



Date: March 25, 2013
From: Administrative Investigation Board
Subj: Allegations of Mismanagement of the GI Clinic, Dorn VAMC Columbia, SC
To: Deputy Under Secretary for Health for Operations and Management (10N)

I. Background

During the summer of 2012, VHA Central Office became aware of a facility disclosure concerning a cancer patient whose treatment was delayed due to a backlog in Gastroenterology (GI) Clinic appointments.

II. Purpose and Authority

As a result of the preliminary issue identified, an Administrative Investigation Board (AIB) was charged on October 25, 2012, by the VHA Deputy Under Secretary for Health for Operations and Management to conduct a comprehensive review of issues surrounding the mismanagement of the Gastroenterology Clinic at the Dorn VAMC. Specifically, the Board was asked to look into the following:

- a. Determine the roles and responsibilities of the involved medical center, Network, and national level officials;
- b. Who was aware, at the facility and network levels, that there were potentially at-risk Veterans and/or delays in patient treatment? When did these individuals become aware of that fact and what actions did they take?
- c. Were staffing levels appropriate given the caseload of the above identified clinic?
- d. Were fee and other contract resources sufficiently allocated to address clinical needs given the caseload of the above identified clinic?
- e. Did leadership adequately address critical concerns particularly in the area of nurse staffing?
- f. Did facility leadership provide sufficient administrative, secretarial, and clerical support for clinical and non-clinical operations?
- g. Did any actions or inactions of leadership in connection with the management of the GI Clinic contribute to adverse patient care outcomes?

- h. How many open consults are there in the GI clinic?
- i. When did facility leadership become aware of this backlog?
- j. How did they respond?
- k. Did they report this to the Network or VHA Central Office?

III. Preliminary Statement

- a. There were no significant procedural issues to report.
- b. A site visit was conducted at the William Jennings Dorn, VAMC Columbia, SC November 6-8, 2012. During the site visit and on December 27, 2012, the following witnesses were interviewed:

- 1) (b)(6) GI Scheduler, VAMC Columbia
- 2) (b)(6), GI Case Manager, VAMC Columbia
- 3) (b)(6) GI Nurse Manager, VAMC Columbia
- 4) (b)(6) GI Staff Physician, VAMC Columbia
- 5) (b)(6) Administrative Officer, Medicine Service, VAMC Columbia
- 6) (b)(6) GI Section Chief, VAMC Columbia
- 7) (b)(6) GI Staff Nurse, VAMC Columbia
- 8) (b)(6) Director of Translational Clinic Research/Hospitalist, VAMC Columbia (previous Chief of Medicine Service), VAMC Columbia
- 9) (b)(6), Associate Director for Nursing/Patient Care Services, VAMC Columbia
- 10) (b)(6) Associate Executive Nurse for Primary and Specialty Care, VAMC Columbia
- 11) (b)(6) Chief of Staff, VAMC Columbia
- 12) (b)(6), Assistant Director, VAMC Columbia (previous Acting Associate Director)
- (b)(6) Associate Director, VAMC Salem (previous Acting Director, VAMC Columbia)
- 14) (b)(6) Director, VAMC Columbia
- 15) (b)(6) Chief Financial Officer, VAMC Columbia (previous AA/Chief of Staff, VAMC Columbia)
- 16) (b)(6), MD, Acting Chief Medical Officer, VISN 7 Office
- 17) (b)(6), Chief Financial Officer, VISN 7 Office
- 18) (b)(6), Ph.D., Quality Manager, VISN 7 Office
- 19) (b)(6), Patient Safety Officer, VISN 7 Office
- 20) (b)(6), RN, Quality Manager, VAMC Columbia
- 21) (b)(6) Chief Human Resources, VAMC Columbia
- 22) (b)(6) Director, VAMC Atlanta (former Acting Network Director, VISN

7)

- c. All VISN staff were interviewed by v-tel. (b)(6) and (b)(6) were on (b)(6) leave and interviewed by phone.
- d. One employee, (b)(6), was represented by AFGE during her interview. There were no issues associated with AFGE representation..
- e. All members of the Administrative Investigation Board were present for all of the interviews except (b)(6). All members have reviewed his testimony prior to the completion of this report.

