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

VA Medical Center in Wichita, Kansas and Community Based Outpatient Clinic in Salina, Kansas March 22, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based upon information provided by a senior official at the Department of Veterans Affairs Medical Center (VAMC) Wichita regarding the alleged deletion of a "non-sanctioned" or unauthorized Home Based Primary Care (HBPC) patient consult list by two VAMC HBPC employees (HBPC1 and HBPC2). HBPC1 and HBPC2 allegedly deleted a patient consult list after a litigation hold memo was sent out by VA Central Office (VACO) to all VA employees on or about May 14, 2014. During the course of this investigation, the senior official referred to the VA Office of Inspector General (OIG) additional allegations he received regarding incorrect scheduling training provided by a Primary Care Lead medical support assistant (MSA) to Community Based Outpatient Clinic (CBOC) Salina staff.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG agents interviewed multiple employees at VAMC Wichita and at CBOCs Parsons and Salina during the course of this investigation.

- **Records Reviewed:** VA OIG agents reviewed emails discussing scheduling errors that the Primary Care Lead MSA at CBOC Salina sent to staff.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

VAMC Wichita Scheduling

- VA OIG agents interviewed several HBPC personnel regarding the existence of an HBPC Home Health Services waiting list that was not a sanctioned electronic waiting list (EWL). The employees confirmed that HBPC personnel kept two tracking lists on the SharePoint drive, which included the HBPC Home Health Services list and a list of patients waiting to be placed into the HBPC Program. Several employees stated the lists were not secret because they were on SharePoint (meaning multiple HBPC personnel had access to them) and that they were used to keep track of patient referrals waiting to be placed into HBPC "so they don't fall through the cracks." Because the HBPC Program was at capacity, one list was used to fill vacancies in the HBPC when necessary. While that list had previously been determined to be an unsanctioned list, it had been deactivated (albeit not deleted per se) at the direction of the director. The Home Health Services list was a duplicate list for patients who were already entered into the EWL.

- HBPC1, who was interviewed on two occasions, stated she instructed other HBPC personnel to delete the HBPC Home Health Services list, which contained patients already in Veterans Health Information Systems and Technology Architecture (VistA). She also stated she was not aware of the litigation hold memo from VACO at the time. She said she might have misunderstood the instructions she received from her supervisor telling her to have only one patient list for HBPC, that is, VistA. When asked if she instructed any other HBPC personnel to delete or get rid of lists, she stated that she learned that the CBOC Parsons HBPC had an additional list. The list was for CBOC Parsons patients waiting to get into HBPC who were currently being seen by Primary Care at CBOC Parsons. She advised that they could not have a separate list and needed to put the information into VistA and get rid of the list because she had been instructed to have the information only in VistA. She said she believed that this was before the litigation hold memo was sent to the VAMCs.

- There was an attempt to interview HBPC2; however; she requested counsel and the interview was terminated. HBPC2 commented that this was all a "big misunderstanding." A second interview of HBPC2 was not conducted because the investigation did not find anything indicative of intentional and/or malicious falsification of wait time data.

- Interviews conducted at CBOC Parsons revealed that the "Parsons list" in question was a folder used as a consult tracking list and it was not deleted or destroyed after HBPC1's request to do so. The folder containing the consult tracking list was not secret and was not used to manipulate wait times. Agents reviewed the folder and were informed by the HBPC nurse who maintained the folder that the consult list was not used to manipulate wait times.

CBOC Salina Scheduling

- An MSA trainer stated that she had never instructed staff to "back out" (exit the system and go back in) of VistA to change the "desired date" to the first available appointment date to reflect no wait time.

- A Primary Care Lead MSA stated that she had never instructed staff to back out of VistA in order to change the desired date to the first available appointment date to reflect no wait time. She stated that she had always instructed MSAs to ask the veteran, "When do you want to be seen?" and to use the veteran's desired date. She explained that it was the Primary Care MSA's responsibility to ensure that the veteran's wait time between the clinic's appointment and the patient's desired date was less than 14 days. This was not an attempt to manipulate times, but to make sure the patient care was not affected. If this couldn't be met by the MSA, then it was the MSA's job to pass the scheduling responsibility to the nurses in the applicable clinics to schedule the follow-up appointment. She further explained that if the time between the veteran's desired date and the clinic's appointment date was greater than 14 days, then patient care could be affected. She explained that she was not a clinician, but her main responsibility was to make sure veterans' care was not adversely affected. She did instruct her schedulers to back out of VistA in order to reflect the patient's desired date when a scheduling error

(that is, an inadvertent date) was made.

