



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON DC 20420

December 1, 2015

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-15-2774

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Minneapolis Department of Veterans Affairs (VA) Health Care System, Minneapolis, Minnesota (the Medical Center). The whistleblower alleged that staff at the Medical Center improperly handled Veterans' appointments, and that these practices constitute a violation of law, VA directives, and a substantial and specific danger to public health. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

When this referral was received, the Interim Under Secretary for Health (I/USH) was assigned to review this matter and prepare a report in compliance with § 1213(d)(5) requirements. The I/USH, in turn, directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. VA substantiates the first allegation, does not substantiate the second and third allegations, and makes eight recommendations, including seven to the Medical Center and one recommendation to the Veterans Health Administration. We will send your office follow-up information describing actions that have been taken by the Medical Center and other entities to implement these recommendations.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in blue ink, reading "Robert L. Nabors II", is written over a printed name and title. The signature is stylized and includes a long horizontal flourish at the end.

Robert L. Nabors II  
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS  
Washington, DC**

**Report to the  
Office of Special Counsel  
OSC File Number DI-15-2774**

**Department of Veterans Affairs  
Minneapolis Veterans Affairs Health Care System  
Minneapolis, Minnesota**



**Report Date: November 27, 2015**

**TRIM 2015-D-4799**

## Executive Summary

The then Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Minneapolis VA Health Care System, (hereafter, the Medical Center) located in Minneapolis, Minnesota. **Whistleblower (b6)** (hereafter, the whistleblower), a medical support assistant (MSA) who consented to the release of her name, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on June 22–25, 2015.

### Specific Allegations of the Whistleblower

1. Neurology Department providers failed to timely enter follow-up orders, which prevented MSAs from scheduling patient appointments;
2. When physician residents left the Department, MSAs maintained an improper paper patient waiting list for months pending the arrival of new residents; and
3. Patient appointments were cancelled at the direction of providers with no attempt to reschedule or contact the affected individual.

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, VA makes the following conclusions and recommendations.

### Conclusions for Allegation 1

- VA **substantiated** that Neurology clinic providers were not consistently entering “return to clinic” (RTC) orders for follow-up appointments; however, it was not a written policy requirement at the time of **Whistleblower (b6)**’ employment.
- VA **did not substantiate** that MSAs were prevented from scheduling follow-up appointments without a RTC order.
- At the time of the whistleblower’s employment, the Medical Center’s instructions for RTC orders, which they verbally presented during training, were not consistent with the local or national written requirements.

### **Recommendation to the Medical Center**

1. Provide additional training to MSAs, Program Support Assistants (PSA), clinic nurses, supervisors, and providers on the new requirement (June 2015) for an RTC order for follow-up appointments. Monitor compliance and address non-compliance with additional instructional, administrative, or disciplinary action.

### **Recommendation to the Veterans Health Administration (VHA)**

2. Ensure the revision of VHA Directive 2010-027 includes the current requirement for RTC orders for follow-up appointments.

### **Conclusion for Allegation 2**

- VA concluded that MSAs used a printed daily patient appointment list to track completion of clinic visits and follow-up orders by providers, which is in compliance with VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
- VA **did not substantiate** that MSAs maintained an improper paper patient waiting list for months when physician residents left the Department pending the arrival of new residents, other than in the case of one MSA.
- VA verified that there was a delay in establishing new Neurology residents' clinical profiles in the summer 2014 because the Neurology PSA did not receive the residents' schedule from the university's residency program coordinator in a timely fashion.
- VA **did not substantiate** that other specialty clinics experienced delays in establishing physician resident clinics or in scheduling patients who were assigned to new incoming residents, although we did find variability in scheduling practices.

### **Recommendations to the Medical Center**

3. Perform a record review of all 2013–2014 Neurology chief resident's patients seen from January – June 2014 to evaluate the timeliness of follow-up care, as these Veterans may have been affected by the MSA's difficulty booking appointments secondary to the delay in establishing new clinic profiles and take appropriate action as necessary.
4. Evaluate the best scheduling practices across the Medical Center and standardize and share them, particularly as it regards to resident clinics around the end of the academic year.

