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

Community Based Outpatient Clinic in West Roxbury, Massachusetts May 4, 2017

1. Summary of Why the Investigation Was Initiated

This investigation was initiated in late 2015 based on information provided by a confidential complainant. The complainant alleged that a large number of documents regarding scheduling of veteran follow-up appointments in 2015 had been recovered in a closet by a Department of Veterans Affairs (VA) clinic coordinator. The clinic coordinator identified the documents as the work product of a particular employee. The complainant stated that an initial review of these materials, coupled with a search of the scheduling data systems and patient notes, indicated that as many as 400 patients might not have been appropriately scheduled for follow-up appointments, medicine refills, consults, etc. A further review of the patients who had not been scheduled for appointments revealed that more than 40 of these veterans had died since their previous appointment.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed four VA employees.

- **Records Reviewed:** VA OIG reviewed VA medical records and the results of an Administrative Board of Investigation (ABI) dated November 18, 2015.

3. Summary of the Evidence Obtained From the Investigation

The complainant stated that a clinic coordinator identified the documents found in a closet at the facility as the work product of a particular employee, a medical support assistant (MSA). The complainant further stated that an initial review of these materials, coupled with a search of the scheduling data systems and patient notes, indicated that as many as 400 patients might not have been appropriately scheduled for follow-up appointments, medicine refills, etc. The complainant gave us a document titled, "BHS Scheduling Matter," which had been drafted by Boston Healthcare System (BHS) management to outline the initial allegations. The document stated in part:

> On Thursday Sep 3, 2015, VA Boston HCS Executive Leadership was notified that a clinic coordinator discovered a stack of paper documents and post-its related to [specialty clinic] patient follow-up visits, requests for medications refills, and phone call requests. Preliminary investigation suggests that patients on the list may not have been appropriately scheduled for [specialty clinic] follow-up appointments, received appropriate follow up phone calls, or received appropriate assistance with prescription refills. Initial assessment by the [specialty] section is that approximately 400 patients may be affected. A

preliminary review of 44 patients from this list who died indicates that 37 had appropriately scheduled follow-up appointments. The remaining seven all had care or died during the interval prior to a requested return visit. We learned that in transcribing data from the paper documents to tracking sheets to begin patient follow-up, staff shredded some of the original paper documents, beginning as early as last week.

Issue 1: The MSA Stored Patient Data, Documents, and So Forth, in an Examination Room Closet, Many of Which Contained Unmet Patient Scheduling Needs.

Interviews Conducted

- The clinic coordinator explained that she had reviewed the documents that had been found in the closet and recognized them as the work of a specific MSA. She stated that the MSA has significant issues with organization and work ethic and had been counseled on these matters in the past. She further stated that she and her staff had been working since the documents had been discovered to ensure that every patient of the specialty clinic was scheduled appropriately. She added that although many specialty clinic patients had not been appropriately scheduled, the specialty clinic did not have a history of wait time issues, nor did she feel that the influx of appointments necessary to respond to this incident would prevent patients from receiving care within a reasonable time frame.

  When re-interviewed, the clinic coordinator stated that her staff found a new folder of the MSA's notes and other such work product in a drawer in her workspace. She added that they had since conducted an exhaustive search to ensure that no other folders were located anywhere in the specialty clinic. She stated that some of the documentation in the new folder contained materials from 2014 and that her staff was continuing to ensure that all patients were scheduled for appropriate follow-up visits. She said that an information technology specialist had been working with her and her staff to conduct a search of the Veterans Health Information System and Technology Architecture (VistA) database to ensure that all patients had been accounted for.

- The MSA stated that the documents in question belonged to her and that she had placed them in the storage closet out of concern that they contained sensitive patient information. She also stated that her decision to store the documents in the closet was not an attempt to conceal her falling behind in her workload. She further stated that her supervisor had spoken with her on various occasions about backlogged work and her methods of tracking overdue tasks, but the only help she received was the scheduling of more overtime work for her and her coworkers. She acknowledged feeling overwhelmed by the amount of work her position required. She also identified several institutional problems, such as doctors' work schedules, that she felt negatively affected her ability to schedule patients efficiently. She stated that, despite her troubles in keeping up with her workload, she never felt any pressure from any supervisor to misrepresent data concerning wait times.

- BHS administrator 1 stated that, leading up to this incident, he had known the MSA as the backbone of the specialty clinic. He also stated that in the past, the MSA had been recognized as a dependable person who carried the weight of the clinic in ensuring that scheduling ran smoothly. He added that he had never seen or heard pressure from management concerning wait times. He attributed this to the leadership styles of current management and, more importantly, to the fact that there were actually no wait time issues to be concerned about, aside from those stemming from this incident. He stated that he saw the situation involving the MSA as being caused by the MSA's excessive workload, which was then compounded by the fact that there were communication issues between the MSA and the clinic coordinator.