She stated she was instructed by her supervisors to use the 14-day measure, which is a VA national standard. She would receive a daily report from the VA Health Administrative Support (HAS) Department with the list of schedulers who had made appointments that fell outside the 14-day measure. She would then contact her schedulers to ask if there was a reason for it and see if it was a scheduling error. If it were an error, she would ask that the scheduler correct it in the system. She never instructed MSAs to "zero out" wait times when they were reported on the HAS list, but rather to reflect what the wait time actually is by capturing it correctly or passing the information to clinical staff.

- Interviews with four MSA schedulers at VAMC Wichita, who were trained by the Primary Care Lead MSA, did not substantiate that the Primary Care Lead MSA provided incorrect scheduling training. None of the employees stated they had been directed by the Primary Care Lead MSA to change veterans' desired dates to reflect the first available clinic dates. When MSAs cannot fit appointments in the 14-day measure of their desired dates, this information was to be passed on to the appropriate clinic nurse via VistA mail or Instant Message. One MSA noted that when a scheduling error was made (that is, inadvertently entering in the wrong date), then it had to be fixed by going into the VistA system and then backing out after the correct date was entered.

- A CBOC Salina MSA (CBOC Salina MSA1) stated that she was not instructed by the Primary Care Lead MSA to "fix" scheduling errors when they fell outside of the 14-day measure nor was she told by the Primary Care Lead MSA to use the patient's desired date as the next available clinic date. She stated she recently had been corrected by the Primary Care Lead MSA on the correct procedure to schedule patients in VistA by using their desired date and not the next available appointment at the clinic. She was not scheduling properly and was inadvertently using the next available clinic date as the patient's desired date. She stated that she was not doing this in order to manipulate wait times. If the patient's desired date fell outside the 14-day window, then she would refer the appointment to the clinical staff. She also stated that an employee who filled in sometimes for the schedulers had also been recently retrained because she was using the next available clinic date as the patient's desired date. She added that she felt CBOC Salina was understaffed.

- Another CBOC Salina MSA (CBOC Salina MSA2) advised that he was trained by the Primary Care Lead MSA. He stated that the Primary Care Lead MSA had instructed him to make follow-up appointments within the 14-day measure, and if unable to do so, then to relay the information to the appropriate clinic nurse. He further stated that the 14-day measure using patients' desired dates was "fuzzy" and unclear because of clinic availability and due to veterans changing their desired dates after the appointments had already been entered into VistA. CBOC Salina MSA2 further commented that not meeting the 14-day measure did not delay any care and did not violate policy—which is that the patient must be scheduled for a follow-up visit within 30 days of the desired date—however, he said he felt that the reflected wait time for follow-up appointments was inaccurate. He had been told in the past by the Primary Care Lead MSA to make

corrections when he scheduled a follow-up appointment that fell outside of the 14-day measure but not outside of the 30-day policy. He stated that the Primary Care Lead MSA emailed him requesting him to "please make the necessary corrections," and he would go back into VistA and put the appointment date as the desired date, which would in effect reflect a zero-day wait time, thus removing it from the [HAS] report. He commented that this was not outside of the 30-day follow-up appointment policy. He also commented that the CBOC did not have the staff to handle its current appointments and that VistA was an outdated system.

Records Reviewed

A review of emails pertaining to a Veterans Health Administration fact-finding report showed that the Primary Care Lead MSA directed schedulers to back out of VistA when the veteran changed his/her desired date or if there was a scheduling error. While VAMC management determined some of the Primary Care Lead MSA's instructions were inaccurate and in need of clarification, the Primary Care Lead MSA commented in one email that she was not asking "to fix anything that is not in error." In another email, the Primary Care Lead MSA stated, "we should not manipulate data in any way."

4. Conclusion

The investigation confirmed the existence of two HBPC patient lists, which were located on the VAMC's SharePoint drive. However, all HBPC patients were entered into VistA and nothing indicative of intentional and/or malicious falsification of wait time data was discovered. One list was deleted at the direction of HBPC1, who said she was not aware of the litigation hold memo at the time. An internal review conducted by VAMC personnel concluded that no veterans experienced an adverse effect as a result of being placed on the HBPC lists.

The investigation did not substantiate that the Primary Care Lead MSA was fraudulently providing incorrect scheduling instructions to CBOC Salina staff.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 30, 2015.

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