



DEPARTMENT OF VETERANS AFFAIRS  
Washington DC 20420

February 25, 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

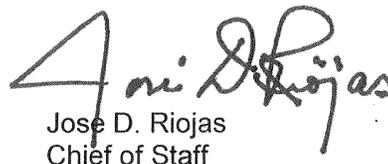
Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Cheyenne VA Medical Center (hereafter, the Medical Center), in Cheyenne, Wyoming. The whistleblower alleged that scheduling protocols at the Fort Collins Community-Based Outpatient Clinic (CBOC) are not in accordance with VA policy, possibly constituting a violation of law, rule, or regulation, and posing a threat to public health and safety. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code § 1213(d)(5).

The Secretary asked the Under Secretary for Health to review this matter and to take any actions deemed necessary under the above code. He, in turn, directed the Office of the Medical Inspector (OMI) to conduct an investigation. In its investigation, OMI substantiated that providers do not always conduct patient follow up when appointments are canceled. OMI substantiated that patient consults, returns, and long-term appointments are not scheduled in accordance with VA policy. OMI also substantiated that Medical Center and CBOC staff are not permitted to schedule patient appointments more than 90 days in advance, although it did not believe that this practice was a clear violation of VA policy. And, OMI substantiated that the Medical Center had failed to properly train staff on scheduling policies. However, as OMI was not provided any specific Veterans' cases affected by these practices, it could not substantiate that the failure to properly train staff resulted in a danger to public health and safety. While OMI's investigation found non-compliance with certain VA policies, it did not reveal violations of statutory laws, mandatory rules, or regulations. Findings from the investigation are contained in the report, which I am submitting for your review. I have reviewed these findings and agree with the recommendations in the report. We will send your office follow-up information describing actions that have and will be taken by the Medical Center to implement these recommendations.

Thank you for the opportunity to respond.

Sincerely,

  
Jose D. Riojas  
Chief of Staff

Enclosure

**OFFICE OF THE MEDICAL INSPECTOR  
Report to the  
Office of Special Counsel  
OSC File Number  
DI-13-4425**

**Department of Veterans Affairs  
Veterans Affairs Medical Center, Cheyenne, Wyoming and  
Community-Based Outpatient Clinic, Fort Collins, Colorado**



**Veterans Health Administration  
Washington, DC**

**Report Date: December 23, 2013  
TRIM 2013-D-1482**

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

## Executive Summary

The Under Secretary for Health 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 the 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.

The whistleblower made the primary allegation that the Medical Center's action related to scheduling patient appointments may have engaged in actions that constitute a violation of law, rule, or regulation, and a substantial and specific danger to public health. The whistleblower specifically alleged that:

1. Providers do not always conduct patient follow-up when appointments are canceled;
2. Cheyenne VAMC and Fort Collins administrative staff are not permitted to schedule patient appointments more than 90 days in advance, in violation of agency policy;
3. Consult, return, and long-term appointments are not scheduled in accordance with agency policy; and
4. The failure to properly train staff on scheduling policies and the failure to schedule in accordance with policies results in a danger to public health and safety.

OMI **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. OMI **did not substantiate** allegations when the facts showed the allegations were unfounded. OMI **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegations.

Based on its investigation, OMI makes the following conclusions and recommendations.

### Conclusions

- OMI substantiated that at least one provider did not review the charts of patients when the Clinic canceled their appointments.
- OMI substantiated that the Medical Center and Clinic administrative staff are not permitted to schedule patient appointments more than 90 days in advance; however, OMI did not substantiate a clear violation of agency policy, as the policy is internally inconsistent in its requirement to ensure that schedules must be open and available at least 3 to 4 months into the future, in advising the use of the

Recall/Reminder software for appointments scheduled greater than 90-120 days, and in expressly prohibiting the practice of blocking appointments.