### **Conclusion for Allegation 3**

- VA **did not substantiate** that the Medical Center cancelled patient appointments at the direction of providers with no attempt to reschedule or contact the affected individual; they did reschedule and send notification by United States mail (blind scheduling).
- Neurology Clinic PSAs used blind scheduling to reschedule resident conflict clinics, which is a violation of VHA policy, and VA concluded that 48 percent of cancellations were associated with resident conflict clinics.
- The use of “other” as a reason for clinic appointment cancellations does not provide useful tracking information for process improvement.
- The medical review of the electronic health record (EHR) of the Veterans’ complaints lodged with the Patient Advocate in the Neurology Clinic for the reason of “Excessive Delay in Scheduling or Rescheduling Appointment” demonstrated no delays in treatment, but two patients without a follow-up plan.

### **Recommendations to the Medical Center**

5. Educate all schedulers with the current scheduling instructions and emphasize VHA’s policy against blind scheduling, monitor for compliance, and take necessary actions for noncompliance.
6. Monitor cancellations to ensure accurate recording of reasons for cancellations, and track trends and take necessary actions as issues are identified.
7. Track the two Veterans without follow-up plans identified to ensure their continuity of care.
8. Assign staff to oversee the scheduling process utilizing VHA’s Scheduling Trigger Tool.

### **Summary Statement**

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, VHA Human Resources (HR) has examined personnel issues to establish accountability, and the Office of Accountability Review (OAR) has reviewed the report and has or will address potential senior leadership accountability. VA found violations of VHA policy and a potential risk to public health and safety related to the actions of one MSA.

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## **I. Introduction**

The I/USH requested that OMI assemble and lead a VA team to investigate allegations lodged with OSC concerning the Medical Center. The whistleblower, **Whistleblower (b6)**, an MSA who consented to the release of her name, alleged chronic mismanagement in the Medical Center's outpatient Neurology Department that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center on June 22–25, 2015.

## **II. Facility Profile**

The Medical Center, part of Veterans Integrated Service Network (VISN) 23, is a tertiary care Level 1A facility consisting of the main hospital, 11 community-based outpatient clinics (CBOC), and 2 outreach clinics affiliated with the CBOCs.<sup>1</sup> As a teaching hospital providing a full range of patient care services with state-of-the-art technology, as well as education and research, the Medical Center serves more than 100,000 unique patients. It provides comprehensive health care through primary care, tertiary care, and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation (PM&R), neurology, oncology, geriatrics and extended care, and dentistry.

The Medical Center has more than 150 active affiliations with local universities, including the University of Minnesota Medical and Dental Schools. Over 1,400 residents, interns, and students trained at the Medical Center last year. In conjunction with affiliations, residency training programs exist in all of the medical, surgical, psychiatric, diagnostic specialties and subspecialties, and oral surgery. The Medical Center has its own accredited hospital-based training programs for radiology technicians, nurse anesthetists, podiatry, and dental residents. Through the University of Minnesota School of Nursing, 20 nursing students will complete their junior and senior year clinical rotations at the Medical Center.

## **III. Specific Allegations of the Whistleblower**

1. Neurology Department providers failed to timely enter follow-up orders, which prevented MSAs from scheduling patient appointments;
2. When physician residents left the Department, MSAs maintained an improper paper patient waiting list for months pending the arrival of new residents; and

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<sup>1</sup> Complexity Level 1A: complexity levels are determined by patient population (volume and complexity of care), complexity of clinical services offered, and education and research (number of residents, affiliated teaching programs, and research dollars). Complexity level 1 is the most complex and level 3 is the least complex; complexity for level 2 facilities is considered moderate. (See VHA Executive Decision Memo (EDM), 2011 *Facility Complexity Level Model*).

3. Patient appointments were cancelled at the direction of providers with no attempt to reschedule or contact the affected individual.

#### IV. Conduct of Investigation

The VA team consisted of (b6), Deputy Medical Inspector; (b6), Nurse Practitioner (NP), Clinical Program Manager; and (b6) Registered Nurse (RN), Clinical Program Manager, all of OMI; (b6), HR Specialist, representing OAR; and (b6) VHA Office of Access and Clinical Administration Programs. The team reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured the Medical Center's Neurology and Urology outpatient clinical areas and held entrance and exit briefings with Medical Center leadership.

