VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Patient Scheduling Issues at VA Medical Center Tampa, Florida

February 5, 2016
15-03026-101

ACRONYMS

FY	Fiscal Year
HAS	Health Administration Service
JAHVH	James A. Haley Veterans' Hospital
NVCC	Non-VA Medical Care Coordination
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
PI	Performance Improvement
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VCL	Veterans Choice List
VCP	Veterans Choice Program
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

Report Highlights: Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, FL

Why We Did This Review

In December 2014, the Office of Inspector General (OIG) received allegations about the Veterans Choice Program (VCP) at the James A. Haley Veterans' Hospital (JAHVH), a VA Medical Center (VAMC) in Tampa, Florida. The complainant alleged that when a veteran received an appointment in the community through the VCP, the facility did not cancel the existing VA appointment thus blocking other veterans from using that appointment slot and causing an access problem at JAHVH. The complainant also alleged that supervisors did not inform schedulers of errors identified in scheduling audits. Lastly, the complainant alleged mismanagement of the Veterans Choice List (VCL).

What We Found

We substantiated that JAHVH staff did not always cancel the VA appointment when staff made a VCP appointment. We examined 56 records of veterans who completed a VCP appointment and found that for 12 of the veterans (21 percent), staff did not cancel the veterans' corresponding VA appointment. This occurred because Non-VA Care Coordination staff did not receive prompt notification from the contractor, Health Net, when a veteran scheduled a VCP appointment and no longer needed the VA appointment.

We substantiated that prior to May 2015, the Performance Improvement (PI) supervisor did not notify schedulers of errors identified during scheduling audits because the PI team was correcting the errors, and notifying schedulers was not his priority.

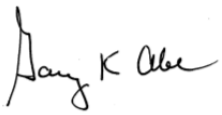
We substantiated that JAHVH did not add all eligible veterans to the VCL when their scheduled appointment was greater than 30 days from their preferred date. Additionally, we substantiated that staff inappropriately removed veterans from the VCL. This occurred because JAHVH schedulers thought they were appropriately removing the veteran from the Electronic Wait List, when they were actually removing the veteran from the VCL.

What We Recommended

We recommended the Director of the James A. Haley Veterans' Hospital ensure the facility receives prompt notification of scheduled VCP appointments and determine if the contractor complies with the requirements. We also recommended the Director ensure appropriate staff receive scheduling audit results and PI staff verify correction of errors, and staff receive training regarding management of the VCL.

Management Comments

The Director of JAHVH concurred with our recommendations. Based on actions already implemented, we consider Recommendations 2, 3, 4, and 5 closed, and will follow up on the implementation of Recommendation 1.



GARY K. ABE
Acting Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

INTRODUCTION

Allegations

In December 2014, the Office of Inspector General (OIG) received allegations concerning the Veterans Choice Program (VCP) at the James A. Haley Veterans' Hospital (JAHVH), a VA Medical Center (VAMC) in Tampa, Florida. The complainant alleged that when a veteran received an appointment in the community through the VCP, the facility did not cancel the existing VA appointment thus blocking other veterans from using that appointment slot and causing an access problem for veterans at JAHVH.

The allegation also stated that although JAHVH staff identified numerous scheduling errors, supervisors did not inform the schedulers of their errors, which allowed errors to continue. During our site visit to JAHVH in June 2015, the complainant further alleged that not all eligible veterans with an appointment scheduled greater than 30 days from their preferred date were added to the Veterans Choice List (VCL), and that staff removed veterans from the VCL, contrary to policy.

Background

On August 7, 2014, the Veterans Access, Choice, and Accountability Act of 2014 was signed into law. To implement this Act, the Veterans Health Administration (VHA) initiated the VCP on November 5, 2014, allowing eligible veterans to use providers outside the VA system.

VCP Eligibility Requirements

To be eligible to use the VCP, a veteran must have enrolled in VA health care on or before August 1, 2014, or be a recently discharged combat veteran within 5 years of separation. The veteran must also meet certain criteria, including one of the following:

- The veteran has a wait of more than 30 days from the veteran's preferred date of an appointment or the clinically determined date by the veteran's provider.
- The veteran resides more than 40 miles from the closest VA health care facility.

If the veteran meets the criteria, VA facilities must place the veteran on the VCL. At that point, the veteran has the choice to obtain a VCP appointment outside the VA or keep the existing VA appointment.

