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

VA Medical Center in Gainesville, Florida
February 26, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was instigated pursuant to information received from a reporter. The reporter inquired about a "secret waiting list" found at the Malcolm Randall Veterans Affairs Medical Center (VAMC) Gainesville, FL, by an inspection team—later determined to be the VA Access Audit Team.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG employees interviewed three clerks, three individuals in the clerks' supervisory chain, and a Malcolm Randall VAMC senior manager.

- **Records Reviewed:** VA OIG employees reviewed the performance appraisals for three clerks and a supervisor.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A senior manager at the Malcolm Randall VAMC stated that on May 13, 2014, during the VA Access Audit at the VAMC, a paper wait list of 219 patients awaiting recall for future appointments was found in the Mental Health Clinic (MHC). She said that this was due to Medical Administration Service (MAS) clerks at the MHC not having the correct training on, and access to, VA's scheduling system, the Veterans Integrated System Technology Architecture (VistA). Four clerks were later identified as having maintained a paper list. She added that on that same day, three employees were placed on administrative leave during the investigation because they were the supervisors of the clerks involved.

- A program support assistant (PSA) in the MHC, PSA 1, explained that the paper list in question was a patient return list (also called a recall list) created by the clerks to schedule appointments over 120 days out. The PSA further explained that the list was created because the clerks did not have the training nor the access to place patient appointments over 120 days out on the recall list within VistA. The list was used in the same manner that the electronic recall list would have been used, with the clerks reviewing the list daily and placing patients within any available appointment. Throughout the interview, she expressed concern regarding the clerks' lack of training and access to proper electronic databases, noting that they requested training, but never received it.

- PSA 2 explained that the reason for the paper list was that the clerks within the MHC could not schedule patients over 90 or 120 days because they did not have access to the proper section of the computer system. He further explained that he was unaware that the list was not authorized to be used until it was identified during the VA Access Audit as a concern.

- PSA 3 explained that the reason for the recall list was that the clerks within the MHC did not have the training to schedule patients for appointments 120 days out or greater. The paper list was a fix for this problem. She advised that the list was created to make sure the veterans received timely and excellent care. She further explained that the clerks would check the list daily to ensure the vets received their needed appointments.

- Supervisor 1 stated he became aware of the list at issue on May 13, 2014; however, he was informed that the list had actually been discovered by Supervisor 3 on May 9, 2014, during preparation for the VA Access Audit. He had been away and did not meet with the Access Audit team during their visit. He explained that he had recently been informed that the MHC clerks did not have VistA access—allowing them to schedule appointments beyond 120 days— and that the paper list had been created by the clerks to compensate for this lack of access. When questioned whether he or senior level management received bonuses for reduced or short patient wait times, he responded that he was aware of such bonuses; however, he was unaware of anyone, including himself, who had received such a bonus.

- Supervisor 2 stated he became aware of this list on May 13, 2014, after being notified by a health systems specialist from the James A. Haley VAMC, in Tampa, FL, who was at the Malcolm Randall VAMC to assist the VA Access Audit team; however, Supervisor 3 later informed him that the list had actually been discovered on May 9, 2014, during a preparation for the Access Audit team. He was unsure why Supervisor 3 failed to notify him of the list before Tuesday, May 13, 2014. He explained that an MHC clerk had identified the list and provided it to a member of the Access Audit team. He was unaware of how long the unauthorized list in question had been in existence and was unsure if the list was self-initiated or management-implemented. When questioned whether he or senior level management received bonuses for reduced or negative patient wait times, he responded that he was aware of such bonuses; however, he was unaware of anyone receiving such a bonus.

- Supervisor 3 stated she became aware of the suspected list on May 9, 2014, during preparation for the Access Audit team. She explained that upon discovery of the list, her staff explained that the list contained names of patients awaiting appointments scheduling for 4 to 6 months out. She further explained that the list was unauthorized, as it was proper protocol to schedule all patient appointments within VistA. She was unaware of how long the list had been in existence. She stated that she was unaware that the clerks did not have the training or correct VistA access to allow them to schedule appointments beyond 120 days, and that the list had been created by the clerks to compensate for this lack of access.

