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

VA Medical Center in Columbia, South Carolina
December 20, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was prompted by an allegation in May 2014 claiming that the scheduling of diagnostic tests, such as pulmonary function tests and mammograms, was mismanaged. Specifically, it was alleged that the facility's Systems Redesign Team changed the designation of some of the tests and that those tests were removed from the consult list.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** The Department of Veterans Affairs (VA) Office of Inspector General (OIG) interviewed the complainant and a senior leader.

- **Records Reviewed:** VA OIG did not review any records. The complainant did not provide any details that identified which records to review; no time frames were given or patients identified as to what prompted his suspicions.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

VA OIG learned of the allegation when a VA Medical Center (VAMC) staff member contacted a VA OIG special agent and stated that the complainant had claimed that VAMC Columbia staff had mishandled patient consults.

- The complainant, who had previously told the deputy chief of VA Police & Security Service for the facility that VAMC Columbia mishandled patient consults, stated that his comments related only to appointments made in the Pulmonary/Respiratory Care Service. He also stated that he had never intended for his original comments to the Deputy Chief of Police to be relayed to VA OIG. He explained that the Systems Redesign Team was aligned under the chief of staff (COS) and was supervised by the compliance officer/administrative assistant to the COS at VAMC Columbia. He reported that a change had been implemented to reflect orders rather than consults and he felt that patients could "fall through the cracks" with this new protocol.[1] It seemed that he could not identify any incidents as to when that had occurred and he said he had not heard about that occurring. He suggested that the reason orders were used instead of consults was to decrease the number of pending consults. He explained that an order was texted to staff to schedule a patient for an appointment. When the patient showed, a consult was

[1] While the complainant may have felt this way, he was unable to provide any specific information to follow up on as far as dates, patients, or time frames. Our inquiry did not find any indication that this had occurred.

generated. A consult would stay "on the books" only for the day of the appointment. The results would be attached to the consult to complete the process, which made the consult appear to have a "short life." However, in the past, the facility would use consults rather than orders and he did not feel the change was wise, but he could not provide any examples of delays in patient care or harm to patients because of the change. He said he did not believe there were any inappropriate actions being conducted at VAMC Columbia.

- A senior official was specifically questioned about his knowledge of the Systems Redesign Team being created at VAMC Columbia to lessen the number of consults. He explained that a team was assembled to work on the issue of outstanding consults after VA Central Office personnel asked VA field staff to address the matter. He added that, under the direction of a senior leader at VAMC Columbia, the decision was made to remove orders, such as pulmonary function tests and mammograms, from the consult list. He stated that the senior leader had advised that those types of tests should never have been categorized as consults and, therefore, they were removed from the consult list. However, those procedures were not closed but were converted to orders, continued to be tracked and appropriately worked, and it did not adversely affect patient care. He further stated that at no time was any decision made to inappropriately adjust the consult list. He stated that removing orders from the list did have an effect on the overall consult numbers but did not negatively affect patient care.

4. Conclusion

The investigation revealed that patient consults were not mishandled or inappropriately closed. The investigation found that certain tests, such as pulmonary function tests and mammograms, were being erroneously classified as consults and should not have been placed on the consult list. These procedures were properly converted to orders and were tracked until completion.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on May 2, 2016.

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for Investigations