These are my comments on the investigation conducted at the employees at the Minneapolis Veterans Affairs Hospital in Minnesota.

Untimely RTC Orders

I made that report because at the time of my employment failure of these providers had gotten so out of control several folders bearing each providers name and day of the week were being kept inside the drawer of a locked file cabinet in the front office of the clinic.

The contents of each folder had to do with patients needing follow-up appointments without the necessary order denoting when the patients were to receive their follow-up appointments and these orders are only be written by licensed clinical staff. However, not all provider's failed to enter these orders. Those who were reverent to enter orders names have been provided to the investigating team.

The first time I remember someone confronting me about orders it was to allow provider's additional time to get caught up on getting orders into CPRS. The Lead Worker at the time Neurology Lead Worker told me to, "Back off the orders!" That was during the month of April 2014. I was new and still in training under the tutelage of Veronica. It was part of her job to observe me closely and to make a secondary report for my supervisor based on my depth of knowledge concerning data of the computer proficiency.

At first it seemed various providers didn't enter orders for two (2) to three (3) patients.

The patient always being present, would inform me their provider told them to stop and see someone me at the desk for a follow-up appointment. If an order was not visible the Lead Worker usually reacted as if she was shockingly puzzled or she would suggest to patient's I may have been unable to locate the order because I was new and nervous.

Initially, what was done is , she would make note to herself by marking the specified time and date next to the patient's name on a print out of the appointment list for that day. The next step was notifying me to indicate the exact specified time and date next to the exact patient on a [1]separate appointment list for the day that I had. Neurology Lead Worker would remind me throughout the day not to schedule any patient's in that specified time and date slot.

Every patient did not just leave the office when if she acted like she was assuring them an appointment had been scheduled for them and some did not take her words away with them as easily as others may have. Some patients expressed serious concern thing's such their own memory or needing a note confirming the appointment to bring home to a family member. Some bluntly expressed they had been "promised" an appointment like that before but it had gotten cancelled so in those cases patients asked for a printed letter of confirmation regarding their appointment.

After April 2014 frequency of orders not being written-grew. In an apparent attempt to alleviate tension in the clinic the Lead Worker had finally started getting up out of her seat at the front desk to go remind certain provider's they had forgotten to write an order for follow-up.

That only helped for a little while.

[1] Although the list were exact we each had our own list

Around that time Supervisor expressed questions to me about Patient Desire Dates and It was then that I advised her that the clinic had been using some five and one half by eight (5 ½ X 8) inches sheets of paper to remind providers orders for patients were not entered. Cheryl's response to me at time and on another occasion was, [2]"And what did Neurology Lead Worker say?

Supervisor told me that provider's had the responsibility of completing order's within a twenty-four (24) hour period. However, Supervisor never ever directed me to continue using the paper list. Neurology Lead Worker did. At first the wait list were neon green made of paper a little short of stock. When Neurology Lead Worker was out of the office I was unable to locate the green stock. She was at another clinic and I had to seek her help because I had run out of the list. I called her and spoke with her explaining that the hassle of trying to re-create the look of the list took me over an hour. At that time she told me I could find it on the hard drive, except it was not on the hard drive of the computer I was assigned it was only on the computer Neurology Lead Worker was assigned to. When she arrived back at the Neurology clinic she directed me to the template located on the computer she used at the hospital and ran off several more blank copies of the list.

Rather Supervisor advised me that she would be introducing a color-coded checkout method. The patient would hand-off a colored card, the MSA at the check the patient out and schedule a follow-up. The color coded card would be put inside of a tray in the office and the process would continue for each patient. To ensure each provider writing a timely order, no patient was to leave an encounter without a card. However, that process was never introduced

I also advised Supervisor that several providers had complained to me about being flagged within CPRS reminding them no written order was written.

[3]All the while the Lead worker had also been going back over several months of some appointment list's dating back to January of 2014 claiming that she had been conducting quality audits on the last MSA's work, [4]a process which undeservingly had gotten handed down to me.

Sometime around May 21, 2014 an email indicative of mounting frustration's over orders not written in a timely matter got sent throughout the facility by Veronica. In the email several inconsistencies and lack of responsibilities were addressed.

