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



VA Outpatient Clinic in Jacksonville, Florida February 26, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated pursuant to information received through the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline. A complainant alleged that employees at the Outpatient Clinic (OPC) Jacksonville Prosthetics Department had been instructed to create a new consult for prescription eyeglasses in the Veterans Health Information Systems and Technology Architecture (VistA), the VA's scheduling system, if more than 30 days had elapsed from the time the patient received a prescription for eyeglasses to the time the veteran acted on the prescription.

2. Description of the Conduct of the Investigation

- Interviews Conducted: VA OIG interviewed the complainant, a supervisory Prosthetic employee representative, a senior manager of Prosthetics, the chief of Prosthetics, and the Veterans Integrated Service Network (VISN) 8 Prosthetics representative.
- **Records Reviewed:** VA OIG reviewed selected emails related to this investigation.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

• The complainant advised that last year a Prosthetics Department supervisor issued new instructions regarding how eyeglass prescription consults were recorded that differed from what the VA Central Office (VACO) Business Practice Guidelines indicated. He stated that when an eyeglass prescription is issued, a consult is created in the system. Once the veteran takes the prescription to a vendor to get his/her glasses, the purchase order is completed and the consult is closed. If the consult is not acted upon by the veteran within 21 to 30 days, the consult is closed. The prescriptions are still valid at this point as they are good for 1 year. After the 21 to 30 days, if the veteran goes to a vendor, the consult should be reopened via cloning, which returns the consult in the system to the original date it was opened. The change that was put in place last year by the Prosthetics Department supervisors was that the consults were no longer to be cloned, and should be recreated once the veteran acts on the eyeglass prescription after 30 days.

When the consults are recreated, the consult date is established on that new date and makes it appear that there was no wait time. The complainant stated that this was done to make the Prosthetics Unit look better when the timeliness reports are reviewed. The complainant advised that these instructions came from Prosthetics management and that he had an email from Prosthetics Department managers that stated this was the new procedure in place. He provided a copy of the email that was originally sent on July 16,

2013, and re-sent on July 17, 2013. The email included the subject line "CLONING OF CONSULTS" and was sent to all VA Prosthetics departments under the managers' supervision. The email stated that, effective immediately, employees would not clone any consults over 30 days old. It further stated that a new consult would be created instead, once the consult is acted upon after 30 days. The reason for this change was that the North Florida/South Georgia Veterans Health System (NF/SG VHS) Prosthetics continually has very low percentages on the Consult Completion Timeliness Report from VACO.

• A Supervisory Prosthetics representative at another VAMC advised that the process in place according to the Business Practice Guidelines, as provided by VACO, is as follows:

The consult is opened when the prescription for the eyeglasses is written. If it is not acted upon within 5 days, the consult is placed into a pending status. At 30 days, if the consult is not acted upon, it is closed. After this point, once it is acted upon by the veteran, the consult is cloned so that the purchase order can be filled by the Prosthetics Unit. When it is cloned, the original information remains in place to include the date the original consult was established.

She stated that this is the process that they have been using at her facility, and she provided a copy of the *Prosthetics and Sensory Aids Service Business Practice Guidelines for Prosthetics Consult Management*.

- The Prosthetics managers were interviewed and both stated that the decision to not clone eyeglass consults beyond 30 days was made at the local level. When asked what had given them the authority to make this decision to create a consult in lieu of cloning a consult in this manner, both stated that the VACO memo allowed this procedure to occur and that they had discussed this plan with the VISN 8 Prosthetics representatives, who gave permission to create new consults. Neither could provide any documentation proving permission was given by the Prosthetics representatives. Neither was sure if all of the other systems in VISN 8 had been discussing this or if anyone else in VISN 8 was doing what they are.
- The assistant chief of Prosthetics described the current practice in place for facilities including VAMC Gainesville, VAMC Lake City, OPC Jacksonville, OPC Tallahassee, and OPC Villages. She advised that a consult is opened when the eyeglass prescription is written by the doctor. If the consult is not acted upon by the veteran within 5 days, it is changed to a pending status up until 21 days. If there is still no action by the veteran, the consult is closed at this point. The prescription is still valid for 1 year from the date it was issued. Once the veteran acts upon the consult after this occurs, the consult must be in either the open or pending status to be processed. An option available to achieve this is to clone the original consult. If the consult is cloned, the original date it was opened is used on the timeliness report and the Prosthetics Unit receives a bad review for this late action on the consult. The chief of Prosthetics claimed that in order to avoid this, the Prosthetics purchasing agents have the authority to create a new (duplicate) consult per a VACO memo. She further stated that this VACO memo was not clear about what types of consults would fall into this category. An interpretation of this memo at the local level

