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

Endoscopy Clinic Amarillo at the VA Medical Center Texas
Outpatient Clinic Lubbock at the VA Medical Center Texas
March 8, 2016

1. Summary of Why the Investigation Was Initiated

This case was initiated based on information provided to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) by Congressman Mac Thornberry expressing concerns over recent allegations about negligent employee performance at the Amarillo, TX, VA Health Care System. The allegations investigated by VA OIG were:

- The Endoscopy Clinic Amarillo has such a huge backlog that they placed patients on a paper list. When a slot opened up, they were taken from the paper list and put on the electronic list (many have been on this list for more than 150 days). It was reported that the Endoscopy Department has been changing documentation and has shredded and is shredding the paper lists and some documentation.

- The Outpatient Clinic (OPC) Lubbock has been shredding papers and changing documentation as to the requested date patients asked to be seen. They are doing this at the request of their managers. It was reported that they do have a paper list that veterans are placed on. Once a slot opened up, they were then put on the "real" list and it appears that they were only on a waiting list for 25 to 35 days when, in fact, they have been waiting for more than 150 days. Staff reported they were never trained in patient scheduling. They do not use the electronic scheduling system because no one ever trained them. They report a severe shortage of registered nurses and providers, which has caused huge backlogs in veterans' care. Lack of training and lack of access to documentation was reported. There were reports that employees were told by their managers to change the desired dates of veterans to a date that would reflect shorter patient wait time.

2. Description of the Conduct of the Investigation

- **Interviews:** Staff interviewed at the VA Medical Center (VAMC) Amarillo included medical personnel and the director of VAMC Amarillo. OPC Lubbock staff interviewed included several medical staff members.

- **Records:** VA OIG reviewed records, including performance evaluations and Talent Management System (TMS) training records for fiscal years (FYs) 2013 and 2014 for employees interviewed at VAMC Amarillo and OPC Lubbock; scheduling data for the second and third quarters of FY 2014 from OPC Lubbock; emails provided by staff; and Veterans Health Administration (VHA) directives.

3. Summary of the Evidence Obtained From the Investigation

Interviews

- A VAMC Amarillo Endoscopy Clinic scheduling employee was interviewed regarding scheduling practices. The interview did not substantiate any allegations of wrongdoing concerning manipulation of patient wait times or scheduling or the destruction of any patient paper lists.

- A number of VAMC Amarillo medical personnel were interviewed; their interviews did not substantiate any allegations of wrongdoing concerning manipulation of patient wait times or scheduling or the destruction of any patient paper lists.

- When a VAMC Amarillo manager was interviewed, it was discovered that the Endoscopy Clinic had been using two approved ledger books for a number of years. The clinic had a "Black Book" and a Specimen-Pathology book that may contain patient information. The Black Book is maintained and locked up in the Pyxis Machine and contains a copy of the procedures completed for the day, what was found, if there were pathology or specimens obtained, and what the recommended follow-up was at that time. All the information in the books was also in the Veterans Integrated System Technology Architecture (VistA) and the Computerized Patient Record System (CPRS). It was explained that the reason for having the Black Book is for continuity of care for patients, so the nurse can track all the information for the procedure and that all processes were properly completed. This also included completion of the appropriate follow-up care.

  The Specimen-Pathology book was used to track the tissues obtained during procedures. When the Laboratory takes custody of a specimen, a Laboratory staff member initials and verifies the change in custody and also verifies the accuracy of the information on the specimen label. This paper is kept with the Nurse Practitioner until the specimens are returned from the Laboratory. When the nurse finishes with the proper follow-up, the tissue records are discarded properly. The use of the Black Book and Specimen-Pathology book was reported to management and approved by a Privacy Officer. The nurse manager provided copies of emails regarding the approval of the books. She also explained that about a year and a half ago when the directive came out about the management of paper logs, the older Black Books were destroyed. Clinic operations and consults during the recent construction were also discussed.

- Eleven employees who were involved in patient scheduling at OPC Lubbock were interviewed concerning scheduling practices and destruction of patient records. Ten of the interviewees provided no support for the allegations of manipulation of patient wait times and the destruction of patient paper lists. One scheduling employee provided information contradictory to the 10 other employees who were interviewed.

- One OPC Lubbock employee reported that the clinic's practice was to use the "next available date" as the "desired date." He said that this practice was used until all the recent media coverage regarding patient wait time manipulation at VA. He believed that a former OPC Lubbock supervisor may have provided these instructions.

- Three additional employees involved in scheduling at the OPC Lubbock and one medical staff member were also interviewed regarding scheduling practices and destruction of patient records. None of the interviews we conducted provided support for the allegations of manipulation of patient wait times or the destruction of patient paper lists.

- The VAMC Director in Amarillo was interviewed. However, the interview provided no information in support of the allegations of wrongdoing concerning manipulation of patient wait times or the destruction of any patient paper lists.

Review of Records

- The FY 2013 Performance Appraisal Program forms for 10 of the employees from the OPC Lubbock revealed that the employees were required to "Accurately schedule appointments according to the VHA Directive 2003-962." Also, only one employee's Performance Elements/Standards stated, "The incumbent will accurately schedule appointments according to MCM [Medical Center Memorandum] 136-12-0909 and VHA Directive 2010-027 on Outpatient Scheduling Processes and Procedures, as it applies to new enrollees, established patients."

- The FY 2014 performance evaluations for the employees interviewed at VAMC Amarillo and OPC Lubbock disclosed the Performance Elements/Standards on most of the employees' Performance Appraisal Program forms contained the wording, "Scheduling Procedures: Critical Element: Demonstrates proper scheduling techniques by following current established directives, policies and associated performance measures. This includes appropriate use of desired date, EWL [Electronic Wait List], Recall Clinics, consult management and patient eligibility."

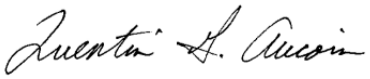
- Data related to appointment scheduling, specifically the period of time between the desired date and the appointment date, for appointments occurring in the second and third quarter of FY 2014 for OPC Lubbock, was obtained from VHA. The data were analyzed by the VA OIG Data Management Division and divided into individual reports reflecting: percentage of scheduled appointments for which the desired date was equal to the appointment date; percentage of scheduled appointments for which the scheduled date was within 7 days of the desired date; and percentage of scheduled appointments for which the scheduled date was within 14 days of the desired date. The data reflect that an average 94.5 percent of all scheduled appointments were reported as scheduled within the 14-day period of the veteran's desired date.

4. Conclusion

The Endoscopy Clinic Amarillo was using paper records to ensure continuity of care and to track the tissues samples. Emails showed that management was aware of these paper records and they were destroyed in accordance with VA directives. We did not substantiate any allegations of wrongdoing concerning manipulation of patient wait times or scheduling, or the destruction of any patient paper lists at the Endoscopy Clinic Amarillo. At the OPC Lubbock, only one employee reported that the clinic's practice had been to use the next available date as the desired date, which he believed to be due to the instructions of a former

supervisor. He reported this practice was discontinued after all the recent media coverage regarding patient wait time manipulation at VA. Interviews with other OPC Lubbock employees did not provide support for the allegations of manipulation of patient wait times or the destruction of patient paper lists.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 9, 2015.



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