VCP Contract

On October 30, 2014, VA signed a modification to the Patient-Centered Community Care (PC3) contract, expanding its contracts with Health Net and Tri West Healthcare Alliance, to include implementing the VCP. PC3 is a nationwide program to provide eligible veterans access to certain medical care when the local VA medical facility cannot readily provide the care, due to long wait times, geographic inaccessibility, or other factors. JAHVH uses the contractor Health Net.

RESULTS AND RECOMMENDATIONS

Allegation 1 Did JAHVH Staff Appropriately Cancel VA Appointments After Veterans Scheduled VCP Appointments?

Assessment

We substantiated that JAHVH staff did not always cancel the VA appointment when a VCP appointment was made. This practice blocked other veterans from using that appointment slot at JAHVH.

Criteria

The modification to the PC3 contract that implemented VCL states that, for veterans on the VCL because the veteran has an appointment wait time greater than 30 days, the contractor shall notify VA when the veteran is scheduled for an appointment through VCP. This notification is necessary so that VA can cancel the veteran's VA appointment. However, the contract is silent on the time frame and method of notification.

JAHVH's local procedures for VCP states that if the veteran decides to use an outside provider, Health Net should notify VA of this choice by updating a portal that JAHVH staff can access. At JAHVH, Non-VA Care Coordination (NVCC) staff monitor the Health Net portal and notify JAHVH Health Administration Service (HAS) staff when a veteran has scheduled a VCP appointment in the community so HAS staff can cancel the internal VA appointment.

What We Did

In June 2015, we conducted a site visit at JAHVH and interviewed management and staff responsible for managing and tracking VCP appointments. From October 1, 2014, through June 10, 2015, 383 veterans at JAHVH opted to obtain an appointment through the VCP. We compared details of this data from JAHVH with records in VA's Compensation and Pension Records Interchange System and the Health Net portal.

JAHVH records indicated that, as of June 10, 2015, 68 of the 383 veterans had a scheduled appointment through VCP. Of the remaining 315 veterans, the records indicated that 304 veterans had a pending VCP appointment. This means that the veterans had not scheduled an appointment at that time, or if they did, JAHVH had not yet received a notification. The remaining 11 veterans declined or withdrew from VCP care.

We reviewed the appointment history of 100 of the veterans. We determined that as of June 10, 2015, only 56 of the 100 veterans actually completed a VCP appointment. The remaining 44 veterans did not complete their VCP appointment because they did not show up for their appointment, they declined care, or they were not yet scheduled for an appointment.

What We Found

We examined the 56 records of veterans who completed a VCP appointment and found that for 12 of the 56 veterans (21 percent), HAS staff did not cancel the veteran's corresponding VA appointment. Typically, NVCC staff monitor the Health Net portal for veterans who opt for and schedule VCP appointments. When NVCC staff identified veterans with scheduled VCP appointments, they provided those veterans' names to HAS staff via email. HAS staff then canceled the corresponding VA appointments and notified the respective clinics so they could use the appointment slots for other veterans waiting for care. However, according to NVCC and HAS staff, the Health Net portal was not always timely updated.

VA Appointments Not Cancelled

We identified 12 veterans who had a VCP appointment and the facility did not cancel the VA appointment. Furthermore, 11 of the 12 veterans went to both their VCP appointment and VA appointment. For example, on December 12, 2014, a veteran scheduled an orthopedic appointment at JAHVH for April 2, 2015. Because the appointment wait time was greater than 30 days from the veteran's preferred date, the veteran chose to schedule a VCP orthopedic appointment for February 3, 2015. The facility did not cancel the original JAHVH appointment and, according to the VA medical records, the veteran attended both appointments. Because the facility did not cancel these VA appointments for veterans who obtained care through VCP, the VA appointments were not available for other veterans waiting for care.

Why This Occurred

NVCC staff did not immediately know when a veteran scheduled a VCP appointment and no longer needed the corresponding VA appointment. According to VA documents, Health Net's mechanism to notify JAHVH that a veteran scheduled a VCP appointment is to update their portal with a scheduled appointment date. According to NVCC staff, since they do not receive notification from Health Net that a VCP appointment has been scheduled, they perform a daily manual search of individual names in the Health Net portal to identify veterans who have scheduled VCP appointments. NVCC and HAS staff reported that Health Net did not always update the portal in a timely manner. The modification to the PC3 contract that implemented VCL did not specify how soon Health Net should update the portal when a veteran schedules a VCP appointment.