IV. Findings of Facts and Conclusions

- a. **Did facility leadership, VISN staff and/or others act appropriately at the time they became aware of GI clinic backlogs and potentially at-risk Veterans and/or delays in patient treatment?**

Facts:

1. (b)(6) submitted an email to (b)(6) and (b)(6) dated July 25, 2011 stating there was a backlog of 2500 consults in GI and that they were scheduling into February, 2012. (Email dated July 25, 2011, Tab 68). He further reiterated in his testimony that 700 of these were critical. (b)(6) testimony, page 22, Tab 9). 
2. On August 4, 2011 (b)(6) requested funding from VISN 7 to support non-VA care to address this backlog. (b)(6) testimony, pages 5-6, Tab 13).
3. On September 9, 2011 the VISN transferred approximately \$12.5 M of which \$1,029,700 was earmarked for non-VA care in the GI Clinic to support the needs of 700 critical GI patients. (b)(6) testimony, page 5, Tab 13).
4. There was no evidence to show that the \$1 million were used to support non-VA care for GI Clinic patients (b)(6) testimony, page 22, Tab 9; and (b)(6) testimony, page 16, Tab 16; (b)(6) testimony, page 8, Tab 13).
5. On November 29, 2011 Medical Service notified the Chief of Staff of nursing staffing shortages and staffing shortages of Gastroenterologists. (b)(6) email, Tab 68).
6. On December 19, 2011 Medical Service notified the Chief of Staff's office of approximately 2500 GI consults waiting. (b)(6)'s email, Tab 64). 
7. On December 27, 2011 Medical Service notified the Chief of Staff's Office that the GI backlog has increased to 3800 (b)(6) email, Tab 65). 
8. In early January, 2012 the GI Task Force organized and met. (Tab 56)
9. On January 10, 2012, the Chief of Staff sent an email to the Business Office indicating not to "send out anymore non-VA care GI requests for endoscopy until further notice." He further stated they were in the process of "attempting to internalize as many of these 700 cases as possible." (b)(6) email, Tab 68).

10. In February of 2012 the OIG CAP review reported findings regarding untimeliness for GI procedures. (Page 9, CAP report, Tab 70).
11. In May of 2012 an index patient was identified. (b)(6) testified that a patient had been scheduled for a procedure which he believed got cancelled several times. When the patient “presented again to the Emergency Room with worsening dysphasia. He was then admitted, he was scoped and he had esophageal cancer...” and that was the facility’s first realization that patients were “falling through the cracks.” (b)(6) testimony, page 22, Tab 12). (b)(6) testified she recalled a patient originally being scheduled for an endoscopy in (b)(6) 2011 whose appointments were subsequently cancelled two or three times and eventually showed up in the Emergency Room and had cancer in his throat. (b)(6) testimony, page 22, Tab 15).
12. (b)(6) testified that he reported to the OIG in June of 2011 his concerns of a “Systematic failure to fill nurse case manager and case manager positions in a timely fashion.” (b)(6) testimony, page 27, Tab 9).
13. On June 12, 2012 the Chief of Staff determined institutional disclosure was appropriate for the clinical index case. (b)(6) testimony, page 26, Tab 12).
14. On June 19, 2012 the facility completed an Issue Brief, entitled “GI Backlog and Related Potential Institutional Disclosures”. (Tab 54).
15. On August 6-7, 2012, a Management Review of the Gastroenterology Section site visit conducted (b)(6) (b)(6) The review team’s report provided multiple suggestions to improve the management of the GI clinic. (Tab 55).
16. On August 13-16, 2012 the VHA Office of the Medical Inspector visited the facility and submitted their report, dated September 13, 2012. (Tab 69).
17. When asked if it took the index patient coming to light to perhaps make the point that additional staffing was needed (b)(6) testified “I think two things. One was the index patient, it was a real patient, he suffered, he is now deceased. That in combination with the fact that we went from January to the end of May and we didn't make any progress. We didn't increase significantly the backlog but we didn't decrease the backlog either.” (b)(6) testimony, pages 26-27, Tab 12).
18. Leadership at the facility and the VISN was inconsistent and frequently involved interim appointments for critical leadership positions. (Director timelines, Tab 27).
19. (b)(6) testified that the facility did not monitor the consult process “the way we should have.” He indicated the administration of the hospital left this to the GI clinic and the Department of Medicine. (b)(6) testimony, page 5, Tab 12).
20. (b)(6) testified that there were five different Medical Center Directors in a three year period of time and that they do “have different priorities and go in different directions.” (b)(6) testimony, page 5, Tab 12).
21. (b)(6) testified that Fecal Immunochemical Tests (FIT) testing as a screening mechanism “produced a tremendous backlog” and that Primary Care providers defaulted to GI Clinic for procedures by sending consults. (b)(6) testimony, pages 5-6, Tab 12).

