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

VA Medical Center in Dublin, Georgia
March 31, 2016

1. Summary of Why the Investigation Was Initiated

This Department of Veterans Affairs (VA) Office of Inspector General (OIG) investigation was initiated pursuant to a referral from Congressman Jack Kingston, regarding allegations of a "batch closure" of more than 2,000 Non-VA Care Coordination (NVCC) consults at the Carl Vinson VA Medical Center (VAMC), Dublin, GA, which resulted in veterans not receiving the care they were entitled to receive.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed five VAMC employees, including an employee from the director's office; a manager in the Health Administration Service (HAS); a manager in Social Work; the director; and an employee in the chief of staff's office. We also interviewed a manager in Quality Management at Veterans Integrated Service Network (VISN) 7.

- **Records Reviewed:** VA OIG examined a PowerPoint presentation detailing the effort to reduce open consults; a Report of Contact indicating VAMC Dublin met its goal to reduce consults based upon its batch closure; and a VA OIG Office of Healthcare Inspections (OHI) report[1], which concluded that facility staff improperly batch-closed 1,546 NVCC consults on April 25, 2014, in order to meet organizational goals.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A director's office employee involved with the Fee Basis Program stated that once, when a manager in HAS was on leave, a Fee Basis employee presented concerns about how consults were being addressed. The director's office employee learned that reviews were being conducted on all consults over 90 days old in accordance with guidance provided by VA Central Office (VACO), as outlined in a PowerPoint presentation titled *Consult Initiative-Task 4*. After calling someone at VACO, who was identified in the PowerPoint presentation, the director's office employee was referred to, and contacted a VACO Chief Business Office (CBO) employee for further guidance. According to the director's office employee, the CBO employee agreed that the best solution, as identified in the PowerPoint presentation, was to do a batch closure of the consults over 90 days old.

  The director's office employee explained that the batch closure was necessary because

[1] *Improper Closure of Non-VA Care Consults Carl Vinson VA Medical Center Dublin, Georgia* (Report No. 14-03010-251, August 12, 2014)

75 percent of the consults over 90 days old were not accepted by providers, as the patients' status and/or their medication had changed. As a result, providers often required new consults from VA. The director's office employee stated that before completing the batch closure, they "had numerous safeguards in place" to ensure "no veterans fell through the cracks" and they also had numerous copies of electronic records of patients whose consults were discontinued. The director's office employee said the intention was to create new consults after completing the batch closure. The director's office employee said she "was the one that hit the key" on the computer to complete the batch closure; however, other staff agreed to move forward with her recommendation to batch close, including an employee in the chief of staff's office and a Social Work manager. Approximately 1,546 consults were deleted during the batch closure.

After completing the batch closure, a manager from VISN 7 Quality Management, who noticed the consult closures, contacted her and advised it was not a wise decision to conduct the batch closure. Shortly thereafter, the CBO employee contacted the director's office employee and apologized for improperly advising her to conduct the batch closure. The director's office employee indicated she and others never expected to meet the consult closure goal and believed it to be an impossibility. The director's office employee stated the director asked her to look into the matter after the NVCC employee first presented concerns about how consults were being addressed.

- A manager from the HAS stated that, after returning from leave in April 2014, she learned that a staff member had batch-closed almost 2,000 consults. She explained that batch closure access was previously taken away from everyone when a new consult process started. The new process required VISN authorization for batch closures. The HAS manager talked with the director who thought only Optometry and Audiology consults were batch-closed. Thereafter, a decision was made to do a 100 percent review, because the HAS manager was concerned the batch closure had an effect on patient care.

- A Social Work manager stated that on April 24, 2014, she sent the director's office employee the Veterans Health Administration PowerPoint presentation, titled *Consult Initiative-Task 4*, because she wanted her to check page 6 of the presentation indicating the appropriate process. The director and other VAMC Dublin administrators met with the Social Work manager to ask whether or not batch closure was an option. The Social Work manager said "yes," but advised it had not been used in that way before, and said that the consult team should follow the procedures and individually review patient medical charts.

  The Social Work manager stated that a chief of staff's office employee had suggested that the director's office employee contact the VISN 7 office to confirm that a batch closure was appropriate. The Social Work manager stated the director said, "They don't know what they're doing" and "[the director's office employee] spoke with the source [the CBO employee]." The Social Work manager was under the impression that the director's office employee spoke with the CBO employee and another VACO manager, and that the director's office employee had received some level of concurrence to conduct the batch closure in an email. The Social Work manager also said that on April 25, 2014, she was asked to attend a meeting, during which she reiterated her stance, but apparently the

decision [to proceed] had been made. Before the batch closure, the Social Work manager removed Audiology, Optometry, and Cardiology consults from the batch closure list.

- The director stated he could not recall the exact date of the batch closure, but they had "big issues" with consults exceeding 90 days and their vendors would not accept consults over 90 days old. The director confirmed there were a total of 1,546 consults closed. He stated his intent was to have the closed consults renewed within 3 weeks. His primary issues with the consults were with Audiology and Optometry, because there were insufficient providers in the Dublin area to service the overwhelming number of consults.

  The director stated a consult cleanup team worked on the consult closures at VAMC Dublin, and he subsequently accepted their recommendation to do the batch closing. The director confirmed that the director's office employee had received guidance from the CBO employee to move forward with the batch closure. The director said he was never contacted directly by anyone from VISN 7 regarding the decision to conduct a batch closure; however, the director's office employee did inform the director of the VISN's position, indicating that conducting the batch closure was not a good idea. The director stated they attempted to undo the closures with no success. When asked in a follow up interview why staff had failed to bring the batch closure to the attention of OIG staff during the in-brief meeting for an OIG investigation regarding allegations of improper batch closure of consults (which involved many VAMC managers including the director), the director replied, "I think they were just answering your questions" and then he stated, "I don't know why they did not mention it."

