ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

VA Medical Center in Bay Pines, Florida
February 26, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated pursuant to information received by the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline. The anonymous complainant alleged that the former VA Medical Center (VAMC) Bay Pines (now C. W. Bill Young [CWBY] VAMC) was "changing and destroying records and appointments" at the Outpatient Clinic Lakeside in order to cover mistakes before the OIG could review its records.

During the course of this investigation, investigators received three additional anonymous complaints through the VA OIG Hotline alleging the widespread cancellation of Gastroenterology (GI) Clinic consults and procedures. One complainant reported that more than 500 such consults had been canceled while the other two complaints placed the figure at 1,000 or more.

All complaints were made anonymously and no supporting documentation was provided.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG investigators and a health care inspector interviewed a sampling of employees assigned to the Outpatient Clinic Lakeside and other CWBY VAMC offices. These included current and former Health Administration Service (HAS) managers, a patient service assistant supervisor, appointment clerks, a Primary Care Management Module (PCMM) employee, medical support assistants, a manager in the Human Resources Employee Relations Section of CWBY VAMC, a program analyst, and the chief of staff at the CWBY VAMC.

- **Records Reviewed:** VA OIG investigators and the inspector reviewed documents associated with an administrative investigation concerning a former HAS chief.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The HAS Acting Chief stated during his initial interview that he supervised more than 350 clerks and that it was common practice to schedule appointments up to a year in advance. He said he tried to reduce that window to 90 days. New patients were currently being scheduled 2 to 3 months out, which he acknowledged was still beyond the 14-day target. He said he was aware that in some cases, schedulers would enter the next available appointment as the "desired date," but also felt that the scheduling policies

had become progressively more confusing in recent years. He stated he was not aware of any unofficial lists or any direction to destroy records.

Following the review of an Administrative Investigation Board (AIB) conducted by the Veterans Health Administration, which referenced the placement of 1,500 unassigned patients into a PCMM database in lieu of the Electronic Wait List (EWL), OIG employees re-interviewed the acting chief of HAS. He initially said he had never heard of 1,500 patients being on a PCMM wait list, but later said "that could be," as there were about 800 patients who currently were due to be assigned providers. He acknowledged the "snowbird" population caused numbers to grow. He said he was aware of consults having been canceled by HAS staff prior to his arrival. He said the staff would make two attempts to contact the patient and schedule an appointment by phone and one attempt by letter.

If there was no response from the patient, the clerks had been given the authority to cancel the consult. He said that process was no longer in place and now it fell to the original provider to determine the disposition of the consult, after the three attempts at contacting the veteran. He said he had never heard of batch canceling taking place. He said he had heard that "blind scheduling" of consults had taken place. He referenced a previous practice in which clerks would attempt to telephone patients if they were trying to schedule an appointment within the next 2 weeks, but would only send a letter if they were trying to schedule an appointment beyond that period. He said schedulers had since been instructed to "engage" the patient with regard to all consults.

- A patient service assistant supervisor said clerks were able to schedule patients up to 180 days out, but had been told to reduce that to 90 days. She said they were currently scheduling patients 1 to 3 months out and that her clerks did not use the EWL because all appointments beyond 180 days went on a recall list and the rest were scheduled. She said she was not aware of any "secret" lists and had never heard of anyone being directed to destroy records. She was not aware of anyone having been told to inappropriately change or cancel appointments in order to improve wait time data.

- Clerk 1, said clerks were able to schedule established patients up to 6 months out. He further said patients requiring an annual appointment were placed on the Recall Reminder List (RRL). They had used the EWL in the past, but no longer did so, since all patients were either scheduled or placed on the RRL. He acknowledged the practice of advising patients regarding what appointments were available and letting them pick which one they wanted. He said he was not aware of any unofficial lists or of any direction to destroy records.

- Clerk 2, said he dealt primarily with established patients and was not very familiar with the EWL. He said he worked in several specialty clinics and said the scheduling of consults was handled differently in each one. He estimated that 60 percent of the patients would invariably request to be seen within a week. In situations in which he could not accommodate the patient's desired date, he scheduled the appointment at the next available time. He then entered the date the patient had initially requested in the "Other Info" section of the Veterans Health Information Systems and Technology Architecture

(VistA) system. He said he was not aware of any unofficial lists or of any direction to destroy records.