Conclusions:

1. When the issue of the backlog was first reported in the June 19, 2012 Issue Brief it was not the first time there had been a backlog in the GI Clinic. The backlog dated back to at least July 2011.
2. Though funding was promptly requested and obtained from VISN 7 in the summer of 2011 to address backlogged GI consults, management systems were not in place at the Medical Center to assure those funds were used to eliminate the backlog.
3. There was a lack of communication, coordination, and sound administrative practices which all contributed to the recurrence of a significant accumulating backlog of GI Clinic cases.
4. Management was aware of several factors that lead to the backlog and failed to take effective and timely action to correct the problem.
5. Rotating leadership among facility and VISN may have contributed to untimely resolution of GI backlogs and lack of follow-up.
6. The backlogs in the GI Clinic contributed to poor patient care outcomes.

Recommendation:

1. Appropriate administrative action be taken against (b)(6) and (b)(6) for failing to take swift corrective action to mitigate the backlog in GI.

*The Board recognizes (b)(6)

b. Given the workload, was there adequate staffing in the GI clinic?

Facts:

1. A nurse manager was acting Nurse Manager for over a two year period of time prior to the hiring of (b)(6). (b)(6) testimony, page 3, Tab 4 and (b)(6) testimony, page 6, Tab 11).
2. (b)(6) testified "The other problem we had was a lack of staffing in GI clinic and in the endoscopy area and the lack of clerks in this area. That is fairly long standing." He clarified to state that the staffing shortage was in the areas of nursing and clerical. (b)(6) testimony, page 5, Tab 12).
3. (b)(6) testified that the HR process of hiring was "taking a considerable period of time to bring new staff on board." In addition he stated that "The Planning Council, which had to do with requests for new FTE's was primarily an administrative committee rather than having clinical staff on it, so it was hard to get clinical staff through this committee." (b)(6) testimony, page 6, Tab 12).
4. (b)(6) testified that the "the hiring process really hindered us" and "It took a lot of persuading through nursing to get me the staff that I wanted

and...I'm sad to see it takes a crisis to get finally people (sic) to move and get me the hiring actions that I need, because once they recognized that I needed them or once they realized this has become such an issue, there was no more hesitancy on urging leadership to get me the staff that I needed. It was expedited actually, but I still don't have everyone on board.”

- (b)(6) testimony, page 13, Tab 4).
5. The entire Nursing Service was limited to one support HR Specialist. (b)(6) testimony, page 10, Tab 11). Human Resources is understaffed compared with VISN and national averages and the national VHA staffing goals. (HR Staffing Ratios, Tab 31).
 6. There was an insufficient number of clerical staff for the GI Clinic (b)(6) testimony, page 5, Tab 4).
 7. There was an insufficient number of on duty nurses for the GI Clinic based on the workload. (b)(6) testified that the limited number of nursing staffing and only having one case manager that “My estimation, it didn't take me very long, took me about six months to realize the workload far out exceeded our capability in meeting that workload.” (b)(6) testimony, page 5, Tab 4).
 8. GI nurse positions did not rate high enough on the nursing priority hiring list to receive approval for hiring. (b)(6) testimony, page 6, Tab 8; and (b)(6) testimony, page 12, Tab 11).
 9. Authorized GI Clinic staffing was increased from 25.7 FTEE in FY11 to 35.7 FTEE in FY13. (GI Clinic staffing, Tab 28).
 10. On board GI Clinic staffing increased from 20.7FTEE in FY11 to 28.8 FTEE in FY13. (GI Clinic staffing, Tab 28).

