



DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420

July 16, 2014

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-13-4425

Dear Ms. Lerner:

I am responding to your request for supplemental information on the Office of the Medical Inspector's (OMI) investigation into allegations by a whistleblower at the Department of Veterans Affairs (VA) Medical Center in Cheyenne, Wyoming (hereafter, Cheyenne VAMC). The whistleblower alleged that scheduling protocols at the Fort Collins Community Based Outpatient Clinic (hereafter, Fort Collins CBOC) were not in accordance with VA policy, possibly constituting a violation of law, rule, or regulation, and posing a threat to public health and safety. OMI's original report was submitted to your office February 25, 2014, and it contained seven recommendations for the Cheyenne VAMC, and four for the Veterans Health Administration (VHA).

OMI has prepared a supplemental report addressing the status of these recommendations. However, there have been significant developments concerning investigations into the Cheyenne VAMC matter since that time. On the afternoon of June 10, 2014, the Inspector General (OIG) shared with VA a list of VHA sites at which OIG investigators were currently investigating issues relating to scheduling and/or wait list improprieties and asked that VA not conduct further visits at these sites until the OIG completes its work. The Cheyenne VAMC and Fort Collins CBOC were both on this list. On the evening of June 18, 2014, the OIG alerted VA that the U.S. Attorney's Office declined criminal prosecution and that this site was now clear for additional VA review. The OMI is conducting a clinical review of all cases associated with this site to determine whether any deaths occurred while the patient was waiting for care and to determine if whether delay in care was associated with harm to any patient waiting for an appointment. VA will provide updated supplemental information as it becomes available.

Sincerely,

A handwritten signature in black ink, appearing to read "Carolyn M. Clancy", with a small "MD" to the right.

Carolyn M. Clancy, MD
Interim Under Secretary for Health

Enclosure

**Office of the Medical Inspector
Supplemental Report
to the
Office of Special Counsel
Veterans Affairs Medical Center, Cheyenne Wyoming and
Community Based Outpatient Clinic, Fort Collins, Colorado
OSC File No. DI-13-4425
July 16, 2014**

TRIM 2014-D-504

Background

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate a complaint filed with the Office of Special Counsel (OSC) by an anonymous individual (hereafter, the whistleblower) about improper scheduling protocols at Fort Collins Veterans Affairs (VA) Community Based Outpatient Clinic, Fort Collins, Colorado (hereafter, the Clinic) part of Cheyenne VA Medical Center, Cheyenne Wyoming, (hereafter, the Medical Center). OMI conducted a site visit to the Medical Center and Clinic on November 18–20, 2013.

Based on its findings, OMI made seven recommendations for the Medical Center, and four recommendations for VHA, all endorsed by the USH. OMI and the Office of the Deputy Under Secretary for Health for Operations and Management reviewed and concurred with the Medical Center's action plan in response to report recommendations; these actions have now been completed as described below. OMI has made a new additional recommendation at the end of this supplemental report.

Recommendation 1: The Medical Center should ensure that all outpatient scheduling is in compliance with VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* including:

- a. Ensuring that all clinical providers follow up on patient cancellations as stated in the directive.
- b. Aligning the VistA scheduling system's scheduling parameters so that they will be congruent with the VHA policy.
- c. Conducting a review of the directive for all current and newly assigned providers and medical support assistants (MSAs), and provide a copy of the directive.
- d. Closely monitoring the patients recaptured off of the Recall/Reminder discrepancy list for quality issues and address as appropriate.
- e. Developing a process to ensure that MSAs monitor and manage the patients on the Recall/Reminder discrepancy list on a regular basis.
- f. Discontinuing the practice of blind scheduling of patients.

Resolution: In response to the above recommendation, the Medical Center took the following actions:

