



DEPARTMENT OF VETERANS AFFAIRS  
Washington DC 20420

OCT 07 2014

The Honorable Carolyn N. Lerner  
Special Counsel  
U.S. Office of Special Counsel  
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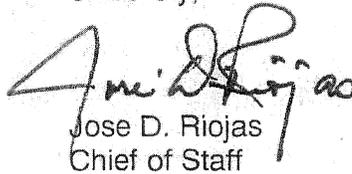
RE: OSC File No. DI-13-4425 and DI-14-3017

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 VA Medical Center in Cheyenne, Wyoming. On July 24, 2014 your office requested a supplemental report to address three issues concerning the report. We have addressed each issue in the accompanying document.

Thank you for the opportunity to respond to your inquiry.

Sincerely,

  
Jose D. Riojas  
Chief of Staff

Enclosure

**Department of Veterans Affairs Supplemental Report  
to the  
Office of Special Counsel  
Fort Collins Multi-Specialty Outpatient Clinic  
Fort Collins, CO**

October 3, 2014

TRIM 2014-D-1238

**Reponses to OSC follow-up questions on the Fort Collins Multi-Specialty Outpatient Clinic (hereafter, the Clinic) OSC Report File No. DI-13-4425 and OSC DI-14-3017.**

- 1) Acknowledgement of the referral in OSC DI-14-3017, including whether the agency reviewed the e-mails provided by OSC in its referral. If the agency did review the emails, we request a discussion of the review and analysis. If not, we request an explanation of the reasoning for that decision.**

**Response:**

The Department acknowledges the referral in OSC DI-14-3017, the substance of which was the subject of an Office of the Medical Inspector review in May 2014 and a Veteran Affairs (VA) Office of the Inspector General (OIG) investigation in June 2014. The VA Office of Accountability Review (OAR) reviewed the subject emails in both investigations and found the emails provided evidence of improper use of the scheduling system. The Department did not find senior Cheyenne Health Care Center (hereafter, the Medical Center) and Veterans Integrated Service Network (VISN) leaders to have directed the manipulation of wait time data; however, they did find some senior leaders to have exercised ineffective oversight with respect to the input and reporting of such data.

VA has proposed disciplinary actions against 6 individuals involved in the matter. Once a decision has been made on the disciplinary actions, VA will update the information and provide it to the OSC, so as not to compromise the individual employees' due process.

VA's Office of Inspector General (OIG) is in the midst of investigating similar allegations regarding scheduling procedures at other VA medical centers across the country and Veterans Health Administration (VHA) is analyzing data from a recent national audit of appointment practices. On the evening of June 18, 2014, OIG delivered to OAR an OIG Criminal Investigations Division Comprehensive Report of Investigation regarding allegations that two Cheyenne VAMC employees had manipulated data entries related to patient appointments and wait times at the Fort Collins CBOC. The cover letter accompanying that report indicated that "[t]he U.S. Attorney's Office [had] declined

criminal prosecution of [the two employees] for the actions substantiated by [OIG's] investigation."

- 2) Whether the Department considered disciplinary action for the members of management who directed the manipulation of wait time data or engaged in other wrongdoing, including an explanation of how the agency made its determination whether or not to issue disciplinary action and to whom, and the status of any disciplinary actions taken.

**Response:** See response to question 1 above.

- 3) A more in-depth discussion of the Department's new health and safety review, including:
- a. Who is doing the review?
  - b. Which specific sites are included in the review?
  - c. Which patient files are being reviewed and how the universe of files was determined
  - d. What is being reviewed in each file and how it bears on a health and safety finding?
  - e. When the review will begin and end, or when we can expect a first update on the status of the review?

**Response:** In an attempt to address the concerns raised by OSC related to patient safety associated with the Clinic's scheduling issues (substantiated in OSC 13-4425). The Department has completed three reviews outlined below: the first review completed by VHA Central Office addresses the concerns about whether or not Cheyenne/Fort Collins was "another Phoenix;" the second review completed by the Medical Center addresses the Recall/Reminder Discrepancy list; and the third review completed by the Medical Center addresses Veterans receiving non-VA inpatient care. All of these reviews have been completed and the results, along with the methodology for each, are described below:

#### Cheyenne/Fort Collins another Phoenix?

VA's response to OSC's concern that the Clinic is "another Phoenix" used similar methodology as the Office of the Inspector General's Phoenix review. VHA searched the VA Austin Databases for the Clinic's New Enrollee Appointment Request (NEAR) *report from January 1, 2005, through November 30, 2013, to find Veterans who had indicated on their Form 1010 EZ a request for an appointment in the Cheyenne VAMC.* The Austin database does not separate the Clinic's data from the Medical Center's data or its other clinics' data. The NEAR database search went back to 2005 in an attempt to capture all Veterans who had requested an appointment at the Clinic that could still be unappointed at the time that the Medical Center had directed altering the recording of desired dates beginning in March 2013.

