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

Central Texas Veterans Affairs Health Care System and South Texas Veterans Affairs Health Care System

March 8, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based on information provided by a medical support assistant (MSA). The complainant alleged to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) that Veterans Health Administration (VHA) facilities in San Antonio and Austin, TX, did not follow proper appointment scheduling protocols. In particular, the complainant alleged that scheduling staff were improperly directed to make patients' "desired dates" for appointments to be the same date as the first available date, and to avoid utilizing the electronic waiting list (EWL). Throughout the investigation, additional allegations required VA OIG special agents to expand the scope and methodology of the initial investigation. At the conclusion of the investigation, schedulers and supervisors from the VA Hospital San Antonio and a specialty clinic, VA Federal Clinic (VAFC) North Central, Frank Tejeda VA Outpatient Clinic (OPC), OPC Austin, Consolidated Outpatient Appointment Center (COPAC) Kerrville, and the VA Medical Center (VAMC) Temple were interviewed.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the complainant, multiple individuals, including schedulers and supervisors, from VAMC San Antonio and a specialty clinic, North Central VAFC, OPC Austin, VAMC Temple, and COPAC Kerrville were interviewed.

- **Records Reviewed:**

  1) Performance plans and ratings for multiple supervisors and employees at VAMC San Antonio, VA OPC Austin, VAFC North Central, VAMC Temple, and COPAC Kerrville.

  2) Scheduling training records for multiple employees involved in scheduling at the Audie L. Murphy VA Hospital, VAFC North Central, San Antonio VA Dental Clinic, OPC Austin, and COPAC Kerrville.

  3) Employee emails for San Antonio, Austin, and Temple VA medical facilities.

  4) Appointment data including schedulers' names, patients' names, clinic names, "create dates," desired dates, and appointment dates regarding the VAMC San Antonio, VAFC North Central, Frank Tejeda OPC, Austin OPC, and COPAC Kerrville.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- Complainant told the OIG that he was trained to "zero out" a patient by making the first available date the patient's "desired date." Complainant would enter the Veterans Health Information Systems and Technology Architecture (VistA), and instead of scheduling the veteran for their appointment, would search for the first available date. After locating the first available date, the complainant would inform the veteran about the date. The veteran would agree with the first available date, and the complainant would then log that date as the desired date. The complainant was never instructed to continue this practice in another VA facility. The complainant assumed that management wanted him to continue the practice at their facility, as well.

- One of the individuals interviewed admitted that for a 3 to 6 month period in 2011–2012, she would document a patient's desired date in close enough proximity to the appointment date to not go past the 14-day requirement, regardless of what the true desired date was. The individual indicated that an administrative support assistant would provide her with a list of VA patients and the time between their desired dates and the appointment dates. If the time was over 14 days, this person instructed her to "fix it." The individual never asked this administrative support assistant what he meant by fix it. She would go into the appointment system and then reset the patient's appointment for the same appointment date, but with a desired date that was within the 14-day time frame. The administrative support assistant told her on one occasion not to have the desired date and appointment date on the same day because it would look like they were "gaming the system." She never thought she was doing anything wrong. The practice of manipulating the desired date ended just prior to moving into a new facility.

- An administrative support assistant denied ever providing a list or spreadsheet to any VA employee and instructing them to change the desired date to comply with the 14-day timetable. He indicated there were other ways to schedule patients by overbooking and placing them in open administrative slots. He was aware of a practice, when he was a clerk, of making the desired date fall within the 14- or 30-day timetable, regardless of what the patient's true desired date was. He could not provide a list or spreadsheet of patients to clerks because he did not have access to that type of report in the system. He stated he was never taught anything from VHA Directive 2010-027.

- An administrative employee, OPC Austin, denied ever instructing anyone to change a VA patient's desired date. He called the 14-day goal unrealistic. He was not aware that anyone at his facility was changing the desired date to be within a specific time frame. He never heard anyone in upper-level administration instructing anyone to change the desired date.

- A management analyst, VAMC San Antonio, stated that a potential scheduling error is defined as a desired date which is equal to the create date. The potential error is forwarded to the scheduler to see if the patient actually wished to be seen on that particular day. She denied that the potential scheduling error spreadsheet was a

mechanism for schedulers to manipulate a patient's desired date. She denied instructing the complainant to manipulate patients' desired dates or wait times.

- A management analyst, VAMC San Antonio, stated that the Southern Texas VA Health Care System (STVHCS) does use the EWL if it is necessary. Medical Administration Service (MAS) schedulers are trained to not use the "next available date" function in VistA. Schedulers must receive a specific date or range of dates from providers. The desired date is established by the patient, while monitoring the date or dates the provider has indicated they wish to see the patient. Prior to 2009, VAMC San Antonio did have problems with schedulers making patients' desired dates the first available date. She has never instructed any employees to manipulate a patient's desired date. Lying about the wait times would not help a clinic because the data would not accurately reflect if there was an access issue.

- A supervisor and a lead MSA at VAFC North Central stated that schedulers should not change a patient's desired date. The EWL is not used at VAFC North Central because there is no need to use it. They denied instructing the complainant to manipulate patient appointment information. The lead MSA stated schedulers did not get in trouble for scheduling patients outside the 14 days.

