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-16-0825

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Robert J. Dole Department of Veterans Affairs (VA) Health Care System, Wichita, Kansas (the Medical Center). The whistleblower alleged defects in the anesthesia and surgery program at the Medical Center and that these practices may constitute violations of law, rules or regulations, and gross mismanagement, which may lead to 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).

The Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. The report substantiates none of the four allegations and makes four recommendations to the Medical Center.

Thank you for the opportunity to respond.

Sincerely,

[Signature]

Robert D. Snyder  
Chief of Staff

Enclosure
Executive Summary

The Under Secretary for Health (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 Robert J. Dole VA Health Care System, (hereafter, the Medical Center) located in Wichita, Kansas. (hereafter, the whistleblower), alleged that Medical Center officials failed to address the numerous issues with supplies and scheduling, resulting in dangers to patients. The VA team conducted a site visit to the Medical Center on May 31–June 3, 2016.

Specific Allegations of the Whistleblower

1. The Dole VA has insufficient anesthesiology staff to safely cover all of its operating rooms.

2. Chronic supply and staffing shortages at the Dole VA place patients at risk and facility management is aware of these shortages but has taken no action to resolve the deficiencies.

3. Specialty consults are ordered and canceled without appropriate clinical review.

4. Surgical patients are entered into inappropriate wait lists in order to shorten reported wait times.

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 does not substantiate that the Medical Center has insufficient anesthesiology staff to safely cover all of its operating rooms.

- The Medical Center has responded to its increased surgical workload by increasing the number of anesthesia providers.

- The Medical Center’s anesthesia provider scheduling process includes emergency coverage.
- Not annotating the anesthesia providers in the Veterans Health Information Systems and Technology Architecture (VistA) surgical package hampers analysis.

**Recommendation to the Medical Center**

1. The Medical Center should include the assigned anesthesia provider in the VistA surgical package.

**Conclusions for Allegation 2**

- VA does not substantiate that chronic supply and staffing shortages at the Medical Center placed patients at risk, and facility management was aware of these shortages but had taken no action to resolve the deficiencies.

- VA found evidence of senior level management evaluating staffing needs and using multiple different methods to provide resources (Veterans Access, Choice, and Accountability Act (VACAA) full time equivalent (FTE) increases due to increasing demand).

- VA found evidence of efforts to improve supply availability and tracking through the installation of the Pyxis (a supply cabinet with a built-in inventory system) and Jitterbug systems, and evidence of monitoring unit level supply areas for temperature and humidity.

- There was evidence of improvement in processing purchase orders for prosthetics and no evidence of delaying purchase orders to save costs.

- Although there was evidence of short-term shortages of intravenous tubing and sterile surgical light handles, the cause was either local or national level vendor shortages outside the control of the Medical Center, which had to rely on alternative items; these short-term shortages did not impact Veteran care.

**Recommendation to the Medical Center**

None.

**Conclusions for Allegation 3**

- VA does not substantiate specialty consults are canceled without appropriate clinical review.

- There are ongoing efforts between primary care and orthopedics to ensure appropriate Veteran care and workup prior to referral to the specialist.

- Only clinical staff determines whether to accept the consult or return it to the originating provider for additional treatment or information.
Recommendations to the Medical Center

2. Continue with efforts to improve the quality of consults sent to specialists to maximize specialty appointment utilization.

Conclusions for Allegation 4

• VA does not substantiate that surgical patients are entered into inappropriate wait lists in order to shorten reported wait times.

• Prior to the third quarter of fiscal year (FY) 2014, secondary to inadequate training in the use of the VistA Surgical Package, the rearranging of operating room-scheduled cases resulted in high cancellation rates. While this resulted in decreased wait time metrics, it was not done to decrease wait time metrics.

• National Surgery Office (NSO) identified high cancellation rates in FY 2014 and assisted the Medical Center in developing plans to correct the deficiency.

• There is evidence of a significantly decreased number of cancellations in calendar year (CY) 2015.

• There is evidence of increasing wait times in CY 2015 for some surgical specialties, reflecting better data collection and a reduction in inappropriately canceled surgeries.

• The Medical Center actively pursued solutions to improve surgical process flow.

• Nurses in the outpatient clinics use approved worklists to track Veterans’ care needs in the period of time prior to the Veteran becoming a viable candidate for surgery.

Recommendations to the Medical Center

3. Standardize the nursing-approved worklists in the outpatient clinics, continue periodic audits, and begin recording and reporting results to the appropriate Medical Center committee.

4. Ensure all employees who enter data into the VistA Surgical Package have proper training; audit for compliance.

Summary Statement

OMI has developed this report in consultation with other Veterans Health Administration (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 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 no violations of VA and VHA policy, and notes no substantial and specific danger to public health and safety exists at the Medical Center.
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I. Introduction

The Under Secretary for Health (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 Robert J. Dole VA Health Care System, (hereafter, the Medical Center) located in Wichita, Kansas. **whistleblower** (hereafter, the whistleblower), alleged that officials at the Medical Center failed to address numerous issues with staffing, supplies, scheduling, and data manipulation, resulting in dangers to patients. VA conducted a site visit to the Medical Center on May 31–June 3, 2016.