- a. The Medical Center has developed and outlined a policy and procedure to ensure that providers follow up on all patient cancellations. During an emergency or short notice cancellation, the provider electronically notifies Business Office staff of the cancellation. The MSA or Administrative Officer of the Day prints the *Cancelled Patient List* and sends them to the appropriate clinical service so that appropriate actions can be taken by the clinical leadership. An assigned provider/licensed independent practitioner (LIP) currently reviews 100 percent of all provider clinic cancellations.
- b. Medical Center leadership reviewed the VistA system's scheduling parameters to ensure that they were congruent with VHA policy. Business Office staff ensures that all clinics meet VHA Directive 2010-027 and Medical Center Memorandum (MCM) 111-11-01, *Clinic Management and Outpatient Scheduling Processes and Procedures*, and that all clinics have availability at least 90 days in the future. The Clinic is in compliance with the mandate to have access within 3 to 4 months as outlined in VHA Directive 2010-027.
- c. Clinic leadership sent the national and local scheduling policies, VHA Directive 2010-027 and MCM 111-11-01 respectively, to all clinical staff and required documentation of receipt. They discussed these policies at the January and February 2014 provider and nursing staff meetings. Business Office leadership provided the MSAs copies of VHA Directive 2010-027 during mandatory refresher training held on January 13 and January 28, 2014. Currently upon hire, they give copies to all newly assigned staff. Within 2 weeks of hire, they follow up with new staff to answer questions, and ensure comprehension and compliance with the policy.
- d. Business Office staff developed a standard operating procedure (SOP) for the Recall/Reminder discrepancy list. The Clinic's leadership sent a copy of this SOP to all clinical staff; adherence to this SOP is monitored by the clinic supervisors. On March 20, 2014, Business Office staff conducted a review of the discrepancy list for all Medical Center multiservice outpatient clinics (MSOC). There were 687 patients on the list, a decrease of 76 percent since November 2013. The designated Patient Aligned Care Teams (PACT) teams closely monitor the patients recaptured from the Recall/Reminder discrepancy list for any quality issues and appropriately address issues as they arise.
- e. MSAs run the clinic schedule for their assigned clinics once per week, and they confirm that the patient has been seen or has a scheduled appointment. If the patient has an appointment, the Recall/Reminder is removed. If the patient has not been scheduled, the MSA contacts the patient and schedules an appointment. The Lead MSA reviews the discrepancy lists weekly to verify that the MSAs have completed this task.
- f. At the time of the OMI site visit, MSAs were instructed to immediately discontinue the practice of blind scheduling. During the January 2014 MSA refresher training, Business Office leadership defined and addressed blind scheduling in detail. To ensure compliance, Business Office staff is monitoring blind

scheduling by calling two patients per MSA per week to verify that the MSAs have personally contacted the patient. During this call, Business Office staff confirms with the patient that the MSA asked him/her when they would like to be seen.

Action Ongoing

Recommendation 2: The Medical Center should ensure that all staff with access to the scheduling package receives retraining on the proper use of the Create Date and Desired Date, and monitor compliance.

Resolution: As a part of the refresher training, Business Office leadership retrained the MSAs on the proper use of the Create Date and Desired Date. In addition, to ensure compliance, the Business Office staff conducts monthly audits of scheduling practices of every staff member with access.

Action Ongoing

Recommendation 3: The Medical Center should ensure that Soft Skills training is completed by all appropriate staff within the required time frame.

Resolution: Business Office staff conducted Soft Skills training on December 19–20, 2013. Currently, all staff with access to scheduling is in compliance. All newly assigned MSAs (or other staff with scheduling access) are to receive Soft Skills training within 1 year of their employment, as per national and local policy.

Action Complete

Recommendation 4: The Medical Center should staff the Clinic to be in compliance with the PACT staffing model.

Resolution: The optimal PACT teamlet staffing ratio is three full time equivalent (FTE) clinical and administrative staff (a registered nurse, a licensed practical nurse or health technician, and a scheduling clerk) for every one FTE primary care provider (PCP). Clinic leadership presented an overview of the PACT staffing model at the monthly staff meeting in January 2014 and conducted face-to-face meetings with individual providers. The Clinic is working toward optimal staffing and have improved its staffing ratio from 1.36:1 in November 2013 to its current ratio of 2.66:1 by hiring additional PACT teamlet staff.

Action Ongoing

Recommendation 5: The Medical Center should review Advanced Clinic Access principles and strategies in accordance with the PACT model.

Resolution: The Chief of Staff and Associate Chief of Staff, Ambulatory Care conducted training and education to the clinical staff on the Advanced Clinic Access principles and strategies in accordance with the PACT model. This training is documented in the minutes of staff meetings held with providers, nurses, and MSAs,

discussing the PACT model including: What is a PACT Team, The Principles of PACT, What is a Huddle, and How to Scrub Panels.

Action Ongoing

Recommendation 6: The Medical Center should develop a contingency plan for short-term and long-term provider absences.

Resolution: In February 2014, Clinic leadership developed a proposed policy to address short- and long-term provider absences. This policy addresses implementing the short-term cancellation policy, identifying a coverage provider daily to see patients, implementing a telehealth option for more flexibility, and utilizing a back-up LIP for long-term absences. They are currently using this proposed policy and are working on finalizing it in the near future.

Action Ongoing

Recommendation 7: The Medical Center should consider extending clinic hours to appropriately facilitate access and recapture the patients on the Recall/Reminder discrepancy list.

