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

Gastroenterology Clinic at VA Medical Center in Minneapolis, Minnesota February 29, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based on information provided by two former employees of the U.S. Department of Veterans Affairs Medical Center (VAMC) in Minneapolis, MN. The employees alleged that while they worked as medical support assistants (MSAs) in the VAMC Minneapolis Gastroenterology (GI) Clinic, they were instructed to alter appointment and scheduling records. They also alleged that they were instructed by management to cancel veterans' appointments without the veterans' knowledge, but made entries in the computerized scheduling system indicating that the veterans were contacted. Both employees had previously been removed from Federal service and claimed that they brought these concerns up to management prior to their removal.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the two complainants, VA OIG interviewed nearly two dozen employees of the Minneapolis GI clinic, including an MSA responsible for scheduling, a VAMC Minneapolis employee assigned to assist one of the complainants temporarily, the VAMC Minneapolis Clinic Director, the chief nurse for Primary Care, and a former VAMC employee and close friend of one of the complainants. An additional 19 people were interviewed, the majority of whom were VA employees who worked or filled in at the GI clinic, including MSAs, nurses, and physicians.

- **Records Reviewed:**

  - More than 21,000 emails and Microsoft Lync messages from the above-mentioned interviewees were reviewed. The emails reviewed covered the date range of January to November 2014.
  - A copy of a flow chart titled "Consult Process" was provided by the VAMC Minneapolis. This chart is not specific to the GI clinic, but to all the specialty clinics.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

The current VA employees interviewed stated almost the exact same thing: that no manipulation of the patient scheduling system took place and none of them were

directed to alter or falsify any information regarding VA patients. This included appointment times, scheduling, medical records, or anything else dealing with patients. Many employees did confirm the existence of a spreadsheet used by the GI clinic, but all stated it was used solely for patient tracking purposes, not for patient scheduling.

- Complainant 1 is one of two individuals featured in a local television news story in which she made allegations about scheduling at the GI clinic. At the time of the interview, she was not employed as she had a pending personnel grievance against VAMC Minneapolis for alleged wrongful termination. Prior to her termination from the VAMC, she had been the supervisory MSA in the GI clinic for about a year and the time of our investigation, and before that, an MSA in another VAMC clinic.

  Complainant 1 alleged that her supervisor directed her and the other MSAs to routinely go into GI patient scheduling records and falsify the reason the patient's appointment was being canceled and/or the reason their pending consult was being discontinued. Stated reasons included that the patient canceled the appointment, that the patient stated he/she did not want the procedure at all, or that the patient could not be reached to schedule an appointment. She stated that her supervisor frequently would provide the MSAs with a list of patients who needed one of these reasons put in the system. Since she did not contact these patients herself, she assumed that another MSA or her supervisor had contacted them.

  Complainant 1 stated that many patients would call in complaining they were never contacted for their appointments or that they never received letters explaining the results of their examination. According to this complainant, one of her MSAs was sending out results letters.

  Complainant 1 claimed all patients were to be contacted by telephone with a follow-up letter, and this was not happening.

  Complainant 1 claimed she sent numerous emails to her supervisor from March 2014 up until her employment was terminated. In those emails, she stated that they were doing things incorrectly in the GI clinic and that patients were having their consults discontinued in error. We showed complainant 1 copies of emails that complainant 1 sent to her supervisor in which complainant 1 stated all consults were caught up and things were running smoothly in the clinic. Complainant 1 had no reaction to these email messages.

  She was asked about her television appearance during which she admitted to putting false information into the patient systems. At the time, she thought the information was accurate because her supervisor told her to input the data. She was under the impression someone else was contacting the patients and assumed that either her supervisor or another MSA was doing it. She later believed the information was false and started to question whether patients were being contacted at all after so many patients telephoned to complain that they had no appointments. She admitted she had no proof of this. She asked her supervisor whether the patients were being contacted and her supervisor said they were. Complainant 1 admitted contacting patients was not her job, being the supervisor, but that it was the job of the MSAs who worked for her.

- Complainant 2 was also featured, along with complainant 1, in a local television news story in which they made allegations regarding scheduling practices at the GI clinic. At the time of the interview, she was not employed as she had a grievance pending against VAMC Minneapolis for alleged wrongful termination. She was previously an MSA assigned to the VAMC's GI Clinic.