NVCC and HAS staff told us that because Health Net did not always update the portal in a timely manner, they typically identified veterans who scheduled VCP appointments after, or shortly before, the scheduled corresponding VA appointment. As an example, NVCC staff explained how they were able to identify a veteran with a scheduled appointment date of March 9, 2015; however, Health Net did not update their portal with this information until June 9, 2015—3 months after the scheduled appointment. JAHVH should contact the responsible contracting officer to determine if Health Net complies with the modification to the PC3 contract requiring the contractor to notify VA when a veteran is scheduled for an appointment through VCP.

What Resulted

NVCC staff were unable to timely identify veterans who scheduled VCP appointments, which limited the facility's ability to cancel the veterans' corresponding VA appointments. Because the facility did not cancel these VA appointments for veterans who obtained care through VCP, the VA appointments were not available for other veterans waiting for care. We determined that missed appointment opportunities occurred at JAHVH for more than 21 percent of instances (12 of 56) in which a veteran completed a VCP appointment. This included 11 instances in which veterans went to both their VCP appointment and VA appointment, eliminating the opportunity for another veteran to use the VA appointment. As veterans' use of VCP appointments increases, the risk of additional missed VA appointment opportunities also increases.

Recommendations

1. We recommended the Director of James A. Haley Veterans' Hospital coordinate with the responsible contracting officer to develop a mechanism to ensure the facility receives prompt notification of scheduled Veterans Choice Program appointments.

2. We recommended the Director of James A. Haley Veterans' Hospital request that the responsible contracting officer determine if Health Net complies with the modification to the Patient-Centered Community Care contract requiring the contractor to notify VA when a veteran is scheduled for an appointment through the Veterans Choice Program.

Management Comments

The Director of JAHVH concurred with the recommendations. The Director stated that JAHVH inquired about availability of an automated notification when a veteran has been scheduled for an appointment in the community, but determined that such changes would require a modification to the current contract, and at this time there are no plans to initiate one. JAHVH also confirmed that Health Net is not obligated to provide an electronic alert and is compliant with the contract by updating the portal when a veteran has been scheduled for an appointment in the community. Therefore, HAS will continue to retrieve community appointments through the Health Net portal and cancel VA appointments accordingly.

OIG Response

The Director noted that JAHVH confirmed the contractor is compliant with the contract by updating the Health Net portal. However, the JAHVH had not yet developed a mechanism, in coordination with the contracting officer, to receive prompt updates to the portal. Although the JAHVH inquired about an automated notification, the outcome of this action did not result in JAHVH receiving more timely notifications of scheduled VCP appointments and therefore the issue remains. JAHVH needs to continue to coordinate with the contracting officer to develop a mechanism that ensures the contractor promptly supplies the necessary information to the Health Net portal. We will monitor the facility's progress and follow up on the

implementation of Recommendation 1 until the proposed actions are completed. The Director's corrective actions regarding Recommendation 2 are acceptable, and we consider Recommendation 2 closed. Appendix B provides the full text of the JAHVH Director's comments.

Allegation 2 Did Supervisors Inform Staff of Scheduling Errors Identified During Audits?

Assessment

We substantiated that prior to May 2015, the Performance Improvement (PI) staff supervisor did not notify schedulers of errors that the PI staff identified during scheduling audits.

Criteria

VHA Directive 2010-027 requires facilities to perform a standardized yearly scheduler audit of the timeliness and appropriateness of scheduling actions, and of the accuracy of desired dates.[1] The Directive also states that facilities should ensure that competency or performance deficiencies identified by the annual scheduler audit are effectively addressed.

According to the PI supervisor and staff at JAHVH, the PI staff perform ongoing scheduling audits, which includes auditing the accuracy of desired dates entered by schedulers. According to JAHVH management, supervisors are responsible for communicating scheduling errors to their employees, and determine if additional training is in order.

What We Did

In June 2015, we conducted a site visit at JAHVH and interviewed PI staff, the PI supervisor, and other scheduling supervisors to examine JAHVH's processes and procedures for scheduling audits.