Resolution: Clinic leadership implemented extended clinic hours to facilitate access and accommodate patient appointments. In addition, Saturday clinics are held from 8 a.m. until 12 p.m.

Action Complete

Recommendation 8: VHA should consider revising the current VHA directive on scheduling to make the standards specific and clear.

Resolution: The VHA Scheduling Policy (VHA Directive 2010-027) will need to be updated in the wake of discussions at the June 2014 State of the Art (SOTA) Scheduling Conference and other lessons learned and analysis currently being conducted. All materials including the new Directive, a Handbook, and Training Guides will need to be developed. Estimated date to move into concurrence is September 1, 2014.

Action Ongoing

Recommendation 9: VHA should consider conducting an assessment of the Medical Center and Clinic's scheduling system, PACT model, and access to care to determine the overall program needs.

Resolution: The Director, ACAP, the ACAP team of subject matter experts in scheduling, the Clinic PACT teams, and the Medical Center scheduling action team are in the process of developing a strategic plan addressing all recommendations made by OMI. This group is reviewing data, SOPs, and current policies to identify opportunities for improvement. In addition, the Director, ACAP, plans to schedule a site visit during which the Medical Center scheduling action team and the Clinic PACT teams present their progress to ACAP and Veterans Integrated Service Network 19 leadership. After

the Clinic and Medical Center develop and launch the strategic plan, they will subsequently conduct an overview of the data to identify trends to be shared across VHA.

Action Ongoing

Recommendation 10: VHA should review the position description rating of MSAs and consider upgrading the position.

Resolution: A June 2014 review of the Medical Support Assistant (MSA) GS-0679 occupational series indicated a need to reassess the application of the qualification standard with the one-time on-boarding action for conversion of the occupation to Hybrid Title 38. While the GS-5 is currently the full performance level, the qualification standard was written at the GS-6 level specifically to address Patient Aligned Care Teams (PACT) and specialty care areas. VHA needs to pursue policy, regulation and legislative solutions.

Action Ongoing

Recommendation 11: VHA should consider conducting a VHA-wide audit of scheduling practices to determine the validity of the access data reported.

Resolution: In mid-April, the Secretary of Veterans Affairs directed the Veterans Health Administration (VHA) to complete a nation-wide Access Audit to ensure a full understanding of VA's policy among scheduling staff, identify any inappropriate scheduling practices used by employees regarding Veteran preferences for appointment dates, and review waiting list management.

The audit was conducted in two phases. The Phase One findings were a strong basis to commence immediate action, even while Phase Two data were being collected. Ultimately, VA chose to limit Phase Two data collection after initial assessments restated high consistency with the findings of Phase One.

As a result, beginning May 21, 2014, VA launched the Accelerating Access to Care Initiative, a nation-wide program to ensure timely access to care. VHA provided training to VHA, VISN and facility staff to implement this plan. On the first day of the Accelerating Care initiative, VHA provided training to over 900 VHA field staff. As directed by President Obama, VHA has identified Veterans across the system experiencing waits that do not meet Veterans expectations for timeliness. VA began contacting and scheduling all Veterans who were waiting for care in VA clinics or arranging for care in the community, while simultaneously addressing the underlying issues that impede Veterans' access.

This initiative identified roughly 100,000 Veterans nationwide who were experiencing long wait times for receipt of their VA health care. VHA assessed each of its clinics using productivity data to determine if greater productivity can be gained (e.g. for clinics with lower productivity). Additionally, each VHA medical center has assessed if it can provide expanded clinic hours to increase clinic capacity. Lastly, each VHA medical

center assessed if care is available through non-VA care or through the national, Patient Centered Care in the Community (PC3) contract.

Action Ongoing

Additional statement:

The OMI report on this case (DI-13-4425) is a single standalone report on concerns about improper entry of appointment scheduling data at the Clinic. The report was provided to OSC in February 2014 before concerns regarding delays in appointment scheduling at Phoenix had come to light.

OMI has prepared this supplemental report addressing the status of these recommendations. However, there have been significant developments concerning investigations into the Cheyenne VAMC matter since that time. On the afternoon of June 10, 2014, the Inspector General (OIG) shared with VA a list of VHA sites at which OIG investigators were currently investigating issues relating to scheduling and/or wait list improprieties and asked that VA not conduct further visits at these sites until the OIG completes its work. The Cheyenne VAMC and Fort Collins CBOC were both on this list. On the evening of June 18, 2014, the OIG alerted VA that the U.S. Attorney's Office declined criminal prosecution and that this site was now clear for additional VA review.

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