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

VA Medical Center in Biloxi, Mississippi / Joint Ambulatory Care Center in Pensacola, Florida
May 9, 2016

1. Summary of Why the Investigation Was Initiated

The investigation was based on three distinct allegations concerning patient care at the Department of Veterans Affairs (VA) Medical Center (VAMC) Biloxi, MS and the Joint Ambulatory Care Center (JACC), Pensacola, FL including:

1. Allegation that an employee at VAMC Biloxi was instructed to destroy lists of JACC Pensacola patients waiting for prosthetics appointments
2. Allegation developed during the course of a Veterans Health Administration (VHA) audit of the facility of an unofficial list of veterans awaiting appointments
3. Information revealed during the course of the investigation that a scheduler disclosed the existence of a "Consult List" containing the names of approximately 10,000 patients awaiting appointments

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed more than 25 witnesses, including scheduling personnel, managers, medical staff, senior medical staff, and executive leadership.

- **Records Reviewed:** VA OIG reviewed policies and procedures, paper documentation containing patient information obtained from an employee's desk, medical records of patients who needed consults, and secure messaging templates used to communicate patient appointment requests.

3. Summary of the Evidence Obtained From the Investigation

Allegation 1: Destruction of a Patient List in Prosthetics Service

Interviews Conducted

- The complainant advised that JACC Pensacola Prosthetics Service employees did not have access keys to schedule patient appointments or a clerk to schedule patient fittings and delivery appointments. This created the need for a list of patients who needed fittings and delivery appointments to be routinely sent to the VAMC Biloxi Prosthetics Service so its clerks could schedule the fittings and delivery appointments. In May 2014, Prosthetics Service employees were advised to stop using paper lists to schedule patients and to destroy any existing lists.

- VHA ordered all VA medical facilities to cease using paper list to schedule outpatient appointments. Manager 1 in Prosthetics Service directed Prosthetics employees to follow this instruction and to destroy any existing paper lists. The only permissible scheduling methods would involve the VA electronic scheduling system. Manager 1 directed that all the patient-specific items be documented and put in a "call back waiting system" that could be monitored by the facility, not just Prosthetics Service.

- Manager 2 in Prosthetics Service at VAMC Biloxi advised that the nationwide effort to eliminate paper lists were discussed in meetings for all sections under the Gulf Coast Veterans Health Care System. The approved electronic scheduling system to schedule patient appointments (he did not recall the name of the electronic system) would be used by all. As of May 9, 2014, training had not yet been implemented. He explained that Prosthetics Service was emailing a list of patients' names from its Pensacola, FL, lab to the Biloxi, MS, lab in order to facilitate the patients in Pensacola getting appointments scheduled. Manager 2 was told to stop using this method and to use the electronic scheduling system, but no one in the Prosthetics Service knew how to use this system.

  Prosthetics Service had two working labs: one in Biloxi, MS, and one in Pensacola, FL. The office in Pensacola was understaffed and the assigned purchasing officer could not act as both the purchasing agent and the clerk (who scheduled the appointment for the patient to receive his or her item). So, after the purchasing officer received items that were ordered for patients, he sent (via encrypted email) a spreadsheet with names of patients who were ready to be scheduled to receive his or her item from the lab in Biloxi. The clerks at the lab in Biloxi scheduled appointments for the patients listed on the spreadsheet. Manager 2 stated that Prosthetics was unfamiliar with the electronic scheduling system in May 2014.

  Manager 2 explained that in May 2014, Manager 1 received an email for action from the director's office requiring multiple supervisors to certify that they were not using paper lists to schedule patients. Manager 1 ordered the cessation of patient lists in Prosthetics and also ordered the destruction of any existing lists. This direction was given so that the certification would accurately reflect that Prosthetics Service was no longer using paper lists to schedule patients.

  Manager 2 explained that a staff assistant told Manager 1 that emailing lists was no longer appropriate and also obtained input from the Information Security Officer (ISO), who confirmed that Prosthetics Service could not email the list of names. The staff assistant then arranged for them to get training on the electronic scheduling system. The second-line manager, then (while still in the assistant's office) called the complainant and told him to delete his list of patient names and that they will cease using lists.

  When re-interviewed, Manager 2 stated anyone who had scheduling authority in Prosthetics Service, including staff in the JACC in Pensacola, FL, had received training regarding the Electronic Wait List (EWL). Manager 2 received an email from facility leadership stating everyone who had scheduling authority needed to attend a group meeting regarding EWL and recall reminders. The email stated no supervisors were to attend, only employees who held scheduling keys. This was in order to determine if

anyone had been coerced by their supervisors to do things they did not want to do in regard to scheduling patients.

Manager 2 enacted an Access Clinic (walk-in clinic) for Prosthetics, which eliminated the need for EWL and recall reminders. Patients were provided letters indicating walk-in hours of operation. When the Access Clinic first opened, patient wait times averaged 45 minutes to 1 hour. They have decreased wait times to 30 to 45 minutes. The only scheduling needed in their department involves an amputee clinic (held 1 day per month), a wheel chair set-up clinic, and a wheelchair clinic (held 2 days per month). These patients are scheduled on an as-needed basis by personnel who handle scheduling needs at the JACC, which also operates as an Access Clinic.

- Manager 1 stated she recently attended training on the EWL, conducted by the Medical Administration Service (MAS), during which the attendees were advised that the EWL was defined as 90 days plus 1. Instructions also covered prioritization of patients on the EWL. Manager 1 questioned the use of EWL explaining that VAMC Biloxi does the scheduling for JACC Pensacola, because of the lack of staffing at Pensacola. Manager 1 advised that when an ordered product for a patient is received in Pensacola, a staff member notates the appropriate patient and receipt of the product on a Microsoft Excel spreadsheet, which is forwarded to VAMC Biloxi so the patient appointment can be scheduled for product pickup. Manager 1 stated that this appointment is not an initial appointment. She also stated that in May 2014, she received an Action Item from the director's office. The email required her to sign/certify that the Prosthetics Department did not maintain a list of patient names. Manager 1 believed the service chiefs of all the services who schedule appointments received this email. Manager 1 was upset about the letter and said she told them that she would not sign the letter, she would not lie, and that they (upper management) were told in a prior meeting about the Pensacola list of names.

  Manager 1 stated she did not feel comfortable signing the letter because, at the meeting, she was instructed to use a "recall list" and her staff had not received training. Manager 1 stated she modified the statement explaining her staff needed training on the system and she was told by an assistant to the director that the front office would not accept the modified letter. Manager 1 stated she told them she "did not feel comfortable signing anything that she felt was inaccurate." The assistant advised, "All you're signing is saying you have had the training." Manager 1 said that she re-read the letter and declined to sign it.

  Manager 1 further explained her department does not have MAS support. Manager 1 stated she had medical support assistants (MSAs) who completed the scheduling, and when she found out about something, she had to go and request training for the staff.

  While meeting with the staff assistant, a conference call was placed to the ISO. The ISO confirmed that Prosthetics Service staff could not email the list of names. The staff assistant then arranged for Prosthetics Service to get training on the electronic scheduling system.

Manager 1 directed the destruction of all inappropriate scheduling lists in Prosthetics Service. After providing this specific guidance, Manager 1 signed the certification required of all supervisors at the Gulf Coast VA Health Care System.

- An administrative officer (AO1) at VAMC Biloxi stated that she obtained scheduling keys in 2014 after completing three self-guided courses in the Training Management System (TMS) and also a Softskills training course. She earned certificates of completion from each course.