On one occasion the supervisor sat with me over lab orders for the Blood Draw clinic not being written in a timely manner and as a result several appointments had to be scheduled after these appointments had occurred. Because I was new at the time and unaware the appointment needed to be entered in the current day current month current year format a subsequently error of several appointments being scheduled in 2014 for the patient to be seen in 2015 occurred. This was a regular process, scheduling appointments after they had happened instead of having a written order to accommodate the need to schedule an appointment in the Blood Draw clinic.

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[2] I made the opportunity for the wait list to become visually evident to Ms. Gilbert, explaining to her the process of the technique used for completing a list and then filing it with a provider in his/her office inbox and Ms. Gilbert's response on each occasion was, "And what did Neurology Lead Worker say?".

[3] She was really scheduling backlogged appointments.

[4] Neurology clinic providers were absolutely irritated about the flags but ignored requests put inside of their mail bins.

Shortly after around May 21, 2015 another meeting took place between the supervisor and some Lead MSA's. After the meeting I was confronted by Veronica. At that time she said to me, "I don't know what you did but you cooked the books or something!" I then counter-confronted Neurology Lead Worker in my defense; to remind her how I had just started work there. Then she apologized to me. She told me that her reason for speaking to me the way that she did was due to stress because of concurrent investigations going on at the time which were being conducted over the Arizona VA and Minneapolis.VA complaints and issues. She continued by going on about how people were losing their jobs and then she slapped her hands saying, "Felicia, you just don't understand people are losing their jobs!" My response to her was, "If they lied then they should lose their jobs! Good for them!" A Neurology clinic nurse was present during this altercation.

Discrepancies with the Scheduling Standards near Graduation of PGY-4 Residents

During the investigations other MSAs stated "…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. As an MSA at the time I was employed, I was only given permission to schedule a patient with the chief resident under the clinic profile titled "Inpatient Team". At that time I was instructed by the Chief Neurologist, Supervisor and the Lead Worker that the Inpatient Team clinic was only to be used for patients who had gotten approved for an appointment after having been to the emergency department, by consult, if a provider had verbally instructed to have a patient scheduled in that particular clinic; verbal instructions which were made orally or through a provider's written order but the Neurology did not allow me to make my own discretionary judgments as to when the Inpatient Team clinic profile was scheduled into

Some patients had been with a graduating PGY-4 resident from the time the resident was PGY-1. There were time when these patients were scheduled with the attending physician but the attending physician's or Neurology Chief made judgement as to which PGY-2, PGY-3 or soon to be PGY-4 residents the patient would transition to.

These MSAs may have been given free leisure to schedule going forward only after the incident involving occurrences of any delayed creation of resident clinic profiles. That practice was not in place at the time I was employed there. Furthermore, standard action or contingent plan for care had not been stated at that time nor has it been up to this point.

I would like to clarify that resident clinics only ran once per week for approximately four (4) and ½ (4 ½) hours per day

At the time the clinics were not built I was still under tutelage of the Lead Worker. All appointments that were scheduled without the discretion of the attending physician or Neurology chief are appointments scheduled under Veronica's direction.

Even when an appointment slot was open and the resident was available several patients expressed themselves as not being able to show for any appointments unless it was held a certain day of the week. In those cases patient's had no choice often but to reject the offered date for a date and proximate time closer to they saw as customary for themselves because of transportation issues.

That was not a task Neurology Lead Worker allowed me to single-handedly work without her direction either. If patients expressed the conflict Neurology Lead Worker instructed me on attempting to schedule the appointment at all points; from calling patients family members to contacting the travel department up to contacting Veterans Service Offices in various counties. While Neurology Lead Worker worked in the Neurology clinic any work completed without her prior knowledge and approval was rare, mainly done when she was away at meetings or on a personal break and even then she always left a notepad with her written instructions for me to follow until her return; she would also contact me by phone to inquiring to ensure I had followed each of the steps laid out by her or provide me with additional instruction. She said to me," I am your Lead Worker and you will do what I say!" An email was also sent be her explaining why she was to "hard" on me while I worked there. She said, "I only train you the way I was…" and added that she had my best interests when it came to my career there. I still have that email from her.