- OMI substantiated that appointment scheduling (including consult, return, and long-term appointments) is not done in compliance with Veterans Health Administration (VHA) directives.
- OMI is concerned that the medical support assistants' (MSA) scheduling practices result in erroneous information compromising the validity of the scheduling data reported by the Medical Center.
- OMI did substantiate that the Medical Center had failed to properly train staff on scheduling policies. Although all MSAs received the Talent Management System (TMS) Scheduler Training, and all but one had received the required Soft Skills training within the first year, the hands on training failed to reinforce the initial training and taught practices that were not compliant with VHA directives.
- Due to the lack of specific cases for evaluation, OMI could not substantiate that the failure to properly train staff resulted in a danger to public health and safety.
- The VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, includes some guidelines that are unclear and conflicting.
- The inadequate implementation of Patient Aligned Care Teams (PACT) and Advanced Clinic Access has contributed to the difficulties with scheduling.
- Staffing shortages have adversely affected the ability of the MSAs to keep up with the workload. The downgrade of the MSA position from GS-6 to GS-5, has reportedly affected the Medical Center's ability to hire MSAs with the skills to manage all of the required functions.

## **Recommendations**

### **The Medical Center should:**

1. 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 Veterans Health Information Systems and Technology Architecture (VistA) scheduling system's scheduling parameters so that they will be congruent with VHA policy.

- c) Conducting a review of the directive for all current and newly assigned providers and 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.
2. Ensure that all staff with access to the scheduling package receives re-training on the proper use of the Create Date and Desired Date and monitor compliance.
  3. Ensure that Soft Skills training is completed by all appropriate staff within the required time frame.
  4. Staff the Clinic to be in compliance with PACT staffing model.
  5. Review Advanced Clinic Access principles and strategies in accordance with the PACT model.
  6. Develop a contingency plan for short-term and long-term provider absences.
  7. Consider extending Clinic hours to appropriately facilitate access and recapture all of the patients on the Recall/Reminder discrepancy list.

**VHA should:**

8. Consider revising the current VHA directive on scheduling to make the standards specific and clear.
9. 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.
10. Review the position description rating of MSAs and consider upgrading the position.
11. Consider conducting a VHA-wide audit of scheduling practices to determine the validity of the access data reported.

## **Summary Statement**

While OMI's investigation and review of its findings found non-compliance with VHA policy, it did not reveal violations or apparent violations of statutory laws, mandatory rules, or regulations.

## **I. Introduction**

The Under Secretary for Health requested that OMI investigate a complaint filed with OSC by the whistleblower about improper scheduling protocols at the Clinic part of the Medical Center. OMI conducted a site visit to the Medical Center and Clinic on November 18–20, 2013.

The whistleblower made the primary allegation that the Medical Center's action related to scheduling patient appointments may have engaged in actions that constitute a violation of law, rule, or regulation, and a substantial and specific danger to public health.

## **II. Facility Profile**

The Medical Center is a Veterans Integrated Service Network (VISN) 19, Level 2 facility, providing primary and secondary inpatient services in medicine and surgery. It also provides outpatient services in medicine, surgery, and psychiatry at the main campus and clinics. The Medical Center has an operating bed level of 22 hospital beds, 16 medical and 6 surgical beds, and maintains a VA Regional Office on its grounds. It has CBOCs in Fort Collins and Greeley, Colorado, and in Sidney, Nebraska.

The Clinic is a multispecialty outpatient clinic located approximately 45 miles from the Medical Center; its staff served 6,364 unique Veteran patients in fiscal year (FY) 2013.

## **III. Background**

VHA hospitals and clinics are required to use VistA, an electronic scheduling system, to schedule outpatient clinic appointments, and the Computerized Patient Record System to request consults. VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, provides policy for implementing processes and procedures for the scheduling of outpatient clinic appointments, and for ensuring the competency of the staff directly or indirectly involved in any components of the scheduling process, providing guidance to employees performing these duties about the importance of reducing delays and increasing and ensuring timely access to care for Veterans. The directive defines the flow of Veterans through enrollment, assignment of a primary care provider, and scheduling of appointments. It also provides guidance on managing backlog through the use of an electronic wait list and of the Recall/Reminder discrepancy list in which the Veterans themselves select a date and time to be seen, known as the Desired Date and defined as "the date on which the patient or provider wants the patient to be seen."

At the Medical Center and Clinic, the employees primarily responsible for scheduling patients are MSAs. MSAs assist in reducing appointment backlogs through the use of the Recall/Reminder software, which allows Veterans to schedule appointments on or close to their Desired Date of service by providing a reminder service for appointments

intended to be scheduled greater than 3 to 4 months in the future. The use of the Recall/Reminder software is intended to facilitate scheduling the appointments closer to the date on which the patient or provider wants the patient to be seen, ideally resulting in a decrease in the need for cancellations by the patient.