II. Facility Profile

Part of Veterans Integrated Service Network (VISN) 15, the Medical Center is a complexity level 1c facility and teaching hospital providing a full range of patient care services including medicine, surgery, outpatient psychiatry, physical medicine and rehabilitation, cardiology, neurology, oncology, dentistry, visual impairment and low vision rehabilitation, spinal cord dysfunction, traumatic brain injury, polytrauma, pain management, posttraumatic stress disorder, homeless, Mental Health Intensive Care Management, prosthetics/orthotics, and extended care services. The Medical Center operates six Community-Based Outpatient Clinics (CBOC) in Hays, Salina, Hutchinson, Dodge City, Liberal, and Parsons, Kansas.

III. Specific Allegations of the Whistleblower

1. The Dole VA has insufficient anesthesiology staff to safely cover all of its operating rooms.

2. Chronic supply and staffing shortages at the Dole VA place patients at risk and facility management is aware of these shortages but has taken no action to resolve the deficiencies.

3. Specialty consults are ordered and canceled without appropriate clinical review.

4. Surgical patients are entered into inappropriate wait lists in order to shorten reported wait times.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of **M.D., Deputy Medical Inspector (a surgeon)** and **Clinical Program Manager**, both of OMI; **M.D., National Consultant for**

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1 VHA divides facilities into one of five levels – 1a, 1b, 1c, 2, and 3. Level 1a are the most complex facilities and level 3 the least complex. The intent of the complexity levels is to group similar organizations for operational reports, performance reviews and comparisons, and research studies and budget funding under the Veterans Equitable Resource Allocation model.
We interviewed the whistleblower by phone on May 24, 2016, toured the Medical Center's supply/logistics area, orthopedic and ophthalmology clinics, and held entrance and exit briefings with Medical Center leadership. Attending the entrance briefing included:

- VISN 15 Quality Management Officer (QMO) (by phone)
- Assistant Director and Acting Medical Center Director
- Nurse Executive
- Survey Coordinator
- Interim Chief of Staff (CoS)
- Executive Assistant (EA) to the Assistant Director

Attendance at the exit briefing included:

- VISN 15 QMO (by phone)
- Medical Center Director (by phone)
- Assistant Director and Acting Medical Center Director
- Nurse Executive
- Survey Coordinator
- CoS
- EA to the Assistant Director
- EA to the Medical Center Director
- Group Practice Manager
- QMO

We interviewed the following Medical Center employees:

- Assistant Director
- Chief Anesthesia
- Chief of Dental Service
- Chief, Specialty Clinics (SC)
- Acting Chief of Surgery (by phone)
- Orthopedic Surgeon
- Chief Primary Care (PC)
- Surgery Resident
- Orthopedic Physician Assistant
- Certified Registered Nurse Anesthetist (CRNA), Staff Anesthetist
- CRNA, Staff Anesthetist
- Manager SC
- Operating Room (OR) case manager
V. Findings, Conclusions, and Recommendations

Background

In December 2014, the Veterans Health Administration (VHA) National Surgery Office (NSO) identified the Medical Center as a facility that would benefit from management support to improve surgical efficiency. The Medical Center had sustained weak performance in OR efficiency metrics, particularly OR cancellation rates. As a result of this effort, the Medical Center leadership chartered a Surgical and Specialty Care Collaborative to identify opportunities to improve orthopedic surgical clinic access, and orthopedic surgery cancellations. The whistleblower was a co-chair of this collaborative, which started January 30, 2015. Subsequent to this initial effort to improve surgical efficiency, Medical Center leadership organized a value stream analysis event, which resulted in two other rapid process improvements on the same issues indicated above.

Allegation 1

The Dole VA has insufficient anesthesiology staff to safely cover all of its operating rooms.

Findings

VHA has two types of anesthesia providers: Anesthesiologists, who are physicians with specialty training in anesthesiology, and CRNAs, who are registered nurses with advanced training in anesthesia techniques. VHA credentials and privileges both types of providers to manage complex airways and to administer local, spinal, and general anesthesia.

Adequate staffing in the OR helps ensure patient safety. The scheduling process for surgery starts by assembling a complete team: surgeons, anesthesia staff, and nurses to meet the needs of the Veteran and his/her procedure, within a particular OR, at a designated date and time. Each OR requires individual scheduling and staffing. At the
time of our site visit, the Medical Center had four main ORs and three endoscopy suites. The staffing requirement for each of these sites depends on the type of procedure, number of procedures, and patient considerations.