Ultimately Neurology Lead Worker confronted me because so many appointment shad not gotten scheduled. This was around the early part of July 2014. After the confrontation a meeting was held at the Neurology clinic between the supervisor, Neurology Lead Worker and myself and at that time I reminded the Lead Worker of her comments made regarding when she had anticipated scheduling for what was still a large portion of the patients who needed to be transitioned to other provider's due to graduation at that time. Because the Lead Worker was going away for a two (2) week vacation I asked her the day before, "What are we going to do with all of these, they're not scheduled?" [Unscheduled appointments]. The Lead Worker's response at that time was, "Leave them until I get back." [From vacation]. The Lead worker did not leave for her vacation until after the second (2^{nd}) week in July 2014.

Clarification of What I Stated to Investigators.

Investigators state that the clinics profiles for incoming PGY-1 residents were built in early July 2014. However, my clarification is the more accurate account for what was stated by me to them.

I did not intentionally indicate a drawer full of appointments had been locked inside of a drawer and that this incomplete work spanned as far back as April of 2014 up to September of 2014.

I was asked a series of questions and throughout my being question I provided answers along with dates, including proximate times of the year in which they had occurred.

I did intend to complain about the clinic profiles which were not built, just as they occurred and the appointments which had gotten scheduled according to a patient's Desire Date only to have an individual of the clinic cancel the appointments without enlightening the patient or anyone else beside himself for that matter. I also stated to investigators the presence of the individuals' work he'd done which involved appointments being canceled due to unforeseen events taking place in the lives of provider's at the time. However, the report did not include my comment to them indicating that I had spoken to the individual myself. I asked him to allow me to help him contact the patient's before cancelling and rescheduling. Therefore, no hostility would be put on display by a patient in the clinic lobby; for the most part it was against the rules and highly disrespectful. To them I also shared the comment made by my supervisor at the time about the cancelling going on which was, "I know he's still doing it..." among some other things said about how she was going to catch him in the act.

However, the series of questions that were asked doesn't do the best job of indication how the issues brought up in the actual complaint were made.

Two of the complaints made are those that made up a conjoined delay. The other issues are those which were fast growing, part of an individual; system that may have violated policy and posed threat to public safety but carried out over various periods throughout the time I was employed there.

I implicated to investigator's that the issues with the resident clinic's begin to wane away sometime in early August 2014 after the last meeting between the Lead Worker, supervisor and myself and at that meeting the Lead Worker acknowledged backlog created and failed contingency. At that time the Lead Worker accepted the task of researching and scheduling any unverified orders requiring follow-up appointments from April 2014 to July 31, 2014. Therefore I sated to investigators, from August to September of 2014 my only challenges were that of trying to successfully ensure patients appointments were not getting scheduled [5]out of order.

I spoke with investigators about two (2) Lead Workers coming to Neurology on separate occasions after my training Lead Worker bailed from Neurology after I spoke with her over some derogatory comments she kept bringing up to me and which are unrelated to this matter. The two substitute Lead MSAs stayed for short periods, the first (1st) MSA remained at the clinic for one (1) week. His immediate response's to me as to what he could observe about the clinic where that providers rarely entered orders in to CPRS in timely manner or otherwise rather they needed to be counseled on consistent bases, reasons MSAs needed clear communication through a written order. The second (2nd) MSA stated on his initial day to substitute, "Your provider's suck! Do they always do this, not put their orders in?" Afterward the second (2nd) MSA was promoted, and although I continued to work in Neurology without the assistance of an additional MSA he became my manager and promised me that after his additional conversation with the supervisor one of his projects as new manager would be going around speaking to provider's about the importance of having an order in CPRS.

I also brought up clinic conflict which was centered on enrolled patients who had been discharged from Neurology yet a new consult had been ordered by a referring physician. the patient had No one in the clinic was able to provide standard contingency for seeing these patients having consults and in many cases consults along with associated appointments were being canceled in those cases when, a patient had previously been discharged from the clinic for less than one (1) year, discharged exactly one (1) year or discharged more than two (2) years. I was asked to contact patients involved in these scenarios to explain to them the cancellation. However, there was no solid procedure to base justifying the contact regarding cancellation upon.

We also discussed the Neurology PSA cancelling previously scheduled thirty (30) minute slot appointments simply to accommodate his ease in creating sixty (60) minute consult appointments in order raise the appearance of the PSAs productivity.

