Department of Veteran Affairs (VA)
National Consult Delay Review
Fact Sheet
April 2014

Summary:
The Department of Veterans Affairs (VA) cares deeply for every Veteran we are privileged to serve. Our goal is to provide the best quality, safe and effective health care our Veterans have earned and deserve. We take seriously any issue that occurs at any one of the more than 1,700 VA health care facilities across the country.

Any adverse incident for a Veteran within our care is one too many. When an incident occurs in our system we aggressively identify, correct and work to prevent additional risks. We conduct a thorough review to understand what happened, prevent similar incidents in the future, and share lessons learned across the system.

As a result of the consult delay issue VA discovered at two of our medical centers, the Veterans Health Administration (VHA) continues to conduct a national review of consults across the system. We have redesigned the consult process to better monitor consult timeliness. We continue to take action to strengthen oversight mechanisms and prevent a similar delay at other VA medical centers. We take any issue of this nature extremely seriously and offer our sincerest condolences to families and individuals who have been affected and lost a loved one.

Key Facts:

As a result of the consult delay issue VA discovered at two of our medical centers, VHA continues to conduct a national review of consults across the system, which includes a review of all consults since 1999. Within this time frame over a quarter billion consults were requested across VA's system of care. A consult is a request by one provider for the clinical opinion or services of a second provider or physician.

- During this review, VA looked at all open since 1999 to ensure that proper care has been administered to patients. Within this time frame over a quarter billion consults were requested in VA.

- While these are the results of the review of high interest consults, the system-wide review of consults continues.

- High interest consults are defined as consults in the following seven areas: gastrointestinal endoscopy; cardiac catheterization; cardiology; cardiac surgery; oncology; bronchoscopy; and thoracic surgery.

- VA is re-writing the business practices of its consult system that will allow the system to distinguish true clinical consultation from other administrative uses of the consult package, and clinical staff has undergone training on the use of the system.

- Based on findings from a system-wide review high interest consults and new cases of gastrointestinal cancer, VA identified 76 patients in our health care system for whom institutional disclosures were provided or attempted, based predominantly on their gastrointestinal care. Of these 76 patients, 23 have passed away.

- VA uses an electronic consult management system containing all electronic consult requests. The system is intended to be used for scheduling appointments for patients in need of clinical consultations with health care providers. However, in additional to clinical consultations, the system also was used for a variety of other purposes including electronic communications between providers and notes to reserve spots in transportation vehicles. A review of data in this system showed that the vast majority of these open consult requests were not clinical in nature, and so were not closed after the request was completed—although the requests were 'open' in the system, they did not correspond to patients awaiting treatment or diagnosis.

- When an adverse event occurs, VHA contacts the patient or their representative when the patient has either been harmed or may have been harmed during their care – this is known as an institutional disclosure. VHA's first priority is to notify the patient or their representative of the adverse event, as well as the patient's rights and recourse. VHA is committed to a process of full and open disclosure to Veterans and their families.

Data Chart:

The Department of Veterans Affairs (VA) cares deeply for every Veteran we are privileged to serve. Our goal is to provide the best quality, safe and effective health care our Veterans have earned and deserve. We take seriously any issue that occurs at any one of the more than 1,700 VA health care facilities across the country.

Any adverse incident for a Veteran within our care is one too many. When an incident occurs in our system we aggressively identify, correct, and work to prevent additional risks. We conduct a thorough review to understand what happened, prevent similar incidents in the future, and share lessons learned across the system.

As a result of the consult delay issue VA discovered at two of our medical centers, the Veterans Health Administration (VHA) continues to conduct a national review of consults across the system. We have redesigned the consult process to better monitor consult timeliness. We continue to take action to strengthen oversight mechanisms and prevent a similar delay at another VA medical center. We take any issue of this nature extremely seriously and offer our sincerest condolences to families and individuals who have been affected and lost a loved one.

Based on findings from a system-wide review of high interest consults and new cases of gastrointestinal malignancy, VA identified 76 patients in our health care system for whom institutional disclosures were provided or attempted, based predominantly on their gastrointestinal care. Of these 76 patients, 23 have passed away.

VISN 1	Station Name	Institutional Disclosures	Mortality
1	VA Maine HCS	0	0
1	VA Connecticut HCS - West Haven	0	0
1	Bedford VAMC	0	0
1	VA Boston HCS	0	0
1	Northampton VAMC Central Western Massachusetts	0	0

1	Manchester VAMC	0	0
1	Providence VAMC	0	0
1	White River Junction VAMC	0	0
VISN 2	**Station Name**	**Institutional Disclosures**	**Mortality**
2	Bath VAMC	1	0
2	Canandaigua VAMC	0	0
2	Albany	0	0
2	Syracuse	0	0
2	Western NY HCS	0	0
VISN 3	**Station Name**	**Institutional Disclosures**	**Mortality**
3	New Jersey HCS	0	0
3	Bronx VAMC	0	0
3	Northport VAMC	0	0
3	Hudson Valley HCS	0	0
3	NY Harbor HCS	0	0
VISN 4	**Station Name**	**Institutional Disclosures**	**Mortality**

4	Wilmington VAMC	0	0
4	Coatesville VAMC	0	0
4	Erie VAMC	1	0
4	Altoona VAMC	0	0
4	Lebanon VAMC	0	0
4	Philadelphia VAMC	2	0
4	Butler	0	0
4	Pittsburgh HCS	0	0
4	Wilkes-Barre VAMC	0	0
4	Clarksburg	0	0
VISN 5	**Station Name**	**Institutional Disclosures**	**Mortality**
5	Washington, DC VAMC	0	0
5	Maryland HCS	0	0
5	Martinsburg VAMC	0	0
VISN 6	**Station Name**	**Institutional Disclosures**	**Mortality**
6	Asheville VAMC	0	0