The Medical Center reported that it had been expanding surgical services over the past several years and had hired additional anesthesia providers. We reviewed data from the Medical Center’s HR department related to staffing in the anesthesia service. In successive years, the staff increased steadily, and as far back as 2010, fee-basis (contracted) CRNAs were replaced with full-time positions. Staffing and surgeries performed for the years 2012-2015 were:

<table>
<thead>
<tr>
<th>Year</th>
<th>Anesthesiologists</th>
<th>CRNAs</th>
<th>Fee-Basis</th>
<th>Surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3,251</td>
</tr>
<tr>
<td>2013</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>4,346</td>
</tr>
<tr>
<td>2014</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>4,013</td>
</tr>
<tr>
<td>2015</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>2,931</td>
</tr>
</tbody>
</table>

The staffing charts for the Surgical Care Service in fiscal year (FY) 2013 and FY 2014, indicate that the anesthesia service grew from four anesthesiologists and three CRNA authorizations in FY 2013 to four anesthesiologists and five CRNAs in FY 2014. These authorizations are consistent with requisitions signed by the former Chief of Surgery in April and June of 2014. As of June 2016, one additional CRNA is awaiting a start date, which will increase the service’s manpower to five anesthesiologists and five CRNAs (one anesthesiologist position was placed on hold at the direction of the CoS).

A member of the anesthesia staff interviewed described the growth of the section during his tenure, 2008 to the present, and the process for scheduling anesthesia providers to support operating procedures. Since 2010, the anesthesia staff publishes the schedule 60 days in advance to provide adequate lead time for the surgical scheduler to plan for the number of staffed rooms. The anesthesia providers review the Veteran’s record 24 hours before the actual surgical date to address any relevant clinical issues, and to avoid cancellations or delays on the day of surgery. The review serves as the basis for clinical assignments on the day of surgery, and includes the previous day’s schedule to ensure a balanced workload among anesthesia providers. The final matching of anesthesia providers with procedures occurs 24 hours prior to each case. To ensure proper backup for surgical emergencies, the schedule includes an additional anesthesia provider assigned to a float position each day. The anesthesia staff member indicated that since 2010, the Medical Center added additional orthopedic surgeons and a surgical residency program, which increased workload. He also indicated that in approximately 2013, anesthesia began providing support to some endoscopy procedures, which had previously been the responsibility of the Specialty Clinics.

We interviewed two additional anesthesia providers who indicated that, although the Medical Center has increased its surgical workload, there has been a simultaneous increase in anesthesia providers. One said that formerly the anesthesia providers would time their cases to ensure adequate anesthesia backup whenever there was a
challenging case in progress. Since the addition of the float anesthesia provider process in 2014, this is no longer necessary. Neither anesthesia provider could recall any instance in which they felt that they did not have immediate access to another qualified anesthesia provider, even in off hours. Neither could recall any instance of an anesthesia provider being pulled away from an ongoing surgical case to manage an emergency.

We reviewed reasons for delays in surgery. In FYs 2014 and 2015, 152 delays were related to anesthesia. After the completion of the surgical portion of a case, the anesthesia provider brings the Veteran to the Post Anesthesia Care Unit (PACU), and does not leave the PACU until the Veteran is stable, to insure patient safety. Only 13 of the surgical delays were the result of an unavailable anesthesia provider because the provider was attending to another Veteran’s needs (e.g., the previous surgical case); the remaining 139 were for computer or equipment issues, difficult arterial or venous line insertions, or difficult anesthetic blocks. The average delay in these 13 cases was 25 minutes. There were no cancellations related to unavailable anesthesia providers, and there were no incident reports related to anesthesia. During these 2 years, 8,857 surgeries were performed at the Medical Center making delays in surgery due to unavailable anesthesia staff 0.1 percent of the total surgical cases.

Also in these 2 years, 1,905 surgeries (of the 8,857 total) were performed under general anesthesia. This workload averages to 3.66 cases per day for each fiscal year. While the Medical Center does not record anesthesia providers in the Veterans Health Information Systems and Technology Architecture (VistA) Surgical Package system, preventing specific analysis, if the Medical Center performed each of these cases in a different OR, the absolute maximum number of anesthesia providers needed to cover the general anesthesia average case load would be four full time equivalents (FTE). During the subject time period, a minimum of 7.0 FTEs anesthesia providers worked at the Medical Center Therefore, VA found no evidence that the surgical workload exceeded anesthesia support, nor that the anesthesia providers could not safely cover all of the ORs.

Conclusions for Allegation 1

- **VA does not substantiate** that the Medical Center has insufficient anesthesiology staff to safely cover all of its operating rooms.
- The Medical Center has responded to its increased surgical workload by increasing the number of anesthesia providers.
- The Medical Center’s anesthesia provider scheduling process includes emergency coverage.
- Not annotating the anesthesia providers in the VistA surgical package hampers analysis.
Recommendation to the Medical Center

1. The Medical Center should include the assigned anesthesia provider in the VistA surgical package.

Allegation 2

Chronic supply and staffing shortages at the Dole VA place patients at risk and facility management is aware of these shortages but has taken no action to resolve the deficiencies.