- A manager from Quality Management in VISN 7 stated she learned of the batch closure on April 28, 2014, after her team noticed an unusual decrease in open consults exceeding 90 days for VAMC Dublin. The manager and others then spoke with the CBO employee who advised she did not approve the batch closure that the director's office employee conducted. The VISN 7 Quality Management manager stated that, based on the information the director's office employee provided to the CBO employee in the April 25, 2014, email (Subject: Non-VA Care Consult Completion), the director's office employee never disclosed her intention of conducting a batch closure; instead the director's office employee stated she intended to administratively close consults. This would have required a clinical review prior to closing. The VISN 7 Quality Management manager also stated the CBO employee said she was not familiar with an option to batch close. The VISN 7 Quality Management manager stated she spoke with the director's office employee and informed her it was not appropriate to take such action without first consulting VISN 7 staff.

- An employee in the chief of staff's office was interviewed and said that, beginning in January 2013; she was tasked with the oversight role of the consult cleanup process. On April 24 or April 25, 2014, a meeting was called to address the cleanup of NVCC consults. Attendees included the director, the director's office employee, the Social Work manager, and herself. The director's office employee introduced a PowerPoint presentation, *Consult Initiative-Task 4*, which discussed the option of a group closure (batch closure). The director's office employee asked the Social Work manager to review the PowerPoint presentation and explain the group closure option.

The chief of staff's office employee asked if they had spoken with the VISN 7 Quality Management manager or another VISN 7 representative about their intention of completing the batch closure. (They routinely spoke with VISN 7 officials throughout the consult cleanup process.) According to the employee, the director responded by saying, "We don't think the VISN knows any more than we do, and we don't think they know what they're doing." The director's office employee stated that she sent an email to the CBO employee for guidance on the batch closure, and if the CBO employee gave them the OK, they would be moving forward to complete the batch closure. During a conversation on or about April 25, 2014, the Director's office employee informed the chief of staff's office employee that the CBO employee had given authorization to move forward with the batch closure. No one had access to the menu to complete the batch closure until the director's office employee met with Information Technology staff to obtain the key.

The chief of staff's office employee stated no one mentioned the batch closure during the May 8, 2014, OIG in-brief about alleged batch closures of consults, and it appeared they were only going to answer questions specifically asked by OIG staff. The chief of staff's office employee stated she thought about reporting her concerns regarding the batch closure to the VISN, but she chose not to, because "when leadership makes a decision, we don't go up against it, specifically [the director]." The chief of staff's office employee stated she suspected the director's office employee's urgency to complete the batch closure was to have it completed before the HAS manager returned from leave because she knew the HAS manager would have likely opposed the idea.

Records Reviewed

- A Social Work manager provided a PowerPoint presentation titled *Consult Initiative-Task 4*, which she and the director's office employee referred to for guidance regarding the batch closure.

- A manager in Quality Management provided a Report of Contact from a VISN 7 employee regarding the batch closure. Review of the document disclosed that it stated, "Dublin leadership's lack of involvement resulted in an ineffective consult management process" and it noted that, as a result of the batch closure, VAMC Dublin was able to meet its [consult reduction] goal.

On August 12, 2014, OHI published *Improper Closure of Non-VA Care Consults Carl Vinson VA Medical Center Dublin, Georgia*[2] related to this investigation. OHI concluded that facility staff improperly batch-closed 1,546 NVCC consults on April 25, 2014, in order to meet organizational goals. In addition, OHI inspectors noted a director's office employee's description of her discussion with an employee of the CBO, regarding the batch closing, was contradicted by an April 25, 2014, email the director's office employee sent to the CBO employee. In the email to the CBO employee, the director's office employee did not mention anything about conducting a batch closure; rather, it stated old consults would be administratively closed [an entirely different process], which was the plan the CBO

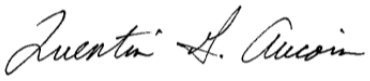
[2] Note: The OHI report addressed the issue of veterans not receiving care they were entitled to receive.

employee concurred with. OHI reviews substantiated that 648 patients whose consults were batch closed had not been seen by the NVCC provider at the time of consult closure.

4. Conclusion

The investigation revealed an employee improperly used the batch closure option to close 1,546 NVCC consults at the request of VAMC Dublin's director, to give the appearance that the facility met a consult cleanup goal established by VACO in a timely manner. An analysis by OHI revealed that 648 patients whose consults were batch closed has not been seen by the NVCC provider at the time of consult closure. At the onset of this investigation, an OIG special agent briefed the director and his assembled team, and advised them that the investigation would focus on an allegation of improper cancellation of consults. The director and his assembled team did not disclose problems with batch closures that had been improperly completed the previous month. When the director was asked in a follow-up interview to explain why the improper batch cancellation of NVCC consults was not mentioned during the initial briefing hosted by the director—given the very specific allegations that would be investigated by OIG—the director responded, "I think they were just answering your questions," and added, "I don't know why they did not mention it." Withholding this information during the initial meeting hosted by the director could have delayed the OIG investigation on improper NVCC consult closures. The director's omission of key information he possessed regarding improper closures he directed demonstrated a lack of candor.

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



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