  She had never used the EWL after earning her scheduling keys because when she first began scheduling, all appointments were made within a 30-day period. JACC Pensacola, an access clinic for Prosthetics, had three employees with scheduling keys.

Allegation 2: Alleged Unofficial Wait Lists

Interviews Conducted

In May 2014, a VAMC Biloxi employee alleged that an unofficial list of veterans awaiting appointments was discovered during the VHA Access Audit at VAMC Biloxi. The list was provided to the VHA Access Audit Team by a VAMC employee and management was unsure what was contained in the items provided. A member of the team reportedly seized the list and sent it to the VA Central Office (VACO). The complainant was concerned that the veterans on the list would not be seen quickly because the list was apparently sent to VACO for further administrative review rather than being used for immediate local corrective action.

This list was determined to be a stack of various documents regarding appointments to be scheduled, appointments that were previously scheduled, doctor's orders, and so forth. These documents were obtained from an employee who fell behind in completing her daily work and were provided to the VHA Access Audit Team before VAMC Biloxi upper management knew of their existence.

- The OIG staff conducted a phone interview with the members of the VHA Access Audit Team who were at VAMC Biloxi. Members of the team included two business managers (Team Member 1 and Team Member 2) from another VAMC and the chief of Prosthetics at a different VAMC. Team Member 1 stated the team interviewed the scheduler and her union representative.

  Team Member 1 explained the VHA Access Audit Team had started the day at VAMC Biloxi with an entrance briefing and proceeded to interview employees. Team Member 1 advised that the scheduler at VAMC Biloxi, who was interviewed along with her union representative, stated there was an employee who had documentation with patient information in her desk drawer. In addition, the scheduler said she had a Microsoft Excel spreadsheet she was keeping of new enrollees and had been using those for a while to ensure patients were in the system. The scheduler told the team that she created the spreadsheet on her own and her supervisor was aware of its use. The scheduler also explained to the team that this facility was not using the EWL. Team Member 1 advised

that the union representative had an email from the director's office requesting assistance from employees in dealing with a Consult List containing 10,000 consults. Team Member 1 stated there were emails in the stack of documentation they were given. The team contacted VACO regarding all the information they were being given and were told to obtain a copy of all the documentation and mail it to the Under Secretary for Health.

Team Member 1 interviewed a scheduler at the Community Based Outpatient Clinic (CBOC) Eglin, who stated he did not use a veteran's "desired date" when scheduling, but uses the "next available date." The scheduler uses the "back-out" method to "zero out" the appointment wait time. The employee explained to the team that he was trained in a different state and did not receive this training in this region, but he was shown how to schedule by other employees, not a supervisor, in his previous assignment. The employees at Eglin stated they received little training and that was the way they have always scheduled.

Team Member 1 stated that some VAMC Biloxi schedulers used the back-out method and some employees scheduled properly. Team Member 1 added that when the team was leaving Biloxi, the director was not happy and asked for the identities of the employees interviewed by the VHA Access Audit Team. The information was not provided to the director; however, the director did advise Team Member 1 that he would use his own methods to identify the employees interviewed by the VHA Access Audit Team.

- VA OIG interviewed the scheduler who discovered the "stack of documentation" and also provided the records to the VHA Access Audit Team. The documentation was found in the desk of a clerk at VAMC Biloxi. The discovery was made while her direct supervisor (Supervisor 1) was on leave when another supervisor (Supervisor 2) brought training material requiring each employee's signature to acknowledge receipt. The training material dealt with the use of lists and the retention of patient information. The scheduler stated that Supervisor 2 went around the office to hand out a "packet of information" providing employees with instructions on the use of any type of patient information or lists. After receiving the informational packet, each employee was required to sign a document verifying the receipt of the instructions. Shortly after receiving the informational packet, the clerk told the scheduler that she had "a stack" of documents in her desk. The clerk showed the scheduler the stack of documents that she had compiled. The scheduler stated she subsequently stopped Supervisor 2 in the waiting area of the Primary Care Clinic to inform her of existence of the aforementioned documentation.

  When the scheduler arrived at work the next day, she pulled the clerk to the back of the office to sort the documents into piles of what was completed, what needed to be completed, and the clerk's personal paperwork. The scheduler estimated that the stack of documents from the clerk was larger than a ream of paper.[1] The scheduler stated some of the items were original documents and some were copies, to include doctor's orders and a list of patients to call for appointments, and so forth. The scheduler said some of the retained documents pertained to completed work, but she had kept the associated

[1] Paper used for printers and copiers is generally packaged in reams containing 500 sheets of blank paper.

documents. Under normal circumstances, once all the calls had been made to patients, or the information on the paper had been documented in the system, the paperwork would have been shredded.

On the next workday, the clerk continued to address the stack of documents. The scheduler stated she checked on the clerk a few times and the clerk advised she had spoken to Supervisor 1 and the clerk was retiring effective on Friday of that week. From that point on, the clerk was kept in the back of the office. The scheduler stated she was interviewed by the VHA Access Audit Team. She answered the team's questions and was asked to provide a copy of the documentation. She also confirmed that she provided the documentation in question to the VHA Access Audit Team. She proceeded to explain the routing of the documentation and various phone calls that had been made. This was done because VAMC Biloxi management had also requested a copy of the documentation. The scheduler stated that the clerk advised she had trouble keeping up with all the duties of her job. The clerk reportedly stated that she did not handle patients needing appointments very well and failed to keep proper documentation in the system.

- Supervisor 1 stated that she had been informed by the scheduler that the clerk had a drawer full of papers that "were orders and such." Supervisor 1 stated the scheduler said she had reported the clerk's documentation to Supervisor 2 while Supervisor 1 was on leave. Supervisor 1 instructed the scheduler to bring the documents to her. Supervisor 1 looked through the documents and identified many as old appointment lists and routing forms for prescription lists that contained very generic patient information for the doctor at a patient appointment.

  When re-interviewed, Supervisor 1 provided a statement regarding the meeting with the clerk. She also provided an email from a doctor (Doctor 1) in Primary Care, showing that the patient appointment numbers were bad. The doctor's email stated that she was asked to use the future date as the desired date if the patient felt that the future appointment would be fine, which she referred to, as "gaming the system." She stated that sometimes the doctor adds an addendum to the note originally provided by the nurse when a patient sees the nurse first. When a doctor does this, the provider does not get credit for the visit. After a meeting with a managing physician at VAMC Biloxi, Doctor 1 advised her that "heads were going to roll if the primary care numbers did not improve." She also stated the doctors often left as soon as they see their last patient and did not stay until 4:30 p.m., which is the conclusion of normal operation hours at the facility.

  When Supervisor 1 was interviewed about the EWL, she stated they were using it as part of their scheduling practices. She stated that Manager 3 obtained information from other VA facilities and compiled a handout explaining how to place patients on EWL. As a rule, they scheduled patients within 90 days due to providers extending appointment hours and patients seeing nurses to take care of their immediate needs. If they were unable to schedule a patient within 90 days, they placed the patient on EWL. This usually occurred if a patient needed some type of "specialty" treatment, such as Podiatry and there was no availability. Schedulers were calling patients who need appointments daily. The last time she checked there were approximately 20 patients on the EWL.