The whistleblower was aware of multiple issues with supplies for both the OR and Medical Center, in general. He stated that there were shortages of sterile gloves size 7½, intravenous (IV) tubing, and surgical equipment and supplies, and that the previous Chief of Surgery sent residents “...across town to borrow instruments and supplies for general surgery.” Additionally, he indicated that there were significant issues in a supply room in the specialty clinic relating to mismanagement of the Pyxis system (a supply cabinet with a built-in inventory system) leading to severe shortages in the specialty clinic. He also stated that there were supplies and equipment stored in the specialty clinic in an environment not climate controlled.

Findings

We interviewed the former CoS who was aware of reports of supply shortages including gloves and IV tubing and issues with prosthetics but indicated that the Assistant Director handled these issues. We interviewed the Assistant Director who stated that past issues with gloves and IV tubing were the result of national shortages from suppliers, and that all facilities in the area were experiencing these shortages. Additionally, she reported that other services in the Medical Center would take supplies from the OR supply area, making it difficult to maintain adequate supplies in the OR. To reduce imbalances, the Medical Center installed the Pyxis system to control and track supply demand in the various clinical areas.

We toured the Medical Center’s supply/logistics area, OR, orthopedic, and ophthalmology clinics, and talked with the individuals familiar with the requirements in these areas. The logistics staff told us that the Medical Center had purchased the Pyxis system approximately 4 years ago (2012), but only installed it 2 years ago (2014). This year, the Medical Center added an additional system called Jitterbug to track supplies not in the Pyxis locked cabinets. We toured the specific SC location identified by the whistleblower and were able to identify temperature and humidity monitors, as well as the Pyxis and Jitterbug systems in use. The Pyxis system is an enclosed, locked cabinet, accessible only to staff who have the proper fingerprint and password identifiers. Logistics places a Jitterbug device on shelving units where oversized items are stored and the user must push a button each time a specific supply item is removed from the shelf.
The supply staff member interviewed stated that although unit-level supplies may be low, they usually have resupply in the warehouse. Supply staff monitors stock levels and replenishes items daily, or more frequently, if needed. An automated program in the supply warehouse queries the Pyxis cabinets in each location to list current stock levels. The supply technicians replenish unit-level supplies from this list, and every 24 hours they manually scan for items not included in the Pyxis cabinet. The supply staff member reported that in 2013 and 2014, they had issues keeping up with surgical supplies, due to an increase in case volume. Supply adjusted stocking when they recognized the workload changes. The problem with IV tubing was a national issue, and supply worked with subject matter experts in the Medical Center to identify suitable replacement tubing. This staff member did not recall any issues with surgical gloves. The staff member also told us that there had been supply issues with the prime vendor, but they developed back-up supply sources to address urgent needs in the event the prime vendor could not respond to their needs. In 2014, the Medical Center formed a working group to improve OR flow, which included supplies, and although supply staff was not a member of the group, they did provide input on the supply process. The supply staff member also told us about the temperature and humidity monitors located in the specialty clinic and elsewhere in the Medical Center; until approximately 2 years ago (2014), the monitors worked locally but did not interface with the central monitoring station. In order to monitor these parameters, the supply technicians manually recorded the temperature and humidity in a log during daily rounds. For greater efficiency, the Medical Center directed the vendor to interface the system with central monitoring; temperature and humidity monitoring are now automatic, and the central system generates an alarm when parameters exceed established ranges.

The Medical Center provided a copy of standard operating procedure (SOP) 14-06 (May 2013) for receiving and processing loaner instruments, documenting the time required to process previously borrowed equipment (48 hours) or equipment new to the facility (72 hours). Implantable devices require delivery 3 business days prior to the scheduled surgery to give adequate time for the biological indicator (sterility) tests to incubate.²

A SC staff member informed VA that supply is very amenable to changes; the only issue this individual could recall having was a shortage of special blood collection bags used in the oncology clinic to treat polycythemia vera. This individual also recalled a shortage of gloves in the distant past but indicated that this was a national issue. Neither event had any impact on Veteran outcomes. There were no vacant nursing positions in the clinic.

We interviewed another individual from the SC regarding issues with supply; the individual could not recall any widespread issues with supplies in the Medical Center, but did remember occasional missing items from the exam rooms.

² Robert J. Dole VA Medical Center Standard Operating Procedure and Competency Series 14-06, Receiving and Processing Loaner Instruments.
We interviewed the staff from the OR who could not recall any time in the past 3 years that necessary supplies had not been available for cases in the OR. The individual did recall an issue with IV tubing, but reported the Medical Center had identified a suitable substitute and the missing item was available within 2 days. There also had been a city-wide issue getting sterile handles for the surgical lights, but this did not impact care, and it was resolved when the vendor fixed its issues with the manufacturer. The Medical Center produced lists of supplies, including surgical light handles, procured from a local hospital in October 2013, and April 2014, indicating that this was necessary due to "manufacturer backorder," and also produced purchase orders for these items, indicating that they had paid the hospital for these supplies. This individual also recalled the surgical glove problem. One surgeon had special order gloves (size 6), but decided that he wanted the next size up (size 6½). Since these were a special order just for that surgeon, it took approximately 2 days to get the new gloves into the system. In the meantime, the surgeon continued to use his previously requested size 6 gloves; there was no impact on any surgical procedures.