  One of complainant 2's allegations was that she and other MSAs assigned to the GI clinic were changing scheduled consults for VA patients without notifying patients. She stated the patients should have been contacted via telephone to set appointments, as well as to confirm upcoming appointments. This was done on occasion, but she was instructed by the nurse manager (complainant 1's supervisor) to stop calling patients and to just send a scheduling letter. Complainant 2 admitted she did not always send these letters. She added that the nurse manager would give her a list of patient names and instruct her to change the consults because the patients' consult appointments were getting close to being more than 30 days old. When the nurse manager gave her this list, she would tell complainant 2 to put in the system that the patient refused the procedure or that the patient did not respond to calls or a letter.

  Complainant 2 was certain that none of the patients on the lists she was given were contacted because she would have been the one to contact them. Also, there were never any notes in the computer system showing that contact was attempted. When asked what happens to a consult when it is canceled, she stated it is just simply closed out. She also stated that patient results letters were being sent out by MSAs in the GI Clinic, and that many patients would call in stating they never got their letters.

  Complainant 2 stated that the nurse manager had the MSAs change the "desired date" for patients so that the GI Clinic would be in compliance with the 14-day policy, wherein patients' appointments were to be scheduled within 14 days of their desired appointment dates.

  This complainant claimed she brought her concerns about patient scheduling to her supervisor, complainant 1, as well as to the nurse manager.

- We interviewed a current employee of VAMC Minneapolis who was assigned to work in the GI Clinic on a temporary basis in 2014. He started off doing small jobs like making copies, but was soon put in the same office as complainant 1, the GI MSA supervisor. He was tasked by complainant 1 to call veterans who had appointments in the GI Clinic to confirm the appointment. Each day, she would provide him a list of patients that he needed to call. He would then follow up the call with a confirmation letter. He had nothing to do with the scheduling of appointments, just contacting veterans to confirm future appointments. If veterans needed to reschedule, he would put them in touch with complainant 1 or the nurse manager. If he could not physically talk to a veteran, he would leave a message to call him back. Any patient he could not contact would not come off the list and he would try each day until he made contact.

  The employee was not aware of any of the GI employees manipulating patient schedules. He had never heard the term "desired date." He never put notes in the system regarding a patient canceling an appointment as he would transfer those calls to complainant 1 or to

the nurse manager. He did not feel there would be too many of these notes as his sole job was to contact the veterans, and he claimed he contacted 100 percent of those he was supposed to contact.

At no time while he worked there did complainant 1 (or any other GI employee, including complainant 2) say anything to him regarding scheduling manipulation, patient wait times, or patient deaths. The first he heard of any of this was when the two complainants were on the local news making these allegations.

- We interviewed an MSA at VAMC Minneapolis, who is currently assigned to the GI Clinic and had been in this same position for more than a year at the time of our investigation. One of her primary duties was the scheduling of GI patients, as well as confirming appointments with veterans for future appointments. She was familiar with the 14-day policy under which veterans were to be seen within 14 days of their desired appointment dates. She has always been under the impression this policy did not apply to the GI Clinic because all GI patients are seen through a referral process using consults. No GI patient is a new patient as he or she would have already been seen by a Primary Care physician first.

  The MSA stated there was no truth to the allegations that she and other MSAs were ordered to input false information or cancel appointments for patients without the patient's knowledge. She was never asked to falsify anything or put false comments in the VA system regarding patients. She did say that the GI Clinic uses a database, similar to a spreadsheet, to keep track of patients. This database had nothing to do with scheduling and was for patient tracking only.

  One of her primary duties was to contact veterans to confirm upcoming appointments. She did this by making telephone calls and following up with a letter. The other MSAs, as well as her supervisor, complainant 1, also did this task. She stated the GI Clinic takes great care of the veterans and it would be rare for any to fall through the cracks. She added that only a supervisor, like complainant 1, would be able to discontinue a consult and this was only after a patient could not be contacted by phone or failed to respond to the letter. Even if a patient's consult had been canceled, and the patient called in, the GI Clinic would make sure that this veteran was seen as soon as possible. In the few instances this happened, the referring doctor would be notified via the VA system so a new consult could be created once the doctor saw that patient again. Also, only the doctors dealt with the results letters that would be sent to the patients. She never dealt with them and was confident that no MSA or complainant 1 would have been involved in these either.

