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

## VA Community Based Outpatient Clinic in Horsham, Pennsylvania March 8, 2016

### 1. Summary of Why the Investigation Was Initiated

The investigation was initiated pursuant to information provided to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) on May 16, 2014, by the associate director (AD) of the VA Medical Center (VAMC) in Philadelphia, PA. The AD had been informed during a Veterans Health Administration (VHA) Stand Down Audit Team exit briefing, that medical support assistants (MSA) at the VA Community Based Outpatient Clinic (CBOC) in Horsham, PA, allegedly reported being instructed through "upper level Health Administration Management" to identify the next available date as the "desired date." They were reportedly given lists of veterans with scheduled appointments and were being instructed to change the desired date to the next available date. They reported being issued a letter and being asked to sign it, to indicate that they did not change or manipulate the desired dates, which they refused to sign.

### 2. Description of the Conduct of the Investigation

- **Interviews Conducted:** Twelve current and former VAMC employees were interviewed, including the former director of the VAMC Philadelphia; three MSAs; a nurse; a nurse manager; three service chiefs; an administrative officer; a CBOC supervisor; and an assistant service chief.

- **Records Reviewed:** VA OIG reviewed Microsoft Excel spreadsheet depicting wait times at CBOC Horsham and the Veterans Health Administration Stand Down Access Audit results.

### 3. Summary of the Evidence Obtained From the Investigation

#### Interviews Conducted

- We interviewed four employees in a single day at the CBOC: two MSAs, a nurse, and a nurse manager. The MSAs and the nurse stated that when a patient is making a future appointment, the next available date is entered into Veterans Information Systems and Technology Architecture (VistA) as the patient's desired date. This may be due to the scheduling staff "negotiating" with the patient as to what date he/she is available to come in for his/her next appointment. The nurse manager stated that if a patient says he/she wants a specific date, the person scheduling the appointment goes into VistA and finds the date. The patient's desired date is identified as the original date the patient wanted to be seen. If a patient is willing to negotiate on the date of the exam, then the appointment date and the desired date are entered as the same date. If the patient is not ready to negotiate on the desired date, then the first desired date the patient wanted is what would

be entered in VistA. The desired date should be the date the patient requests but the policy does state that VA can negotiate the date with the patient. The two MSAs advised that emails were sent to the CBOC MSAs asking them to "correct scheduling errors" when the patient's desired date drastically differed from the patient's appointment date. The individuals who had asked that corrections be made to the scheduling errors included a nurse manager and three supervisors. The MSAs stated that, when an appointment is requested for a provider on scheduled leave, they were instructed to make the desired date a date after the provider returns from leave; however, the patient can request to see a different provider at an earlier date. To initiate an orthopedic consult, one is required to order an MRI—whether it is needed or not. That initial and refresher training on scheduling practices was deficient, which creates room for scheduling errors to occur.

All four interviewees (the two MSAs, the nurse, and the nurse manager) stated that training for the scheduling of patients is lacking because the only training available is through the Talent Management System, which is conducted on an annual basis. None of these interviewees could provide information in regard to management personnel receiving bonuses based upon low wait times.

- The nurse manager explained that corrections requested of the staff were made so as to correct errors believed to have been made relating to the method sometimes used by MSAs to access a physician's calendar, thus ensuring that the proper desired date is reflected as the date negotiated with the patient.

- A CBOC supervisor advised that the changing of desired dates comes into play when correcting errors are identified in an "error report." In these instances, MSAs were given lists of veteran appointments they made, asked to research the appointments in which there were possibly errors, to make the appropriate corrections. She did not have any information relative to a faxed letter that was allegedly sent to CBOC employees. She also had no knowledge of anyone getting bonuses based upon low wait times.

- An administrative officer provided information similar to that provided by the CBOC supervisor relative to desired dates and the correcting of errors identified in error reports. She stated that she didn't specifically tell the MSAs to correct the errors by making the appointment date and the desired date the same. Later in the interview, she clarified this point, explaining that she may have discussed this with the CBOC supervisor if the latter had asked her about it. However, she could not be sure. She stressed the overall objective was to correct errors, not to skew the data, and she had no information regarding wait times and its effect on senior staff bonuses, as this was never discussed in her presence.