We interviewed several clinicians regarding supplies. One clinician interviewed could recall no issues with supplies in 12 years of employment. Another clinician indicated that occasionally the Medical Center would have to share equipment with other facilities in the area (e.g., ventilators) but had no specific examples of supply issues. This individual indicated that the process for ordering prosthetic supplies (artificial joints, breast implants, etc.) had changed recently and now requires the ordering clinic to complete an ordering consult. We reviewed a memorandum of March 29, 2016, directing implementation of this implant pre-authorization process.³

Another clinician recalled issues with IV tubing but denied that this had caused any surgery cancellations. The individual could not recall any issues related to surgical gloves. He did remember that there had been issues with back-ordered supplies but stated this was similar to other hospitals at which he had worked.

A member of leadership stated that, unlike other areas in the country, hiring nurses at the Medical Center is relatively straightforward because of their competitive pay and benefits compared to local competition. This individual described the impact of the Veterans Access, Choice, and Accountability Act (VACAA) in relation to hiring staff. In 2014, the Medical Center circulated a survey regarding personnel requirements to support the Act. The CoS requested some 52 critical positions; internal documentation indicated that VACAA funded 44.5 FTEs, 29.86 of them for Surgery. The Medical Center provided evidence that in August 2014, staff selection and hiring of positions on the VACAA funded list had begun and continued through September 2015, to fill all FTEs.

VA reviewed a specific instance provided by the whistleblower on an issue with prosthetics ordering that he believed indicated an intentional delay in ordering

prosthetics until the last minute to manage costs. The whistleblower provided the name of a Veteran, who gave the VA team permission to review her medical record. After establishing a surgical date with the Veteran on Date 2015, the Veteran's provider placed a schedule request for surgery on Date. On Date, a former OR nurse manager emailed the Chief of Supply requesting specific implantable prosthetics for this Veteran, but the clinic had not yet submitted a consult for the prosthetic implants. The vendor for this prosthetic requires the operating surgeon to complete a training package prior to release of the product. The surgeon completed the training on Date, and the former Chief of Surgery signed the consult request later the same morning. That afternoon, the prosthetics staff processed the order and submitted it to contracting for procurement; this was on a Friday afternoon. The next day, the vendor shipped the implants; however, the shipping company was confused as to where to deliver the package and did not leave it at the Medical Center. The package was delivered on Tuesday Date 9:00 a.m., but the OR could not locate it, so they cancelled the procedure and rescheduled it for Date, when it was completed.

We also reviewed prosthetics purchasing for the Medical Center. The average time to process all prosthetics orders (including lenses for glasses, wheelchairs, and implantable surgical devices) in FY 2014 was 9 days, which increased to 12 days in FY 2015 (above national average), but decreased to 6 days in FY 2016 (below national average).

**Conclusions for Allegation 2**

- VA does not substantiate that chronic supply and staffing shortages at the Medical Center placed patients at risk and facility management was aware of these shortages but had taken no action to resolve the deficiencies.

- VA found evidence of senior level management evaluating staffing needs, and using multiple different methods to provide resources (VACAA, FTE increases due to increasing demand).

- VA found evidence of efforts to improve supply availability and tracking through the installation of the Pyxis and Jitterbug systems, and evidence of monitoring unit level supply areas for temperature and humidity.

- There was evidence of improvement in processing purchase orders for prosthetics, and no evidence of delaying purchase orders to save costs.

- Although there was evidence of short-term shortages of IV tubing and sterile surgical light handles, the cause was either local or national level vendor shortages outside the control of the Medical Center, which had to rely on alternative items; these short-term shortages did not impact Veteran care.
Recommendation to the Medical Center

None.

Allegation 3

Specialty consults are ordered and canceled without appropriate clinical review.

The whistleblower stated that he had reviewed over 300 consults in 10 different clinics for any discernable patterns in cancellations or discontinuation of the consult. He stated that all the consults he analyzed had clinical reviews and explained that his concern was the appropriateness of ordering the consult. He determined that in many of these examples, the primary care provider (PCP) had not attempted to render any sort of treatment for the ailment prior to referral, which he felt was inappropriate.

