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

VA Health Care System (VAHCS) in El Paso, Texas March 8, 2016

1. Summary of Why the Investigation Was Initiated

This investigation started with information received from the Federal Bureau of Investigation (FBI), El Paso, advising that Congressman Beto O'Rourke wanted the FBI to look into the possibility of the manipulation of patient wait times at the Veterans Affairs Health Care System (VAHCS) El Paso. FBI/El Paso requested that the Department of Veterans Affairs (VA) Office of Inspector General (OIG) partner with them in the inquiry and interview a random sampling of appointment schedulers from various clinics within the facility.

2. Description of the Conduct of the Investigation

Interviews Conducted: VA OIG staff and FBI interviewed current and former randomly selected employees and included the following: supervisory scheduler, Health Administration Services (HAS); medical support assistants (MSAs) in the Specialty Clinic, Mental Health Clinic, Dental Clinic, and the Community Based Outpatient Clinic (CBOC) Eastside; Primary Care supervisor, HAS; Health Benefit advisor assistant, Eligibility; Enrollment Coordinator/Health Benefit advisor, Eligibility; retired supervisor, HAS; VAHCS Associate Director; chief, HAS; former VAHCS Director.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A former supervisory scheduler within HAS stated that he followed proper procedures as to the "desired date," and as a supervisor, trained schedulers appropriately. He was aware some schedulers incorrectly used the "next available date" as the patient's desired date, which would show a zero-day wait time. He thought that was either a learned practice because it was easier or was done out of ignorance. In the instances in which he noticed that happening, he had the scheduler remake the appointment to reflect the appropriate dates. He was never instructed to cancel and reschedule an appointment to get around wait times/restart the clock. He was not aware of any off-the-book wait lists, and had never destroyed or been instructed to destroy patient appointment information.

- An MSA stated that he always asked the veteran for his/her desired date, but only the create date and appointment date were captured in the system; the desired date was not. He had never been instructed to cancel and reschedule an appointment to get around wait times and had never destroyed patient appointment information.

- A Primary Care supervisor, HAS, stated that clerks were not to go in and out of the system when scheduling an appointment unless they were entering the veteran's desired

date, although some MSAs were still confused. She stated that regulations concerning scheduling were considered guidance and could not always be followed "to a T," as clerks wanted to avoid asking a veteran when he/she wanted to come in before they knew if that date was available. She said that most scheduling errors were mistakes, and clerks gained nothing by incorrectly going in and out of the system, as they were not rated on wait times. She had not heard of clerks canceling and rescheduling appointments to get around wait times. She was not aware of any unofficial lists being used, and she had never destroyed patient appointment information.

- A Health Benefit advisor assistant said that he was aware that the desired date was chosen by the veteran and he always asked but there was no place on the computer to enter that date. According to the employee, training was adequate but additional training would be helpful. He was unaware of what "going in and out" meant. He was not aware of any off-the-book lists and had never destroyed or been asked to destroy patient appointment information.

- An Enrollment Coordinator/Health Benefit advisor stated that schedulers asked the veteran for his/her desired date but did not enter it into the system until checking to see if it was available. If so, they entered that date and made the appointment. Otherwise the veteran was given available dates and if the veteran agreed to a date, it was the new desired date. He had heard of going in and out of the Veterans Health Information Systems Technology Architecture (VistA) database, which used to be done to skew numbers but not anymore. It meant that a scheduler would go in and look for a date that was available, go back out, and then come back in to schedule the appointment. That way, it seemed like there was no wait time. The employee stated that this was the manner in which the schedulers were taught, but he did not think it was done to make the wait times zero on purpose. After what happened in Phoenix[*], meetings were held on station. He stated there were no lists other than what was in VistA, and he had never destroyed patient information.

- An MSA for a Mental Health Clinic stated that after what happened in Phoenix, MSAs received refresher training. He did not feel training was adequate and would like more but did not feel that his supervisors were open to it. Not everyone followed procedures as to desired dates but he did. When scheduling an appointment, he pulled up the calendar and told the veteran what was available, and the date they agreed upon was entered into the computer. There was no field for the desired date, which was provided by the veteran, except in the "comments" field, which did not have enough character space. Only the appointment date and the date the appointment was made were captured. Going in and out, which the employee was initially taught to do, was standard practice up until the recent training/meeting held by an associate director following the news about the Phoenix facility. It shrank the wait times. The desired date could be something other than what the veteran wanted because of (Mental Health) clinician availability and the way the system allowed scheduling. At one time, some clinicians entered text orders in the shared drive instead of in the Computerized Patient Record System. When the

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

associate director became aware of this practice, in 2014, she instructed them to stop. In the past, some Mental Health clinicians told him to code clinic cancellations as patient cancellations but that stopped. He was frustrated by the lack of communication and establishment of universal proper procedures between the HAS and Mental Health.