VA initially interviewed the whistleblower via teleconference on June 15, 2015, and conducted a second interview with her at the Medical Center on June 22, 2015. VA also interviewed the following employees:

- (b6) Acting VISN Director
- (b6) Medical Center Director
- (b6), MD, Acting Chief, Neurology
- (b6) MD, Neurology
- (b6) MD, Neurology
- (b6), MD, Neurology
- (b6), MD, Neurology
- (b6), MD, Chief, Specialty Care
- (b6), MD, Chief, Urology Clinic
- (b6), Physician Assistant, Urology
- (b6) RN, Clinic Coordinator, Specialty Care
- (b6) RN, Quality Management Officer
- (b6) RN, Patient Safety Manager
- (b6) RN, Risk Manager
- (b6) RN, Neurology
- (b6) RN, Urology Nurse Surgery Coordinator
- (b6) Clinical Applications Coordinator
- (b6) Chief, Health Information Management
- (b6), Chief, Patient Advocacy
- (b6), Compliance Officer
- (b6), Clinical Profile Manager
- (b6) Supervisor, Medical Records File Room
- (b6), Program Supervisory Specialist, Primary Care (PC)
- (b6), PSA, Neurology and Vascular, Clinic Coordinator
- (b6), MSA Supervisor, Specialty Care
- (b6), MSA Supervisor, PC
- (b6), MSA Supervisor, PM&R

- (b6) [REDACTED], former Lead MSA
- (b6) [REDACTED], MSA Educator
- (b6) [REDACTED], MSA, Neurology
- (b6) [REDACTED], MSA, Neurology Clinic
- (b6) [REDACTED], MSA, Urology Clinic
- (b6) [REDACTED], MSA, PM&R, Speech
- (b6) [REDACTED] former MSA

## V. Findings, Conclusions, and Recommendations

### Allegation 1

**Neurology Department providers failed to timely enter follow-up orders, which prevented MSAs from scheduling patient appointments.**

#### Background

VHA requires hospitals and clinics to use the electronic scheduling system, Veterans Health Information Systems and Technology Architecture (VistA) for documentation in a patient's EHR.<sup>2</sup> This record serves as a means of communication for all involved in the care of the patient. The Medical Center utilizes VA's decentralized hospital computer programs (DHCP) to schedule patients for an appointment for initial or follow-up care; this system allows for electronic scheduling of outpatient care. The VistA and DHCP systems are separate systems that are not linked electronically. DHCP does not block an MSA from scheduling an appointment without a RTC order.

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, establishes policy for scheduling outpatient clinic appointments and ensuring the competency of staff directly or indirectly involved in any component of the scheduling process. In addition, it provides guidance to employees on the importance of reducing delays and ensuring timely access to care for Veterans. The directive defines the flow of Veterans through enrollment, assignment to a primary care provider, and scheduling of appointments. It also provides guidance on managing backlog through the use of an electronic wait list (EWL) for new patients, and of the Recall/Reminder discrepancy list for enrolled patients desiring follow-up beyond the currently available time frame for appointments. Veterans select a date and time to be seen, in coordination with the clinically indicated date (CID), which is the provider's recommended follow-up window for an appointment.

At VHA facilities, MSAs are the employees primarily responsible for scheduling patients. They assist in reducing appointment backlogs by booking short-term, follow-up patient

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<sup>2</sup> VistA is an automated environment, which ties together workstations and personal computers with graphical user interfaces at VHA facilities, as well as software developed by local medical facility staff. VistA also includes the links that allow commercial off-the-shelf software and products to be used with existing and future technologies ([http://www.ehealth.va.gov/VistA\\_Monograph.asp](http://www.ehealth.va.gov/VistA_Monograph.asp)).

appointments prior to the Veteran leaving the clinic, and using Recall/Reminder software to schedule reminders for Veterans to call to schedule long-term, follow-up appointments on or close to the provider-recommended CID of service. Ideally, scheduling appointments close to the CID results in fewer patient cancellations.

VHA has developed mandatory training, including three modules in VA's Talent Management System that cover the three major areas of scheduling: Business Rules, Making Appointments, and the Recall/Reminder. MSAs are required to complete this training prior to receiving access to the scheduling menu. The goal is to provide clinically appropriate quality care for Veterans, when they want and need it, by scheduling appointments that meet their needs without excessive and unnecessary wait times or delays.

The Neurology Clinic provides outpatient care to patients with neurological disorders, e.g., diseases of the brain, spinal cord, and the connecting nerves. During clinic visits, the neurology provider evaluates, examines, treats, and determines the appropriate follow-up care for the patient. The provider records relevant findings in the patient's EHR; this documentation includes a plan-of-care section where the provider details the follow-up care recommended for the patient. The provider can also place orders for additional diagnostic studies, medications, treatments, and recommended follow-up date in the EHR. MSAs perform clerical duties in the Neurology Clinic, including scheduling appointments for patients.