Findings

We interviewed a provider in PC, where the majority of the specialty consults originate, to discuss the process for initiating a specialty consult. This provider stated that there have been issues with consults sent with missing data to specialists. As a result, the Medical Center endorsed and periodically updates service agreements for specialties developed by the clinical teams. These agreements outline treatments or tests that the referring provider should attempt prior to requesting a consult, such as imaging or laboratory studies. For example, an orthopedic complaint (not acute fractures or other urgent issues) should have a physical therapy trial prior to the orthopedic appointment to determine whether more conservative measures would correct the ailment prior to consideration of an invasive procedure. The provider described ongoing efforts to maintain the PCPs’ compliance with these service agreements. She also provided evidence of a clinical template developed for the Computerized Patient Record System (CPRS) for orthopedics, which specifically guides the PCP through the necessary steps to take prior to actually requesting a consult.

We interviewed a member of the surgical staff who also described his efforts to provide training and tools to PCPs, including in-service training initiated in January 2015 after the NSO partnership agreement. He described some frustration with the continuing issue of incomplete consults.

Two staff members in the clinic described the process for reviewing new routine consults as starting with the clinic registered nurse (RN), who reviews it for compliance with the appropriate service agreement. If elements are missing, the RN cancels the consult and returns it to the originating PCP or other provider with a note outlining the missing requirements and recommending the reissue of the consult if still needed after addressing the missing treatments or tests. Urgent and emergent consults go directly to either the surgeon or physician assistant (PA) for review and follow up in CPRS. If the clinical team approves a consult by either method above, they send it to the scheduler to contact the Veteran and make the appointment. Occasionally, Veterans contacted do not want to complete the consult, and this results in a discontinuation. Only providers
and RNs have CPRS menu access to cancel or discontinue a consult; nonclinical MSAs cannot do this.

We reviewed the 498 cancelled orthopedic consults from FYs 2014 and 2015: all included a recommendation to resubmit after completing the missing agreed-upon criteria, if still needed. Of the cancelled consults, 89 percent (445) were due to incomplete service agreement criteria; the other 11 percent (53) were canceled by staff secondary to patient request, unavailability of the patient (e.g., currently hospitalized or unable to contact after multiple attempts to schedule), or because the Medical Center does not provide the requested service (e.g., orthopedic oncology).

Conclusions for Allegation 3

- VA does not substantiate specialty consults are canceled without appropriate clinical review.

- There are ongoing efforts between primary care and orthopedics to ensure appropriate Veteran care and workup prior to referral to the specialist.

- Only clinical staff determines whether to accept the consult or return it to the originating provider for additional treatment or information.

Recommendation to the Medical Center

2. Continue with efforts to improve the quality of consults sent to specialists to maximize specialty appointment utilization.

Allegation 4

Surgical patients are entered into inappropriate wait lists in order to shorten reported wait times.

Findings

VA personnel at the Medical Center must follow a procedure with multiple steps in both evaluating a Veteran for surgery and then scheduling him or her for that surgery. Initially, when a provider determines that a Veteran has a condition that may benefit from an operation, the surgeon must determine whether the Veteran is a good surgical candidate. Due to Veteran-specific medical conditions, providers may then require specific preoperative evaluations and/or treatments to determine whether the benefits of the operation outweigh the surgical risks. At times, a Veteran may have a medical condition that needs improvement prior to surgery in order to tolerate the procedure. All Veteran-specific pre-operative testing and medical consultations require completion before a provider requests a scheduled surgical procedure.4

When it is determined that the Veteran is a surgical candidate, the Medical Center, in accordance with VHA Directive 1128 (November 24, 2014), utilizes the VistA Surgery

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Package to request or schedule a surgical procedure on a date agreed to by both the surgeon and Veteran. In addition to Veteran-specific pre-operative testing and medical consultations noted above, there are routine pre-operative anesthesia evaluation and testing requirements that do not delay surgical requests.

We interviewed personnel responsible for all phases of scheduling Veterans for surgical procedures. The non-surgical provider refers the Veteran to a surgeon using a consult. Not all referred patients will qualify as surgical candidates; some need extensive clinical workup or stabilizing of their medical issues before they may be considered for a surgical procedure. Nurses in the outpatient clinics use an approved worklist site (maintained on a shared drive with controls to protect personal health information) to track Veterans’ complex plans to stabilize their medical conditions. Use of this worklist precedes the final determination to utilize an operation as treatment and this occurs before scheduling the Veteran in the VistA Surgical Package.

We interviewed the two members in the quality department, and both were fully aware of the nursing worklists and the latter periodically audits the worklists informally to ensure that appointments are associated with the evaluation and treatment listed for each Veteran. One member stated that her observations were that these worklists help staff ensure Veterans stay on track with the preoperative evaluation and/or treatments in preparation for consideration as surgical candidates. While there were no written findings on these informal audits for our review, the compliance auditor produced a memorandum to the Medical Center Director on July 14, 2015, indicating she had reviewed the surgical scheduling process and found it fully compliant with VHA Directive 1128.