What We Found

We determined that prior to May 2015, the PI staff supervisor did not notify schedulers or their supervisors of scheduling errors that the PI staff identified. PI staff stated they annotated the errors they identified on a sheet of paper they would turn in to the PI supervisor. On May 18, 2015, VHA issued a memo titled "Clarification of VHA Outpatient Scheduling Policy and Procedures and Interim Guidance" which provided facilities updated Outpatient Scheduling Standard Operating Procedures.

The PI staff identified scheduled appointments that had the same desired date and appointment create date in the scheduling system by using their "VCL Daily Audit" report, which they referred to as the 30-day report. PI staff stated that they used this report to identify scheduling errors showing that the scheduler incorrectly entered the desired date as the same date they created the appointment.

PI staff reviewed provider notes found in Computerized Patient Record System or Veterans Health Information Systems and Technology

[1] At the time of this review, the prompt in which schedulers entered the preferred or clinically indicated appointment date was called "Desired Date" in VHA's scheduling system. According to VHA's Outpatient Scheduling Standard Operating Procedures, the name of this prompt will change to "Preferred Date" in the future. For the purposes of this review, we referred to this prompt as the desired date.

Architecture (VistA) to determine if the provider indicated a specific date. They stated that if they identified provider notes or patient requests that indicated a date different from what the scheduler entered, they would revise the entered date in accordance with what the provider requested, and annotate comments to support their change. For example, a veteran was referred for a physical therapy appointment on January 13, 2015, and the scheduler entered that date as the desired date. However, the notes found in the veteran's record stated that the patient requested an appointment date of February 24, 2015. The PI staff member corrected the entered date to February 24, 2015, and annotated notes regarding the change.

Why This Occurred

The PI supervisor stated that because the PI team was tasked to correct the errors they identified, notifying the schedulers or their supervisors was not his priority. The PI supervisor stated the error documents that PI staff turned in would accumulate on his desk and he eventually shredded them instead of giving them to the scheduling supervisors. According to the PI supervisor, PI staff, scheduling supervisors, and schedulers now receive notification of their errors and are responsible for correcting them. However, the PI supervisor noted that there was no mechanism in place to ensure the schedulers actually corrected the errors. JAHVH should inform the appropriate staff of the audit results and ensure those staff properly correct the identified errors.

What Resulted

As a result of failing to notify scheduling supervisors of scheduling errors, schedulers were not aware of the mistakes they were making and the scheduling supervisors could not identify the need to provide additional training.

Recommendations

3. We recommended the Director of James A. Haley Veterans' Hospital ensure Performance Improvement services transmit all scheduling audit results to appropriate staff for awareness and corrective action.

4. We recommended the Director of James A. Haley Veterans' Hospital ensure Performance Improvement services develop a procedure to verify the schedulers properly correct identified errors.

Management Comments

The Director of JAHVH concurred with our recommendations. The Director stated that PI services developed an audit program report in May 2015, which is sent daily to all supervisors of staff with the ability to schedule appointments, and includes instructions on how to take action for each tab. The supervisors share the audit results with appropriate staff for awareness and corrective action.

OIG Response

The Director noted that the supervisors and appropriate staff now receive the audit results for awareness and corrective action. The JAHVH stated

supervisors are required to reply to their Section Chief and PI Section in writing with actions taken on each record before the end of the day. Based on corrective actions already implemented, we consider Recommendations 3 and 4 closed. Appendix B provides the full text of the JAHVH Director's comments.

Allegation 3 Did JAHVH Maintain an Accurate Veterans Choice List?

Assessment

We substantiated that JAHVH did not add all eligible veterans to the VCL when their scheduled appointment was greater than 30 days from their preferred date. We also determined that staff inappropriately removed veterans from the JAHVH VCL.

Criteria

According to VCP implementation guidance, VA staff should add to the VCL any patient who has a scheduled appointment greater than 30 days from the clinically indicated or patient preferred date. On November 21, 2014, VHA instructed staff not to remove patients from the VCL at any point in time. VHA's Outpatient Scheduling Standard Operating Procedures states that for patient appointments with written *return to clinic* requests, the clinically indicated date is the date documented by the clinicians or licensed providers in their request.