Conclusions:

1. There were routine and ongoing delays in hiring staff.
2. The HR staffing ratio at Columbia VAMC is well below both the VISN and national averages. The national goal is 85:1 (employees to HR Specialists). Columbia currently has a ratio of 138:1, VISN 7 is 118:1 and VHA nationally is 105:1.
3. Physician staffing appears adequate; however, it was negatively impacted by the Moncrief Army Hospital Sharing Agreement.
4. The Resource Planning and FTEE Committees, which met monthly, were not effective in approving vacancies to meet patient care needs and in fact contributed to the delay in approving/hiring new staff.
5. Leadership did not act quickly enough to address the staffing deficiencies in the GI Clinic area.

Recommendations:

1. Assess the adequacy of Human Resources staffing and their internal recruitment processes.

2. Review and evaluate the current process for approving and filling vacancies for all clinical and administrative services.
3. Consider appropriate administrative action be taken against (b)(6) (b)(6) for not addressing the staffing shortages, position review processes and untimely, recruitment of critical staff..

*The Board recognizes (b)(6)

c. Were fee and other contract resources sufficiently allocated to address clinical needs given the caseload of the GI clinic?

Facts:

1. (b)(6) submitted an email to (b)(6) dated July 25, 2011 stating there was a backlog of 2500 consults in GI and that they were scheduling into February. (Tab 68). He further reiterated in his testimony that 700 of these consults were critical. (b)(6) testimony, page 22, Tab 9).
2. On August 4, 2011 (b)(6) requested funding from VISN to eliminate the GI Clinic backlog using non-VA care. (b)(6) testimony, pages 5-6, Tab 13).
3. On September 9, 2011 the VISN 7 Office transferred approximately \$12.5 M of which \$1,029,700 was earmarked for non-VA care in the GI Clinic to support the needs of 700 critical GI patients. (b)(6) testimony, page 6, Tab 13; (b)(6) testimony, page 15, Tab 16).
4. (b)(6) testified that he could not verify the funding the VISN Office sent to support non-VA care for the critical GI cases was ever used for that purpose. He testified that Nursing Service had eliminated a FOBT Coordinator who did all the tracking for critical cases and "There simply wasn't anyone to do it." (b)(6) testified that the facility needed money to support the Non-VA Care Program at the facility, but that "They didn't put any on the GI 1358." (b)(6) testimony, page 22, Tab 9; and (b)(6) testimony, page 16, Tab 16).
5. The Medical Center entered into a sharing agreement with Moncrieff Army Hospital in an attempt to reduce the GI Clinic backlog. (b)(6) testified, "Roughly in May, (b)(6) indicated that we could hire another gastroenterologist mainly because she wanted to have a sharing agreement with Moncrief (sic) Army Hospital...that was part of her solution to the GI crisis..." However, he went on to testify that roughly 50% of the patients were active duty and therefore did not help the VA backlog "as much as one might think." (b)(6) testimony, page 13, lines 8 – 21, Tab 9). (b)(6) testified the same, stating that although they received 60 free consults the amount of staff they needed to send over there "takes away from us." (b)(6) testimony, page 41, lines 9-22, Tab 16).

Conclusions:

1. Medical Center leadership timely requested non-VA care funding upon learning of pending 700 critical GI patient consults in July, 2011; however, there is no evidence these funds were authorized or obligated for non-VA care for GI patients in an effort to reduce the backlog.
2. Medical Center leadership did not utilize non-VA care or contract services in an effort to reduce the backlog for the critical cases brought to their attention in December, 2011.

Recommendation:

1. The Medical Center Director should develop a process to ensure resources are allocated adequately and timely, to meet patient care demands.

d. Did any actions or inactions of leadership in connection with the management of the GI Clinic contribute to adverse patient care outcomes?