There are three distinct processes used at the Medical Center to schedule surgeries after the provider determines the Veteran is a surgical candidate. The Medical Center’s privacy officer and information technology officers evaluate, approve, and ensure compliance with all applicable guidelines for the MS Outlook calendar request utilized in the first step. The surgical nurse case manager talks with the patient about the date of surgery agreed upon by the surgeon and Veteran, reconciles this information with the MS Outlook calendar, and sends the request to the surgical scheduler.

In the second step, the surgical scheduler enters the Veteran-specific information into the VistA Surgical Package as a “request” for surgery. There are no restrictions on future dates for this request for surgery. Usually, the MS Outlook calendar request results in an entry on the same day in the VistA Surgical Package. If the MS Outlook calendar request comes very late in the day (e.g., the last few minutes of the duty day), or before the weekend, the scheduler enters the request into VistA first thing in the morning of the next business day. This “request” surgery date in the VistA Surgical Package is the date that VA Surgical Quality Improvement Program (VASQIP) uses to calculate surgical wait times. The end user cannot modify this audit date. Seventy-two hours prior to the surgery “request” date, the surgery schedule, rooms and order of cases are finalized; the surgical scheduler then changes the surgery “request” to “scheduled.” The surgical team uses this schedule to ensure the appropriate assignment of resources (staff and equipment) to the correct room at the right time. If a surgical case’s date, room, or order needs rearranging, the surgical scheduler can
reschedule the Veteran to a different time or a different room. If the Veteran is no longer a surgical candidate (e.g., sudden illness or injury), the scheduler cancels the surgery. After a cancellation, the Veteran may be rescheduled with a new "request" date. VASQIP tracks all surgical cancellations in the national report.

In the third step, the surgical scheduler enters the Veteran into the CPRS system and assigns a pre-operative (day of surgery) appointment in the ambulatory surgery unit. This appointment provides visibility of the scheduled surgery date to staff without access to the VistA surgical package but does not influence reported wait-time data. Usually, the surgical scheduler completes this step closer to the surgical date, as it has the case time associated with it that would trigger when the Veteran needs to be at the Medical Center for his/her procedure. Below is a schematic of the entire surgical scheduling process.

We interviewed two members knowledgeable about the VistA Surgical Package. The Medical Center detailed an individual into the scheduler role from March 2013 through November 2015 (with a 1-month gap in April, 2014). We interviewed this individual who stated that until approximately August 2015, because of the training provided, she would book surgical patients as "scheduled" the day she received the request, instead of just requesting the procedure. Then, if she needed to change a date, room, or case order, she had been trained to cancel and rebook the patient. As noted above, this
process would change the date used by VASQIP to calculate wait time. Starting in August 2015, this individual discovered on her own an available option to “reschedule” the surgical date rather than “cancel” it if there were changes in the date, room, or case order. She recalled this event clearly, because canceling the Veteran had required her to re-enter all the information about the surgical procedure and other requirements but rescheduling only required her to change the date, room, or time as the system retained all the other information, saving a large amount of her time. This individual denied that anyone instructed her to wait to put patients in the VistA Surgical Package for any reason. She also indicated that she booked Veterans’ pre-operative (day of surgery) appointments in CPRS, but unlike the VistA Surgical Package that has no limits on when you can schedule surgery, CPRS would not allow appointments to be made any earlier than 90 days ahead. Because she could not always book the CPRS appointment at the same time as the VISTA Surgical Package, 30 days out she would compare the VistA Surgical Package scheduled procedures with MS Outlook calendar and then ensure she scheduled the Veterans pre-operative (day of surgery) appointment in CPRS, which the preoperative staff would use to notify the Veteran about what time to come to the Medical Center.

The second member interviewed about the VistA Surgical Package scheduler took over full-time in December 2015. She reported her training reflected the scheduling process as designed and included the use of the “request” function in VistA Surgical Package to reserve the date, then converting it to “scheduled” 72 hours prior to the actual surgery date to fix the room and time allowing assignment of resources to the surgical case and notification of the Veteran’s report time.

We interviewed a case manager familiar with surgical scheduling who stated that the issue with scheduling and canceling surgeries became apparent sometime around the first of the current calendar year. The Medical Center made process changes and the high number of surgical cancellations has begun to improve. Another member of the surgery staff told us that the Medical Center leadership had been addressing surgical process improvement and that she had worked on at least three surgical service and specialty care process improvement projects since December 2014.

The NSO identified the Medical Center as a site demonstrating sustained weak performance across all four efficiency index measures for at least three of the four quarters (FY 2013, Quarter 2 through FY 2014, Quarter 4). As a result, the Medical Center agreed to participate in the FYs 2014-2015 Surgical Flow Improvement Initiative. Data from the VASQIP reports from the same time period indicate the following cancellation rates:
The decrease in cancellation rates is consistent with the description that the former VistA Surgical Package scheduler provided regarding her adapting her process to reschedule rather than cancel and re-book surgical cases.

We reviewed VASQIP data for FY 2013–FY 2015, and 1st Qtr FY 2016 for cancellation rates with a reason listed as “Other,” which would include situations described above (time, room, or surgical order changes canceled erroneously versus rescheduled).