What We Did

In June 2015, we conducted a site visit at JAHVH and interviewed PI staff, the PI supervisor, and other scheduling supervisors to determine JAHVH's processes and procedures for managing the VCL. To determine if all eligible veterans were added to the VCL, and if veterans were inappropriately removed from the VCL, we obtained and reviewed JAHVH's "VCL Daily Audit" report and "VCL Disposition List" report from VistA.

The "VCL Daily Audit" report is a local report created by PI staff that identifies all appointments scheduled greater than 30 days from the preferred date. To determine if staff added eligible veterans to the VCL, as required, we reviewed 30 judgmentally selected appointments scheduled during fiscal year (FY) 2015 from the "VCL Daily Audit" report. The "VCL Disposition List" is a local report created by PI staff that identifies all of the veterans removed from the VCL. To determine the number of veterans removed from the VCL, we obtained and analyzed the "VCL Disposition List" for the period of October 1, 2014, through June 10, 2015.

What We Found

We determined that staff at JAHVH did not add all eligible veterans to the VCL, as required, and that staff inappropriately removed veterans from the JAHVH VCL. From October 2014 to May 2015, PI staff were responsible for adding eligible veterans to the VCL. Starting in May 2015, JAHVH changed this process and assigned schedulers to add eligible veterans to the VCL upon scheduling an appointment.

Eligible Veterans Not Added to VCL

We reviewed 30 appointments scheduled in FY 2015 and determined that 13 of the 30 veterans (43 percent) were not added to the VCL even though their appointment was scheduled greater than 30 days from their preferred date. PI staff further stated that since schedulers became responsible for adding veterans to the VCL in May 2015, PI staff identified eligible veterans who were not placed on the VCL by schedulers. We reviewed a June 8, 2015, list created by PI services of approximately 90 veterans eligible

for the VCL. We reviewed 10 of the 90 veterans and verified that none of the 10 veterans had been added to the VCL as of June 10, 2015. PI staff reported that they give these lists to the schedulers' supervisors for the schedulers to add waiting veterans to the VCL.

Veterans Removed From VCL

We determined that JAHVH staff removed more than 1,300 veterans from the VCL. About 300 of those veterans removed from the VCL were for services that are not eligible for the VCP, such as dental, Compensation and Pension exams, and dialysis. JAHVH's "VCL Disposition List" shows 1,354 veterans were removed from the VCL from October 1, 2014, through June 10, 2015. Of those, 1,030 veterans were removed after November 21, 2014, when VHA provided clarification to the field, which instructed staff not to remove patients from the VCL. The veterans were removed from the VCL by schedulers, the PI supervisor, and PI staff. VA guidance states that if VA staff place veterans on the VCL in error, the veterans must be notified of the error and of their ineligibility for the Choice Program. However, these veterans are not to be removed from the VCL.

Why This Occurred

From October 2014 through May 2015, while PI staff were responsible for adding eligible veterans to the VCL, the PI supervisor acknowledged that PI staff delayed adding veterans to the VCL. After May 2015, JAHVH schedulers did not place all eligible veterans on the VCL because the VCL task was a new process for the schedulers at JAHVH, which required additional training.

Besides not adding all eligible veterans to the VCL, JAHVH schedulers also unknowingly removed veterans from the VCL. Staff told us that when a scheduler created an appointment for a veteran on the VCL, VistA displayed a prompt so the schedulers could decide if they wanted to remove the veteran from the Electronic Wait List. This occurred because the facility used the same mechanism for the VCL and the Electronic Wait List. When the scheduler thought they were removing the veteran from the Electronic Wait List by answering "yes" to the prompt, they were actually removing the veteran from the VCL.

Furthermore, JAHVH staff and supervisors told us that they thought they were to remove veterans from the VCL if veterans were placed on the VCL in error. This occurred in part because VHA did not issue guidance on the removal of veterans from the VCL until November 2014. For example, if an incorrect desired date was discovered and the veteran's wait time was actually less than 30 days, then they could remove the veteran from the VCL. However, this contradicts guidance provided by VA in November 2014, which states, "If the veteran was placed on the VCL in error, the veteran must be notified of the error and that they are not eligible for the Choice Program. However, the veteran is NOT removed from the VCL." JAHVH should ensure supervisors provide additional training to schedulers regarding

the management of the VCL to make sure staff timely add all eligible veterans to the VCL and that veterans remain on the VCL.