VHA has developed mandatory training that consists of a series of three TMS scheduling modules, covering the three major areas of scheduling: Business Rules, Make Appointment, and Recall/Reminder. MSAs are required to complete this training prior to receiving VistA access to the scheduling menu options. The goal is to provide clinically appropriate quality care for eligible Veterans when they want and need it, by creating appointments that meet their needs without excessive, unnecessary wait times or delays.

#### **IV. Conduct of Investigation**

An OMI team consisting of (b) (6) M.D., Deputy Medical Inspector, Professional Services; (b) (6) M.D., Medical Investigator; (b) (6) Registered Nurse (RN), Clinical Program Manager; and (b) (6) Associate Director, Access and Clinic Administration Program, subject matter expert, conducted the site visit and reviewed reports, memorandums, and other relevant documents. A list of these documents is provided in Attachment A.

OMI held an entrance briefing with the Medical Center leadership, including: (b) (6) M.D., Chief of Staff; (b) (6) Associate Director; (b) (6) Associate Director for Patient Care/Chief Nurse Executive; (b) (6) Acting Quality Manager; (b) (6) Chief, Business Office; (b) (6) M.D., Associate Chief of Staff, Ambulatory Care; (b) (6) Nurse Manager, Ambulatory Care; (b) (6) Multi Service Outpatient Clinic (MSOC) Supervisor; and (b) (6) Administrative Officer, Ambulatory Care. VISN 19 staff attending via teleconference included (b) (6) Chief Financial Officer/Acting Deputy Network Director; (b) (6) Business Manager; (b) (6) Clinical Manager; (b) (6) Administrative Assistant; and (b) (6) Deputy Business Manager.

OMI, accompanied by the Acting Quality Manager and the MSOC Supervisor, toured the Clinic.

OMI held individual interviews with the following Medical Center staff: (b) (6) M.D., Associate Chief of Staff, Ambulatory Care; (b) (6) Nurse Manager, Ambulatory Care; (b) (6) Chief, Business Office; (b) (6) MSOC Supervisor; (b) (6) former Clinic Acting Nurse Manager; (b) (6) M.D., staff physician; (b) (6) Lead MSA, assigned to the Medical Center; (b) (6) MSA, assigned to the Medical Center; and (b) (6) and (b) (6) MSAs, assigned to the Clinic. (b) (6) Nurse Practitioner, was interviewed by videoconference. The OMI team interviewed (b) (6) MSA, and (b) (6) Health Technician/MSA, individually, by teleconference.

OMI held an exit briefing with (b) (6) RN, Ph.D., the Medical Center Director, the Chief of Staff, the Associate Director, and the Chief Nurse Executive, by videoconference. The following VISN 19 staff participated by teleconference: (b) (6) Network Director; (b) (6) M.D., Chief Medical Officer; (b) (6) Quality Management Officer; (b) (6) Acting Deputy Network Director/Chief Fiscal Officer; (b) (6) Chief Business Implementation Manager; (b) (6) Deputy Chief Business Implementation Manager; (b) (6) Staff Officer to the Chief Medical Officer; and (b) (6) Executive Assistant to the Director.

The Office of General Counsel reviewed OMI's findings to determine whether there were violations of law, rule, or regulation.

OMI **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. OMI **did not substantiate** allegations when the facts showed the allegations were unfounded. OMI **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegations.

## V. Findings

### Allegation 1

#### **Providers do not always conduct patient follow-up when appointments are canceled.**

Per VHA Directive 2010-027, providers are required to follow up on their patients when appointments are canceled. During her interview with OMI, a nurse practitioner said she did not always ensure a review of her canceled appointments. Specifically, she stated that last year she had an unanticipated but scheduled leave from November 5, 2012, through December 13, 2012 (39 days), reporting that due to her workload she had not conducted a medical review of her patient's charts prior to taking her time off. Another provider did act as her surrogate during her absence, managing urgent issues as they arose; however, routine primary care needs were not addressed. When the nurse practitioner returned to work, she was informed that the MSAs had mailed appointment cancellation letters to patients when they were unable to contact them to reschedule their appointments.