## Findings

**Whistleblower b6)** was employed as an MSA at the Medical Center from March 23, 2014, through March 6, 2015. During her employment, MSAs were verbally instructed that a RTC order was needed for follow-up appointments. All administrative staff members that we interviewed, including those responsible for training the clerical staff, stated that during their initial training they were told that providers must enter an RTC order for all follow-up appointments. However, neither the Medical Center's nor VHA's policies required a written order for follow-up and Neurology Clinic and MSA leadership confirmed that there are no technical barriers in DHPC that prevent staff from scheduling appointments without a RTC order, thus staff can schedule appointments without orders. If the provider did not enter a RTC order, clinic managers encouraged the MSAs to remind the provider that he/she should do so. **Whistleblower b6)** stated she placed written RTC order reminders in provider's mail boxes. Her former supervisor confirmed that she instructed **Whistleblower b6)** to use these written reminders to notify providers to enter an RTC order. One MSA stated that she schedules follow-up appointments based on what the provider documents in the patient's EHR notes, and does not check for presence of a RTC order.

The clinic manager stated that an employee had voiced concerns in June or July 2014, that Neurology providers were not routinely entering RTC orders for follow-up appointments. The Medical Center investigated the concerns and noted that Neurology providers did not routinely enter RTC orders for clinic patients. On September 11, 2014,

the clinic manager and MSA supervisor met with the Neurology providers, discussed the value and reasons for the recommendation for RTC orders for follow-up appointments, and provided training related to entering RTC orders in the computerized patient record system (CPRS). Thereafter, the clinic manager noted that Neurology providers still did not consistently enter RTC orders, and therefore, met with the Chief of Neurology on November 18, 2014, to emphasize that RTC orders for follow-up appointments allowed easier comparison of the actual appointment date with the providers' CID. It also allowed MSA managers to better track employees' job efficiency. On December 4, 2014, the clinic manager and the MSA supervisor met again with the Neurology providers and reviewed the Medical Center's expectation that they enter RTC orders.

Since that meeting, the Medical Center reported Neurology providers have been compliant with entering orders for follow-up appointments. The VA team's random review of 60 records revealed that 58 out of 60 follow-up appointments had accompanying RTC orders entered by a Neurology provider. The two remaining Veterans without RTC orders had been scheduled for follow-up appointments and seen within the time frame recommended by the provider.

We reviewed the training information provided to MSAs during the time of [Whistleblower b6] employment and found no written requirement for providers to enter an RTC order before a MSA could schedule a follow-up appointment. The Minneapolis VA Health Care System Policy # TX-08F, *Care of Patients (TX), Outpatient Scheduling Process and Clinic Operations*, (in place during the whistleblower's employment) states that "Providers must document the return to clinic date/clinically indicated date (i.e. specific day or timeframe). Additional documentation is to include explanation of rationale and timeframes for medications, diagnostic tests, laboratory studies, consultations, and procedures."<sup>3</sup> Specifically, this policy did not require a RTC order prior to scheduling a patient for a follow-up appointment.

The VHA national guidance in place during the time of [Whistleblower b6] employment, VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, states that "[i]n order for the provider and scheduler to have a clear understanding of the intent for a return appointment, the provider must document the return date in CPRS, preferably through an order."<sup>4</sup> Thus, the directive recommends, but does not require, that an RTC order for a follow-up appointment be entered in CPRS. During [Whistleblower b6]'s employment, some providers were entering RTC orders in CPRS and some entered their recommendations for RTC follow-up in their progress note, which was permissible at the time. On June 8, 2015, VHA made a change to its recommendation and published a

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<sup>3</sup> Minneapolis VA Health Care System Policy # TX-08F, *Care of Patients (TX), Outpatient Scheduling Process and Clinic Operations*, February 23, 2015.

<sup>4</sup> VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*. June 9, 2010.

memorandum, which states that “providers are now required to enter the RTC order in CPRS.”<sup>5</sup>

Our review of the Medical Center’s Patient Advocate reports for fiscal year (FY) 2014 and 2015 (year-to-date) revealed no patient complaints related to not being scheduled for an appointment.

### **Conclusions for Allegation 1**

- VA **substantiated** that Neurology clinic providers were not consistently entering RTC orders for follow-up appointments; however, it was not a written policy requirement at the time of [Whistleblower b6]’ employment.
- VA **did not substantiate** that MSAs were prevented from scheduling follow-up appointments without a RTC order. Although MSAs were told that a RTC was needed for follow-up appointments, the DHCP program allows administrative staff to schedule follow-up appointments without an RTC order.
- At the time of the whistleblower’s employment, the Medical Center’s instructions for RTC orders, which they verbally presented during training, was not consistent with the local or national written requirements.

