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

VA Outpatient Clinic in Harlingen, Texas
March 8, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated by an anonymous complaint to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline, which alleged that a VA Texas Valley Coastal Bend (TVCB) Health Care System management official threatened the employment of an employee at the VA Outpatient Clinic (OPC) in Harlingen for not falsifying VA patient scheduling numbers. In addition, we proactively investigated the issue of whether VA patient appointment wait times were being manipulated throughout the VA TVCB Health Care System.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG agents interviewed 11 current and former VA employees during the course of this investigation.

- **Records Reviewed:** Investigators reviewed a hard copy graph, which represented the monthly percentage of VA patients scheduled at OPC Harlingen within the 14-day standard for the period from April 2013 through March 2014.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- An anonymous complainant contacted VA OIG Hotline with an allegation that a VA Harlingen staff member's employment had been threatened for refusing to falsify patient scheduling numbers. The employee noticed the scheduling data showed that most appointments were made within the 14-day standard. But he/she received complaints from veterans (including a congressional complaint) that they had to wait months for an appointment. Based on a quick analysis of the scheduling data, the number of doctors available, and the number of patients a doctor could see in a day, the employee concluded that the numbers from the scheduling audit did not make sense and he/she questioned the validity of those numbers.

  Despite warnings from his/her peers, the employee talked to a TVCB Health Care System management official about the numbers and how they did not make sense to him/her. The employee felt it was a rushed conversation and that the TVCB Health Care System management official "blew it off." There was no resolution. However, the next day, at the end of the daily morning meeting, the TVCB Health Care System management official stated that she wanted to make it clear that neither she, nor anybody else at OPC Harlingen, directed anybody to manipulate the numbers.

The employee instructed Medical Administration Service (MAS) supervisors and staff to make sure that they were putting in the true "desired date" into the system. As a result, the numbers started changing (getting worse). The employee speculated that prior to the changes that the employee initiated, the numbers were seemingly perfect so that OPC Harlingen would look good. Nobody was supportive of what the employee had been doing (that is, reporting correct numbers). He/she believed that the lack of adequate training was one of the problems. The employee provided a hard copy graph representing the monthly percentage of VA patients scheduled at OPC Harlingen within the 14-day standard for the period from April 2013 through March 2014.

The employee did not confirm that there was a 2-hour "arm twisting" phone call with the TVCB Health Care System management official, as was alleged in the original complaint to the VA OIG Hotline. Rather, there were phone conversations during which there were disagreements, but never lengthy conversations with the official.

- A scheduling manager at the TVCB Health Care System stated that she did not have a working knowledge of what went on in scheduling prior to January 2014, after the former chief of MAS retired. She recommended we speak to another OPC Harlingen supervisor who was training the schedulers.

- Supervisor 2, OPC Harlingen, stated that he had concerns regarding reports that showed standards were attained 99.9 percent of the time. He discussed his concerns with the former chief of MAS and with the TVCB Health Care System management official in about March or April 2013. Supervisor 2 was informed this was the way they scheduled "down here" and this was the way they reported it. He stated that when he first arrived, the official told him that they were not going to use the Electronic Wait List (EWL). Supervisor 2 pointed out that patients were being scheduled after 90 days and therefore the EWL should be used. But instead of using the EWL, they scheduled patients on the 120-day grid.

  In September/October 2013, Supervisor 2 reported that scheduling was being conducted inappropriately. He had witnessed that clerks were using the "next available date" and making it the patient's desired date. He felt that the fear of reprisal from the TVCB Health Care System management official and from the former chief of MAS was real. He described an environment in which the TVCB Health Care System management official berated people in the morning report if they had numbers that were not within standard. He stated people "got smart" and quit reporting numbers outside the standard.

- A scheduling staff member at OPC McAllen stated that he was not aware of any secret list and was not privy to report results related to scheduling. He stated that, at his facility, it was impossible to schedule within 14 days due to the limited number of physicians. However, there was a big push to meet the 14-day standard. He did not know if it was considered manipulation, but he was told, when scheduling, to go into Veterans Health Information Systems and Technology Architecture (VistA), look for the next available date, back out of the system, then go back in, and input the next available date. This could be looked at as manipulating the numbers, but it was what he was told to do. If he scheduled a patient who showed a 16-day wait time, his name would have come up

during the morning report and he would have been instructed by his supervisor to change it. He would have had to make it look like a zero. Using the "backing out" method kept him out of trouble. He stated that the backing out method of scheduling was still being used. It was his belief that his supervisor received instruction from supervisory levels above (the scheduling manager and the chief of MAS) to use the backing out method.