The EWL wasn't being used prior to Spring 2014 because until then they did not seem to have any problems scheduling appointments. After Phoenix,[2] everyone began looking at appointment availability. Patients were waiting 4 to 5 months for appointments. When the Patient Aligned Care Team (PACT) was opened, the waiting time issue was solved. This hadn't been implemented in the past because of compliance issues with PACT rules. The providers used to leave at 3:30 p.m. and were now extending their hours. A doctor's appointment lasted approximately 30 minutes. She stated they had a problem with providers leaving the facility for other employment opportunities and were currently understaffed.

- Supervisor 2 advised that she thought she was being interviewed regarding the documents found earlier when she was asking each clerk about scheduling EWL and their keeping of a list. She stated a list was defined as any note, logbooks, Microsoft Excel spreadsheets, and so forth. She advised that she saw a clerk jotting down an initial of a veteran and last four of the veteran's social security on a logbook when a nurse came and requested she contact a veteran. She told the clerk that was an inappropriate list and the clerk corrected the situation immediately by calling the veteran and erasing the veteran's information.

  Supervisor 2 learned about the situation at the VHA Audit Access Team out-brief and was informed that the scheduler had provided a copy of the documents to the VHA Audit Access Team. Supervisor 2 stated she never saw the documents the clerk possessed or was working on. She was under the impression that the clerk was working on "doctors' orders." Supervisor 2 explained that under normal circumstances, the doctor's orders were processed by the clerk during the day when the clerk was not checking in patients and then the orders were shredded. The orders that had not been scheduled would have been considered items that the clerk had failed to complete in her assigned duties.

  Supervisor 2 stated she was not aware of any tracking spreadsheet used in the Primary Care Clinic, but the scheduler had mentioned an electronic tracking spreadsheet used in the Call Center for the new enrollees. Supervisor 2 understood the Call Center spreadsheet was to make sure an appointment was made for new patients. She opined that the Call Center spreadsheet would fit as an unauthorized list by her definition. Supervisor 3 at VAMC Biloxi stated that the Call Center had been reestablished in 2013, to better handle patient calls for appointments.

- Supervisor 3 advised that the Call Center had 12 employees who answered the phone and the calls were tracked in a "GNAV" system.[3] Demographics were gathered from the veteran callers and calls were transferred to MSAs who scheduled and canceled appointments, and put in lab work, X-rays, and doctor's orders for appointments for veterans. Call Center employees were not allowed to schedule new patient appointments, except for Panama City and Eglin new patients. The Biloxi VA Call Center was

[2] Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

[3] Global Navigator (GNAV) is a management information system that records the activity of calls, tracks the performance of agents, and coordinates the scheduling of personnel. It is a visual desktop interface that provides contact center data to managers and supervisors.

averaging 800 calls per day. Supervisor 3 stated her lead clerk has been keeping a message in Outlook to ensure appointments were being made for new patients. When a new patient wanted to be seen, a message was sent to the PACT nurse, clerk, and various other people in the specific clinic for an appointment to be scheduled. Supervisor 3 said there was a 24-hour guideline to return the call to the veteran. Supervisor 3 stated the Call Center was trying to obtain new software called Tele Records Management (TRM), so communications between the Call Center and other scheduling areas should be better. She expected that the new software would allow for "tracking" within the electronic system. Supervisor 3 currently had her staff copy her on all new patient messages, which she personally verified that an appointment had been scheduled in the Veterans Information Systems and Technology Architecture (VistA). If no appointment had been scheduled in VistA for the new patient, she followed up with a second message to ensure an appointment was made. She verified that approximately 20 patients per week were scheduled for appointments and 1 or 2 required a second follow-up email.

Supervisor 3 also explained that, at the end of the day, Call Center employees made reminder calls for the next day's appointments for the CBOCs associated with VAMC Biloxi. If a veteran wanted to reschedule an appointment, Call Center staff could make that change.

In a follow-up interview, Supervisor 3 explained she was trained in 2012 on the EWL. She stated that the EWL was being used by schedulers, and all her staff had been trained. She trained each employee independently in her office and had each one of them sign a document acknowledging he/she could schedule using the EWL. She randomly checked her employees to make sure they were scheduling correctly. In regard to past scheduling practices, prior to being a supervisor, she was trained to "go in and back out" appointment dates, which would result in a patient's desired appointment date being the patient's actual appointment date. The second-line manager informed her that her staff needed to know exactly what the desired appointment date should reflect. She has provided one-on-one training to her staff regarding desired dates. Even though she frequently discussed with her staff the need to schedule correctly, most of the staff had been employed for a long time and resist change.

- Manager 5 stated after the Phoenix publicity began, she started conducting training on the EWL. The training was requested by management to educate staff. She located PowerPoint presentations about the EWL and reduced a VACO 60-slide presentation, along with a slide that was received by management, to a 12-slide informational tool. She also conducted three training classes open to employees before there was an action item to "stand down" on training because the inspection teams were coming out. She later received a message taking the training off of stand down, meaning she could resume the training. She stated that supervisors were provided access to the SharePoint drive containing the reduced presentation. Manager 5 encouraged managers to print and hand-deliver the presentation to their staff to answer any questions. All clerks who had scheduling ability were trained using TMS. Manager 5 explained that there were three modules in TMS with pre-tests and a test for Softskills that must be completed by a clerk in order for that clerk to receive access to schedule appointments. In addition, starting in

2013, VAMC Biloxi administered a post-test that required a 100 percent score to receive scheduling keys.

- A supervisory clerk stated that the Call Center answered numerous calls each day and scheduled patient appointments at the time of each call. The supervisory clerk explained she had access to a "new registration" Microsoft Excel spreadsheet located on the shared drive that showed the new patients who were requesting an appointment. When she saw a new patient call, she sent an appointment request to the scheduler. The supervisory clerk believed there was a concern with the relatively new call center staff making new patient appointments since the current call center had not be in operation long. There were often 200 new patient appointments requested each month and she reviewed her spreadsheet monthly to ensure all appointment requests were appropriately addressed. The supervisory clerk stated that she had been contacted by new patients who had not been scheduled for new appointments.

  She advised that new patient appointments could not be scheduled at her location with the exclusions of CBOC Eglin and Outpatient Clinic (OPC) Panama City, and that there were communication issues with scheduling appointments. There were clinics for which Call Center schedulers could not schedule appointments. The supervisory clerk had been instructed to contact only certain clinics via their respective PACT line, which was not regularly answered. The supervisory clerk had been instructed that Lync[4] messages were not to be used for scheduling appointments. She kept her own Microsoft Excel spreadsheets that listed each patient's last name, last four digits of their social security number, date of call for appointment request, and doctor that patient assigned to see with date of scheduled appointment, if received. The purpose of the spreadsheets was to ensure no one fell through the cracks and that patients were seen. She also documented instances in which contacting a veteran was unsuccessful. If multiple attempts were unsuccessful, a letter was sent to the veteran requesting the veteran call back for an appointment. The supervisory clerk explained 60 to 90 days was usually the longest wait a patient had for an appointment. The supervisory clerk explained they could not book out further than 90 days. The supervisory clerk advised that, currently (at the time of the interview), if a veteran in the VA system called for an appointment, the Call Center staff scheduled the appointment and no documentation was kept because the appointment had been scheduled.

  When re-interviewed, the supervisory clerk stated she had been a scheduling clerk for many years. She didn't use the EWL and had never used it due to patients' appointments being scheduled with a 90-day period. The supervisory clerk advised that for a while no one had heard of the EWL and later was told that the EWL was for new patients not scheduled within a 90-day period.

