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

VA Medical Center in Kansas City, Missouri
March 25, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based upon information provided by Veterans Integrated Service Network (VISN) 15 management regarding scheduling practices in the Cardiology Clinic of the Veterans Affairs Medical Center (VAMC) in Kansas City, MO. A VAMC Kansas City internal review of the scheduling practices in the Cardiology Clinic revealed that a Cardiology scheduling clerk's practices were erratic and potentially unreliable. Some Cardiology providers used a "yellow sheet" to indicate dates for return appointments for their patients. In May 2014, approximately 1,032 of these yellow sheets were found in a drawer and file cabinet that had apparently not been processed by the clerk.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted five interviews.

- **Records Reviewed:** We reviewed records maintained by the Kansas City VAMC Human Resources Section (in particular, a memo documenting additional interviews conducted by the facility staff).

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A Cardiology Clinic clerk told OIG staff that it was her job to schedule the follow-up appointments by using the yellow sheets in the Cardiology Clinic, but she instead kept the yellow sheets in a locked drawer because she claimed a Registered Nurse (RN) told her to schedule consult appointments only, and not follow-up appointments. She stated that the reported reason for this instruction was that only the consult appointments were tracked by VAMC Kansas City management. She stated that she advised the RN and Scheduling Supervisor 1 about her backlog of yellow sheets during a May 2014 meeting they held with Supervisor 2. She stated that she also informed a manager in May 2014 about her backlog of yellow sheets and the need to reschedule the associated patients.

  The clerk claimed that when the manager first found the yellow sheets in her possession, the manager lied to VAMC Kansas City management when he told them that she had said she did not have time to schedule the yellow sheet appointments due to all of her other assignments. The manager related the details to upper management as was provided by the RN following a conversation between the RN and the clerk when the drawer full of yellow sheets was initially discovered on May 22, 2014. The clerk claimed that she did not schedule the yellow sheet appointments because she was specifically instructed not to

schedule recall appointments, which is what was primarily included on yellow sheets. The RN who discovered the yellow sheets did articulate priorities for scheduling when speaking to the clerk; however, the RN specifically denied that she told the clerk not to schedule follow-up appointments. The clerk also stated that she sent emails to the aforementioned parties, notifying them about the yellow sheets, but she suspected that VAMC Kansas City had erased her emails.

VA OIG found only one relevant email chain that started on May 14, 2014, from a Supervisory MSA to the clerk regarding a previous meeting that day that covered the clerk's need to meet with the Supervisory MSA for instructions. The email went on to describe the need for the clerk to provide administrative support to the Cardiology Patient Aligned Care Team. The clerk responded on May 15, 2014. The clerk did refer to four consults from March that were awaiting final disposition and that there were recall patients who needed to be scheduled. The clerk advised that the RN had told her not to focus on the recall appointments because only consults were being tracked. There was no mention of 1,032 yellow sheets stuffed in a desk drawer in the clerk's response. She stated that no one instructed her to destroy records.

- The RN stated that she originally notified other personnel about the yellow sheets in the clerk's drawer, after first seeing them during a May 2014 conversation with the clerk. When the clerk opened the drawer and showed the RN the stack of yellow sheets, the RN told the clerk to fill in open appointments using her backlog of yellow sheets. The RN stated that the clerk said, "I don't have time to go through all these." The RN then informed other personnel about the clerk not having time to go through the yellow sheets. The entirety of the 1,032 yellow sheets was found the following week.

  The clerk told the RN there was currently a backlog on follow-up appointments. On several occasions, the clerk told her that the backlog was sometimes 70–80 patients in number, and other times, zero. The RN stated that the clerk never specified what the reason for the backlog was, yellow sheets or otherwise. She was previously unaware that the clerk had 1,032 yellow sheets in her possession, and added that they needed to be addressed, as the simple existence of a yellow sheet did not mean that a follow-up appointment was needed. She denied instructing the clerk not to process the yellow sheets (that is, not to schedule follow-up appointments), and advised that, in fact, all of the Cardiology Clinics were empty in June 2014 because the clerk had not been scheduling any appointments.

  The RN added that the clerk never mentioned the yellow sheets or follow-up appointments during the aforementioned May 2014 meeting that included Supervisors 1 and 2. She added that the clerk did, in fact, process some of the yellow sheets, but it seemed to be haphazard, and the clinic staff had to trust that the clerk was processing the yellow sheets and follow-up appointments. If a follow-up appointment were deemed to be critical, the Cardiology Clinic would ensure that the appointment had been scheduled.

- Supervisors 1 and 2, as well as the manager, all told VA OIG staff that the clerk never notified them about the yellow sheets. The manager stated that the clerk's reasoning for

having the yellow sheets was inconsistent. The clerk also advised the manager initially that she did not send emails about having the yellow sheets in her possession, but later the clerk claimed that she did.

Records Reviewed

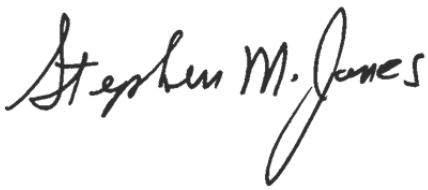
- VA OIG staff reviewed a memo documenting additional interviews conducted by the facility that was maintained by the VAMC Kansas City Human Resources Section. The individuals interviewed consisted of a nurse co-leader, a nurse manager, and Registered Nurse 2. The memo reported that all three individuals told VAMC Kansas City that the clerk never mentioned the yellow sheets to them.

- An email dated May 14, 2014, from a Supervisory MSA to the clerk regarding a previous meeting that day addressing the clerk's need to meet with the Supervisory MSA for instructions was reviewed. The email went on to describe the need for the clerk to provide needed administrative support to the Cardiology Patient Aligned Care Team. The clerk responded on May 15, 2014. The response did refer to four consults from March that were awaiting final disposition and that there were recall patients who needed to be scheduled. However, the clerk's response did not mention the 1,032 unprocessed yellow sheets.

4. Conclusion

The investigation substantiated that the clerk maintained paper records relating to the scheduling of patients in the Cardiology Clinic that she did not process. An immediate review of the paper records by VAMC Kansas City scheduling supervisors and clinical staff was completed over the course of 2 days in May 2014 and identified that 37 of the 1,032 sheets represented delayed appointments, and all 37 were immediately scheduled. A clinical review by VAMC Kansas City officials found no specific harm to patients as a result of the scheduling delays.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 2, 2014.



STEPHEN M. JONES
Deputy Assistant Inspector General
for Investigations

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