- Service Chief 1 stated that she doesn't schedule patients and had no knowledge relative to the scheduling of patients until after the Phoenix[*] matter came about. She also didn't receive any emails or have any conversations with the CBOC Supervisor in regard to wait lists or the scheduling of patients before the Phoenix matter was raised. She believes a

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

patient's desired date is the date the patient wants the appointment to be. She reported that in response to the Phoenix matter, a training session took place with CBOC employees during which the employees were told that the correction of scheduling errors is fine, but not the manipulation of data. She had no information as to wait times or orthopedic consults and MRIs.

- An assistant service Chief and Service Chief 2 provided similar information relating to the scheduling and correcting of scheduling errors. The only discrepancy between the interviews, however, was that Service Chief 2 said that he was the person who sent the scheduling error report to the CBOC supervisor to correct errors. It was his belief that the MSAs were not actually contacting veterans as part of the process to correct scheduling errors, though they should have been. Rather, they were only changing the desired date to match or be close to the appointment date. He further advised that he made no effort to validate whether or not this was occurring. Both stated that at no time did they advise anyone to change data to conform to any standards. Neither was aware of any specific bonus being paid for meeting the appointment/access standards. Service Chief 2 commented that VistA is antiquated, difficult to use, and needs updating.

- Service Chief 3 advised that there are Veterans Integrated Service Network (VISN) performance measures to be met regarding wait times, but in regard to the scheduling of patients within 14 days, that is one measure that is not usually met. No pressure was ever placed on him to meet these measures. In fact, his bonus is based upon his clinical work, not on any performance measure dealing with wait times. He reviews various reports depicting, among other things, wait times for appointments. An item of concern was when inaccurate data were possibly being entered into VistA relative to wait times. These inaccurate data make it appear that a patient is waiting for an appointment longer than the patient's desired date. These inaccuracies are termed errors and these reports are forwarded to the CBOC supervisor to address. In addressing these errors, at no time did he direct anyone to falsify data nor was he ever asked to do so by his supervisors.

- MSA3 was interviewed and stated that she was directed by her supervisor to change desired dates to equal appointment dates, not just to look for errors to correct, as necessary. The investigators noted that this statement was inconsistent with that of the supervisor and the other interviewees who advised that they were only instructed to check for errors and correct, as necessary. OIG found no information to explain MSA3's differing understanding of correcting errors relating to the desired date.

- The former director of VAMC Philadelphia stated that he did not advise any VA employee to manipulate patient wait times or desired dates. In regard to wait times being discussed as part of performance measures, he stated that all performance measures were discussed routinely within VISN 4. He did not recall ever mentioning to another employee that wait times were part of his rating; however, he commented that they were a part of his performance measures, along with 50-60 other items. He also did not recall discussing performance measures at a town hall meeting. As for bonuses being based upon meeting performance measures, he stated that performance awards were tied to meeting numerous performance measures. He has no recall of receiving reports entitled "Error Report," and he never instructed any employee to close a patient consult and then

reopen the consult closer to the appointment date. He further stated that neither his supervisors nor VA Central Office managers instructed him or provided guidance regarding bonuses or wait times.

- At the request of the investigators, a CBOC supervisor forwarded an email to CBOC Horsham staff inviting them to contact the investigators if they had any information to share regarding wait time lists, manipulation of desired dates within VistA, or any other patient scheduling matters. No one responded.

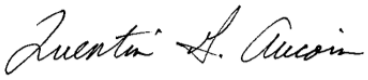
**Records Reviewed**

OIG reviewed wait time data for the CBOC. The data, broken down by month, showed that from November 2011 to the present, the CBOC, for primary care, had either no patients waiting for appointments or at most six patients waiting. Of the patients who were waiting, very few were waiting more than 14 days.

## 4. Conclusion

The investigation revealed that VHA policies relating to the creation of desired date were not followed. There also appeared to be misunderstandings relating to the correction of the desired date contained on an "error report" and management failed to adequately follow up with support staff to ensure that any corrections made were properly done. No one could produce the letter requesting that MSAs certify they did not change or manipulate desired dates.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on October 31, 2014.



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