  She explained that previously, when working in Primary Care, a VA physician was always scheduled out to the 90-day mark. There was a "block" that would not allow clerks to schedule beyond 90 days. So, if someone called and needed an appointment but

[4] Microsoft Lync is a collaboration/communication software program that allows a person to communicate with another person who is on the same active directory domain.

no slots were available within 90 days, the veteran's name would go in a paper file in the clerk's desk. When an opening became available, the veteran would be scheduled. This system was used because schedulers did not understand how the EWL worked. She was aware of one clerk who kept names of unscheduled patients. The supervisory clerk was also a supervisory clerk in Primary Care and she kept up with unscheduled patients on a piece of paper. Once the patient was scheduled, she took their demographics page out of the file and shredded it. She and other clerks scheduled this way not knowing it was wrong.

The supervisory clerk had heard about the EWL, but had no training using the system. She did not know anything about the EWL or the New Enrollee Appointment Request (NEAR) report until Phoenix occurred in spring 2014. Because of Phoenix, her supervisor, Supervisor 3, gave schedulers sections of a spreadsheet, which was given to Supervisor 3 by the second-line manager. The schedulers were given Standard Operating Procedures (SOPs). The Accelerated Care Initiative (ACI) was introduced; it involved calling a patient three times when attempting to schedule. If no response were obtained, they would send a letter. If no response to the letter came within 30 days, the patient was removed from the NEAR report. The supervisory clerk was unaware the EWL had been in place since 2002. She was recently provided documentation on how to use the EWL, which was the first time since she had started working at the VA facility. She knew the EWL existed, but was told not to place anyone on it. While working in Primary Care, she was in charge of assigning new patients to PACT teams. She would then follow up with clerks to see if patients had been scheduled. When she left Primary Care, she was no longer involved with this practice. The supervisory clerk explained the providers had extended their working day to include 4:00 p.m. appointments, which was why the EWL had not been needed. The providers had openings for approximately 14 patients per day and were all seeing three new patients per day. One doctor worked 10-hour days and was off on Fridays.

Through VHA Support Service Center (VSSC), the supervisory clerk chose the NEAR report, then selected pending for VISN 16 Gulf Coast, and accessed the report. Through ACI, she contacted the patient as previously stated. She kept track of patients who were scheduled and canceled in a Veterans Integrated Service Network (VISN)-approved spreadsheet. An executive assistant in Pensacola, FL, advised the supervisory clerk of the spreadsheet. The supervisory clerk was told not to contact Pensacola patients. She ran a report every morning and called everyone on the list whether it involved 5 or 50 patients. There were three stages in the NEAR report: in process (making calls and sending letters), canceled, and the EWL. She stated providers in Pensacola, FL, were not adding extra appointment slots. She had one patient from Fairhope, AL, whom she was trying to schedule. She could schedule him within a month in Mobile, AL, but the patient requested to be seen at JACC Pensacola. He later called and said no one from Pensacola, FL, had returned his phone call. The supervisory clerk said Pensacola was doing "some" scheduling, but it took a while for the patients to be seen. She stated the JACC could schedule appointments. The supervisory clerk said she was supposed to act as the Call Center for Pensacola. If patients called and said they'd been waiting 3 weeks for an appointment, she scheduled an appointment for them. The Call Center could schedule follow-up appointments for patients. In addition to scheduling for Biloxi, MS, the

supervisory clerk also scheduled for CBOC Eglin, OPC Panama City, and Gulf Coast VA Health Care System in Mobile, AL.

The supervisory clerk stated too many people (referring to VA employees) were concerned about "pleasing" providers and not following policy. For example, if a patient was 15 minutes late for an appointment, they were supposed to work that patient into the provider's schedule for that day. However, some employees were telling these patients they needed to reschedule. In addition, when providers canceled clinics, policy stated they were supposed to reschedule patients within 14 days. In some places this wasn't occurring. Policy also stated patients were to be scheduled within 14 days of their desired date, but this wasn't occurring either.

The supervisory clerk stated she had a meeting with an administrative officer (AO2), regarding consult management. They were discussing scheduling and AO2 told her not to "go out and go back in" anymore. She stated she had been scheduling this way for a long time because she didn't know any other way. The supervisory clerk's supervisor in Primary Care, Supervisor 2, told her three different times not to go in and out when scheduling patients. She was also told to train the schedulers not to do this. Then, 1 week later, Supervisor 1 told her they could go back to the old way. The supervisory clerk did not schedule the right way until approximately 2 months prior to the interview when told to do so by Supervisor 1. She felt that Supervisor 1 was trying to make things right in regard to scheduling. The supervisory clerk had not been asking patients to provide a desired appointment date, she was only advising them of the next available appointment. Supervisor 1 told her she was "gaming" the system. The supervisory clerk stated everyone in Primary Care scheduled differently.

The supervisory clerk had not received any official training regarding scheduling practices. In order to obtain her scheduling keys when first hired, a VA employee sat down with her and gave her all the answers to the scheduling test. She also stated that proper training was not provided for new employees. The supervisory clerk had not been provided a PowerPoint presentation on scheduling criteria; however, she had one regarding the check-in process.

The supervisory clerk had a meeting with the current director of VAMC Biloxi and the former acting director about one month prior to the interview. During this meeting, the supervisory clerk was asked about what she was doing with the NEAR list and she stated she was calling all patients except for Pensacola's patients, further advising that Pensacola was behind in scheduling. The acting director told her she should be scheduling for Pensacola but the current director told her that Supervisor 2 would make that decision.

- A managing official at VAMC Biloxi stated that the Call Center had no way to track when a veteran called in. The official further stated a veteran call only came to the Call Center after a 2-minute wait for a member of PACT, which was synonymous to the Primary Care Team. After 2 minutes without an answer, the call automatically rolled to the Call Center for answering. When a new veteran's call was received by the Call Center to make an appointment, the caller's information was routed to the designated

PACT. The veteran's name, contact number, and a message stating that this was a new patient requesting an appointment was noted on a Microsoft Excel spreadsheet and forwarded via encrypted email to a member of the designated PACT. Each day, the Call Center was compiling and forwarding an email containing the names of new veterans requesting appointments.

The managing official also stated that the emails were sent to the MAS supervisor for the team. The spreadsheet was also copied to a manager in Primary Care. If there were new patients in outlying areas, the email was sent to the supervisor of the respective clinic location. The use of the spreadsheet was discontinued after receiving direction from VISN management, about a month prior to the interview, that the use of lists of any kind must be discontinued. Currently (at the time of the interview), if a new patient called into the particular PACT clerk for an appointment as a new enrollee to VA, a clerk would take the information, verified the veteran's eligibility, and set a new patient appointment. The managing official stated that currently the Call Center was using an encrypted Lync message template to refer a patient for an appointment in cases when a Call Center representative was unable to schedule one in Primary Care. All of the Call Center staff were using the template for new patient appointment requests. One encrypted email per new patient was sent to the PACT supervisor and nurse manager for the respective team.

The managing official advised that there was a confirmation through the read receipt request on the encrypted email. To actually confirm an appointment was made, a check in the Computerized Patient Record System (CPRS) would be necessary. If a veteran called again stating he/she had not been scheduled, a check of CPRS or VistA was completed. If the veteran did not have an appointment scheduled, another Lync message template, with additional comments explaining that this was a second request, would be forwarded to the PACT supervisor and nurse manager. The official verified that only the sender of the original Lync message and those copied could access the message.

