July 2012, the most recent months available at the time of our review.

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

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<sup>4</sup> National Kidney Center website, [www.nationalkidneycenter.org](http://www.nationalkidneycenter.org), accessed September 14, 2012.

<sup>5</sup> An AV fistula is made by directly connecting an artery to a vein, usually in the forearm, to create vascular access that can be used for repeat needle insertions. Fistulas can take several weeks to mature and be ready for use.

<sup>6</sup> An AV graft connects an artery and vein using a synthetic tube. Grafts can be used sooner than fistulas, but are more prone to infection and clotting.

<sup>7</sup> National Institute of Health's National Kidney and Urologic Disease Information Clearinghouse (NKUDIC) website, <http://kidney.niddk.nih.gov/kudiseases/pubs/vascularaccess/>, accessed September 14, 2012.

<sup>8</sup> VSSC maintains VA data for the purpose of health care delivery analysis and evaluation; website, <http://vssc.med.va.gov>, accessed September 14, 2012.

## Case Summary 1

The patient has a history of diabetes mellitus, hypertension, and chronic kidney disease. Facility physicians have monitored his kidney disease since 2005, and he was enrolled in the facility Care Coordination Home Telehealth (CCHT)<sup>9</sup> program in 2011.

In March 2012, the patient was hospitalized at a non-VA hospital for pneumonia, and during that hospitalization, he was started on dialysis. Shortly after discharge, the patient was evaluated at the facility, and a nephrologist initiated a request for non-VA dialysis due to the unavailability of facility dialysis services.

The patient underwent dialysis using a temporary catheter, and in April 2012, during a CCHT telephone conversation, inquired about having a permanent dialysis catheter placed. Two days later, a nephrology nurse made an appointment for the patient to be seen in the Vascular Lab in early June. At the June vascular encounter, a provider explained to the patient that the follow-up plan included vein mapping followed by determination of a surgical date for establishment of permanent dialysis access. Vein mapping was anticipated to occur in September, but an appointment had not been scheduled at the time of our onsite inspection in August.

## Case Summary 2

The patient has received primary care through a facility community based outpatient clinic since 2004. He has been enrolled in the CCHT program since May 2012 for difficult-to-control diabetes associated with episodes of hypoglycemia.

During May and June 2012, the patient was noted to have multiple red-alert readings on his CCHT Health Buddy™,<sup>10</sup> with his heart rate recorded to range from 48 to 123 beats per minute. In June 2012, the patient requested that his primary care physician (PCP) review the heart rate information. The next day, the PCP entered a cardiology consult for Holter monitoring. The patient was scheduled for a Holter monitor appointment in September 2012.

## Inspection Results

### Issue 1: Excessive Wait Times

We substantiated that patients experienced long wait times for permanent dialysis access surgery and Holter monitoring.

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<sup>9</sup> The CCHT Program utilizes Care Coordinators to provide professional assessments, coordination and planning of healthcare services, and acts on behalf of the patient to ensure clinical services are provided.

<sup>10</sup> The Health Buddy™ is an in-home device used by patients in the CCHT Program to remotely collect and transmit health information, such as vital signs and symptoms, to a healthcare provider for review.

We reviewed consult requests for the 195 patients named on the VSSC completed and pending Vascular Lab appointment lists for June and July 2012, and identified 6 additional patients who had begun the dialysis permanent access placement process in March and April. One patient had prioritized scheduling outside the usual AV access process. The remaining 5 patients had an average wait time of 49.8 days (range, 48–54 days) from initial referral by nephrology staff to a Vascular Lab appointment. These patients then waited, on average, an additional 44.8 days (range, 0–77 days) for vein mapping and then 27.6 days (range, 13–64 days) for surgery. The average overall patient wait time from nephrology referral to access surgery was 122.2 days (range, 89–138 days).

We reviewed 213 referrals for Holter monitors from the July 2012 VSSC pending appointment list. We found the average time for appointments made in May and June 2012 was 68 days (median, 70 days; range, 7–109 days).

## **Issue 2: Consult Review Process**

We found that clinician review of cardiology consults was not evident in the EHR of patients referred for Holter monitoring and that results were not linked to the consult as required.

