ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

Community Based Outpatient Clinic in Marianna, Florida
February 26, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated in response to information received from an employee at the North Florida/South Georgia Veterans Health System (NF/SG VHS), Gainesville, FL, concerning two issues at the Community Based Outpatient Clinic (CBOC) Marianna, FL. The first issue involved a psychiatrist providing the facility Medical Administrative Services (MAS) clerks scheduling notices for patient follow-up visits via a paper list instead of using the Veterans Health Information Systems and Technology Architecture (VistA) system. The second issue involved a telehealth nurse who was maintaining a list of patients requiring scheduling in VistA for telehealth services.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** We interviewed three CBOC employees.

- **Records Reviewed:** We reviewed patient lists (a log book from the Mental Health Clinic and a list from the Telehealth Program) obtained during the course of the investigation.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A mental health provider at the CBOC was identified as the individual using a paper list. She stated that she used the list due to her lack of familiarity with VistA. The list comprised the patient schedule for the day, provided to her by a clerk. Instead of logging into VistA multiple times each day to make notes to the clerk for scheduling, follow-up appointments, and to track no-shows, she made notes on the daily patient schedule as the day progressed. At the end of the day, she provided the list with the annotated notes to the clerk, who would, in turn, enter the follow-up appointments into the recall module in VistA, make clerk notes for no-shows, or add other items needing documentation. These daily lists were maintained in a binder by the clerk as a future reference for the provider. The provider had informed the Chief Medical Officer (CMO) of the scheduling lists during a meeting. She stated that she was instructed to provide the clerk this information via VistA instead of using paper notes after the CMO was notified of the paper list. She also stated that the use of the paper notes, at no time, affected, delayed, or denied any patient required medical care.

- A clerk who received the notes from the provider stated that at the start of each day, she would print out the provider's patient schedule from VistA and provide it to the doctor. At the end of the day, the provider would return the list to the clerk with notes for each patient, to include follow-up appointments and other items needing to be noted in VistA

in the clerk notes. The clerk stated that she maintained these notes/lists in a binder in her office area. She also stated that at no time was patient care affected by the use of the paper notes/lists.

- A nurse was interviewed regarding the second issue raised by the employee with NF/SG VHS. She confirmed that she received a list of patients to schedule in VistA for telehealth appointments via an unsecure shared drive on the facility's Intranet. She would then print out and maintain the patient list to contact patients who were already scheduled for colonoscopies, to determine if they desired additional related services. If they did, the she would then schedule them in VistA. She stated that she was responsible for bringing the existence of the list to the attention of the CMO at CBOC Marianna, who, in turn, brought it to the attention of the director. Since then, she stated that the patient information was maintained on a secure electronic file. She used the electronic file to contact the patients and schedule them if needed. She also stated that at no time was patient care affected by the use of the paper lists.

Records Reviewed

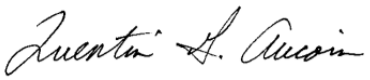
VA OIG staff reviewed and confirmed that the previously mentioned paper lists contained patient information.

4. Conclusion

The investigation into both issues revealed that the paper lists were maintained in a secure environment. The issues were brought to the attention of facility management by the employees who maintained the lists prior to the investigation. In addition, the practice of using the lists ceased immediately after the staff identified the practice of using the lists. The lists were used to further patient care and the relevant information was timely entered into VistA.

No delay or denial of patient care was identified due to the use of the lists. Prior to the investigation, the employees involved were informed of proper scheduling procedures in accordance with facility and Veterans Health Administration directives and policy.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014.



QUENTIN G. AUCOIN
Assistant Inspector General
for Investigations

For more information about this summary, please contact the Office of Inspector General at (202) 461-4720.