### **Recommendation to the Medical Center**

9. Provide additional training to MSAs, PSAs, clinic nurses, supervisors, and providers on the new requirement (June 2015) for an RTC order for follow-up appointments. Monitor compliance and address noncompliance with additional instructional, administrative, or disciplinary action.

### **Recommendation to VHA**

10. Ensure the revision of VHA Directive 2010-027 includes the current requirement for RTC orders for follow-up appointments.

### **Allegation 2**

**When physician residents left the Department, MSAs maintained an improper paper patient waiting list for months pending the arrival of new residents.**

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<sup>5</sup> Memorandum from Acting Deputy Under Secretary for Health for Operations and Management CORRECTION-Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance, June 8, 2015.

## Patient Appointment Lists

### Background

MSAs use printed patient appointment lists at the start of a work day to facilitate clinic management. On this working sheet, MSAs note whether scheduled patients arrived for their appointment and complete follow-up needs of any patient who underwent evaluation that day, including consult referrals, additional tests, and RTC scheduling (including use of EWL and Recall/Reminder discrepancy lists); or “no-show” and require rescheduling.<sup>6</sup> Providers must enter a clinical note in the EHR within 24 hours of the patient’s visit. If a Veteran leaves the clinic prior to the provider completing the note and associated orders, the MSAs use the printed sheet to track the Veteran’s follow-up requirements. After ensuring that all required tasks related to each patient on the patient appointment list are completed, the MSAs file the list in a locked file cabinet. Staff interviewed stated this practice was put in place as a result of a 2014 General Counsel litigation hold memorandum requiring the facility to keep all paperwork related to scheduling.<sup>7</sup>

The whistleblower reported keeping her list of clinic appointments for months to reconcile the workload for each day and catch up at a later date. (This was not the EWL).

### Finding

During interviews, all current MSAs appropriately articulated the procedures for managing printed patient appointment lists, the EWL, and the Recall/Reminder discrepancy list. We also found that MSA supervisors ran a report of unverified orders at least bi-monthly that is used to track items that require action by MSAs, and work with them to ensure completion of each Veteran’s plan of care.

## Clinical Profiles

### Background

The Medical Center’s Clinical Profile Manager (CPM) prepares clinical profiles, or appointment templates, of individual providers to allow MSAs or others to schedule appointments. In the Neurology Clinic, clinical profiles are specialized and provider-specific. Profile information includes the type of clinic, the day and time of the provider’s availability, and the type and length of appointment. To establish a clinical profile, the clinic’s PSA completes a request form by checking a series of boxes to indicate the name of the clinic, the appointment length in minutes, and the specific days of the week to schedule. He or she then sends the form to the CPM, who creates the profile in the

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<sup>6</sup> A patient appointment list is a print out of all of the clinic appointments for that particular day.

<sup>7</sup> VA General Counsel Memorandum, *Litigation Hold Concerning Alleged Consult and Appointment Delays with the VA Health Care System (VHA)*, May 13, 2014.

scheduling software for use by MSAs, and emails the PSA informing him or her of the date the profile is in effect.

If a MSA selects a date before the effective date of the profile when attempting to schedule a patient appointment, he or she will receive a message that says there is no clinic availability, making it appear that there are no available appointments if the date is selected incorrectly. However, available appointments are visible if an appointment date on or after the profile's effective date is selected. In addition, an MSA can always schedule a patient in another available resident's or attending physician's clinic profile if unable to find an appointment. There are no technical barriers that would prevent a MSA from scheduling a Veteran's follow-up appointment.

The academic year in post-graduate medical (residency) training typically starts in July and ends in June, resulting in the departure of graduating residents and the arrival of new first post-graduate year (PGY) residents (traditionally known as interns) around this time each year. Whenever a provider leaves the Medical Center (such as when a resident physician rotates out), his or her clinical profile must be deactivated. To accomplish this, a second deactivation clinical profile request must be initiated. If the existing profile still contains scheduled patient appointments, the CPM will notify the requester that the action cannot be completed, as a profile cannot be deactivated until all patients have been removed or rescheduled with other providers.