VHA policy requires facilities to establish service agreements and communication processes for consultation services. The local Cardiology Service Agreement states that Cardiology shall receive the consult and schedule an appointment in compliance with VHA requirements. The requesting provider is expected to indicate a desired date for the requested appointment consistent with timeframes in the agreement. However, after reviewing the consult and patient history, cardiology providers may modify the time recommended by the PCP.

We found no evidence of Cardiology review for any of the 213 requests for Holter monitors submitted in May–June 2012, nor was there evidence of any alteration of the timeframe requested by the referring provider. One request for “stat” (immediate) services resulted in an appointment in 30 days. Three requests for services within 72 hours or 1 week resulted in appointments in 10 weeks or more.

Furthermore, we found that the results of monitoring were not linked to the consult request as required and, therefore, not easily available to providers using the EHR.

## **Issue 3: Scheduling Practices**

We found incorrect desired dates were entered by scheduling staff in both the Vascular Lab and in the Cardiology Clinic.

Appointments were routinely made using the next available appointment date instead of patients’ desired dates. A review of scheduling in the June and July 2012 VSSC access

reports for the facility showed that 100 percent of new patient Vascular Lab appointments and 100 percent of all Holter clinic appointments were documented as being scheduled on the patients' desired dates, despite actual wait times of several months.

## Conclusions

Patients requiring AV access surgery or Holter monitoring experienced delays.

Requests for Holter monitors were not reviewed by cardiology providers, even when submitted with a high degree of urgency. Patients with potentially urgent medical needs did not receive prioritized care. Furthermore, once testing is completed, results are not linked to the request and PCPs therefore were not notified.

## Recommendations

**Recommendation 1.** We recommended that the Facility Director ensure that patients receive timely vascular and cardiology care and that compliance is monitored.

**Recommendation 2.** We recommended that the Facility Director ensure that providers document review of consults in the EHR and link results to consult requests and that compliance is monitored.

**Recommendation 3.** We recommended that the Facility Director ensure that staff comply with VHA policy for scheduling outpatient appointments and that compliance is monitored.

## Comments

The VISN and Facility Directors concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 6–9, for the full text of 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:** October 2, 2012

**From:** Director, VA Heart of Texas Health Care Network (10N17)

**Subject:** **Healthcare Inspection – Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas**

**To:** Director, Dallas Office of Healthcare Inspections (54DA)

**Thru:** Director, VHA Management Review Service (VHA 10AR MRS)

1. Thank you for allowing me to respond to this Healthcare Inspection regarding the Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, TX.
2. I concur with the recommendation and have ensured that an implementation plan has been developed.
3. If you have further questions regarding this inspection, please contact Denise B. Elliott, VISN 17 Acting Quality Management Officer, at 817-385-3734.



Lawrence A. Biro  
Director, VA Heart of Texas Health Care Network (10N17)

## Facility Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** September 28, 2012

**From:** Director, VA North Texas Health Care System (549/00)

**Subject:** **Healthcare Inspection – Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas**

**To:** Director, VA Heart of Texas Health Care Network (10N17)

1. We appreciate the opportunity to review the draft report of the healthcare inspection completed August 14, 2012, at the VA North Texas Health Care System in Dallas, TX.
2. Attached you will find the implementation plan for each finding.
3. If you have any questions please call Patricia Bowling, Chief, Clinical Quality Management at 214-857-2327.

FOR AND IN  
THE ABSENCE OF

  
(original signed by.)

Mr. Jeffery Milligan  
Director, VA North Texas Health Care System (549/00)



**Recommendation 3.** We recommended that the Facility Director ensure that staff comply with VHA policy for scheduling outpatient appointments and that compliance is monitored.

**Concur**

**Target Completion Date:** December 1, 2012

**Facility's Response:**

All staff with the ability to schedule patients must complete three education modules in TMS and a 4-hour classroom training yearly. The Vascular Surgery Scheduler received one-on-one training in scheduling. The AV pre-operative evaluation clinic appointment will be requested through a CPRS ADT order which will indicate a desired date within 30 days of the Veteran's anticipated surgery date. Cardiology schedulers will receive the same mandatory and one-on-one training as received by the Vascular Surgery Scheduler. Schedulers are monitored weekly to ensure compliance with VHA scheduling policy.

**Status:** Open

## 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.
Acknowledgments	Cathleen King, MHA, CRRN, Project Leader Larry Ross, MS Jerome Herbers, MD, Medical Consultant Misti Kincaid, BS, Management and Program Analyst

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