- A scheduling supervisor at OPC McAllen (Supervisor 3) was interviewed regarding the allegations at hand. There, the scheduling staff were instructed to use the first available date as the desired date and to persuade the patient that it was the date he/she wanted. They were told to do that by a former supervisor (Former Supervisor 1). The former service chief directed Former Supervisor 1 to instruct his staff accordingly. According to Supervisor 3, it was done that way since he first started working at OPC McAllen. He did not know any better at the time.

  During the summer of 2013, Supervisor 2 explained that they were scheduling incorrectly. The practice discontinued accordingly around January 2014, and was no longer in place at the time of this interview. Sometime later in January 2014, the TVCB Health Care System management official came to OPC McAllen and instructed staff members to schedule the correct way, which they already were. The TVCB Health Care System management official tried to come across as if she did not know that scheduling staff members were using incorrect desired dates before.

  Supervisor 3 did not believe her and explained that if you were outside the standard, you had to explain the reason in meetings, which was a humiliating experience. Supervisor 3 was told that for established patients in Primary Care, they did not put patients who were scheduled over 90 days on the EWL. Instead, they used 120 days and used a recall reminder. According to Supervisor 3, his supervisor never provided instructions to use the first available date as the desired date.

- An administrative supervisor at OPC McAllen (Supervisor 4) stated that when she first arrived there, she noticed that schedules outside of 14 days were not being reported. Supervisor 3 told her that it was the way that the TVCB Health Care System management official wanted it. She was told that if appointments were not within standard, it would get them in trouble. She spoke to administrative officers about the same issue and they all concurred with Supervisor 3's assertion. She stated that the TVCB Health Care System management official came onsite and met with MAS leadership in January after numbers "started showing the truth" and added that she did not tell anybody to not document appointments scheduled outside the 14-day standard. She did not believe the TVCB Health Care System management official and found her to be intimidating.

  Supervisor 4 said that she never instructed her staff to manipulate VA patient wait time numbers and stated that nobody instructed her to manipulate VA patient wait time numbers. She had attended morning report meetings when somebody had to explain the reason they had numbers outside the 14-day standard and it was "not pretty." However, her reports did not put her in a position of being reprimanded during the morning report. She stated that she did not know why her reports were not a problem in morning meetings because she knew patients were being scheduled outside the 14-day standard. She added

that after January 2014, when OPC McAllen received a visit from the TVCB Health Care System management official, they started to report numbers correctly.

- A former scheduling supervisor (Former Scheduling Supervisor 1) at OPC Harlingen stated that, while he was the scheduling supervisor, he felt pressure at every morning meeting with the directors to meet the 14-day standard. It was not stated directly, but it was made clear that nobody should be over the 14-day standard. As a result, it was rare that somebody was scheduled outside the standard. But if it did occur, they (supervision above him) would consider it to be "wrong." And it was understood that it had to be corrected. He knew how to fix it because he had been scheduling for a long time. So he or his staff had to reschedule the patient so it would appear to be within standard. Former Scheduling Supervisor 1 learned how to do this via training he received years ago from representatives from San Antonio. They taught him the backing out method. Former Scheduling Supervisor 1 knew the training was not in line with policy, but did not question it because that was the way they were being trained. The pressure to stay within standard came from the TVCB Health Care System management official. Though the TVCB Health Care System management official was never inappropriate with him directly, he observed her treating others in an inappropriate way. Former Scheduling Supervisor 1was not aware of any patients dying while waiting on appointments.

- A former scheduling supervisor (Former Scheduling Supervisor 2) at OPC Harlingen stated that EWL was a "curse word." As an example, a physician had a physician assistant who was no longer going to assist him, who created a list of 283 patients who needed to be seen. It was his belief that they needed to be put on the EWL, which they were. But at a morning meeting with VA management, which included the TVCB Health Care System management official, the former chief of MAS, and the former director, he was told to get them off the EWL. Although records showed that patients were being scheduled within the 14-day standard, the reality was that this was not what was actually happening. Staff would inform the veteran of what the first available date was and ask if that date was agreeable. If the veteran said yes, that first available date was entered as the veteran's desired date. Former Scheduling Supervisor 2 described the same TVCB Health Care System management official as rude, did not listen, and had a "her way or the highway" mentality.