## Findings

Our review of the clinical profiles in the Neurology Clinic indicated that resident physician profiles are created using the resident's name, rather than by level of training (PGY-1, PGY-2, etc.). [Whistleblower b6] stated that, because each resident has an individual clinical profile, a graduating resident's patients must be transferred to other providers to ensure continuity of care. She said that she was unable to accomplish this transfer when attempting to schedule follow-up appointments for over 950 Veterans cared for by graduating Neurology residents between April and September 2014. [Whistleblower b6] further reported that she had kept a separate list of these patients for months until such time as she was able to schedule follow-up appointments into DHCP, although she was unable to provide this list to us. The Medical Center likewise was unable to locate her reported "wait list," but did provide copies of the clinic appointment worksheets discussed above. Some MSA staff reported that they used the daily patient appointment list to check-off completion of clinic visits, ensuring all patients were checked out or noted as a "No Show" and to track that they had scheduled all follow up appointments for the day. This practice is not prohibited by VHA Directive 2010-027, since these lists were not waiting lists but rather daily clinic worksheets. [Whistleblower b6] is the only MSA interviewed who described not using this as a daily task sheet, but rather she stated she kept her lists for months with her incomplete tasks before she scheduled appointments.

Other MSAs reported that they would schedule follow-up appointments for a graduating resident's patients with other physicians, such as the attending neurologist or the incoming chief resident, during the transition from one academic year to the next. By so

doing there would be only a 2–3 week scheduling delay during the turnover period between graduating and new residents. We also interviewed MSA supervisors in PC, who noted that they purposely block out the PC residents' clinic schedules in DHCP during the last 2 weeks of the academic year and schedule all appointments with attending physicians to account for resident turnover. This practice resulted from experience in scheduling patients during resident transition and in supervising those that were trying to schedule patient appointments during this period.

In 2014, the Neurology PSA did not receive PGY-1 residents' names from the University of Minnesota's Resident Program Coordinator until June 10, 2014. After receiving the names, the Neurology PSA requested clinical profiles for the new residents in late June 2014. As a result, the PGY-1 resident clinic profiles were not entered until early July; however, other PGY residents and attending neurologists had existing active profiles in the system. By contrast, in 2015, the University of Minnesota provided residents' schedules in March, which allowed the PSAs to request the creation of their clinic profiles much earlier. The CPM authorized these profiles on April 29, 2015, and within a matter of hours the PSA had created them. This ensured that clinical profiles for incoming residents were in place much earlier this year.

**Whistleblower b6** also alleged that she encountered similar difficulty in scheduling appointments with new residents after she was reassigned to the Urology Clinic. Veterans seen in Urology are evaluated by an attending, a resident, a physician assistant, or a nurse practitioner. However, we determined that residents' patients are scheduled under the responsible attending urologist's name; thus resident rotations on or off the Urology service have no effect on the MSAs' ability to schedule appointments. We found no evidence of delays in establishing clinics or scheduling patients.

## Conclusions for Allegation 2

- VA concluded that MSAs used the daily patient appointment list as a worksheet to track completion of clinic visits and scheduling of follow-up appointments. This utilization is not expressly prohibited by VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
- VA **did not substantiate** that MSAs maintained an improper paper patient waiting list for months when physician residents left the Department pending the arrival of new residents, other than in the case of one MSA.
- VA verified that there was a delay in establishing new Neurology residents' clinical profiles in the summer of 2014 because the Neurology PSA did not receive the residents' schedule from the university's residency program coordinator in a timely fashion.
- VA **did not substantiate** that the Urology clinic experienced delays in establishing physician resident clinics or in scheduling patients who were assigned to new incoming residents, although we did find variability in scheduling practices.

## **Recommendations to the Medical Center**

11. Perform a record review of all 2013–2014 Neurology chief resident's patients seen from January – June 2014 to evaluate the timeliness of follow-up care, as these Veterans may have been affected by the MSA's difficulty booking appointments secondary to the delay in establishing new clinic profiles and take appropriate action as necessary.
12. Evaluate the best scheduling practices across the Medical Center and standardize and share them, particularly with regards to resident clinics at the end of the academic year.