*Table: Veterans on the Medical Center's NEAR list during each year noted.*

YEAR	NEAR List Enrollees
2005	339
2006	403
2007	429
2008	307
2009	362
2010	374
2011	330
2012	370
2013	341

**3255**

VHA then cross referenced this Veteran database with any deaths that occurred during the known time period when the Medical Center had directed altering the recording of desired dates, March 1, 2013 through November 30, 2013. Eight Veterans on the NEAR list died during this time frame. A VHA physician reviewed the electronic health records (EHR) of these eight Veterans. Each case is described in detail in the following paragraphs.

1. Veteran 1 was a 57-year-old male, Primary Eligibility: service-connected 50 to 100 percent. On May 2, 2005, the Medical Center's Healthcare for Homeless Veterans clinic documented in his EHR that a social worker had evaluated him for economic problems and homelessness, and provided information about programs available. He enrolled on May 4, 2005, and checked "request an appointment" on Form 1010 EZ for July 13, 2007, according to the Medical Center's data. There are no encounters entered for the Clinic, and no documentation that the Veteran attempted to make an appointment at the Clinic. The EHR reflected that this Veteran had received care at many VA Medical Centers including: Salt Lake City, UT, in May 2005; Mountain Home, TN, from October 2005 through July 2007; Tampa, FL, from March 2007 through June 2007; Portland, OR, from September 2007 through May 2012; Roseburg, OR, from March 2009 through December 2012; Puget Sound, WA, from June 2011 through March 2011, and Walla Walla, WA, from April 2012 through July 2013. He was still enrolled at the Walla Walla medical center when he died on July 24, 2013.
2. Veteran 2 was a 93-year-old male, Primary Eligibility: non-service-connected for disability. On January 7, 2013, he underwent a means test and the Medical Center was notified the patient wanted an appointment at the Clinic. The Medical Center enrolled him on January 8, 2013. On February 12, the Clinic set an appointment for him for March 4, 2013. However, on February 25, the Veteran called to cancel this

appointment, saying that he would call back with a new desired date. He did not call back and died May 17, 2013.

3. Veteran 3 was 77-year-old male, Primary Eligibility: non-service-connected for disability. On September 12, 2006, the Medical Center completed his means test. On October 4, 2006, he underwent an audiology appointment as part of compensation and pension evaluation at the Medical Center, where he was enrolled on January 23, 2007. The Veteran requested an appointment at the Medical Center on Form 1010 EZ for November 18, 2008. There are no encounters entered for the Medical Center or the Clinic, and no documentation that the Veteran attempted to make an appointment. This Veteran was also enrolled and received care at the VA Black Hills Health Care System, South Dakota, as documented in his EHR from April 2007 through April 2013. In addition, a private cardiologist at the Health Center of the Rockies treated him. This Veteran died May 27, 2013, while still enrolled at the Black Hills Health Care System.
4. Veteran 4 was a 92-year-old male, Primary Eligibility: non-service-connected for disability. On February 24, 2012, he underwent a means test; the EHR reflects that his income was "greater than Copay Income Threshold." He requested an appointment on his Form 1010 EZ and was placed on the NEAR. The Medical Center enrolled him on February 25, 2012. There are no encounters entered for the Medical Center or Clinic, and no documentation that the Veteran attempted to make an appointment. He died July 6, 2013, while residing at the Cheyenne Health Care Center, a private nursing home.
5. Veteran 5 was a 65-year-old male, Primary Eligibility: non-service-connected for disability. On February 6, 2013, he underwent a means test, requested an appointment on his Form 1010 EZ, and the Medical Center was notified. The Medical Center enrolled him on February 7, 2013, and on March 21, arranged an appointment with him for June 12, 2013; however, on April 20, 2013; however he died of unrelated causes prior to the appointment.
6. Veteran 6 was a 60-year-old male, Primary Eligibility: non-service-connected for disability. He enrolled on October 10, 2010, and indicated on Form 1010 EZ that he would like an appointment; however, the Medical Center was not notified that the Veteran wanted an appointment. He had no documented encounters at the Medical Center or the Clinic. The EHR reflected that this Veteran received care at many other VA Medical Centers, including Omaha, NE, from November 2009 through September 2011; Salt Lake, UT, from September 2011 through December 2012; Sheridan, WY, from April 2012 with last entry in November of that year. He was still enrolled at Sheridan when he died on September 16, 2013.
7. Veteran 7 was a 62-year-old male, Primary Eligibility: non-service-connected for disability. On November 3, 2009, he completed his enrollment application and indicated on his 1010 EZ that he would like an appointment. The Medical Center completed his means test and enrolled him the following day, November 4, 2009.

On November 6, the Medical Center entered a telephone note that the Veteran, after suffering a stroke, had called about a possible transfer to rehabilitation. EHR notes indicate that they informed the Veteran that he would have copayment fees but that the Medical Center was available for further assistance. Although his EHR does not contain an appointment date, the Austin database indicates that he had an appointment that was cancelled due to his admission to Ivins Memorial Hospital in Laramie, WY, where he died September 15, 2013.