Facts:

1. (b)(6), was excluded from discussions regarding clinical backlogs and did not become aware of the GI Clinic backlog until the OIG visit in February of 2012. (b)(6) testified, "...I had no idea that apparently they had been meeting and they knew there was an issue..." (b)(6) testimony, pages 5-7, Tab 21).
2. There was no management or oversight of the consult management process. (b)(6) testified the Medical Center did not monitor the consult process "the way we should have." He indicated "the administration of the hospital left this over to the GI clinic to the Department of Medicine. This was left to the GI Clinic." (b)(6) testimony, page 5, Tab 12).
3. (b)(6) testified that the HR process of hiring was "taking a considerable period of time to bring new staff on board." In addition he stated that "The Planning Council, which had to do with requests for new FTE's was primarily an administrative committee rather than having clinical staff on it, so it was hard to get clinical staff through this committee." (b)(6) testimony, page 6, Tab 12).
4. (b)(6) testified that the "the hiring process really hindered us" and "It took a lot of persuading through nursing to get me the staff that I wanted and...I'm sad to see it takes a crisis to get finally (sic) people to move and get me the hiring actions that I need, because once they recognized that I needed them or once they realized this has become such an issue, there was no more hesitancy on urging leadership to get me the staff that I needed. It was expedited actually, but I still don't have everyone on board." (b)(6) testimony, page 13, Tab 4).

5. GI nurse positions did not rate high enough on the nursing priority hiring list to receive approval for hiring. (Arrington testimony, page 6, Tab 8; and (b)(6) testimony, page 12, Tab 11).
6. (b)(6) testified that he could not verify the funding the VISN Office sent to support feeing out the critical GI cases was ever used for that purpose. He testified Nursing Service had eliminated a FOBT coordinator who did all the tracking for critical cases and "There simply wasn't anyone to do it." (b)(6) testified that the facility needed money to support the Non-VA Care Program at the facility; but, "They didn't put any on the GI 1358." (b)(6) testimony, page 22, Tab 9; and (b)(6) testimony, page 16, Tab 16).
7. Leadership at the facility and the VISN was inconsistent and frequently involved interim appointments for critical leadership positions. (Director timelines, Tab 27).
8. (b)(6) testified there were five different Medical Center Directors in a three year period of time and that they do "have different priorities and go in different directions." (b)(6) testimony, page 5, Tab 12).
9. (b)(6) testified that the HR process of hiring was "taking a considerable period of time to bring new staff on board." In addition he stated "The Planning Council, which had to do with requests for new FTE's was primarily an administrative committee rather than having clinical staff on it, so it was hard to get clinical staff through this committee." (b)(6) testimony, page 6, Tab 12).

Conclusions:

1. Lack of nursing staff caused periodic closure of GI procedure rooms thereby reducing the number of procedures completed in house.
2. The Resource Planning and FTEE Committees, which meet regularly, were not effective in approving vacancies to meet patient care needs.
3. The replacement of vacant staff positions, including nursing and clerical, in the GI Clinic was untimely.
4. There was no follow-up or oversight of the non-VA care process associated with the GI Clinic.
5. Leadership at the facility and the VISN was inconsistent and frequently involved the appointment of rotating "actings" for critical leadership positions.
6. The vacancy approval and hiring process was untimely throughout the Medical Center
7. The exclusion of Quality Management from discussions regarding clinical backlogs and not being aware of the GI Clinic backlog until the OIG visit is indicative of a lack of executive leadership's failure in adequately managing the facility's clinical programs.

Recommendations:

1. The VISN should complete an external review of the Quality Management and Patient Safety Programs to ensure that executive leadership has

incorporated an integrated health care system to avoid failures such as the GI Clinic backlog.

2. The Medical Center, with VISN oversight, should assure improved communications and team building occurs in a systematic manner across departmental lines.

e. Have adequate systems been put into place to ensure that similar failures do not occur again?

Facts:

1. There is an action plan in place to address the current backlog in the GI Clinic. (Tabs 51, 52, 56 and 57).
2. The VISN Quality Manager approved the Medical Center's action plan to reduce the GI backlog. (b)(6) testimony, page 6, Tab 19).
3. GI Clinic backlog report dated October 26, 2011 shows zero patients awaiting initial contact. (Tab 51).
4. As of December 31, 2011 the Medical Center has delayed hiring on all but 80 of their approximately 250 vacant positions in order to assist Human Resources in prioritizing vacancies. (b)(6) testimony, page 19, Tab 13; (b)(6) testimony, pages 13-14, Tab 15; (b)(6) testimony, page 16, Tab 22).
5. Although all vacant positions were abolished, Quadrad members may request approval to reinstate abolished positions to the Planning Board/Council. (b)(6) testimony, page 17, Tab 15; (b)(6) testimony, page 22, Tab 13; (b)(6) testimony, pages 19-20, Tab 22).
6. Administrative and staffing changes have been made including such things as changes in scheduling, increased staffing, elimination of physician pre-op clinic review, elimination of some physician post-op clinic review, FIT test usage, and regularly utilizing a fourth procedure room. Physician concern was expressed about potential lack of continuity of patient care resulting from assignment of providers solely to procedures without seeing patients pre- or post- procedure. (b)(6) testimony, pages 6-8, Tab 5; (b)(6) testimony, pages 11-12, Tab 7; (b)(6) testimony pages 37-38, Tab 15). Employee morale in the GI Clinic is low. (b)(6) testimony, pages 7-8; (b)(6) testimony, page 26; (b)(6) testimony, page 19).
7. Decisions are being made at a higher level in the organization without sufficient regard for staff level input. (b)(6) testimony, pages 4-5 and 14; (b)(6) testimony, page 27; (b)(6) testimony, page 26).
8. GI Clinic staffing authorized increased from 25.7 FTEE in FY11 to 35.7 FTEE in FY13. (Tab 28).
9. GI Clinic on board staffing increased from 20.7 FTEE in FY11 to 28.8 FTEE in FY13. (Tab 28).
10. FOBT Coordinator position was abolished and not reestablished until FY13. (b)(6) testified, "there had been an FOBT Coordinator who tracked and

- did all the tracking for critical cases. Nursing had eliminated that position back in 2010” (b)(6) testimony, page 22). (GI Clinic staffing, Tab 28).
11. Testimony was inconsistent as to whether or not the GI Clinic care delivery system has been adjusted in such a way that would assure success going forward. (b)(6) testimony, pages 35-36, Tab 4; (b)(6) testimony, pages 27-28, Tab 15; (b)(6) testimony, page 21, Tab 11; and (b)(6) testimony, pages 25-26, Tab 9).
 12. (b)(6) testimony, pages 35-36, Tab 15).
 13. (b)(6) testified medical center policy clearly states that consult management is the service chief's responsibility. (b)(6) testimony, page 39, Tab 15).
 14. The Chief of Medicine position is currently vacant subsequent to (b)(6) stepping down in October, 2012. The facility has appointed (b)(6) (b)(6) as Acting Chief of Medicine. (b)(6) testimony, page 8, Tab 9; and Walls testimony, page 7, Tab 6).

Conclusions:

1. GI physician staff are dissatisfied with administrative changes in the GI Clinic as changes to the GI Clinic were made without necessary input from clinic staff. This does not assure their buy-in and may result in job dissatisfaction and a future backlog .
2. The Board concludes that systematic changes necessary to assure all procedures/services are received timely has not occurred. There remains a lack of clarity of roles and responsibilities, high staff turnover, inconsistent testimony as to the current views on the success of the changes implemented, and difficulty in recruitment.

Recommendations:

1. The Medical Centers needs to hire or identify and detail a seasoned Chief of Staff to address the ongoing issues surrounding the GI Clinic for a minimum of 90 days. Following the completion of this detail, this Chief of Staff can serve as a mentor/coach with the permanent Chief of Staff.
2. The Medical Center, with VISN oversight, should develop and implement a system to monitor and assure similar failures do not occur again and that consults are addressed in a timely manner.

V. Summary of Observations Outside the Scope of the Board's Charge

Several issues, beyond the scope of the Board, were identified as themes throughout the Columbia VAMC and warrant further review by VHA, VISN and Medical Center leadership.

1. The numerous detail assignments as Acting Medical Center Director, Acting Associate Director and Acting Assistant Director have led to information gaps and changes in directed plans of action throughout the Medical Center creating opportunities for management and system failures. Additionally, there were several detail assignments at the VISN level during this time. VHA and VISN leadership may want to consider stability, continuity and coordination of both clinical and administrative operations when placing executives in detailed positions.
2. Turnover in Service Chief and other key clinical and administrative positions, in addition to leadership turnover, has created a lack of understanding of role and responsibility clarity throughout the Medical Center. VISN leadership may consider performing a comprehensive review of committee structure and oversight processes to assure overall program coordination and systems management exist within the Medical Center and VISN.
3. Similarly, the significant turnover of staff at all levels not only provides opportunity for delineation of formal roles and responsibilities but for improved relationships throughout the Medical Center to improve employee morale and support team-based care across clinical disciplines as well as between clinical and administrative staff.
4. Overall program coordination and systems management between and among facilities, VISNs and VACO Program Offices is key and requires constant leadership attention which was lacking at the Medical Center and VISN when the backlog in GI consults developed and during the initial attempts to manage the backlog.