- An MSA at the Dental Clinic stated she was taught that there was a wait time that must be zero. She noted that scheduling was different in the Dental Clinic because dental assistants called veterans to schedule appointments. When they decided upon a date, it was given to her to enter into the system. After the assistant director went over scheduling procedures and after the 2010 Scheduling Directive, it became harder for the dental assistants. She dealt with desired and appointment dates, but not the create date. She was taught to go in and out of the system, which did not change the desired date, but the wait time stayed zero. She could not explain how that worked. She stated that her former supervisor taught her to schedule that way without saying why. She still scheduled that way but did not know how she benefited. She was not aware of any off-the-book lists and never destroyed patient appointment information.

- An MSA from the VA Community Based Outpatient Clinic (CBOC) Eastside stated that the CBOC did not have scheduling issues because appointments were available. When scheduling appointments, she asked the veteran when he/she wanted to come in and entered that as the desired date. If he/she wanted the first available appointment, she entered the current date as the desired date. She would like more scheduling training and recently requested it. She was not aware of any off-the-books wait lists. She had never destroyed nor been directed to destroy patient appointment information.

- The retired HAS supervisor stated she provided scheduling training to clerks and addressed proper procedures as to desired date. Wait times were measured but deadlines were not always met due to lack of providers. Going in and going out was a way of searching the calendar to see what the next available appointment was. She saw people do that even though they were not supposed to. She was not aware of any off-the-book lists. She was told not to keep any paper wait lists and she told her clerks the same thing. She never heard of anyone destroying patient appointment information. She was not aware of anyone changing wait times to make them look better.

- The associate director stated that, following events in Phoenix, she met with schedulers under her chain-of-command and went over proper scheduling procedures. She discovered that the Mental Health Clinic created a form for notifying clerks to schedule an appointment instead of putting it in VistA. She ordered it to stop, and brought it to upper management's attention but did not know if they addressed the issue. There was confusion as to who set the desired date, and she addressed that. She was not aware of any schedulers intentionally failing to follow proper scheduling practices in order to change wait times. She also was not aware of any off-the-book lists other than the form used in Mental Health in lieu of text orders. She did not believe Mental Health personnel were trying to manipulate wait times but felt they did what they wanted due to a lack of accountability. She was told that a Mental Health provider instructed schedulers to cancel clinics and code them as patient cancellations. She had not destroyed or heard of anyone destroying patient appointment information. She did not know of any VAHCS

El Paso personnel receiving monetary awards due to wait times, and she had not received any herself.

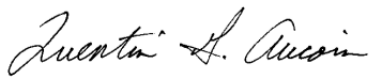
- The service chief stated that the immediate supervisors of schedulers usually handled their training, which was conducted as needed because there was no requirement for annual training. As far as he knew, appropriate (scheduling) processes were followed. Going in and out was done to see what was available in the future, not to make an appointment, and it did not change a wait time. Clerks were supposed to use the veteran's desired date and then tell him/her if it was available. Mental Health supervisors kept their own appointment spreadsheets, which were used only as a backup. He recently participated in a "fact-finding" on a Mental Health provider who allegedly canceled appointments without any reason. He did not receive any monetary awards based on wait times. He believed that he did not have better performance appraisals because of his overall performance, which included wait time measurements. He stated that he was satisfied with his rating because he was following proper procedures. He also stated that the performance measure regarding wait times were changing; however, the facility historically had bad wait times because of issues with provider availability. He had not destroyed or directed anyone else to destroy patient appointment information. He was surprised to learn that some schedulers were not aware that there was a computer field for input of a desired date.

- The former VAHCS El Paso Director, who had just been named Veterans Integrated Service Network (VISN) 20 Deputy Network Director, stated that he had limited familiarity with the VA scheduling package from past experience. Following events in Phoenix, the VAHCS El Paso Associate Director met with schedulers to ensure that they knew proper scheduling practices. He felt that clerks did not intentionally schedule incorrectly but that they misunderstood the process. Wait times at the facility were significant, and he worked to get them down by adding resources and addressing efficiency. He stated that scheduling audits and additional training were currently being conducted but noted that provider access was a challenge. Wait time was a factor on his performance plan prior to 2012, as it was built into access measures. Access was so bad in El Paso that he negotiated the number that the VISN wanted him to reach into something a little more attainable. He did not receive any bonuses/awards based on wait times and was not aware of anyone on station who did. He was not aware of any off-the-book lists. He stated that Mental Health used a form in addition to VistA, but to his knowledge, that practice stopped. He never destroyed or directed anyone else to destroy patient appointment information.

4. Conclusion

The investigation identified policy violations in that schedulers were incorrectly capturing veterans' desired dates when scheduling appointments. Most of the clerks interviewed negotiated with veterans for a date based on provider availability, rather than first asking a veteran for the date he/she desired to be seen—in violation of Veterans Health Administration Scheduling Directive 2010-027.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 28, 2015.



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