- The clerk stated that, on Thursday, May 22, 2014, Supervisor 2 presented paperwork to her and she signed it. She agreed there were items in her desk drawer that she was behind in completing and stated she would lock those items in her desk drawer at night. She could not keep up because she was out often due to personal obligations and was unaware how far behind she actually was. She did not tell her supervisor that she was behind on the work and, when asked, minimized the situation. She stated that when sitting at the desk, she focused on taking care of the patient, not the paperwork, and was probably a couple months behind in some of the items. She received paperwork every day and did not always have time to verify whether it was complete.

  The clerk further stated, on the day her backlog was discovered, she was in the back of the office separating papers and working through the items from her desk. On the following workday, she was still in the back to finish getting caught up, and was given her formal reprimand. The clerk stated she had been contemplating retirement over the weekend and that she had finalized her retirement on the day she received the reprimand. The following day, the scheduler requested all of the documents that the clerk had in her desk drawer. The clerk stated she finished the day by assisting out front at the reception desk, and at the end of the week, her computer access was pulled.

- Physician 1 stated he assumed that people in charge of scheduling patients were doing so correctly. At the time of his email to Supervisor 1, his knowledge of scheduling practices was that of a physician, which he described as being quite limited. He was looking at the situation regarding same-day access in clinics and stated he was using a "common sense approach" in dealing with a reported complaint of patients walking in and requesting to be seen. In April and May, he was shown scheduling procedures. In an email, Physician 1 described a method that could be used to encourage walk-in patients to agree to return at a later date for treatment and described how this new date would be used as the desired date in order to improve the appearance of patient access to Primary Care. Although Physician 1 stressed that this plan did not involve sending sick or injured patients away, the process discussed in his email referenced potential obstacles and problems this plan could potentially create. One problem involved getting credit for later treatment after a nurse sees a walk-in patient without a patient actually being placed in the Primary Care Clinic. Addressing the other part of the email, Physician 1 argued that the appropriate documentation for a patient placed into a "doctor's clinic" should be in the computer system rather than as an addendum to a nurse's note in which a doctor would not receive any "credit for seeing a patient."

  Physician 1 stated that staffing had improved since April 2014 in Primary Care with more doctors coming in the upcoming months. The Biloxi and Pensacola facilities were running at approximately 30 days on getting new enrollees in to see a doctor and the NEAR list was being used. He also advised that all the clinics had extended hours to assist in the patient load in Biloxi and Pensacola, with both of these facilities conducting Saturday clinics. He stated there had been no patients on the EWL since May or June 2014.

Records Reviewed

- An email from a physician in Primary Care stated that employees had been asked to use the future date as the desired date if the patient felt the future appointment would be fine.

- A review of two spreadsheets showed that they were used to track patients, not to schedule appointments. Secure messaging templates showed that messages were sent to the supervisor of Primary Care for each new patient who contacted the Call Center.

- VA OIG Office of Healthcare Inspections (OHI) reviewed a list of patients who were identified as new patients seeking a Primary Care appointment as of May 28, 2014. The first date on the list was June 26, 2013, and appeared to be an outlier with the consistent start date range of December 17, 2013, through May 28, 2014. However, the list also included patients receiving ongoing care. The allegation was that patients had not received a Primary Care appointment. Neither the EWL nor any outside medical records were available for review. VA records were reviewed regarding all patients identified as needing a new Primary Care provider. On July 2, 2014, OHI provided an assessment of the records for inclusion in the investigative report.

  There were 592 patients requesting a Primary Care appointment through either the main campus in Biloxi or one of the CBOCs at the time of the OHI assessment. Of these,

293 patients requested system appointments at the Biloxi location. These patients were excluded:

- Four sought Compensation and Pension Care only.
- One patient name was a duplicate.
- One was deceased.
- Nineteen received care at other VA facilities.
- Three patients could not be found in the medical records system used for the review.
- Three reported receiving private sector Primary Care in their Electronic Health Record (EHR).
- Five were receiving care through other VA services (one in each of the following programs: Home Based Primary Care, Community Living Center, Psychosocial Rehabilitation Recovery Program, Substance Abuse Day Treatment Program, and Hospice).
- Two declined VA care.

Of the remaining 255 patients, 186 (73 percent) did have an outpatient Primary Care appointment documented at the main campus in Biloxi.

The deceased patient's EHR was reviewed further to determine if a possible effect occurred because of the delayed Primary Care appointment. The last encounter with VAMC Biloxi was a telehealth phone encounter in January 2014. A case manager in the private sector called on behalf of the patient seeking rehabilitation nursing home placement assistance. The VA social worker was contacted and verified that the patient was non-service-connected for nursing home care through the VA. The patient did not have a current system Primary Care provider. The VA social worker recommended that the private sector case manager assist the patient with re-establishing VA care. There was no other documented contact and the patient did have an appointment scheduled for June 2014; however, the patient died in April 2014. We could not determine when the appointment was requested or what diagnosis the patient had that required inpatient rehabilitation. The EHR did not provide information to determine whether an earlier appointment would have prevented the patient's death.

The remaining 299 patients on the list requested a Primary Care appointment through one of the CBOCs. These patients were excluded:

- Seven were unreachable.
- Seven received care at other VA facilities.
- Two were deceased.
- Six were not vested.
- Two relocated.
- One declined care.

- Two patient names were duplicates.
- One was incarcerated.

The two deceased patients were further reviewed to determine the effect of possible delayed Primary Care appointment scheduling. One patient died at another VA facility receiving hospice care during the time the CBOC was leaving messages to offer an appointment. The other patient had not received Primary Care since 2011 and died in May 2014. The EHR did not provide information to determine whether having a Primary Care appointment would have affected the outcome nor can we determine when the patient requested to re-establish care.

Of the 271 remaining patients requesting a CBOC Primary Care, there were 167 (61 percent) patients with current appointments. The individual CBOCs' total number of patients who requested Primary Care appointments varied. The review showed that the parent facility had 186 (73 percent) and CBOCs had 167 (61 percent) of the identified patients with Primary Care appointments. Overall, of the 526 patients who requested Primary Care appointments through the system, only 353 (67 percent) received a Primary Care appointment. OHI found that neither the parent facility nor most of the CBOCs were consistently making Primary Care appointments on an ongoing basis.

Allegation 3: Alleged 10,000 Names on Consult List

Interviews Conducted

During the course of the investigation, an interviewee mentioned a consult list containing approximately 10,000 patient names awaiting appointments. The list comprised 8,681 non-VA Care consults for which the consult request date was from July 20, 2009, through February 28, 2014. Initially, the consult list was reportedly generated per VISN direction for all pending consults at VAMC Biloxi. This list was divided by staff and approximately 75 volunteers were compensated to review the pending consults and administratively discontinue the consults if appropriate documentation was discovered. Reportedly, 4,500 consults remained open pending action at the time of this investigation. A copy of the consult list was obtained and sent for analysis to OHI.

- During an interview with the scheduler and her union representative, the scheduler advised that VAMC Biloxi management reportedly asked clerks to look at the consult list and close them out for various reasons. According to the union representative, the consult list review consisted of clinical employees and clerks.

- Supervisor 2 stated that consult list review was conducted to determine the status of each patient's consult. Some of the consults were on the list because a veteran had failed to come to multiple appointments. She said some of the patients, when contacted, stated they did not want the appointment or a particular doctor or location. Outside consults fall under the Non-VA Care area, which is responsible for getting the appointments. Supervisor 2 stated volunteers were requested to follow up on the outstanding consults on the list. She advised that a consult could be administratively closed if all the results were

in VistA Imaging.[5] Supervisor 2 stated a volunteer had to have clinical training, such as a nurse or nurse practitioner. She was also unsure how volunteers assigned to review the consult list were selected.