What Resulted

Veterans opting to use VCP are not eligible to schedule a VCP appointment until they are on the VCL. NVCC staff and the PI supervisor estimated that there have been about 10-20 instances in which Health Net contacted them to determine eligibility for veterans who desired to use the VCP, even though they were not on the VCL. Upon further investigation, NVCC staff and the PI supervisor determined the veterans were indeed eligible for VCP and should have been on the VCL. It remains unknown how many eligible veterans were not added to the VCL.

Recommendation

5. We recommended the Director of James A. Haley Veterans' Hospital ensure supervisors provide additional training to schedulers regarding the management of the Veterans Choice List to ensure staff add all eligible veterans to the Veterans Choice List in a timely manner and that veterans remain on the Veterans Choice List.

Management Comments

The Director of JAHVH concurred with the recommendation. The Director stated that in accordance with the National Clarification to Scheduling Guidelines introduced in May 2015, refresher scheduling training was provided to all staff and supervisors possessing the scheduling menus. Staff were required to self-certify training, and certification memorandums are maintained by PI services. The Director further stated that scheduling menus were removed from those staff that did not attend and certify compliance, and the training is now conducted prior to scheduling menus being assigned.

OIG Response

The Director's corrective actions are acceptable. Based on corrective actions already implemented, we consider Recommendation 5 closed. Appendix B provides the full text of the JAHVH Director's comments.

Appendix A Scope and Methodology

Scope

We conducted our review from May through December 2015. We focused on JAHVH's management of veterans opting to use the VCP from October 1, 2014, through June 10, 2015. We reviewed 100 scheduled or pending VCP appointments from a population of 383 veterans who chose to use the VCP.

Methodology

We conducted a site visit at JAHVH the week of June 8, 2015, and interviewed key VAMC staff and leadership to determine JAHVH's processes and procedures for managing the VCP and VCL. We reviewed applicable laws, as well as national and local policies, procedures, and guidance related to the VCP. We obtained and analyzed VCP data to assess the allegations. Specifically, we obtained and reviewed JAHVH records of the 383 veterans who opted to use VCP from October 1, 2014, through June 10, 2015.

Data Reliability

We used computer-processed data obtained from JAHVH's Quality Management Service. To assess the reliability, we compared details of the data obtained with records in VA's Compensation and Pension Records Interchange system and the Health Net portal. To verify this universe of VCP users, we independently performed a search on June 10, 2015, of the Health Net portal and identified the same number of veterans on the Health Net portal (383) found in the Excel spreadsheet we received from the facility. We concluded that the data we obtained were sufficiently reliable for the purposes of this review.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix B Management Comments

Department of Veterans Affairs

Memorandum

Date: January 16, 2016

From: Director, VISN 8 Sunshine Healthcare Network (10N8)

Subj: OIG Draft Report, Review of Alleged Patient Scheduling Issues at James A. Haley Veterans' Hospital, Tampa, Florida
Project No. 2015-03026-R5-0176

To: Acting Assistant Inspector General for Audits and Evaluations (52)

1. I have reviewed and concur with the findings and recommendations in the draft report. The corrective action plans were implemented for recommendations 1 through 5. We request closure of the recommendations based on the evidence provided.

2. We thank you for the opportunity to review the draft report.

(original signed by:)

Thomas Wisnieski, MPA, FACHE

Attachment

Department of Veterans Affairs

Memorandum

Date: January 11, 2016

From: Director, James A. Haley Veterans' Hospital (673/00)

Subj: OIG Draft Report, Review of Alleged Patient Scheduling Issues at James A. Haley Veterans' Hospital, Tampa, Florida
Project No. 2015-03026-R5-0176

To: Director, VISN 8 Sunshine Network (10N8)

1. I have reviewed the draft report and concur with the report's recommendations. Attached is the corrective action plan for recommendations 1 through 5. We request closure of the recommendations based on the evidence provided.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Debra DellaRatta, Chief, Quality Management Service at (813)-972-2000, extension 6604.

(original signed by:)

Joe D. Battle

Attachment

Attachment

The following Director's comments are submitted in response to the recommendations in the OIG Draft Report:

OIG Recommendations

1. We recommended the Director of James A. Haley Veterans' Hospital coordinate with the responsible contracting officer to develop a mechanism to ensure the facility receives prompt notification of scheduled Veterans Choice Program appointments.