Several interviewees confirmed that during November and December 2012, two MSAs were assigned to the Clinic reception desk, with responsibility for performing multiple duties (including scheduling patient appointments, checking patients in and out, conducting means testing, and other assigned duties), and consequently, could not contact many of the patients whose appointments had been canceled. OMI found that 60 of the 150 patients on the nurse practitioner's Recall/Reminder discrepancy list during her leave were not rescheduled. This was attributed to the fact that the nurse practitioner did not have appointment slots available within 90 days of the canceled

appointment dates, and that the MSAs were unable to schedule anyone beyond 90 days, due to the Medical Center's scheduling practices.

All of the MSAs interviewed by OMI, except one, indicated that if they were unable to reach the patients by telephone they were "blind scheduled," defined as appointments made without the patient's input. Although this practice is in violation of VHA scheduling policy, OMI was told that most Clinic patients keep their blind scheduled appointments. One interviewee indicated that Veterans were instructed to call the Clinic to reschedule if the blind scheduled appointment was unacceptable. If patients called the Clinic to change the blind scheduled appointment, the MSAs reported that they would record the appointment as canceled at the patient's request, instead of by the Clinic (as they should have, as the patient had never agreed to the appointment time). Cancelling an appointment "by patient request" effectively deletes the original Desired Date for the appointment. Any appointments scheduled after such a cancellation would establish a new Desired Date. Some interviewees reported that they assumed patients would call the Clinic if the Veteran did not receive a reschedule notice reminding them to book future appointments.

Upon review of FY 2013 data, OMI determined that the nurse practitioner currently has a total of 975 patients on her Recall/Reminder discrepancy list, which means that these patients have not been able to schedule follow-up appointments. The Clinic currently has a total of total of 2,832 patients on its Recall/Reminder discrepancy list.

Most of the interviewees informed OMI that MSAs are responsible for contacting patients either by telephone or by letter to reschedule canceled appointments.

During his interview, the Associate Chief of Staff, Ambulatory Care, shared that scheduling for primary care is difficult due to a lack of providers. To correct this problem, he indicated that he has selected eight new providers who are currently in various stages of the hiring process.

## **Allegation 2**

**Cheyenne VAMC and Fort Collins administrative staff are not permitted to schedule patient appointments more than 90 days in advance, in violation of agency policy.**

The VistA electronic scheduling system can be manually set up to include specific parameters. The VHA directive on scheduling allows for flexibility in the creation of clinic scheduling profiles. It states that "schedules must be open and available for the patient to make appointments at least three to four months into the future." It is the Medical Center practice to only open appointments 90 days into the future; therefore, MSAs cannot schedule beyond 90 days. VHA policy states that "permissions may be given to schedulers [MSAs] to make appointments beyond these limits when doing so is appropriate and consistent with patient or provider requests. Blocking the scheduling of future appointments by limiting the maximum days into the future an

appointment can be scheduled is inappropriate and is disallowed.” However, additional instructions are to “use the Recall/Reminder software application to manage appointments scheduled beyond the 3 to 4 month scheduling window.” OMI had difficulty interpreting the above statements due to the apparent conflicting guidance.

