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

VA Medical Center in Tampa, Florida
December 20, 2016

1. Summary of Why the Investigation Was Initiated

This referral was initiated by the Department of Veterans Affairs (VA), Office of Inspector General (OIG), Office of Investigations (OI), pursuant to information received from the OIG's Office of Healthcare Inspections (OHI), which stated that OHI was conducting a review at VA Medical Center (VAMC) Tampa subsequent to receiving an anonymous Hotline complaint. The complainant alleged that the Pentad (the top five managers at VAMC Tampa) and possibly Veterans Integrated Service Network (VISN) 8 leadership created a secret wait list for patients awaiting Gastrointestinal (GI)-related medical services. Reportedly, the GI wait list was hidden rather than placed on the Electronic Wait List (EWL). OHI requested OI's involvement in the investigation after they discovered an email string that contained information related to scheduling practices in the GI service that OHI felt might be of interest to OI.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed five VA employees, including a VAMC Tampa senior leader and a VISN 8 senior leader, during the investigation.

- **Records Reviewed:** VA OIG reviewed email provided by a service chief, as well as the results of OHI's inquiry.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The service chief stated that in 2012, he and members of his staff attempted to initiate and use the EWL for patients being scheduled by his staff for procedures greater than 90 days out. The service chief did so as a means to allow the VAMC Tampa Director, VISN management, and the leadership of VA, to be able to see the length of time it took for a veteran to have certain procedures completed. Before "going live" with the EWL, he had been working with an industrial engineer from the VA Engineering Resource Center at VAMC Tampa, to get the EWL system up and running. At that time, during a Missed Opportunities Collaborative, the systems engineer told the service chief that the "Director's Office" stated that they could not go live with the EWL.

  The service chief further explained that the EWL was not used within his department because he was no longer able to book initial consults greater than 90 days out in the Computerized Patient Record System (CPRS). He also said that the GI Department screened all its consults, and if the consult couldn't be scheduled within the 90-day period, the patient was sent to Non-VA Care Coordination (NVCC). He felt that this was

an immense amount of business for NVCC and that VA was overwhelming them with consults. He further stated that he was not aware of a secret wait list.

- The supervisory program specialist stated that she worked with the service chief on the Missed Opportunities Collaborative and was involved in the scheduling of GI procedures. She further stated that the scheduling directive was not clear regarding the use of the EWL when scheduling patients for procedures. She explained that the directive was clearer with respect to the GI clinics than it was with scheduling GI procedures. Although she could not accurately recall, she believed it was during a Missed Opportunity Collaborative that it was explained to her that the EWL was not meant to be used for GI procedures because of the varying necessities and time frames of the procedures. She clarified the email she had previously sent to the service chief. She explained that GI procedures/labs were scheduled within the EWL whereas GI consults/clinics were scheduled in CPRS based on the need of procedure by the condition of the patient. She was not aware of a secret wait list.

- The systems engineer stated that he had been in charge of running the Missed Opportunities Collaborative with the goal of better managing and decreasing the large number of missed appointments by patients. He organized the "pre-work" meetings and presentations while each specific team within the collaborative had an individual coach who worked on the specifics. The goal of the collaborative was for process improvement and to decrease the number of missed appointments within the VISN. He explained that the coach for VAMC Tampa was a former VA employee but did not know where the individual was currently employed. He further explained that he would have very much encouraged the groups within the collaborative to use the EWL. He could not understand why the service chief said that he told him not to use the EWL.

- VAMC Tampa senior leader stated that she only knew of one employee who did not enter patients into the GI EWL and that problem had been addressed with the employee. She further stated that there were no batch closings and all consults were reviewed by a GI doctor or nurse practitioner.

- VISN 8 senior leader stated that she was not aware of any issues with employees closing consults directly, nor did she have knowledge of employees intentionally not entering patients into the EWL. She explained that, through consult management, a data report center contained all the electronic information pertaining to the management and monitoring of patients on the EWL and that it was routinely reviewed by Quality Management.

Records Reviewed

- Investigators reviewed an email string of a conversation that occurred on March 22, 2012, between the service chief and a medical support supervisor, both at VAMC Tampa. The review disclosed that the intent of the email was to maximize and improve the service to patients - reducing the number of missed opportunities within the GI clinic.

- Investigators reviewed a summary of the inspection completed by OHI. OHI's review did not substantiate the allegation that VAMC Tampa was "hiding" a GI wait list. Its review disclosed that the anonymous complainant appeared to be referring to GI consults being sent to non-VA care providers. NVCC is medical care provided to eligible veterans outside VA when VA facilities and services are not reasonably available. The OHI review found that VAMC Tampa:

  - Appropriately designated NVCC consults as "administrative" in accordance with Veterans Health Administration (VHA) Consult Clean-Up guidance and VHA policy

  - Had a long-standing practice of referring routine GI consults to community-based providers if patients couldn't be seen in the GI Clinic within 90 days

  - Did not begin using the official GI EWL until May 19, 2014

- OHI's review did not substantiate the allegation that referrals to non-VA care were not sufficient to meet patient needs. Its review disclosed that NVCC GI care was available, although services were not always provided in a timely manner. OHI found that:

  - All GI consults are triaged by either a nurse practitioner or a physician's assistant. In general, patients with complex issues and/or requiring further clinical assessment are scheduled for a VA GI Clinic provider appointment. Based on the outcome of this appointment, clinical procedures, such as colonoscopies, will be either scheduled in the VAMC Tampa endoscopy lab or when needs cannot be met in-house will be referred to NVCC for completion in the community. The system is designed to closely follow more complex patients in-house. When patients with comorbidities (or other issues that necessitate closer monitoring) are referred to NVCC for GI procedures, the GI consult nurse case manages the patient's care throughout the NVCC process. Healthy patients needing routine screening colonoscopies are referred directly to NVCC.

  - For the period October 1, 2013, through May 28, 2014, VAMC Tampa referred 952 GI consults to NVCC for scheduling. OHI evaluated a sample of 93 randomly selected consults. OHI assessed the time it took to complete the consults from initial submission of the consult to the GI Clinic to the completion of clinical services for the patient. For GI consults sent directly to NVCC after initial triage, the consults were completed within 64 days on average. However, when the patient was first assessed by a VAMC Tampa GI provider and then referred to NVCC, it took an average of 119 days for completion: 61 days from the initial consult until the patient was seen by the VAMC Tampa GI provider and an additional 58 days from that point until clinical services were completed.

4. Conclusion

A joint effort by the VA OIG Office of Investigations and OHI did not substantiate the anonymous Hotline complaint. The anonymous complaint did not include specific details

regarding the alleged secret wait list for GI procedures. Based on the nature of the complaint, it appeared that the complainant was referring to GI consults being sent to non-VA care providers through NVCC—previously known as Fee Basis care. The investigation revealed that NVCC GI care was available, although services were not always provided in a timely fashion. Furthermore, no evidence of a secret wait list for patients awaiting GI services was identified. All GI consults were triaged by either a nurse practitioner or a physician's assistant; this resulted in patients receiving VA GI Clinic provider appointments with follow-on for procedures that were scheduled at VAMC Tampa or referred to NVCC. NVCC consults were defined by VHA policy as "administrative," and therefore, there was no requirement to keep an EWL. Finally, the VAMC Tampa GI Department did not start using the official EWL until May 19, 2014.

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

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