Concur

Facility Response: The Acting Chief, Health Administration Service (HAS), reached out to the previous VISN 8 Field Assistant and the current VISN 8 Region Field Assistant to inquire about availability of an automated notification when a Veteran has been appointed in the Community. The VISN 8 Field Assistant explained that any changes would require a Contract Modification, and at this time there are no plans to initiate one. HAS will continue to retrieve community appointments through the Health Net DOMA portal and cancel VA appointments accordingly.

Date of Completion: December 2015

We request closure of this recommendation based on the evidence provided.

2. We recommended the Director of James A. Haley Veterans' Hospital request that the responsible contracting officer determine if Health Net complies with the modification to the Patient-Centered Community Care contract requiring the contractor to notify VA when the Veteran is scheduled for an appointment through the Veterans Choice Program.

Concur

Facility Response: The Acting Chief, HAS, validated that Health Net complies with the contract by updating the portal with the date/time of the community appointment. Health Net is not obligated to provide an electronic alert. HAS will continue to retrieve community appointments through the portal.

Date of Completion: December 2015

We request closure of this recommendation based on the evidence provided.

3. We recommended the Director of James A. Haley Veterans' Hospital ensure Performance Improvement services transmit all scheduling audit results to appropriate staff for awareness and corrective action.

Concur

Facility Response: The HAS Performance Improvement (PI) section developed an audit program report in May 2015 which utilizes VistA. The report is run daily for the appointments made on the previous date. The report has three tabs that monitor Veteran's Choice List (VCL) entries, VCL Dispositioned entries, and those appointments that should have been added to the VCL but were not. This report is sent daily via Outlook to all supervisors of staff with the ability to schedule appointments, with instructions on how to take action for each tab. The supervisors share the audit results with appropriate staff for awareness and corrective action. The report is also conveyed to the section chiefs and HAS leadership daily.

Date of Completion: May 2015

We request closure of this recommendation based on the evidence provided.

4. We recommended the Director of James A. Haley Veterans' Hospital ensure Performance Improvement services develop a procedure to verify the schedulers properly correct identified errors.

Concur

Facility Response: HAS PI section runs the daily VCL reports to verify VCL entries were made. Those that have been dispositioned from the list are verified for "Deceased status" with Decedent Affairs staff. Veterans not identified as deceased are reported to supervisors to be reentered correctly to the VCL. The HAS PI Committee performs ongoing audits for previously dispositioned Veterans, as well as audits to identify patients scheduled for appointments, but not entered to the VCL as required. The Committee reports their findings to the PI Section Chief. The PI Section Chief then sends a list to supervisors to have the corrective actions entered.

Date of Completion: May 2015

We request closure of this recommendation based on the evidence provided.

5. We recommended the Director of James A. Haley Veterans' Hospital ensure supervisors provide additional training to schedulers regarding the management of the Veterans Choice List to ensure staff add all eligible Veterans to the Veterans Choice List in a timely manner and that Veterans remain on the Veterans Choice List.

Concur

Facility Response: In accordance with the National Clarification to Scheduling Guidelines introduced in May 2015, the PI section conducted refresher scheduling training from July through September 2015. The training included CHOICE, Electronic Wait List/VCL training and was provided to all staff and supervisors possessing the scheduling menus. Staff were required to self-certify that they had attended, understood, and would comply with the training requirements. Training certification for those that attend training is entered in staff's TMS Learning History, and certification memorandums are maintained by the PI section.

The scheduling menus were removed from those staff that did not attend and certify compliance. CHOICE, Electronic Wait List /VCL training is now part of the scheduling training conducted at JAHVH prior to scheduling menus being assigned. Veterans are now entered on the VCL by a scheduler in the respective specialties.

Date of Completion: September 2015

We request closure of this recommendation based on the evidence provided.

Appendix C OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Larry Reinkemeyer, Director Lance Kramer Daniel Morris

Appendix D Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Veterans Benefits Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Bill Nelson, Marco Rubio
U.S. House of Representatives: Gus Bilirakis, Vern Buchanan, Kathy Castor, David Jolly, Thomas Rooney, Dennis Ross

This report is available on our Web site at www.va.gov/oig.