### **Allegation 3**

#### **Consult, return, and long-term appointments are not scheduled in accordance with agency policy.**

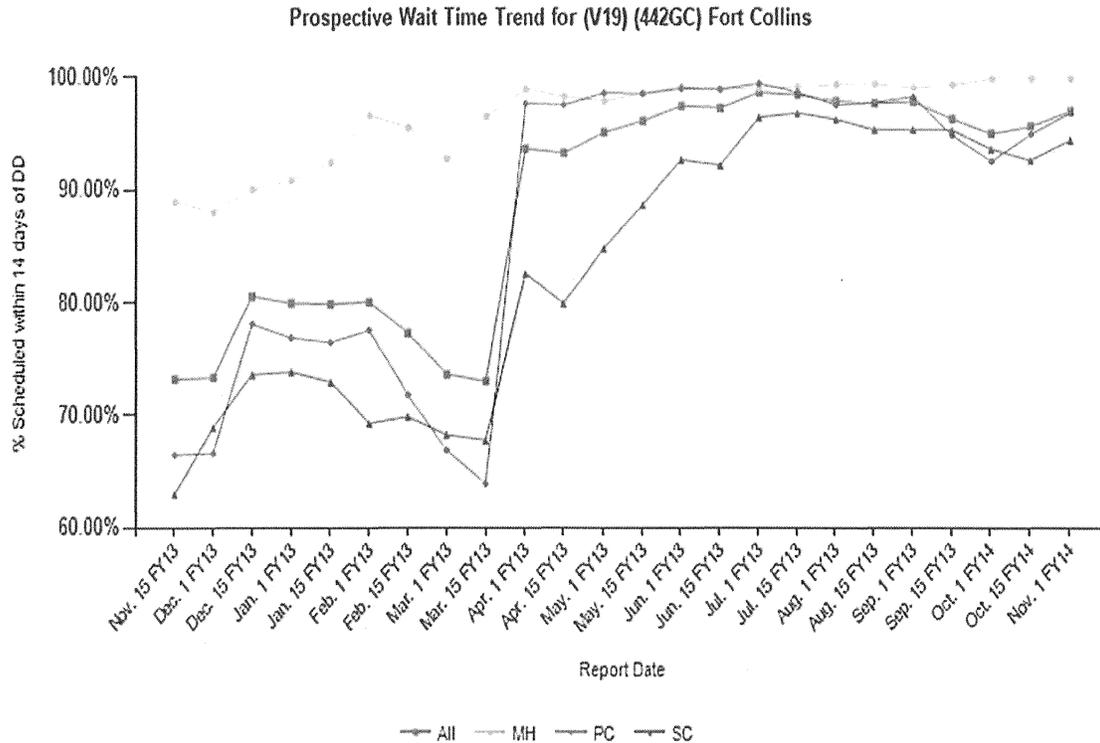
VHA scheduling policy states, “Strive to make follow-up appointments ‘on the spot’ for patients returning within the 3 to 4 month window.” In addition, the policy directs MSAs to use the Recall/Reminder software application to manage appointments scheduled beyond the 3 to 4 month scheduling window for established patients; to ensure that new patients are contacted to create an appointment; to adhere to specific requirements for making contact; and to document the number of attempts necessary to contact the patient.

OMI found that MSAs were unable to clearly articulate VHA policy on return or follow-up appointments. In addition, many did not know how to process “on the spot” specialty care consults, which required that a specialist review the consult request prior to the MSA making the appointment.

With regards to long-term appointments, OMI found that MSAs were given erroneous on-the-job instruction for recording the Desired Date. All interviewees described a direct link between the recorded Desired Date and the appointment date, although the directive clearly states that “the Desired Date needs to be defined by the patient without regard to schedule capacity.” In addition, all interviewees described that they had been instructed to ensure that the recorded Desired Date was within 14 days of the actual appointment date, and many reported that they had been counseled when the actual appointment date exceeded the Desired Date by more than 14 days. They were told that if appointments had not occurred, change the Desired Date to ensure that the actual appointment was less than 14 days after the Desired Date. Several MSAs reported that the Medical Center’s Business Office training included teaching them to make the Desired Date the actual appointment date. In addition, they reported that if the Clinic needed to cancel appointments, they were instructed to change the Desired Date to within 14 days of the new appointment. The directive specifically states that unless the cancellation is requested by the patient, the Desired Date should remain the same as the original appointment’s Desired Date.

The MSAs could not describe daily monitoring or regular review of the Recall/Reminder delinquency list despite requirements to do so by standard procedure per the VHA directive. Some interviewees stated that they would run the Recall/Reminder discrepancy list “if they have time” a few days per week; however, it was not done routinely.

OMI reviewed VHA's Support Services Center (VSSC) data for the Clinic from November 15, 2012, to November 1, 2013. This data was used to calculate the prospective wait time for established patients. As can be seen in the graph below, this report clearly indicates that in March 2013, the process for scheduling established patient follow-up appointments changed not only in primary care but in specialty care as well.



When asked what occurred in March 2013, MSAs told OMI they were instructed by Business Office staff to access the appointment schedule, review it for capacity, inform the Veteran of schedule availability, and then enter the Desired Date as the patient appointment date. Many voiced frustration over the scheduling situation, stating that one provider routinely has no appointments available for at least 6-8 weeks. This information conflicts with the Clinic's reported data that documents a 90 percent compliance rate for scheduling all Clinic appointments within 14 days of the Desired Date. Many of the MSAs reported significant stress when trying to explain to Veterans why they cannot make earlier appointments for them. By entering the Desired Date as the appointment date, the wait time for that patient appears to be zero days. Based on the Clinic's access issue demonstrated by the earlier wait time percentages and the information provided by the MSAs, the wait time days are actually much longer.