### **Allegation 3**

**Patient appointments were cancelled at the direction of providers with no attempt to reschedule or contact the affected individual.**

### **Background**

According to Medical Center Policy #TX-08F, *Outpatient Scheduling Process and Clinic Operations*, February 23, 2015, short-notice clinic cancellations are to be avoided whenever possible. Before canceling a clinic, the service/section/division chief should consider alternatives for patients who already have scheduled appointments. This short-notice cancellation avoidance applies to elective clinic cancellations such as vacations, meetings, continuing education, and other nonemergency reasons. The chief is responsible for developing a contingency plan to ensure coverage in the event of unforeseen circumstances (provider illness or a last minute emergency). All current Neurology and Urology Clinic staff, physicians, MSAs, PSAs, and supervisors could articulate the Medical Center's cancellation policy.

Residency Programs schedule neurology residents to have continuity clinics even while working on other rotations. In his interview, the neurology PSA acknowledged that many of the clinic's cancellations were a result of unanticipated changes in residents' academic schedules sent to the Medical Center by the University. In Neurology, one of the conditions that requires movement of a clinic is a resident "conflict clinic." An example of a "conflict clinic" is if two neurology residents both have a Monday continuity clinic and are doing an Intensive Care Unit (ICU) rotation, they cannot both be gone on the same day leaving the ICU uncovered; therefore, one of the resident's continuity clinics would need to be moved to another day. This would result in moving that resident's entire patient panel previously scheduled to the new clinic day. A short-notice clinic cancellation could result from emergency leave related to illness or injury.

### **Findings**

The neurology PSA stated that he would reschedule the entire conflict clinic to the new date and mail this information to each Veteran requesting they call the clinic if this new date was unacceptable. VHA's Outpatient Scheduling Standard Operating Procedures issued in June 2015 provided: All appointments, including the rescheduling of no-shows, must be made with input from the patient. No "blind scheduling" is allowed.<sup>8</sup> Rescheduling without speaking with the Veteran is a form of blind scheduling, which is contrary to VHA Directive 2010-027 and violates the Standard Operating Procedures.

The chiefs in both the Neurology and Urology Clinics indicated that short-notice cancellations have occurred in the past, most often due to staff illness. They are notified and following notification, MSAs, PSAs, MSA supervisors, and nurses were responsible for alerting patients. In these circumstances the current MSAs said they try to phone all of the affected Veterans. They acknowledged that patients may have arrived at the clinic because attempts to contact them by phone had been unsuccessful. Both maintain that it is clinic policy for staff members to solicit help from other providers to avoid turning patients away. In the Neurology Clinic, if a patient arrived and did not want to be rescheduled to see their specific provider, as long as their condition could be handled by a general neurologist, either another one of the other clinic providers or a Neurology inpatient team physician would see the patient. In the Urology Clinic, the chief stated that since his clinics were general in nature, the MSA would have the patients seen by other providers in the clinic.

We reviewed the Neurology Clinic's utilization summary from May 24, 2014, to June 23, 2015, and found 93 percent utilization of all available clinic appointments. This demonstrates the availability and scheduling of neurology appointments. We also reviewed the number of and reasons for cancellations from March 2014 to the time of the investigation. During the time period reviewed, there were a total 1,229 cancellations with 48 percent (584) designated as "other," without identifying a specific reason. All of these "other" cancellations were associated with residents' clinics. We reviewed a random sample of the cancellations of 60 Veterans that occurred from March 2014 to June 2015, and found that all Veterans were seen prior to the cancellation date or within 6 weeks of the date of cancellation. We found that several MSAs annotated the reasons for cancellations in the remarks section, but confirmed that not all cancellations included a reason. Overall, the reasons provided included:

- Rescheduling to an earlier time for the same day
- Patient residing in another state and the appointment is no longer required
- Rescheduling by patient to another date/time
- Wrong time, the appointment was scheduled and rebooked
- Treated by Non-VA care

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<sup>8</sup> Attachment A to Memorandum from Acting Deputy Under Secretary for Health for Operations and Management to Network Directors, CORRECTION-Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance, June 8, 2015.

- Provider out sick
- Other

In addition, we reviewed the Medical Center's Patient Advocate reports for FY 2014 and FY 2015 to the present, as a marker of Veteran dissatisfaction with the scheduling process. There were 8 complaints filed by 7 Neurology patients under the category of "Excessive Delay in Scheduling or Rescheduling Appointment" during this time period. An independent expert medical review of these Veterans' EHRs demonstrated appropriate and timely care at the time of the complaint; however, reviewers noted that two of the Veterans did not have a recorded follow-up plan.