/es/

(b)(6) [REDACTED] Network Director, Chairperson
Sierra Pacific Network (VISN 21), Mare Island, CA

/es/

(b)(6) [REDACTED] Medical Center Director
VAMC Cleveland, OH

/es/

(b)(6) [REDACTED] Deputy Chief of Staff
Eastern Kansas Health Care System, Leavenworth, KS

/es/
(b)(6) [REDACTED] Deputy Network Director
South Central VA Health Care Network (VISN 16), Ridgeland, MS

/es/
(b)(6) [REDACTED] Human Resources Consultant,
Workforce Management and Consulting Office, VHACO, Washington, DC

Attachments:

Index

Number	Description	Source
1	AIB Charge letter dated October 25, 2012	VHA DUSHOM, 10N Office
2	Transcript of Testimony of – (b)(6) [redacted] dated November 6, 2012	AIB Interview
3	Transcript of Testimony of – (b)(6) [redacted] dated November 6, 2012	AIB Interview
4	Transcript of Testimony of – (b)(6) [redacted] N, dated November 6, 2012	AIB Interview
5	Transcript of Testimony of – (b)(6) [redacted] dated November 6, 2012	AIB Interview
6	Transcript of Testimony of – (b)(6) [redacted] dated November 6, 2012	AIB Interview
7	Transcript of Testimony of – (b)(6) [redacted] dated November 6, 2012	AIB Interview
8	Transcript of Testimony of – (b)(6) [redacted] dated November 7, 2012	AIB Interview
9	Transcript of Testimony of – (b)(6) [redacted] dated November 7, 2012	AIB Interview
10	Transcript of Testimony of – (b)(6) [redacted] dated November 7, 2012	AIB Interview
11	Transcript of Testimony of – (b)(6) [redacted] dated November 7, 2012	AIB Interview
12	Transcript of Testimony of – (b)(6) [redacted] dated November 7, 2012	AIB Interview
13	Transcript of Testimony of – (b)(6) [redacted], dated November 7, 2012	AIB Interview
14	Transcript of Testimony of – (b)(6) [redacted] dated November 7, 2012	AIB Interview
15	Transcript of Testimony of – (b)(6) [redacted], dated November 7, 2012	AIB Interview
16	Transcript of Testimony of – (b)(6) [redacted] dated November 8, 2012	AIB Interview
17	Transcript of Testimony of – (b)(6) [redacted] dated November 8, 2012	AIB Interview
18	Transcript of Testimony of – (b)(6) [redacted] dated November 8, 2012	AIB Interview
19	Transcript of Testimony of – (b)(6) [redacted], (b) [redacted] dated November 8, 2012	AIB Interview
20	Transcript of Testimony of – (b)(6) [redacted] dated November 8, 2012	AIB Interview
21	Transcript of Testimony of – (b)(6) [redacted] dated November 8, 2012	AIB Interview