- We interviewed the VAMC Minneapolis director for the GI Clinic. She has been with the GI Clinic for many years. She is familiar with both complainants as they both worked for her in the GI Clinic. Complainant 1 was the MSA supervisor and complainant 2 was under her as an MSA. Additionally, there were two other MSAs when complainant 1 started, one of whom has since retired.

  When asked about the allegations the complainants made on the local news, the clinic director stated she was shocked and upset because the allegations are "100 percent

untrue." In fact, the clinic director stated complainant 1 sent her numerous emails in which complainant 1 would state that the GI Clinic was doing great and they were all caught up with their patients. She stated that her staff did everything they could to schedule a patient within 14 days of his/her desired date, but due to the volume of GI patients, this did not happen often. She stressed to the MSAs that they must use the desired date and denied ever telling any of her staff to move this date or falsify any information regarding patient scheduling. She had no knowledge of desired dates being changed, and especially not with her blessing or direction.

She admitted that the GI Clinic uses an Access database to track patients for follow-up procedures. This database was in use prior to her arrival many years ago and is still in use. This database is used solely for patient tracking and has nothing to do with patient scheduling. She was familiar with the recall list within Veterans Information Systems and Technology Architecture (VistA), but stated its use was not mandated, and the volume of GI patients would be too cumbersome to use the recall list. This database was not a secret and could be accessed by any GI staff. Each month, the clinic director would print off all the patients who were due for a procedure the following month. While she admits no system is perfect, she was confident that the GI Clinic reached out to all its patients.

The clinic director was asked about complainant 1's allegations that patients who had consults pending were not being contacted and that the MSAs were ordered to put false information into the system as to why the consult was being canceled, as if the patient had refused the procedure or could not be contacted. The clinic director was adamant that this was not true. She would print out pending consults at least once a week to make sure that they did not miss any patients. Prior to the Advance Care Initiative (ACI), the MSAs would normally just send a letter to patients asking them to call in to schedule an appointment. If a patient failed to call in, the consult would be discontinued, but if a patient called in after the discontinuation of the consult, the GI Clinic would make sure he/she got in. Since the ACI went into effect, the patients are now called at least twice with a follow-up letter. The clinic director advised that only the physicians dealt with results letters and it was all electronic. After a doctor filled out a letter to his/her patient, it would be sent electronically to the Medical Media office, where it was printed out and sent to the veteran.

The clinic director was adamant that all of the allegations made against the GI Clinic were false and that she never instructed her staff to falsify any scheduling records or change patient information. The only way any of this might have happened would be if complainant 1 was directing complainant 2 to do these things; the clinic director had no knowledge of this happening. According to the clinic director, at no time while employed at VA did complainant 1 bring any concerns to her, especially anything resembling the allegations complainant 1 made on television. The clinic director provided emails showing communication between herself and complainant 1. Some of them show complainant 1 stating things were caught up in the clinic and did not reference any problems. The clinic director also provided a document that complainant 1 filled out, nominating the clinic director for the 2013 Civil Servant of the Year.

Later, we spoke to the clinic director again for clarification on some information provided during this investigation. The clinic director was specifically asked to describe how the 14-day desired date policy applied to the GI Clinic. She explained that because the GI Clinic is a specialty clinic in which patients get procedures, not just doctor visits, the clinic is very busy with GI procedures. When a veteran is provided a GI consult by his/her primary care physician, the GI staff contact the patient and let him/her know when the clinic will be available for his/her procedure. They then ask these veterans when they would like to be seen based on the clinic's availability. Once a patient chooses a date, that date goes in as his/her desired date, and an appointment close to that date is scheduled. The clinic director stated this is how it had always been done in the GI Clinic and this process was not a secret to anyone. She did not feel they were "gaming" any system, but rather informing veterans of the available dates for their procedures and letting them pick a time for when they wanted to be seen.