And how in the Urology clinic that Lead Worker there discussed the proposal of only scheduling new patients a consult in thirty (30) minute slots rather than following the procedure of scheduling the first (1st) appointment of an existing patients' transitioning to a new Urology provider into these thirty

[5] Some of the written orders carried earlier dates as opposed to orders with later dates only because they had been entered late sometimes weeks after the appointments had taken place. Therefore the risk of scheduling patient out of order was at hand.

(30) minute slots as well. I was asked to only book in the fifteen (15) minute slots of transitioning existing patients even though that was not the procedure. The Lead Worker told me that the Urology PSA's duty scheduling consults for new patients was made complicated as not enough of the thirty (30) minute appointment slots existed at that time. I let investigators know that I spoke to both my manager and supervisor about this issue and I was told by both of them to reject the Lead Worker's proposal and continue scheduling according to procedure. [6][Thirty (30) minute versus fifteen (15) minutes]

I also discussed with investigators how, one of the Urology clinic Surgical Coordinator's discussed with me that certain slots had patient's scheduled into them although it was [7]known how the certain patients wouldn't actually require surgery. In doing so, aside from the procedural pre-dated surgical schedule slots were reserved in VistA to reduce the hassle of needing to search for a slots in events patients unforeseen scheduling conflicts arose because of clinic issues or patients expressed conflict. The Surgical Coordinator told me that she, "… know it's unethical but we do it anyway to save that spot…you don't know how to do it right now but…will train you, he'll show you how to do it before long you'll catch on and you'll be doing it by yourself."

I included making these statements to the investigators.

Investigators didn't mention that I explained to them, it took several days before a manager responded for providing me the user privilege necessary schedule into clinic profiles such as for MRIs, and PSA just to name a couple. I had to request the user privilege myself after several of my voicemail's left for the manager and email went unreturned. To this day I still keep the associated with my personal request and the grant without the manager's approval in my possession.

Clear Hospital Care Plan

[8] The hospitals [9]Care Plan is specific policy for the hospital and in it exist the outline expected of a provider. It clearly states exactly what he/she must document so not to render their work ineffective.

Unconcise MSA Training Material

On the other hand the material the MSAs are provided for training is not so clear. No indicate for/if MSAs should be defaulting to hunting through chart notes and if/when MSAs should be searching for CID's exist in the training. More accurately MSAs are trained to *follow* the order "written" by provider's, schedule according to the patient's Desire Date and avoid acquiesces or urging patient's to accept an appointment for the sake of preference other than their own. In cases of forgotten or delayed orders MSAs are trained to remind providers by practical methods such as flagging the provider through CPRS or speaking directly to the provider. Never is it mentioned in the training manual MSAs should result to putting small pieces of paper with the patient's name, last four (4) of their Social Security Number and dates of service patients were seen inside of provider's inboxes.

I would like to add that these pieces of paper were never secured. Provider's inboxes were made up of stackable trays which and at the time there was no way to prevent anyone who entered the

[6] Existing patient's transitioning to new Urology providers.
[7] Prognosis.
[8] The Minneapolis VA Health Care System Policy # TX-08F, *Care of Patients (TX), Outpatient Scheduling Process and Clinic Operations*, February 23, 2015
[9] "Providers must document the return to clinic date/clinically indicated date (i.e. specific day or timeframe)."

Neurology clinics nurse office where the inboxes were kept from viewing information that should be kept protected because those trays didn't lock. The Urology clinic somewhat shred the same practice in that it, didn't keep locked cabinet's at the front desk throughout the day or after business hours. Even after a Directive to keep documents including appointment list for an indefinite period of time and keep them protected by placing them safely in a locked unit, appointment lists printed by Urology were simply being tucked inside of drawers located at the MSAs desks.

Untimely Orders in Neurology September 2014 December 2014

By reading the report one is able to see how VHA initiated revision of VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures. While I was employed there and after my complaint, trivia arose due to the previous Directive implications existed in one portion of the directive which suggested providers may use discretionary judgement as to when/if an order should be relayed to the MSA in CPRS, as it had been stated previously "preferably…"

Prior to revision the directive clearly indicates that the Facility Director, or Designee, is Responsible for (b) ***Ensuring providers document orders in CPRS and explain rationale and timeframes for*** medications, diagnostic tests, laboratory studies, ***return appointments***, consultations and procedures ***before the patient leaves the examination room*** . Therefore the VHA Directive provided at the time I worked there clearly indicates the responsibility for three (3) associated positions at the hospital; Facility Director, Designee and Provider. Persons in these associated positions are also responsible for (c) Ensuring a check out process occurs following each clinic visit and in terms of scheduling specifically the directive states this assurance consists of an individual providing patients with closure to clinical administration "and follow up visits."