Index

Number	Description	Source
22	Transcript of Testimony of – (b)(6) dated November 8, 2012	AIB Interview
23	Transcript of Testimony of – (b)(6) dated December 27, 2012	AIB Interview
24	VHA Consult Policy, dated September 16, 2008	VAMC Columbia
25	VHA Outpatient Scheduling Processes and Procedures Policy, dated June 9, 2010	VAMC Columbia
26	VAMC Columbia Consult Management Policy, dated November 29, 2011	VAMC Columbia
27	Medical Center Director Appointment Timelines	VAMC Columbia
28	GI Clinic Staffing, FY11, FY12, FY13	VAMC Columbia
29	Nursing Service Organizational Chart, dated 2010	VAMC Columbia
30	Medical Service Organizational Chart, dated July 11, 2012	VAMC Columbia
31	Human Resources Staffing Ratios, dated November 30, 2012	VAMC Columbia
32	GI Clinic Nursing Staffing, dated 2011 and 2012	VAMC Columbia
33	Nursing Service Hiring Priorities, dated FY12	VAMC Columbia
34	GI Clinic Workload Capacity, dated October FY11 through September FY12	VAMC Columbia
35	Open GI Clinic Consults (Active, Pending and Scheduled), undated	VAMC Columbia
36	GI Clinic Stops, dated FY09	VAMC Columbia
37	GI Clinic Stops, dated FY10	VAMC Columbia
38	GI Clinic Stops, dated FY11	VAMC Columbia
39	GI Clinic Stops, dated FY12	VAMC Columbia
40	GI Clinic Cancellations, dated FY09-FY12	VAMC Columbia
41	MACH Clinic Appointments, dated FY09	VAMC Columbia
42	MACH Clinic Appointments, dated FY10	VAMC Columbia
43	MACH Clinic Appointments, dated FY11	VAMC Columbia
44	MACH Clinic Appointments, dated FY12	VAMC Columbia
45	GI Clinic Fee Expenditures, dated FY11	VAMC Columbia
46	GI Clinic Fee Expenditures, dated FY12	VAMC Columbia
47	Fee Delegation Authority, dated May 3, 2012	Angelia Scott
48	Authorizations for GIs, GI tests, GI Procedures, GI Studies and Colonoscopies, dated FY11	VAMC Columbia
49	Authorizations for GIs, GI tests, GI Procedures, GI Studies and Colonoscopies, dated FY12	VAMC Columbia

Index

Number	Description	Source
50	GI Consults by month, w/o Fee, dated CY11 and CY12 to date	VAMC Columbia
51	GI Backlog Report (snapshot), dated September 17, 2012 through October 26, 2012	VAMC Columbia
52	Delayed GI Clinic Report, dated September 18, 2012	VAMC Columbia
53	VISN 7 Issue Brief Tracker Report – Columbia VAMC GI Backlog and Related Potential Institutional Disclosures, dated June 21, 2012	VAMC Columbia
54	VHA Issue Brief, report dated June 19, 2012 updated through November 2, 2012	VAMC Columbia
55	Management Review of Gastroenterology Section, dated August 19, 2012	VAMC Columbia
56	GI Task Force Consults Backlog Plan and updates, dated December 2011 with updates through June 19, 2012	VAMC Columbia
57	Corrective Actions Report Concerning the GI Clinic, undated	VAMC Columbia
58	Endoscopy Procedures by Provider Report, FY09 – FY12	VAMC Columbia
59	Provider Leave Calendar, CY10	VAMC Columbia
60	Provider Leave Calendar, CY11	VAMC Columbia
61	Provider Leave Calendar, CY12	VAMC Columbia
62	Email, Medicine Service Good News/Bad News Report, dated July 14, 2012	(b)(6)
63	Email, Medicine Service Good News/Bad News Report, dated July 28, 2012	(b)(6)
64	Email, Weekly Report, dated December 19, 2011	(b)(6)
65	Email, Weekly Report, dated December 27, 2011	(b)(6)
66	Email, Weekly Report, dated January 9, 2012	(b)(6)
67	Email, Fee GI Consults, dated November 7, 2011	(b)(6)
68	Email, Summary of e-mails for Administrative Board of Investigation, dated November 26, 2012	(b)(6)
69	Office of Medical Inspector Report, dated September 13, 2012	Office of the ADUSH/Clinical (10NC)
70	Office of Inspector General Combined Asset Program (CAP) report, dated April 18, 2012	VAMC Columbia

COMPLETION CERTIFICATE

COMPLETION OF INVESTIGATION

I have reviewed the report of investigation dated March 25, 2013 concerning the facts and circumstances surrounding the allegations of mismanagement of the GI Clinic at the William Jennings Bryan Dorn VAMC Columbia, SC. This investigation was convened by my Charge Letter of October 25, 2012.

I certify that this report has been reviewed for compliance with VA Directive and Handbook 0700, and the subject of the report has been properly investigated.

William Schoenhard

William Schoenhard, FACHE
Deputy Under Secretary for Health for Operations and Management
Convening Authority

4-12-2013
DATE