She was also asked about making phone calls to the patients for scheduling. She stated the GI Clinic used to just send out letters to the patients asking them to call in to schedule their appointments. When the GI Clinic started to lose MSAs and could not backfill them, it was too burdensome to send letters, so she started having her MSAs call the patients. This began in early 2013; well before the Phoenix[*] issues arose and also before the ACI was enacted.

She was also asked about the Access database she maintains. She stated this database was for patient tracking and not for scheduling. Patients go on this database when they need routine procedures at a future date. The future date was outside the VA's scheduling system's ability. For example, a veteran who had a colonoscopy this year might not need another one for another 5 years. He/she would go on this database list so he/she would not be forgotten or lost. The VA does not have anything within VistA that allows the clinic to put in a reminder for a 5-year checkup. This database is not a secret and all GI staff members have access to it.

The clinic director did not recall a 30-day window that the GI Clinic had to adhere to (as referenced in complainant 2's interview).

- We interviewed the chief nurse for Primary Care at VAMC Minneapolis. She is responsible for all the nurses in primary and specialty care, to include the GI Clinic; she works very closely with the clinic manager.

  The chief nurse met complainant 1 on only two occasions, and both involved personnel issues within the GI Clinic. During these two face-to-face meetings, complainant 1 never brought up a single concern she had regarding patient wait times, patient scheduling, or patient harm, as she alleged on television.

  The chief nurse did not recall ever meeting complainant 2 and indicated that she had not spoken to complainant 2 in any manner. At no time did complainant 2 share her concerns about patients in the GI Clinic.

[*] Any reference to Phoenix in this report refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

The chief nurse was not aware of any of the allegations brought by the complainants. There was no gaming of the 14-day appointment policy as the GI Clinic operated under different guidelines than Primary Care because of the consult referrals they used. She stated patients were sent letters asking them to call the VAMC to set their appointments. If a patient failed to call within 30 to 90 days, the consult was discontinued. When this happened, a message would be sent to the patient's Primary Care physician, who would then be responsible for working with the patient to get him/her in via a new consult. The chief nurse denied directing any GI Clinic employee, especially the complainants, to falsify patient scheduling or patient wait times.

The GI Clinic did not use the recall list as it was a specialty clinic and its use would be too difficult. The GI Clinic does use a Microsoft Access database, but this database is for patient tracking purposes only. It had nothing to do with patient scheduling or appointments. This database was not a secret and all GI employees had access to it. There were no other "secret" wait lists of any kind.

- We interviewed a VAMC Minneapolis employee. He said he is close friends with complainant 1 and has been her advocate since she was terminated from the VAMC. They worked together in Clinic 1A for about 3 years before she was promoted to MSA supervisor in the GI clinic and he moved to his current position. We asked him to expand on the comments he made during a newscast in which he and complainant 1 appeared and during which she made allegations of patient scheduling manipulation at the GI clinic.

  He stated in the spring of 2014, he visited the GI Clinic to let them know he had never been scheduled for his consult. The woman at the front desk told him his consult had been canceled and that he must not have received his letter. She tried to schedule him then, but he declined at the time because he did not have his personal calendar with him. Instead, he took the clinic's telephone number and said he would call to get an appointment scheduled. He did not call to get the appointment scheduled. He added that he told the news reporter that his missed consult was not entirely the VA's fault. At first, he had no intention of going on a television news program or talking to a reporter, but when complainant 1 started telling him that hundreds or even thousands of patients were being harmed, he decided to come forward. Complainant 1 also told him about a spreadsheet with thousands of patient names on it that was kept in the GI Clinic.

  He admitted he has no direct knowledge of anything that happened in the GI Clinic, other than what complainant 1 told him. In mid-May (2014), he recalled complainant 1 telling him something about a stack of consults that were more than 45 days old. Other than this bit of information, she never said anything to him that mirrors the allegations she made during her appearance on a televised news program. She never said anything to him about patient scheduling, wait time manipulation, or consults being canceled without the patients being contacted.

  We conducted a second interview of the VAMC Minneapolis employee. During this interview, he stated that some information had become known that showed him complainant 1 had what he described to be "serious issues." After his relationship with complainant 1 soured, he started looking at previous email exchanges he had with her and he discovered that she had manipulated some of the emails between them and provided

an example. When asked directly about the allegations she brought forward during her television appearance, he stated she never said a word to him about any of that. The first he heard of it was when he saw her on the television newscast. They were in almost daily communication and the only things she ever confided in him were the problems she was having with an employee, as well as problems with her boss.