Supervisor 2 explained a Consult Management Meeting was held each Friday, where progress on the consults was discussed, and she provided a list of people who attended the meetings. She advised that VSSC showed unscheduled consults, scheduled consults, active (needing to be scheduled) and pending consults. A check of VistA would show if a patient had been scheduled or seen by a provider. In the Consult Management Meeting, all consults for every service were discussed. She stated that the volunteers were specifically reviewing non-VA Care consults. She advised that non-VA Care was in the red, that is, backlogged, and that was the status nationwide. She explained that if documentation of a consult was in VistA Imaging, the consult could be closed because the patient received the treatment. If a patient did not wish to be seen, an email could be sent to a physician to discontinue a consult. She further stated that VSSC would update in a few days once a consult status was changed. She was unsure whom the volunteers working on the consult list review reported to, but thought it was a physician. When the volunteers were gathered in February or March 2014, she was there to ensure the volunteers understood exactly the instructions for the project. She thought there were 6,000 to 7,000 consults on the list originally. She advised that Non-VA Care was working on the remaining 4,000 consults. She noted that some patients had their appointments, but the documentation had not been received by VA.

- A Clinical Applications employee (CAE) was interviewed regarding the consult list that has been worked on since February or March of 2014. She stated software was created for the consults to be appropriately documented. The CAE was a member of the Consult Oversight Committee (COC), which was headed by a doctor in the Office of Academic Affiliations (OAA doctor). In the fall of 2013, COC was looking at the consult processes and the length of time it was taking for patients to be seen. Other things started happening and the consults were placed on the fast track. The CAE stated the Non-VA Care consults were the consults being reviewed by the staff who volunteered, and the individual services were reviewing their own consults as well. She heard the OAA doctor instructing the reviewers that they could act on a consult only if the report was located. Then the reviewer could complete the consult, or if there was a duplicate consult for the exact same thing, it could be administratively discontinued. The reviewers would look into VistA Imaging to see if the results were available, and if the results were located, the consult would be completed.

  The email list was sent by the OAA doctor, who sent each reviewer a specific 100 consults via encrypted email. Once the review was completed and the spreadsheet was updated, each reviewer sent his or her list to the OAA doctor via encrypted email. The OAA doctor would put each segmented list of 100 back together. The OAA doctor and a supervisor in MAS built and compiled the list. The staff in consult management also worked on the list to clear consults, in addition to the volunteer reviewers. The

[5] The VistA Imaging system integrates clinical images, scanned documents, and other non-textual data into the patient's electronic medical record.

weekly consults meetings were status updates from each of the services; they did not refer the Non-VA Care consults.

The CAE explained Non-VA Care had difficulty finding vendors while another challenge was to get timely appointments with the available vendors. She explained some vendors do not want to see VA patients because of the slowness in receiving payment. The CAE stated it was difficult to get patients' results to the correct places because bill paying was conducted by the VA Consolidated Fee Unit in Flowood, MS, and often the report and the bill were sent together. She advised that consults could not be closed until the report was located in the patient record. She stated the volume of non-VA Care patients required focus on getting specialist appointments instead of on closing the consults. The reports were sometimes scanned into the system and sent to the doctor who originally ordered the consult, but the consult failed to be closed. She stated there were several places for a "disconnect" to occur in non-VA Care consults.

She further explained that on-campus consults were in a better situation because the services monitored the consults more effectively. The Clinical Applications staff often assisted with helping locate consults for closure because notes on consults must be titled specifically to actually close the consult. The majority of the "old" consults were either duplicates or the note titles were incorrect, but the patients had been seen. The OAA doctor had put processes in place to handle the consults, and policies had been changed in an effort to address the consults so this situation does not happen again. Specialists in each service reviewed the consult to make sure the patient was taken care of according to the need, and then they advised their service clerk on when to schedule an appointment.

- A registered nurse (RN) at VAMC Biloxi stated she worked with consults regularly in the course of her work and she participated in reviewing the consults. The consults she reviewed had been sent to consult management to be referred to a non-VA community provider for care in a timely manner. The OAA doctor held a class with random test patients to educate them on what would be appropriate. She believed that all the consults on the list were reviewed. She recalled the review took place in March or April of 2014, and that many MAS people were in the training she attended to review the consult list. She felt that the training was pretty good and the focus was on making sure patients had been seen.

  She was responsible for reviewing a list of 100 consults. She worked on her list for about 2 hours a day for 3 days after her normal work hours. She would check by date to see if there was information in the patient record to match up with a consult. She advised that she could put in administrative notes regarding consults. When she was unable to close a consult, she just added notes telling that documentation was available and the consult should be closed. If she did not see any documentation from the community, she would so notate on the spreadsheet. She did not administratively discontinue any consults; she just notated her findings. Discontinuing a consult would happen in her specialty area after the patient canceled an appointment for the procedure twice; notes were then put into the record showing why the consult was discontinued. She stated that after her review of her list, she sent it back to the OAA doctor.

She had heard that community doctors did not get paid in a timely manner so they did not always see VA patients. For one of the consults she reviewed, she requested that it be checked again because it appeared the consult had been issued for different outside providers and was not completed.

- A VAMC Biloxi Fiscal Service Employee (FSE) explained that, in December 2013, the VISN instructed VAMC Biloxi to review outstanding consults. The FSE explained the process by which consults were reviewed to identify which providers needed to be contacted to obtain reports from patient visits. If there were a report present in the VA system, the consult could be administratively completed by scanning the report into the system, which would allow for completion of the consult. She did not see a spreadsheet for the review, but she could see the review in the system. She had heard several people mention they were working on the consult list review. She was aware of a training held on campus to instruct staff to review consults. She noted that sometimes there were no vendors to whom to send patients and the VA often flooded the market. She had 13 members on her team—5 of those were RNs and the remaining were medical support staff. Three of the individuals who held those positions were hired in the year prior to the interview.

  She explained a consult request was reviewed and authorized by an RN to verify that all testing needed was complete prior to the patient seeing the consult doctor. A medical support staff person would send a fax to the provider and a confirmation would be received from the provider. The provider reviewed and scheduled the appointment with the patient. Once the appointment had been completed, reports were requested and scanned into the VA system. At this time, a consult should be marked as status "completed." A consult can be closed "administratively" if it were a duplicate entry for the exact same consult. In order for a consult to be "discontinued," a doctor must give it his/her approval. If a patient refused a consult appointment, often nurses could explain the need for care via telephone. If the patient still refused, an appointment was made for another consultation with the doctor who ordered the consult. Not everyone had access to the keys to complete or close consults, so sometimes an email was sent requesting staff in her area to assist in changing the status of a consult.

- A manager in the Finance Office at VAMC Biloxi stated that, in March or April 2014, the VISN ordered a facility-wide review of consults for VAMC Biloxi. He explained that the consult management chairman reviewed and distributed lists to staff with medical backgrounds and who had volunteered to review them to make sure nothing was missed. When a consult was created, it was pending until a member of the nursing staff reviewed it to ensure it was appropriate and changed the status to active. A clerk could then work to schedule the consult.