Records Reviewed

We reviewed the results of an ABI regarding this incident that was conducted by the medical center. The ABI was thorough and its findings appeared appropriate when examined by during the OIG investigation. The ABI found that the MSA had been using paper notes and records as a means of completing her daily tasks. Her haphazard recordkeeping system—acquired when she was falling behind on these tasks—was not transferable to others within the department, and that included her supervisor. Since 2014, the MSA's supervisor had asked her to stop creating such records and to communicate her need for assistance, but the MSA's work processes and communication habits did not change.

Issue 2: Excessive Wait Times Caused Patient Deaths

Interviews Conducted

- The clinic coordinator stated that as she attempted to contact each patient to ensure proper scheduling, she encountered several situations in which patients had died and the family had not advised VA. She also stated that she was noting each of the patients who had died and was providing that information to her chain of command so that the circumstances of each could be properly evaluated. At the time of the interview, her review was ongoing.

- The complainant stated that BHS administrator 2 had reviewed the deaths identified in the review and determined that these deaths either occurred before the anticipated follow-up date in the provider notes or were found to have medically complex situations with other life-limiting diagnoses.

Records Reviewed

VA OIG's Office of Healthcare Inspections (OHI) reviewed a total of 46 deceased patients' medical records identified during reviews conducted by the facility and provided to VA OIG.

During the review, OHI evaluated the following:

- Whether there was evidence within the electronic health record (EHR) of an attempt(s) by the patient or caregiver to contact clinic staff with a concern related to their care. This could have occurred via Secure Messaging, a documented telephone call to the Medical Advice Line, or a documented telephone call to another facility staff member. In addition, OHI reviewed encounters within other clinics for evidence of comments/discussions related to delays or unaddressed concerns by the clinic under review.
- Whether there was evidence within the record that the patient experienced a delay in care as it related to their diagnosis. The most recent encounter within the clinic was reviewed and information related to recommended follow-up was evaluated.
- Whether the cause of death (when available) could have been related to any delays or lack of follow-up within the clinic. For example, if a patient was identified as having experienced a delay or lack of follow-up within the clinic, and the cause of death was noted to be associated with specialty care provided by the clinic, OHI reviewed the EHR to assess causality between the delay/lack of follow-up and the listed cause of death.

OHI's review found no evidence of unanswered requests for care, delays in care, or any relationship between a delay and/or lack of follow-up within the specialty clinic that might have contributed to a patient's death.

Issue 3: Documents were shredded at the facility.

Interviews Conducted

- A clinic coordinator explained that as her team members were reviewing the paperwork that had been discovered in the closet, they shredded forms containing duplicate information in the automated system (that is, patient encounter forms). She stated that all original Post-it notes and faxes were preserved and provided to the VA police service earlier in the week of September 6, 2015, at their request. She reiterated that she did not destroy information that was unavailable for review through other means (that is, electronic) and only destroyed the paperwork as a means of ensuring security of personally identifiable information. She stated that she was trying to find ways to work more efficiently and was not making any effort to cover up anything.

- During her subsequent interview, she clarified the documents that had been destroyed during her review process were patient encounter forms and patient appointment lists. She stated that she destroyed these documents because they had proved to be frequently inaccurate and their information was more accurately depicted through VistA printouts. She also stated she did not destroy data that was not duplicated or already updated elsewhere.

4. Conclusion

The investigation determined that the MSA had fallen behind in her scheduling workload and felt overwhelmed. The investigation did not identify any schemes or "gaming" of the system that was intended to improve performance measures, and there were no indications that the specialty clinic suffered from excessive wait times outside of this incident. In conversations with facility staff, the average wait time of the patients who were impacted was not explored. Each patient had a variety of individual circumstances (no show for appointments, failure to return phone calls, etc) that made determining an average wait time extremely difficult. OIG was told that to ensure that no specialty clinic patient had been overlooked, staff reviewed the scheduled appointments of all assigned patients, dating back to 2014, and made sure that patients were scheduled for all appropriate future appointments. Clinic hours were extended to accommodate this additional demand.

The investigation did not find evidence of unanswered requests for care, delays in care, or any relationship between a delay and/or lack of follow-up within the specialty clinic that might have contributed to the patients' deaths.

Our investigation revealed that there were documents that were destroyed by specialty clinic staff. These documents consisted of encounter forms and appointment lists of patients whose information was duplicated in electronic patient records. There were no indications that the destruction of documents was caused by an intentional attempt to deceive investigators or hide facts. While we cannot confirm which documents were actually destroyed, the actions of the clinic staff—to shift toward a review of electronic records for scheduled future appointments for every assigned patient—suggest that the information needed to resolve this incident was available elsewhere.

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

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