I relayed to investigators that sometime around October of 2014 I began noticing multiple orders which had been entered into CPRS at a much later date and some were from the months August and September of 2014. I spoke to the manager again in October and explained that I had been keeping printed daily one-sided, single-paged appointment lists inside of folders labeled with each provider's name being kept inside of locked drawers. When the manager asked why I explained to him that providers were back to not entering orders and it was causing me serious scheduling delays. Therefore providers were invited into the area where at that time MSAs performed most of their duties so the providers could become familiar with where to locate the appointment lists for a previous day. The list highlighted patients who did not have follow-up appointments because no order existed in CPRS and providers could also receive telephone and electronic messages made by patients about things such as medications or letters needing verification. The messages were inserted into the folders because many of the flags being sent to providers were going unanswered at that time as well. Therefore prints from CPRS detailing messages went inside of the provider's folder when over a course a provider would have received several messages from the nurse yet irresponsibly over the course some providers were unresponsive. The manager told me that he would check back with me to see how things were going later.

Of course the manager came back to check in November of 2014 and this time I encouraged him to look inside of the drawer so that he would personally be able to see the vast amount of appointment lists inside of the folders for each provider who had failed to enter an order and at that time the amount

was overwhelmingly large enough to have a meeting scheduled with myself and staff providers including the Neurology chief, my manager and supervisor. I said very little at the meeting outside of commending providers who were diligent at entering orders.

Those were the appointment list I conferred about with investigators, not appointment list as the result of one separate incident spanning from April 2014 to September 2014 involving 950 patients as they claim.

Provider Not Completing Appointment Dispositions

With regard to check-out VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures states, "The check-out process must also include verifying that the disposition of the appointment in the VistA Appointment Management system has been completed. The epidemic of provider's not checking patients out after their appointments was appalling while I was employed there.

From my first full day of training in the clinic until my last day of employment the normal flow of business for many provider's was not completing appointment dispositions. Patients were very upset because they were not able to receive their travel pay benefits for lengthy periods after seeing a provider if the provider was inside of an examination room conducting his/her next appointment.

Oftentimes the initial Neurology Lead Worker checked patients out herself and warned me to never commit the act of checking completing a disposition. On several occasion I had to contact the travel pay and benefits office so that an MSA there would provide me with the step by steps process to relay back to a provider so that he/she completed the disposition. The supervisor was also made aware of this issue and as well an email was sent from the Lead Worker regarding the issue to providers and to the supervisor.

On the contrary I experienced one occasion of a provider not completing a disposition and I did not witness the Lead Worker completing disposition's on behalf of providers.

I spoke to investigators regarding the incomplete dispositions.

I shared names of providers who diligently enter orders in a timely manner.

The Role of MSA Appointment Scheduling and Concerning Chart Notes

The individual's interviewed by investigators that somewhere along the lines, "…during initial training…" My supervisor always warned me, "Never schedule an appointment unless there's an order." so has each person I received training and guidance from.

Supervisors and Managers Working With MSAs from Bi-Monthly Reports

I am puzzled as to how some supervisors or managers expressed to investigators their method of running monthly and bi-monthly reports. I have seen an example of one report containing unverified orders. The order remains unverified until an MSA signs off on it electronically by his/her initials. In its normal state the order is verified by the MSA who scheduled the initial associated appointment prior to any changes being made to the appointment. How was an MSA able to schedule all of the appointments she scheduled and her Lead Worker, manager or supervisor not be made aware. The MSA in particular stated, “Schedules follow-up appointments based on what the provider documents in the patients EHR notes, and does not check for the presence of an RTC order.”

The hospitals training definitely needs some revision and overhaul. This MSAs statements are detrimental and show how much the risk has been added to patients, some who have complex health issues. It is compromising to allow that an MSA rely on providers progress notes (patient’s HER) because providers do not always indicate the CID or specific timeframes in the notes but rather a provider sometimes only implies that he/she would like to see the patient in three (3) months.

Yours Kindly,

Mrs. Felicia Ann Ricks