  He noted that the year before the interview there have been a huge number of Non-VA Care consults that had been sent out to the community. Because of payment delays, many vendors had ceased doing business with the VA. Payments were not made locally. Payments were generated from the VA Consolidated Fee Unit. The bill was received in the Consolidated Fee Unit, matched up with the authorization, and then paid. They still were having trouble getting care in the community, partly because the community had

been saturated with requests for care from non-VA providers, and partly because of delays in payments. He commented that some vendors did not want to accept the amount paid per service by the VA. Vendors were kept on a list and contacted to see if they would take a patient. He was not a part of the review team. He thought the consults were still being reviewed. If a consult were found to be lacking documentation, a list would be compiled per vendor to request documentation via letter for the group of consults. If the documentation were located for the consults, each consult would be annotated that it could be closed and the non-VA Care group would complete the status on the consults.

He stated that the volunteers were paid and coordinated by the OAA doctor. The biggest issue was the vendor issue—more than 40 vendors in the community would not do business with the VA. There had been high workloads and few available vendors. He also stated the VA tried to get the documentation from the vendors to close consults.

He advised that there was a pending contract with a company to assist in having available vendors. VA would send the consult to the contractor who sent the consult out to the vendor; the contractor would pay the vendor and gathered the documentation and sent it back to the VA. He also advised that the facility was bringing on a physician to be the Chief of Non-VA Care and assist in the review of the consults with the five nurses currently on the Non-VA Care staff. There had been a vacancy in the Non-VA Care physician position for approximately 18 months at the time of the interview. He also advised that the Non-VA Care budget had increased from $48 million in fiscal year (FY) 2012 to $55 million last in FY 2013 and was then-currently over $60 million for FY 2014.

He noted that the lack of specialists on staff hindered VAMC Biloxi. He explained that the limited agreements with other facilities were difficult in Biloxi. Most of the specialty care had to go through Non-VA Care and the community had been saturated. The Financial Office manager stated that some vendors whom VA had failed to pay on a timely basis had now been paid and were again willing to take new VA patients. He added that additional staff had been added with yet more to come. More than 300 patients were being seen at the Department of Defense (DOD) site. He discussed a myriad of challenges faced in Non-VA Care and finding convenient care for patients, but stated the consult numbers were continuing to come down.

- An OAA physician explained that, in the 2 years prior to the interview, there had been a national push to review consults. A review with guidelines was sent to the facilities. Approximately 18 months before the interview, the review began of around 12,000 consults. There were a large number of “community” consults at VAMC Biloxi. In the last 6 months, there was a push and the VISN had been monitoring the facilities and their consult status. The goal for consults was less than 1 percent over 90 days. About 18 months ago, he took over the consult review to coordinate the clinical review and the administrative side. He stated that 7 months prior to the interview, there were 10,500 consults listed and now there were approximately 5,000 outstanding total consults both on-campus and in the community. He advised there were weekly meetings with the VAMC chiefs of the services to try to get consults addressed.

After the VISN recently mandated the consults be reviewed and completed quickly, VAMC Biloxi management decided to pay overtime to approximately 70 staff members with experience in consults, such as RNs and other clinical staff. He took the large consult spreadsheet and divided it into segments of 100 random patients and had the paid volunteers review the consults. The reviewers needed to determine why each consult was not completed and what needed to happen to complete them. If the patient was seen for that consult, the consult could be closed, but the reviewer would need to determine where to get the proper documentation. He stated there was still work to be done on the remaining consults. He noted that there were some patients on the consult list that had not been seen for various reasons. Some private physicians refused to take VA patients because VA did not pay enough for services and he had heard that VA failed to pay the bills in a timely fashion. He had talked with the chief of staff's office to see if other VA facilities could see some of the patients. He also advised that a number of patients did not come to their first appointment, which was scheduled within 90 days. He stated there was a policy in place that if a patient did not come to two appointments, the consult was referred back to the original Primary Care physician to discuss the consult with the patient directly. At that time, another "new" consult could be initiated. He stated the list of 8,000 consults was down to 4,500 for outside consults.

A final push at the end of April 2014 was conducted to complete the review. All reviewers had prior access to the systems and a knowledge base to evaluate the situations. He held several trainings and explained the spreadsheet drop-down options. He demonstrated how to locate reports in CPRS and VistA Imaging and how to read the consult notes. An MAS Supervisor assisted in compiling one big spreadsheet. He instructed the volunteers that if they located the report from the outside provider, they could administratively complete the consult, thus sending the information to the Primary Care doctor for review. If the reviewer did not feel comfortable completing the consult, he/she could document on the spreadsheet he/she felt it could not be completed and another person would review it. If no report were found, the reviewer would document "no report found," along with the doctor's and patient's names.

He sent all the segmented spreadsheet lists to the VAMC employee assisting him, who then compiled and sent the reviewed spreadsheet lists to the Fiscal Service employee and Consult Management staff for them to take the final actions needed. He believed that he sent the final list to the MAS Supervisor in May 2014. He knew that in four of the five categories, the review was successful in meeting the mark; however, the outside consult list remained outside the goal. He explained there is a high-risk list he monitored that was to be completed within 60 days, and he believed that the number for the Gulf Coast VA Health Care System was better than other facilities in VISN 16. If a patient "no-shows" for an appointment, he/she would be scheduled for the next available appointment.

He explained that it was a much more complex situation when dealing with outside providers and the system for completing those consults that went with it. He routinely discontinues consults that were non-life threatening and just needed additional tests that should be ordered by the Primary Care doctor. He explained that consult management consisted of both RNs and administrative staff to ensure patients had the testing needed

prior to seeing a specialist, and the Consult Management staff contacted the appropriate specialist's clinic for an appointment.

- The VAMC Biloxi Director stated he had been in the director of the VAMC Biloxi position for 2 years. He had no knowledge of the documents that were recovered from the clerk's desk until the OIG inquiry and stated that situation was against "VA protocol." He also denied knowledge of the two Microsoft Excel spreadsheets that were being used in the Call Center and Primary Care. He advised that even after visits to the clinics, he was not informed of any type of lists being used. He also stated that the OIG interview was the first he heard of a Call Center list and a Primary Care list.

  He never directed anyone to avoid using the EWL or to alter appointment desired dates when scheduling appointments. He had not heard of anyone doing that until he visited the Gulf Coast VA Health Care System facility in Mobile, AL, and was informed by an employee that instructions contrary to VA scheduling policy had been provided as far back as 10 years ago. He stated that he did not instruct anyone to do anything in dealing with the EWL or NEAR reports. Until recently, he was not very knowledgeable about scheduling. He explained that a veteran could move on and off the EWL and NEAR lists, and commented that it was very convoluted. He had heard some other lists might have been used besides the EWL and NEAR lists since the Phoenix investigation. Prior to Phoenix, he could not say that the EWL was being used at Biloxi and the facilities that reported to Biloxi and would have been in violation of policy, including the 2010 VHA directive. He stated that the majority were not following the policies as they were written. He was unaware of any specific supervisors who directed anyone to manipulate dates in the scheduling processes. He did not think any clerks were trying to manipulate the system; they were trained incorrectly.

  Regarding the consult list, he knew there were reviews of the list and there were findings. He specifically remembered a review of Vascular Surgery. He stated that individuals were trying to address the consults and he authorized the overtime needed to get things on track. He stated that the nurse executive, chief of staff, and associate director were in charge of that review. Every morning during morning report, he was informed of the status of each service and their progress with the Consult Review. After the Phoenix case, he began monitoring the EWL and the NEAR lists daily, and held many different meetings at different levels regarding unauthorized lists. He was never made aware of the use of an unauthorized list at VAMC Biloxi. He could not say if his last post of duty was using the EWL and could not remember the 2010 modification. He denied receiving any compensation solely for meeting measures associated with getting patients scheduled.