was used to make the decision to change the cloning process to this new creation scenario last year in order to avoid issues on the timeliness report. VA OIG staff asked the chief of Prosthetics if anyone from VISN 8 was involved in making this decision to adjust the process described in the Business Practice Guidelines. The assistant chief of Prosthetics stated that she thought a former VISN 8 Prosthetics representative was aware of the decision.

• The VISN 8 Prosthetics representative advised that the consults for eyeglass prescriptions are initiated when the prescription is issued. Timeliness measures are based on 5 days being the fulfillment goal and attempt to have 75 percent or better in accomplishing this time frame. Anything outside of 5 days is considered late. If no action takes place after 30 days, the consult is closed. If the veteran acts on the prescription after this point, the consult is to be opened again by cloning it. She stated that the consult should not be recreated at this point because it slows down the process as now the signature of a purchasing agent is required. She stated this is the procedure that should be in place at the medical systems within VISN 8. We asked her to contact the medical systems in VISN 8 and determine who is cloning consults per the guidelines in place.

The VISN 8 Prosthetics representative subsequently contacted the investigator via email and indicated that all medical systems aside from NF/SG VHS were cloning consults when appropriate per the Business Practice Guidelines. When asked if the Business Practice Guidelines were considered a requirement or a best practice, she advised that they are considered by her to be a requirement especially as it relates to timely follow-up and documentation of follow-up action in the veteran's prosthetic record.

In a follow-up interview, the VISN 8 Prosthetics representative advised that her position provides oversight for the Prosthetics Program in VISN 8. Specifically, regarding her position as related to the chief and assistant chief of Prosthetics, she provides guidance, clarifies policy, reviews processes in place, and ensures that policies are adhered to. The representative did not recall being approached by either the chief or assistant chief of Prosthetics regarding the idea of recreating eyeglass prescription consults in lieu of cloning them. She did recall them talking about an idea that would allow them to no longer clone consults, but this was for prosthetics' items over \$3,000.00. She further recalled that she advised them to bring the information up to the group so it could be discussed and to ensure it fell into the policies in place. She also advised them to get prior approval for any adjustments to the current business practice guidelines in place prior to making any changes. When asked what her response would have been if the chief or assistant chief of Prosthetics had approached her and advised they wanted to recreate eyeglass prescription consults in lieu of cloning them per the guidelines, she stated that she would have expressed some concern with recreating new consults because if the original consult is still valid, then there is no need to create a new one. She said she would have recommended against it.

Records Reviewed

The email provided by the complainant advised all VA Prosthetics departments under the supervision of the Prosthetics managers that, effective immediately, employees will not clone any consults over 30 days old. It further stated that a new consult will be created instead once the consult is acted upon after 30 days. The reason for this change was that their system's Prosthetics departments continually had very low percentages on the Consult Completion Timeliness Report from VACO

4. Conclusion

The investigation confirmed that Prosthetic employees at VAMC Gainesville and its affiliated institutions had been instructed by his managers to recreate consults in lieu of cloning them per the business practice guidelines. During interviews, both Prosthetics managers stated that they made a decision at their level to have employees create new consults in lieu of cloning them.

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

QUENTIN G. AUCOIN

Assistant Inspector General

Quentin A. aucoin

for Investigations

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