### **Conclusions for Allegation 3**

- VA **did not substantiate** that the Medical Center cancelled patient appointments at the direction of providers with no attempt to reschedule or contact the affected individual; they did reschedule and send notification by United States mail (blind scheduling).
- Neurology Clinic PSAs used blind scheduling to reschedule resident conflict clinics, which is a violation of VHA policy, and VA concluded that 48 percent of cancellations were associated with resident's "conflict clinics."
- The use of "other" as a reason for clinic appointment cancellations does not provide useful tracking information for process improvement.
- The medical review of the EHR of the Veterans' complaints lodged with the Patient Advocate in the Neurology Clinic for the reason "Excessive Delay in Scheduling or Rescheduling Appointment" demonstrated no delays in treatment, but two patients without a follow-up plan.

### **Recommendations to the Medical Center**

13. Educate all schedulers with the current scheduling instructions and emphasize the VHA policy against blind scheduling, monitor for compliance, and take necessary actions for noncompliance.
14. Monitor cancellations to ensure accurate recording of reasons for cancellations, and track trends and take necessary actions as issues are identified.
15. Track the two Veterans without follow-up plans identified to ensure their continuity of care.
16. Assign staff to oversee the scheduling process utilizing VHA's Scheduling Trigger Tool.

## **Summary Statement**

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, OGC has provided a legal review, VHA HR has examined personnel issues to establish accountability, and OAR has reviewed the report and has or will address potential senior leadership accountability. VA found violations of VHA policy and a potential risk to public health and safety related to the actions of one MSA.

## Attachment A

Documents in addition to the EHRs reviewed.

Minneapolis VA Health Care System (HCS) Access Scheduling Core Concepts, Scheduler Refresher Update Training, 2014.

Minneapolis VA HCS Access Scheduling Core Concepts, Scheduler Refresher Update Training, June 9, 2015.

Minneapolis VA HCS Clinic Profile Request Form.

Minneapolis VA HCS Compliance and Business Integrity Audit Protocol FY 2015.

Minneapolis VA HCS Compliance Committee Agenda, February 25, 2015.

Minneapolis VA HCS Compliance Committee Meeting, February 25, 2015.

Minneapolis VA HCS Neurology Conflict Clinic Roster, Calendar Year 2015.

Minneapolis VA HCS Continuity Coverage for Residents and Movement Disorders Fellows.

Minneapolis VA HCS, *Daily Briefing*, July 17, 2015.

Minneapolis VA HCS Memorandum, *Care of Patients: Consult Management*, Policy TX-43, April 28, 2015.

Minneapolis VA HCS Memorandum, *Facility Certification of Scheduling Directive VHA 2010-027*, April 29, 2015.

Minneapolis VA HCS Memorandum, *Management of Information: Medical Records*, Policy IM-01K, June 7, 2013.

Minneapolis VA HCS Memorandum, Care of Patients (TX): *Outpatient Scheduling Process and Clinic Operations*, Policy TX-08E, June 25, 2009.

Minneapolis VA HCS Memorandum, Care of Patients (TX): *Outpatient Scheduling Process and Clinic Operations*, Policy TX-08F, February 23, 2015.

Minneapolis VA HCS Neurology Clinic Profile Request email, April 29, 2015.

Minneapolis VA HCS, *Outpatient/Specialty Care Standing Orders*, February 2012.

Minneapolis VA HCS Patient Advocate Tracking System Complaints, FY 2014.

Minneapolis VA HCS Patient Advocate Tracking System Complaints, FY 2015.

Minneapolis VA HCS PM&R, Your Next Step in Care Forms.

Minneapolis VA HCS Neurology and Urology Protected Peer Review 2014-2015. (6)

Minneapolis VA HCS Specialty Care Consult Standard Operating Procedure, June 12, 2014.

Minneapolis VA HCS Specialty Care Section Chief Meeting Agenda, June 3, 2015.

Office of the Inspector General Hotline 2015-03213-HL-1154 May 12, 2015.

VA General Counsel Memorandum, Litigation Hold Concerning Alleged Consult and Appointment Delays with the VA Health Care System (VHA), May 13, 2014.

VHA Directive 2006-041, *Veterans Health Care Service Standards*, June 27, 2006.

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

VHA Handbook, 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

VHA Handbook, 1907.01, *Health Information Management and Health Records*, March 15, 2015.

VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, March 4, 2011.

VHA Surgical Complexity listing of all VHA Facilities  
<https://vaww.nso1.med.va.gov/vasqip/DUSHOMembeddedPages/complexity.aspx>

Department of Veterans Affairs Memorandum, CORRECTION: Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance. June 8, 2015.