These data coincide with changes in surgical scheduling described by the case manager and former VistA Surgical Package scheduler and reflect an increased understanding of how to record data. We also reviewed wait times for surgery for calendar year (CY) 2014 through CY 2015 (report from VASQIP Quarter 1 of FY 2015 and FY 2016):

<table>
<thead>
<tr>
<th>Fiscal Year quarter</th>
<th>Cancellation rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 Qtr 3</td>
<td>26.8%</td>
</tr>
<tr>
<td>2013 Qtr 4</td>
<td>26.9%</td>
</tr>
<tr>
<td>2014 Qtr 1</td>
<td>25.9%</td>
</tr>
<tr>
<td>2014 Qtr 2</td>
<td>23.5%</td>
</tr>
<tr>
<td>2014 Qtr 3</td>
<td>15.7%</td>
</tr>
<tr>
<td>2014 Qtr 4</td>
<td>15.1%</td>
</tr>
<tr>
<td>2015 Qtr 1</td>
<td>15.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th># Cancellations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>944</td>
</tr>
<tr>
<td>2014</td>
<td>404</td>
</tr>
<tr>
<td>2015</td>
<td>85</td>
</tr>
<tr>
<td>2016 (1st Qtr)</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th># Cases</th>
<th>Median days</th>
<th>% Completed 0-30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2014</td>
<td>3,967</td>
<td>14</td>
<td>84.1%</td>
</tr>
<tr>
<td>CY 2015</td>
<td>2,890</td>
<td>22</td>
<td>62.2%</td>
</tr>
</tbody>
</table>
Wait times for knee replacement surgery for CY 2014 through CY 2015:

<table>
<thead>
<tr>
<th>Year</th>
<th># Cases</th>
<th>Median days</th>
<th>% Completed 0-30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2014</td>
<td>111</td>
<td>12</td>
<td>59.5%</td>
</tr>
<tr>
<td>CY 2015</td>
<td>130</td>
<td>84.3</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

The increasing median days to surgery and decreasing percentage of surgical procedures scheduled within 30 days in these two charts likely reflect an accurate representation of the audit date noted above. Canceling surgery will reset the audit date, decrease median days to surgery, and increase the percentage of cases scheduled within 30 days. These data combined with the decreasing cancellation rates provide evidence of the change to the practice described by the former and current VistA Surgical Package schedulers and nurse case manager.

Conclusions for Allegation 4

- **VA does not substantiate** that surgical patients are entered into inappropriate wait lists in order to shorten reported wait times.

- There was evidence of high cancellation rates prior to the third quarter of FY 2014, because of inadequate training in the use of the VistA Surgical Package. This decreased wait time metrics but was not an accurate reflection of actual wait times.

- NSO identified high-cancellation rates in FY 2014, and assisted the Medical Center in developing plans to correct the deficiency.

- There is evidence of a significantly decreased number of cancellations in CY 2015.

- There is evidence of increasing wait times in CY 2015 for some surgical specialties, reflecting better data collection and a reduction in inappropriate cancellations.

- The Medical Center actively pursued solutions to improve surgical process flow.

- Nurses in the outpatient clinics use approved worklists to track Veterans’ care needs in the period of time prior to the Veteran becoming a viable candidate for surgery.

Recommendations to the Medical Center

3. Standardize the nursing approved worklists in the outpatient clinics, continue periodic audits, and begin recording and reporting results to the appropriate Medical Center committee.

4. Ensure all employees who enter data into the VistA Surgical Package have proper training; audit for compliance.
Attachment A

Documents in addition to the Electronic Medical Records reviewed.

Partnership Agreement between VHA Office of Systems Redesign and Improvement, VHA National Surgery Office and Robert J. Dole Medical Center/VISN 15 (effective date December 11, 2014).


Memorandum: Review of Surgery Scheduling Practices, Robert J. Dole VA Medical Center, signed by the Compliance Officer, July 14, 2015.

All Incident Reports for 2014 and 2015.

Specialty Care Staff meeting minutes from 2014-2016.

Surgical Service team meeting minutes from 2014-2015.

Surgical Workgroup Workshop documents for SSCC project.

VASQIP reports from FY 2013 to 1st Quarter FY 2016.

In-service training programs provided by orthopedic surgery to primary care providers (from January 2015 to present).

Manpower documents related to VACCA positions from FY 2014 to FY 2015.
Manpower documents related to anesthesia positions from 2008-present.
All pending consult requests FY 2014 and April 2015 through January 2016.
All surgery delay reasons for Medical Center FY 2014–2015.
All anesthesia techniques used in Medical Center FY 2014–2015.
All discontinued surgical consults by reason FY 2014–2015.
All Morbidity and Mortality reports FY through FY 2015.
All operating room staff meeting minutes FY 2015 through present.
CPRS clinical template for orthopedic consults from primary care.
Service agreement between primary care and orthopedic surgery.