Although every MSA had completed the TMS Scheduling Training, which directly reflects the directive, they reported that the on-the-job training had influenced their practice. Additionally, some MSAs reported that their names appeared on a "bad boy" list if their scheduled appointments were greater than 14 days from the recorded Desired Date.

In March 2013, Medical Center leadership became aware that the Clinic was having problems with scheduling, employee morale and professionalism, and lack of teamwork between the MSAs. In response, two Medical Center employees were detailed to the Clinic to address the scheduling problems, replacing two Clinic MSAs who were being permanently reassigned to the Medical Center. The detailed employees reported that scheduling was "fixed" by changing the Desired Dates, and ensuring that future appointments had documented Desired Dates within 14 days of the actual appointment date. They also reported that the workload was too much for two MSAs to handle in addition to their other assigned duties. Subsequently, Medical Center leadership hired additional MSAs to bring the Clinic's MSA staffing to 4.5 full-time employee equivalents (FTEE). Medical Center and Clinic staff told OMI that the downgrading of the MSA position from GS-6 to GS-5 has affected their ability to hire people with the skills to manage all of the required functions.

In FY 2012, the Clinic had four full-time primary care providers (PCP) who cared for 5,626 unique patients. With each patient visiting the Clinic an average of 2.09 times per year, the Clinic provides approximately 11,000 visits annually. According to the Primary Care Management Module (PCMM) Handbook, staff consisting of two MSAs for four PCPs is not in compliance with the PACT.<sup>1</sup> VHA and private data indicate that current levels of support staff in VHA are often below the level of private sector practices, and are at a level that may reduce the productivity of individual providers. At least 2.5 FTEE support staff per provider has been recommended for VHA primary care clinics. A mix of approximately 0.5 RN, 1.0 LPN or medical assistant, and 1.0 medical clerk represents a reasonable combination of staff. Levels above 2.5 FTEE per provider may lead to further improvements in productivity and are encouraged by VHA. Interviewees were aware of PACT and Advanced Clinic Access, but some said that "it cannot be done" at the Clinic.<sup>2</sup>

#### **Allegation 4**

**The failure to properly train staff on scheduling policies and the failure to schedule in accordance with policies results in a danger to public health and safety.**

OMI interviewed five MSAs who either previously worked at the Clinic or are currently working there. All five MSAs had taken the TMS Scheduler Training modules, and three out of the five had completed the required Soft Skills training. MSAs have a year to complete the Soft Skills training; however, OMI noted that one MSA who had not taken the required Soft Skills Training had been employed for over a year. During initial orientation, after the MSA completed the TMS Scheduler Training modules, he/she receives on-the-job training at the Medical Center with staff in the Business Office. All interviewees said that their training was limited, did not have defined training standards, and included instructions that were not in compliance with TMS Scheduler Training modules and VHA Directive 2010-027. The MSAs' competency folders

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<sup>1</sup> PACT: [http://vaww.us.hva.gov/PACT/What\\_is\\_a\\_PACT.asp](http://vaww.us.hva.gov/PACT/What_is_a_PACT.asp)

<sup>2</sup> Advanced Clinic Access: <http://vaww.vasthcs.med.va.gov/AdvanceAccess/>

referenced scheduling, but did not include specific competencies of scheduling such as appropriate use of the Desired Date, use of the Recall/Reminder software, regular review and management of the Recall/Reminder discrepancy list, or cancelling and rescheduling appointments. In addition, the Medical Center was unable to provide evidence of the required annual audits.

Medical Center and Clinic staff reported and OMI found evidence to support that in the past, MSAs were unable to perform all of their required functions due to the scheduling system restrictions, unavailability of appointment slots for some providers, and staffing shortages. Medical Center leadership has initiated remedial actions such as hiring four new MSAs within the past 6 months.

Neither OSC nor any interviewee provided OMI any specific patient information about an adverse effect on medical care resulting from the scheduling issues.