6	Durham VAMC	0	0
6	Fayetteville VAMC	0	0
6	Salisbury VAMC	0	0
6	Hampton VAMC	7	2
6	Richmond	0	0
6	Salem VAMC	0	0
6	Beckley VAMC	0	0
VISN 7	Station Name	Institutional Disclosures	Mortality
7	Birmingham VAMC	0	0
7	Central Alabama HCS	1	0
7	Tuscaloosa VAMC	0	0
7	Atlanta VAMC	0	0
7	Dublin	0	0
7	Augusta	7	3
7	Charleston	2	1
7	Columbia	20	6

VISN 8	Station Name	Institutional Disclosures	Mortality
8	Bay Pines	2	0
8	Miami	2	1
8	Tampa	1	0
8	North Florida/ South Georgia HCS	4	2
8	Orlando	0	0
8	West Palm Beach	5	2
8	Caribbean HCS	0	0
VISN 9	Station Name	Institutional Disclosures	Mortality
9	Lexington VAMC	0	0
9	Louisville VAMC	1	0
9	Mountain Home	0	0
9	Memphis VAMC	0	0
9	Tennessee Valley HCS - Nash	0	0
9	Tennessee Valley HCS - York	0	0
9	Huntington VAMC	1	1

VISN 10	Station Name	Institutional Disclosures	Mortality
10	Columbus	0	0
10	Chillicothe VAMC	0	0
10	Cincinnati VAMC	0	0
10	Dayton VAMC	0	0
10	Cleveland	3	1

VISN 11	Station Name	Institutional Disclosures	Mortality
11	Iliana HCS	0	0
11	Indianapolis	0	0
11	Northern Indiana HCS	0	0
11	Saginaw	0	0
11	Battle Creek VAMC	0	0
11	Detroit	1	0
11	Ann Arbor HCS	0	0

VISN 12	Station Name	Institutional Disclosures	Mortality
12	Hines	0	0

12	James A. Lovell FHCC (N. Chicago)	0	0
12	Iron Mountain	0	0
12	Milwaukee	0	0
12	Tomah VAMC	0	0
12	Madison	0	0
12	Jesse Brown	0	0

VISN 15	Station Name	Institutional Disclosures	Mortality
15	Marion HCS	0	0
15	Wichita	0	0
15	Eastern Kansas HCS	0	0
15	Columbia	0	0
15	Poplar Bluff	0	0
15	Kansas City VAMC	0	0
15	St. Louis VAMC	0	0

VISN 16	Station Name	Institutional Disclosures	Mortality
16	Central Arkansas HCS	1	0

16	Ozarks HCS	0	0
16	Alexandria VAMC	0	0
16	Overton Brooks, Shreveport	0	0
16	Southeast Louisiana HCS	0	0
16	Jackson	0	0
16	Gulf Coast HCS	0	0
16	Muskogee	0	0
16	Oklahoma City VAMC	1	0
16	Houston	0	0
VISN 17	**Station Name**	**Institutional Disclosures**	**Mortality**
17	Central Texas HCS	0	0
17	South Texas HCS	1	0
17	Texas Valley Coastal HCS	0	0
17	North Texas HCS	0	0
VISN 18	**Station Name**	**Institutional Disclosures**	**Mortality**
18	Northern Arizona HCS	2	1

18	Phoenix HCS	0	0
18	Southern Arizona HCS	1	1
18	New Mexico HCS	0	0
18	Amarillo HCS	0	0
18	El Paso HCS	0	0
18	West Texas HCS	0	0
VISN 19	Station Name	Institutional Disclosures	Mortality
19	Eastern Colorado HCS	0	0
19	Grand Junction VAMC	3	1
19	Montana HCS	0	0
19	Salt Lake City HCS	0	0
19	Cheyenne VAMC	1	0
19	Sheridan VAMC	0	0
VISN 20	Station Name	Institutional Disclosures	Mortality
20	Alaska HCS	0	0
20	Boise VAMC	0	0

20	Portland VAMC	1	0
20	Roseburg HCS	0	0
20	Walla Walla VAMC	0	0
20	Spokane VAMC	0	0
20	Southern Oregon Rehabilitation Center & Clinics	0	0
20	Puget Sound HCS	0	0
VISN 21	Station Name	Institutional Disclosures	Mortality
21	San Francisco VAMC	0	0
21	Central California HCS	3	0
21	Northern California HCS	0	0
21	Palo Alto HCS	0	0
21	Pacific Islands HCS	0	0
21	Sierra Nevada HCS	0	0
21	Manila	0	0
VISN 22	Station Name	Institutional Disclosures	Mortality
22	Greater Los Angeles HCS	0	0

22	Loma Linda HCS	0	0
22	Long Beach HCS	0	0
22	San Diego HCS	0	0
22	Southern Nevada HCS	0	0
VISN 23	**Station Name**	**Institutional Disclosures**	**Mortality**
23	Central Iowa HCS	0	0
23	Iowa City HCS	1	1
23	Minneapolis VAMC	0	0
23	St. Cloud VAMC	0	0
23	Nebraska-Western Iowa HCS	0	0
23	Fargo VAMC	0	0
23	Sioux Falls VAMC	0	0
23	Black Hills HCS	0	0
TOTAL		76	23