  In a follow-up interview, Former Scheduling Supervisor 2 explained how he set up an effective program years ago that used a spreadsheet that tracked veterans who received VA outsourced treatment. But the TVCB Health Care System management official and the former chief of MAS put a stop to that process because they said it was illegal.

- The director for the VA TVCB Health Care System did not have a problem if somebody reported scheduling outside the 14-day standard. Supervisor 2 told the director that he was getting resistance from the TVCB Health Care System management official and from the former chief of MAS. Other than that, nobody approached him to complain about mistreatment from the official. In general, the director was not aware of the TVCB Health Care System management official intimidating staff. The TVCB Health Care System management official and the former chief of MAS had informed him that Supervisor 2 was not getting the job done (training). The director did not believe that the

scheduling numbers were a part of the performance metric for 2013. He did not get a bonus for fiscal year 2012. He did not participate in manipulating scheduling numbers so he could get a bonus or an increased bonus. He and the TVCB Health Care System management official had the same performance plan.

- The TVCB Health Care System management official agreed that the scheduling numbers prior to January 2014 were more favorable. Around December 2013, an OPC Harlingen employee had approached her and explained that his staff was not scheduling correctly in order to make the numbers look good and said that his staff told him, "That's what [TVCB Health Care System management official] wants. [TVCB Health Care System management official] wants it to be zero." She told the employee that she did not want him to do that. She wanted staff to perform well but not by "gaming" the system. The day after that conversation, during the daily morning report, she told everybody that she wanted good performance numbers but not by gaming the system. After that, OPC Harlingen started showing less favorable numbers. She explained that the scheduling audits that started about a year before were the reason they were able to figure out that they were scheduling incorrectly. It was not her intent for people to manipulate the numbers to stay within standard, nor was it her intent to "brow beat" her employees. The intent of the scheduling audits was to see if staff were scheduling correctly. If she gave the impression to staff that she wanted them to game the system, she was wrong to do so. She never told anybody not to use the EWL. She also did not tell anybody to remove patients from the EWL if they were supposed to be on it.

  She said that she never experienced undue pressure to meet performance standards and the leaders above her never pressured staff to meet performance standards. If staff felt pressured for whatever reason, it was her fault, not the director's.

- The former chief of MAS, VA TVCB Health Care System, stated that she was not familiar with the backing out method used to assign a VA patient the next available date as the desired date. She did not remember people being afraid during the morning meetings. Everybody wanted to do well. She did not think people were fearful of her. They may have been fearful of the TVCB Health Care System management official and leadership in general. But nobody ever approached her with that issue. She also stated that no one approached her to discuss that it was impossible for the scheduling numbers to be so good. She did not recall Supervisor 2 approaching her and discussing the topic of the scheduling numbers being too good. She noted that Supervisor 2 and the TVCB Health Care System management official did not have a positive relationship and she distanced herself from that. She never instructed scheduling staff to convince patients to choose the next available date as the desired date or to remove patients from the EWL. The TVCB Health Care System management official never directed her to instruct staff to manipulate scheduling numbers. She stated that the TVCB Health Care System management official was never about covering things up. She also said that neither the former director nor the current director ever put undue pressure on staff to make scheduling numbers look good.

Records Reviewed

A review of the graph provided by OPC Harlingen employees clearly showed that the OPC was within standard 95 percent of the time or better. In January/February 2014, that percentage began to decrease, which was consistent with what was stated during the interviews.

4. Conclusion

The investigation did not corroborate the allegation that the TVCB Health Care System management official threatened the employment of an OPC Harlingen employee for refusing to falsify VA patient scheduling numbers. In addition, there was no evidence that the TVCB Health Care System management official directly instructed staff to manipulate the information in VistA to keep scheduling numbers within standards. There was evidence that the employees felt pressure from the TVCB Health Care System management official, which led to the manipulating of VistA in order to keep scheduling numbers within standard. We also found evidence indicating that there had been inappropriate training years ago, which carried through into present-day work activities with regard to scheduling.

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

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