Records Reviewed

- PSA 1's performance appraisal, signed by Supervisor 3, stated that she "continues to process consults in a timely manner; schedules responsibilities, includes scheduling, cancelling, rescheduling patients appointments and/or consults; entering no show information and monitoring the electronic wait list and monitoring both inpatient and outpatient appointments [shows that] she understands her responsibilities when scheduling veterans for appointments in accordance with VISN [Veterans Integrated Service Network] 8 Outpatient Scheduling guidelines." Her fiscal year (FY) 2014 Job Specific Competency, dated March 28, 2014, stated that she "places established patients on Recall if an appointment cannot be made within 90 days of their Desired date."

- PSA 2's performance appraisal, signed by Supervisor 3, stated, "[PSA 2's] responsibilities include scheduling, cancelling, rescheduling patients appointments and/or consults; entering no show information and monitoring the electronic wait list and monitoring both inpatient and outpatient appointments [shows that] he understands his responsibilities when scheduling veterans for appointments in accordance with VISN 8 Outpatient Scheduling guidelines."

- PSA 2's Job Specific Competency, signed by Supervisor 3 and dated March 28, 2014, stated that he "places established patients on Recall if an appointment cannot be made within 90 days of their Desired date."

- PSA 3's performance appraisal, signed by Supervisor 3 on October 29, 2013, stated, "[PSA 3's] responsibilities include scheduling, cancelling, rescheduling patients appointments and/or consults; entering no show information and monitoring the electronic wait list and monitoring both inpatient and outpatient appointments [shows that] she understands her responsibilities when scheduling veterans for appointments in accordance with Veterans Integrated Service Network (VISN) 8 Outpatient Scheduling guidelines." Her FY 2014 Job Specific Competency, signed by Supervisor 3 stated that she 'places established patients on Recall if an appointment cannot be made within 90 days of their Desired date."

- Supervisor 3 was rated by Supervisor 1 and Supervisor 2 as the approving official. The narrative portion of the evaluation, marked as a self-assessment, noted she "reviews, assesses and verifies Competency Assessment [sic] quarterly and recommended continuing education, and program based in-service training. Also she shared her knowledge and skills with staff and recommends changes in response to quality improvement activities and findings and supports MHC scheduling practices to promote access to patients and delivery of quality care despite staffing challenges."

- On April 25, 2014, the director requested certifications from Supervisors 1 and 2 that the Mental Health Service Line, VAMC, were in compliance with the specific requirements outlined in Veterans Health Administration Directive 2010-027.

- On April 28, 2014, Supervisor 1 certified that the Electronic Wait List was the only list being used for Mental Health outpatient appointments.

- On April 30, 2014, Supervisor 2 certified for the director that the Electronic Wait List was the only list for Mental Health Services being used at the VAMC.

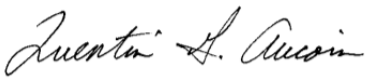
- On May 16, 2014, the MAS Chief indicated that a review of the appointment histories for the patients on the paper MHC list showed that no patient was denied treatment due to the use of the list.

4. Conclusion

The investigation revealed that on May 13, 2014, during the VA Access Audit conducted at the Malcolm Randall VAMC, a paper wait list of 219 patients awaiting recall for future appointments was found at the VAMC MHC. Further investigation showed that Supervisor 3 failed to ensure that the MHC clerks under her supervision had the correct training on, and access to, the VA's scheduling system module for recalling patients who need future appointments.

A review of appointment histories for the 219 patients showed that no patients were denied treatment because of the paper wait list. All clerks now have training and access to the Recall module in VistA and all patient appointments have been entered.

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



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