## VI. Conclusions

- OMI **substantiated** that at least one provider did not review the charts of patients when the Clinic canceled their appointments.
- OMI **substantiated** that the Medical Center and Clinic administrative staff are not permitted to schedule patient appointments more than 90 days in advance; however, OMI did not substantiate a clear violation of agency policy, as the policy is internally inconsistent in its requirement to ensure that schedules must be open and available at least 3 to 4 months into the future, in advising the use of the Recall/Reminder software for appointments scheduled greater than 90-120 days, and in expressly prohibiting the practice of blocking appointments.
- OMI **substantiated** that appointment scheduling (including consult, return, and long-term appointments) is not done in compliance with VHA directives.
- OMI is concerned that the MSAs' scheduling practices result in erroneous information compromising the validity of the scheduling data reported by the Medical Center.
- OMI **did substantiate** that the Medical Center had failed to properly train staff on scheduling policies. Although all MSAs received the TMS Scheduler Training, and all but one had received the required Soft Skills training within the first year, the hands on training failed to reinforce the initial training and taught practices that were not compliant with VHA directives.
- Due to the lack of specific cases for evaluation, OMI **could not substantiate** that the failure to properly train staff resulted in a danger to public health and safety.
- The VHA Directive 2010-027 *VHA Outpatient Scheduling Processes and Procedures* includes some guidelines that are unclear and conflicting.

- The inadequate implementation of PACT and Advanced Clinic Access has contributed to the difficulties with scheduling.
- Staffing shortages have adversely affected the ability of the MSAs to keep up with the workload. The downgrade of the MSA position from GS-6 to GS-5, has reportedly affected the Medical Center's ability to hire MSAs with the skills to manage all of the required functions.

## **VII Recommendations**

### **The Medical Center should:**

1. Ensure that all outpatient scheduling is in compliance with VHA Direct 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 VHA policy.
  - c) Conducting a review of the directive for all current and newly assigned providers and 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.
2. Ensure that all staff with access to the scheduling package receives re-training on the proper use of the Create Date and Desired Date and monitor compliance.
3. Ensure that Soft Skills training is completed by all appropriate staff within the required time frame.
4. Staff the Clinic to be in compliance with PACT staffing model.
5. Review Advanced Clinic Access principles and strategies in accordance with the PACT model.
6. Develop a contingency plan for short-term and long-term provider absences.

7. Consider extending Clinic hours to appropriately facilitate access and recapture all of the patients on the Recall/Reminder discrepancy list.

**VHA should:**

8. Consider revising the current VHA directive on scheduling to make the standards specific and clear.
9. 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.
10. Review the position description rating of MSAs and consider upgrading the position.
11. Consider conducting a VHA-wide audit of scheduling practices to determine the validity of the access data reported.

**Summary Statement**

While OMI's investigation and review of its findings found non-compliance with VHA policy, it did not reveal violations or apparent violations of statutory laws, mandatory rules, or regulations.

## Attachment A

### Documents Reviewed by OMI:

1. VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
2. VHA Directive 2009-070, *VHA Outpatient Scheduling Processes and Procedures*, December 17, 2009.
3. Deputy Under Secretary for Health for Operations and Management Memorandum, *Inappropriate Scheduling Practices*, April 26, 2010.
4. Deputy Under Secretary for Health for Operations and Management Memorandum, *Fiscal Year 2010 Scheduler Training*, March 2, 2010.
5. *VistA Electronic Wait List (EWL) for Scheduling and Primary Care Management Module (PCMM) User Manual*, November 2002 (Revised July 2012).
6. *VistA Recall Reminder User Guide PIMS V.5.3 Scheduling Module Patch SD\*5.3\*536 and Patch OR \*3.0\*302*, September 2009.
7. Medical Center Policy, Ambulatory Care Service Line No. 1, *Standard Operating Procedures For Advance Access Scheduling*, July 2013.
8. Medical Center Memorandum No. 111P-13-01, *Primary Care Advanced Access Scheduling Policy*, July 2, 2013.
9. Medical Center Memorandum No. 11-12-0, *Short Notice Clinic Cancellation of Primary Care and Specialty Clinics*, April 23, 2012.
10. *Cheyenne VA Medical Center 2013 Trip Pack*.
11. Medical Center Ambulatory Care Organization Chart, October 1, 2013.
12. *Primary Care Management Module (PCMM) Handbook*, pages 16-17, (written in 2009).
13. Competency checklists for all MSAs assigned to the Clinic.
14. VSSC data for the Clinic, (November 15, 2012, to November 1, 2013).