8. Veteran 8 was a 24-year-old male, Primary Eligibility: non-service-connected for disability. On October 31, 2012, he completed his enrollment application and indicated on his 1010 EZ that he would like an appointment; the Medical Center completed his means test and notified him that a copayment would be required. He completed his enrollment on November 1, 2012. On January 23, 2013, the Clinic made an appointment for April 8, 2013, but he was a NO SHOW on that date, and the Clinic rescheduled him for June 28, 2013. The Austin database indicates that he died on April 17, 2013. The VHA investigator was unable to obtain further information about his death.

Based on this review, the Department concludes that there is no evidence that the deaths of these eight Veterans resulted from a delay in receiving care at the Cheyenne/Fort Collins health care system.

#### Recall/Reminder Discrepancy

The Recall/Reminder list is part of an electronic, searchable database. When a provider requests that a Veteran return to the clinic for follow-up more than 90 days in the future, he or she is put on the Recall/Reminder list. When it gets close to the listed appointment time, the Medical Center sends the Veteran a recall/reminder in the mail to contact the clinic to schedule the appointment. If the Veteran does not respond to the recall/reminder in 2 weeks, he or she is placed on the Recall/Reminder Discrepancy list, another electronic list. The Agency's report OSC DI-13-4425 raised concerns about the number of Clinic Veterans on the Recall/Reminder Discrepancy list, and its management.

In our report to the OSC, the Department recommended that the Medical Center review the cases of Veterans on the Recall/Reminder Discrepancy list to ensure there were no quality concerns, and, if found, take appropriate action. In response to this recommendation, the Medical Center completed the following actions for any Veteran listed on the Recall/Reminder discrepancy list:

1. Reviewed all Veterans on the Recall/Reminder Discrepancy list to ensure status of appointment, either completed or pending,
2. Reviewed each Veteran record that did not have an appointment to evaluate whether followup care had been provided elsewhere. For those remaining in need of followup care, a Medical Support Assistant (MSA) attempted to contact the Veteran by phone and schedule an appointment.

3. Directed the MSA to send a letter to the Veteran, if unable to contact the Veteran after two attempts.
4. Directed the PACT nurse to clinically review the medical record for level of need, utilizing standardized triage criteria, if the Veteran did not respond to these contact attempts.
5. Directed the Clinic to alert the Veteran's emergency contacts and/or next of kin listed in an effort to reach the Veteran, if the PACT nurses determined need for more than routine care.

Through these efforts, the number of Veterans on the Clinic's Recall/Reminder Discrepancy list decreased 98 percent from the 2832 at the time of the Department's site visit November 2013, to 43 by August 1, 2014. The Medical Center acknowledges that the Recall/Reminder Discrepancy list is fluid and changes hourly as MSAs schedule and clear the Veterans on the list and will Clinic continue to actively contact Veterans.

#### Non-VA inpatient care

The Medical Center audited the records of 724 patients who were hospitalized in non-VA facilities September 2, 2011, July 11, 2013. The Medical Center's information technology staff obtained these records from the Network Authorization Office for Larimer, Weld, and Laramie Counties. The Medical Center's Quality Management Office reviewed the cases to determine whether any of these Veteran's hospitalizations were related to their cancelled appointments. They found no relationship between the hospitalizations and unmet health care needs related to their cancelled appointments.

#### Additional Medical Center activity to improve care: Primary Care Electronic Wait List (EWL) management

At the time of the Department's site visit, the MSAs reported that, if they were concerned about a Veteran calling to schedule an appointment, they would contact a nurse to get the Veteran seen that day. Otherwise, they would either schedule the appointment for a future day, or if an appointment was not available, place the Veteran on the Primary Care Electronic Wait List (EWL).

In November 2013, the Medical Center took actions to reduce the number of patients on the EWL. The PACT nurses triaged calls from Veterans expressing acute issues or concerns using VHG, a web-based triage system that applies various questions and assessments to determine whether routine care is appropriate or more urgent care is needed. The PACT nurse can send a visiting nurse the same day to the Veteran's home to complete further assessment, consult with a provider, or direct the Veteran to seek immediate care in the Emergency Department. In November 2013, these actions reduced the number of Veterans on the primary care EWL to one, a Veteran who remained on the list for 2 days. Since midyear 2014, there has been only one Veteran on the EWL; he waited 8 days, at his request, in order to see a specific provider.

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**Conclusion:** As noted in the original report, the Department did find that the Clinic was manipulating the "desired date" to improve their data reports. This manipulation resulted in reports that appeared to demonstrate that access to care was immediately available at the Clinic. However, the Department found no evidence that this practice constituted a risk to public health and safety because changing the "desired date" was conducted in the context of scheduling the Veteran's appointment.