- The VISN 16 Director stated that she was made aware that there were some employees at VAMC Biloxi who were uncomfortable with the processes in place for scheduling appointments. She discussed the "consult cleanup" and believed the issue was being handled in Biloxi, but was challenged by the capacity in the community and budgetary limitations. She advised that in non-urgent cases, patients could be referred to VAMC Houston for specialist care.

The clear expectation at the time of the interview was that if a veteran could not be scheduled for care, the veteran was to go on the EWL. She stated the 2010 scheduling memo was confusing, the directive itself was convoluted, and the technology was antiquated. She had always been concerned with the clinical necessity for appointments, and noted the VA had added additional processes like the recall reminder, but VA still could not schedule an appointment 1 year out.

She stated she did not operate from a position that lacked integrity and noted that discussions were conducted regarding barriers to meeting measures, but there were no "passes" granted. She also advised that she had facility calls addressing measures to include budgeting until May 2014 when the Phoenix case started, but abandoned those calls when the investigations began. She explained that having a full, solid leadership team at each site was a challenge and there were facilities in challenging positions. She stated that training must be consistent and ongoing for support staff.

She explained that "ghost clinics" occurred when a provider went on an extended leave and other providers covered for the clinic or when a provider was hired and a clinic was set up in advance of the provider's arrival. She added that additional measures have been taken in creating and dismantling clinics recently. She stated there had not been a conversation above her level suggesting manipulation of wait times. There were expectations that the VA would take care of veterans, especially in the current economic times. There was a clear expectation of access for care of veterans from the Secretary down. She advised that the budget was a top-down budget and access to care for veterans was stressed.

- Additional interviews were conducted with employees from VAMC Biloxi Consult Management who advised:

  - There was friction in the Consult Management Service between RNs and clerk staff.

  - The VAMC diverted patients to Consult Management for the patients to be seen and cared for by doctors in the community if the VAMC did not have the specialty doctor needed or if the VA specialty doctor could not see the patient within 90 days. (The employees who were interviewed believed the VAMC was using the Consult Management Service to keep the metrics for VA patient wait times below 90 days.)

  - The Consult Management Service also had a difficult time getting outside doctors to see VA patients because of a lack of specialty doctors in the community; as well, some doctors in the community refused to see VA patients due to not being paid by the VA for the care provided to VA patients. Employees complained that they knew of some doctors in the community who would accept VA patients, but the doctors were not on the authorized list so the VA patients could not be seen by those doctors.

  - Consults could not be completed until the Consult Management Service received documentation that the patient had been seen and the results of the care given by the non-VA doctor. The Consult Management Service had a hard time getting these documents and, therefore, it appeared in CPRS that the patient was not getting the

care he/she needed, when, in fact, the patient may have received the care, but the documents had not been received by Consult Management to complete/close the consult.

Records Reviewed

- VA OHI reviewed a merged list containing 8,681 Non-VA Care consults in which the consult request date was started on July 20, 2009, through February 28, 2014. The review found that, according to the lists, the following actions had been taken on these consults:

  - Discontinued-duplicate
  - Discontinued-other
  - Administratively completed
  - No action taken

  The consults that had an action documented were reviewed to ensure that the patient received the care requested. All patients who had no action taken on their consult were, therefore, excluded. Then, a selected sampling of 272 patients' EHRs (15 percent), dated April 24, 2014, to June 4, 2014, of the remaining 1,788 consults was reviewed. The sampling included consults from a variety of non-VA specialty services. Of these:

  - Three patients never returned to VA after the consult was placed.
  - Sixteen consults did not have the appointments scheduled or services arranged.
  - Twenty consults had appointments scheduled and the patient no-showed, canceled, or no longer needed the service.
  - Sixty-eight consults had appointments scheduled, but there was no evidence in the EHR that the patient received the service or attended the appointment.
  - One hundred and sixty-five consults had the appointment scheduled and there was evidence in the EHR that the service was received.

  The review showed that, overall, the patients did receive the services requested but the appointments were not timely scheduled. Of the 272 patients, 19 were excluded because they did not have an appointment scheduled. The remaining 253 consults for which the service was scheduled showed that:

  - Seventy-two consults were scheduled within 30 days of the request of the consult or were placed for continuation of care already being received.
  - One hundred seven consults were scheduled over 30 days from when the consult was placed but within 6 months.
  - Thirty-five consults were scheduled over 6 months after the consult was placed.

- Thirty-nine had no date of appointment documented, but the EHR indicated in other notes that the patient received the service requested.

4. Conclusion

Allegation 1

The information obtained disclosed that officials in the VAMC Director's office were aware that an unapproved patient list existed for the Prosthetics Service at the CBOC in Pensacola. The investigation found that the order to destroy the records was intended to be an order to no longer use an email list or any paper list for scheduling, to ensure compliance with VHA Scheduling Directive 2010-027.

Allegation 2

The investigation found that a clerk was solely responsible for a "stack" of documents (purported to be an unofficial list of patients awaiting appointments), which was never intended to be misleading as a workaround for the scheduling of patients; rather, it was the result of an employee who failed to adequately complete her work assignments. Upon the discovery by her local management, the clerk was issued a Letter of Counseling and was instructed to prioritize the documents to determine the status of appointments still needing attention. The clerk retired as the result of not being able to keep up with both her work and her personal responsibilities.

Two Microsoft Excel spreadsheets were identified as being used by the lead Call Center clerk and the lead Primary Care clerk. It was determined that these spreadsheets were used as a new patient tracking mechanism, not to schedule appointments. Due to limitations in the communication between the Call Center and Primary Care Clinic clerks, the spreadsheets were used to ensure new patients received timely appointments. Previously, the spreadsheet from the Call Center was emailed daily to Supervisor 1 and her appointee; it contained all new patients who called the Call Center for that day so appointments could be scheduled. The spreadsheets were to ensure no new patients were overlooked in the scheduling process. At the time of the interview, this spreadsheet was no longer being emailed and had been replaced by an email template that was sent to Supervisor 2 for each new patient who called into the Call Center.

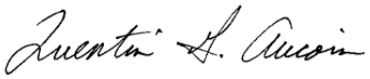
Allegation 3

The investigation determined that there had been a 2-year-long nationwide effort to address pending consults, which were defined as patient referrals to specialists and/or non-VA doctors. Many consults in the computer system were not closed for a variety of reasons, including a lack of outside doctors accepting VA referrals, lack of specialists, poor flow of paperwork from outside doctors back to VA, and missed appointments. The review of consults was an effort to close them if appropriate or get them otherwise addressed and thereafter close them as appropriate. Biloxi's list originally contained about 12,000 line items when its review began about 18 months prior to the investigation. About 6 months before the investigation, when the list was around 10,000 line items, VISN 16 management pushed the Gulf Coast VA Health Care System to finish the consult review. To do so, 75 to 100 clinically licensed VA volunteers were paid to each review 100 consults. Many consults

were closed when documentation was obtained showing the health care visit had occurred. Some were closed as duplicates. Some were closed because patients declined or failed to attend appointments. Ultimately, when Biloxi's review finished in May 2014, about 4,500 consults to outside doctors remained open—meaning those patients were awaiting appointments.

Our review showed that, overall, the patients did generally receive the services requested via consults. However, our findings indicated that consults were not timely scheduled.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 3, 2015.



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