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

## VA Medical Center in Denver, Colorado
## May 19, 2016

### 1. Summary of Why the Investigation Was Initiated

This investigation was initiated following media outlets reporting that a former Department of Veterans Affairs (VA) employee alleged that the VA Medical Center (VAMC) Denver, CO, had kept, or was keeping, a "secret wait list" of patients who were waiting to be seen and treated at the VAMC Denver Sleep Medicine Clinic. During the news broadcasts, it was alleged that in 2012, the VA employee was given a copy of a manual list of names and told to transfer the names to the VA's Electronic Wait List (EWL).

As a result of the allegation, the director of VA's Rocky Mountain Network asked that an Administrative Board of Investigation (ABI) be convened to look into the matter. In addition to the Sleep Medicine Clinic allegation, ABI was also charged with looking into a complaint related to alleged inappropriate scheduling lists in the Mental Health and Audiology Clinics and Prosthetics Service. In addition to past practices, ABI was also tasked to investigate any evidence of inappropriate current practices.

### 2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) did not conduct any interviews.

- **Records Reviewed:** The facility conducted an ABI review. VA OIG reviewed the adequacy of its report, but the OIG did not duplicate the work completed by the ABI.

### 3. Summary of the Evidence Obtained From the Investigation

#### Interviews Conducted

- None performed by VA OIG. ABI interviewed 16 VA employees, all of whom were sworn to truthful testimony, under penalty of disciplinary action for failing to provide such testimony. The employees included a Business Implementation manager, a deputy Business Implementation manager, five medical support assistants (MSAs), a lead MSA, a program support assistant, a program manager, the service chief of a Specialty Clinic, a registered nurse, the facility director and assistant director, a supervisor, and a manager in Health Administration Services.

#### Records Reviewed

The OIG's review of the ABI report disclosed the following information: the board was composed of five VA employees from four separate VA Integrated Service Networks (VISNs). None of the board members worked within the Rocky Mountain Network, which

includes VAMC Denver. Furthermore, at the request of the director, an outside observer was also invited to participate. That individual was affiliated with the United Veterans Committee (UVC). The UVC described itself as a nonprofit coalition of 50 chartered and Federally recognized veterans service organizations and affiliates. In addition to representing its member organizations, the UVC's mission included working with public policymakers to ensure proper support for veterans' issues and concerns.

The board reached the following conclusions regarding the allegation of inappropriate scheduling lists in the Mental Health Clinic (MH):

- MH staff kept a list (a Microsoft Excel file named "Reassignments") to track patients requiring reassignment to a new provider because of the loss of their previous provider.

- Two board members took a random sample from the February 2015 tab of the "Reassignments" workbook and determined that the patients in the sample had continued contact with MH services, despite the fact they were not currently assigned a provider. [The ABI reviewed data from February 2015 in order to provide a current assessment of scheduling issues.]

- The "MHC Enrollment for Intake" document represented a visualization of the provider availability. It was a combination of several provider-scheduling grids in one view. It was used to help staff visualize the next available appointment across providers. Although information found in the workbook could also be found in Veterans Health Information Systems and Technology Architecture (VistA), the workbook was created to fix deficiencies that existed in the VA's VistA scheduling package.

- The "MHC Med Evals" workbook was used to transition patients from staff who were not able to prescribe medications to those who were prescribers. The list did not contain protected health information or personally identifiable information (PII) and all information contained in the workbook was obtained from VistA and the VA's Computerized Patient Record System (CPRS). This workbook posed minimal risk, as all data were duplicative and did not include PII.

The board reached the following conclusions regarding the allegations of inappropriate scheduling and wait lists in the Prosthetics Service and Audiology and Sleep Medicine Clinics:

- Prosthetics Service used a list (named "Items for Scheduling/Letters" aka "Items-in List") to notify MSAs when patient items were received from contractors. This list was not necessary because the service could use an additional signer in CPRS on the consult.

- Based on testimony and evidence reviewed, the board concluded there were currently (at the time of the interview) no inappropriate scheduling lists in Prosthetics.

- Based on testimony and evidence reviewed, the board concluded there were currently no inappropriate scheduling lists in Audiology.

- The 2011 Sleep Study Patient List, as referenced by the local news, was appropriately transferred to the EWL in May 2012 when it was identified.

- Based on testimony heard and evidence reviewed, the board concluded there were currently (at the time of the interview) no inappropriate scheduling lists in Sleep Medicine.

Testimony in the ABI suggested that, in the 2011 to 2012 time frame, the understanding was that only the top 50 clinic "stop codes" were required to use the EWL. (A stop code essentially represents a different modality of care.) The Sleep Medicine Clinic, not being a top 50 clinic stop code, therefore, did not use the EWL, nor was it required to, and tracked patients through the VA's VistA system and a Microsoft Excel document. One of the employees interviewed stated that audits his office performed revealed that there were 500 Sleep Medicine Clinic patients being kept on such a list. Once these patients were identified, they were then placed on the EWL, despite the Sleep Medicine Clinic not being a top 50 stop code. The VA employee proactively took action to put patients in the Sleep Medicine Clinic on the EWL, although there was not a requirement at that time to do so.

The ABI looked into several issues, one of which was related to wait times. The investigator reviewed the parts of the transcribed interviews that dealt with wait time issues. He did not review the transcribed interviews in their entirety.

## 4. Conclusion

The conclusions reached by the board appeared to be justified and appropriate. The board's composition, including a member from the UVC, also appeared to be a good faith effort to examine the issue fairly. Once VA OIG determined that the ABI review results provided reasonable assurance that scheduling issues were being managed effectively, we did not duplicate the review performed by the ABI.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 27, 2016.

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