- A medical support assistant (MSA 1) said she was able to schedule patients as far as 6 months out. She said patients requiring a date further out were entered in the computer as a Recall Reminder. She said she was generally able to schedule most non-urgent appointments within 30 days, but never more than 3 months. When she would ask patients how soon they wanted to be seen, "It's always today." If the patient's requested date was not available, she said she would advise him/her when the next open appointment was. If the patient accepted it, she entered that date as the desired date, "because you agreed to come then." She said she never had to use the EWL because she was always able to get patients either an urgent care slot or a routine appointment within 3 months. She said she was not aware of any unofficial lists or of any direction to destroy records.

- A second MSA (MSA 2) said her duties included handling consults and other appointments for the gastrointestinal and several other specialty clinics. She said consult requests were entered by a provider and then reviewed by a nurse who nearly always indicated the patients should be seen within 2 weeks. She was usually able to schedule patients within that time frame. She said all appointments were scheduled in VistA and she would enter in the comments section the date the patient wanted to come in as the desired date. She said they did not have a wait list or use the RRL. She said she was not aware of any unofficial lists or of any direction to destroy records.

- A PCMM employee said he only dealt with new patients and that they were generally being scheduled about a month and a half out. He said he did not use the EWL because all appointments were being scheduled outright. He did not know of any other unofficial patient lists and was not aware of anyone having destroyed any records.

- An analyst in the Executive Office said EWL data were now being presented to the VAMC Director on a daily basis. He said that as of June 23, 2014, there were 1,010 patients on the EWL. He said this was out of a total pool of approximately 103,000 unique patients serviced by the CWBY VAMC. He said he had no personal knowledge of inappropriate behavior on the part of local schedulers.

- The former HAS Chief said that in July 2013 she attended a Veterans Integrated Systems Network (VISN) 8 meeting, during which it was identified that "Bay Pines was bringing the VISN metrics down." She said a program analyst for the VISN suggested that more than 200 appointments should be rescheduled based on the provider's desired date, in an effort to make the metrics look better. She explained that typically the desired date would be based on the patient's requested date. She said she spoke up and expressed concern that the wait time statistics would be skewed. She said the program analyst acknowledged this, but said it was their [the VISN's] belief that the appointments had originally been scheduled in error. She said she was not aware of any secret lists, paper

lists, or manipulation like that cited in media reports. "No," she said. "We're not a Phoenix."*

- The chief of staff denied either having directed or having learned of the cancellation of GI consults on the scale reported to the VA OIG Hotline and by the Tampa Bay Times. She speculated that the complaints may have originated as the result of a recent review of the GI and other specialty clinics, which disclosed that certain procedures were improperly being coded as consults. She explained that procedures such as electrocardiograms (EKGs), for example, were accomplished by a technician and not a physician, and therefore, were not closed out after they were completed. Following the review, the conversion of these procedures from consults to orders and the closure of already completed consults may have led to the belief that active consults were being canceled on a large scale.

Records Reviewed

- OIG employees reviewed documents associated with an AIB concerning "allegations of unprofessional behavior and/or the creation of a hostile work environment." The AIB gathered information concerning numerous complaints, which included reports that HAS practices—such as "blind scheduling" the placement of 1,500 unassigned patients into the PCMM database in lieu of the EWL, as well as backlogged or delinquent consult management—may have had a potentially negative effect on patient care. While the AIB acknowledged these specific complaints, it appeared to regard them as symptomatic of a larger organizational problem within HAS and its recommendations focused on improved communications, possible restructuring, and other possible initiatives.

- OIG employees reviewed randomly selected canceled and discontinued GI consults from fiscal year 2001 through May 2014 and noted no evidence of inappropriate cancellation or discontinuation of consults.

4. Conclusion

We did not substantiate the allegations. All those interviewed denied that there were any paper or other unofficial lists designed to circumvent official patient lists and there was no indication that anyone had been directed to destroy or manipulate records of any kind. However, the acting HAS Chief and an MSA Scheduler stated that schedulers have entered the next available appointment dates in VistA as patients' desired dates for the medical treatment.

With regard to the cancellation of GI consults and procedures, the chief of staff reported that there had been no mass cancellation of GI consults in an effort to improve statistics; he also stated that an administrative conversion of some consults and removal of other completed consults in the wake of a recent review may have led to that belief. The MSA for GI said consult requests were entered by a provider and then reviewed by a nurse who nearly always

* Any reference to Phoenix in this report refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

indicated the patients should be seen within 2 weeks. She was usually able to schedule patients within that time frame. She said they did not have a wait list or use the RRL.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014.

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