The employee then described an exchange with complainant 1 that contradicts what he said on television, as well as during the first interview we conducted. During both, he stated he had gone to the GI Clinic to complain that he never got his consult letter or a phone call. He now stated that the only reason he actually went to the desk that day was because complainant 1 asked him to come to the GI Clinic to test how complainant 2 would treat him (he had never met her at that point). Complainant 1 stated she was getting complaints regarding the rude manner used by complainant 2 when interacting with African American patients. She then asked the employee, who is African American, to see how he was treated. He went there and asked complainant 2 questions about his own consult, and complainant 2 treated him well. She did inform him that his consult had been canceled, which was news to him.

We asked him if he believed complainant 1's story that was on television. He stated he is not sure but believes "she was more . . . embellishing . . . to exaggerate the situation."

- A total of 26 individuals were interviewed for this investigation, including the 7 individuals detailed above. Of the 19 remaining interviews, the majority were VA employees who worked or filled in at the GI clinic, including MSAs, nurses, and physicians. None of these interviews yielded information that supports the allegations brought by the complainants. They all believed the two of them were lying about what happened in the GI Clinic and none of them could understand why. None had any information regarding the manipulation of patient scheduling or the falsification of patient records as it pertained to appointments or scheduling. The GI physicians who were interviewed also verified that it is they, not the MSAs, who send out the results letters. Most knew of the Access database used in the GI Clinic and stated it had nothing to do with patient scheduling.

Records Reviewed

- During the course of this investigation, more than 21,000 emails and Microsoft Lync messages were reviewed related to the above-mentioned interviewees. The email request covered the date range of January to November 2014. The sole purpose of this review was to find any messages with information relevant to the allegations levied against the GI Clinic regarding wait time manipulation. During the televised newscast, complainant 1 stated that she notified her superiors about the problems in the GI Clinic regarding improper patient scheduling, the falsification of information in the VA's computer system regarding GI Clinic patients, and manipulation of patient wait times. When interviewed by OIG agents, complainant 1 stated that she sent emails to her supervisor detailing her concerns. The review of the mails did not uncover any such communication from complainant 1 in which she claimed she brought her allegations forward prior to her termination. She claims her termination was the result of her

"whistleblowing," but again, no such messages were discovered. In fact, numerous emails and Lync messages—from complainant 1 to her supervisor in which complainant 1 states things such as the clinic was all caught up on the consults and there were no problems—were reviewed.

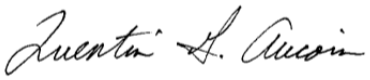
- A copy of a flowchart titled, "Consult Process," was provided by VAMC Minneapolis. This chart is not specific to the GI Clinic, but to all the specialty clinics. It clearly shows that if the facility is unable to contact a patient, the physician who ordered the consult would be notified via the VA system.

4. Conclusion

The investigation did not substantiate that a spreadsheet was used for scheduling purposes. According to the clinic director, as well as others, the GI Clinic uses a Microsoft Access database for the sole purpose of tracking its patients. This database is used for those patients who need to be seen for follow-up care in the future, such as 3-year, 5-year, or 10-year follow-up appointments. The VA's scheduling system does not allow for scheduling appointments that far into the future, so this database is used to ensure no veterans are forgotten or lost. It is a well-known program, is not a secret to anyone, and is accessible by all GI Clinic staff. It is maintained by the clinic director.

The allegations made by the complainants were not substantiated. For example, statements by both complainants that MSAs sent out the results letters contradicted all other information regarding the results letters. The OIG agents were consistently told that results letters were only sent out by the medical providers, through Medical Media. At no time did an MSA have anything to do with results letters. Through other interviews, it was discovered that prior to April/May 2014, GI Clinic patients were only being sent letters asking them to schedule appointments and the only telephone calls were to the patients whose medical issue was deemed urgent. As another example, when asked what happens to a consult when it is canceled, complainant 2 stated it is just simply closed out. Other interviews disputed this. If a consult is discontinued or canceled, the referring physician is notified via system-generated email. The physician then re-schedules the patient by creating another consult.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 26, 2015.



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