- A trainer at VAMC Temple stated that he taught new MAS employees the way to schedule appointments, per VHA directive 2010-027. He was aware that VAMC Temple was not using the EWL list because he claimed the chief of MAS, directed that the EWL would not be used. He taught the staff that the veteran's desired date is input and not changed and then the appointment is scheduled based upon what is available. He did not teach that the desired date should be coded as the first available date. He had a course evaluation form showing that the complainant had previously completed scheduling training that he provided.

- Another individual interviewed during the investigation told us that she did not conduct training for the schedulers. She requested assistance in training schedulers from VAMC Temple, but her request was denied. Until recently, little to no scheduling training and/or manual resources was available for schedulers to follow. On the whole, it was her assessment that OPC Austin did not have enough providers for the number of patients that needed to be seen. OPC Austin schedulers used the provider date in the Return to Clinic Order as the patient's desired date. The individual stated that the administrative support assistant had a list of appointments that had a wait time that was over 14 days that he would instruct schedulers to fix.

- A former employee filed an administrative grievance regarding what he perceived to be a lack of training and guidance on how to properly and accurately schedule patients. He stated that OPC Austin schedulers did make the patient's desired date the first available date. He did not know that it was wrong to schedule that way. He felt that he was never properly trained to schedule. He also stated that there were not enough providers at OPC Austin.

- An MAS employee stated that she was previously employed in MAS at OPC Austin. She stated she was instructed to make patient wait times equal zero at OPC Austin by two

supervisors. She was taught how to manipulate the desired date by one of the supervisors and another employee. After moving to another facility, she was again trained to make the patient wait times equal zero. She alleged that the practice was still occurring in that facility. She stated that she was instructed to continue this practice by her supervisor.

- A supervisor at COPAC Kerrville stated that, from 2007 to March 2014, she and other schedulers were taught to make the patient's desired date the first available date by "going out (of the VistA scheduling system) and going back in." She stated a former VA supervisor threatened to fire her if she did not make the wait times equal zero. The practice was stopped in March 2014. Prior to March 2014, she would receive emails from an MAS employee at VAMC San Antonio about scheduling errors, instructing her to correct them. The MAS employee at VAMC San Antonio mentioned above explained that a scheduling error is when the create date equals the desired date. MAS sends out scheduling error spreadsheets to supervisors so clerks can review the appointment to make sure a potential scheduling error has not occurred.

- The chief of Health Information Management Services (also known as MAS) at VAMC San Antonio stated that a spreadsheet was created to monitor scheduling errors. One type of scheduling error is when the create date and the patient's desired date are the same day. This is a scheduling error for two reasons: 1) it appears in the system to be an emergent care scenario, and 2) the scheduling system will default to today's date if the scheduler does not input anything for the patient's desired date. The spreadsheets are forwarded to the appropriate supervisors, and then to the schedulers, to verify that the appointments are correct. The emails that were previously sent out may have confused the schedulers because supervisors were not explaining what the schedulers needed to do. He has never denied the use of the EWL. VAMC San Antonio uses the EWL, but only sparingly. He stated that it is difficult to provide oversight to groups of schedulers who are not within his chain of command (referring to non-MAS schedulers). He stated that STVHCS has 491 individuals who have scheduling keys. Of the 491 individuals, 223 are MAS employees and 269 are considered non-MAS schedulers who report to other service lines.

- An MAS manager at VAMC Temple stated she was the head of MAS over the OPC Austin at one time. She stated that supervisors and staff would discuss meeting the 14-day performance measure, but nobody encouraged anyone to manipulate the desired date. She stated that Central Texas VA Health Care System (CTVHCS) did not use the EWL because it did not have a need to use the EWL.

- A supervisor at the Frank Tejeda OPC stated that he had used the EWL while working in a specialty clinic at VAMC San Antonio. He was never told by management that he could not use the EWL. He stated that a scheduling error was when the patient's desired date was equal to the create date. He stated that schedulers may have misunderstood what was being asked of them when they were forwarded scheduling errors. He was never instructed to have his employees misrepresent patients' desired dates to reduce wait times.

- An MAS employee in a specialty clinic at VAMC San Antonio stated he was trained by someone no longer employed at VA to make the desired date the first available date. He

indicated he was not aware it was wrong to schedule patients that way until he took the Talent Management System (TMS) online training in May 2014.

- MSA 1 in a specialty clinic at VAFC North Central stated he has never made a patient's desired date the first available date nor has he ever falsified a patient's desired date to reduce wait times. He stated that he understood that a scheduling error was defined as the patient's desired date and the appointment's create date being the same. He understood that he might have made scheduling errors because he was scheduling too quickly and hit the wrong keys. He has never been trained on the EWL and has never had to use one. He believed that schedulers who were incorrectly reporting patient's desired dates were not properly trained.

- A clerk at OPC Austin stated she had previously made the patient's desired date the first available date. She stated she first learned she was scheduling wrong a few months prior to the interview and no longer schedules in that manner. She stated if she had known it was wrong to schedule patients that way, she would never have done it.

- MSA 2 at OPC Austin stated she made the patient's desired date the first available date in order to zero-out patient wait times. She stated that process of scheduling was used at OPC Austin from 2008 to 2013. She was never aware scheduling that way was wrong. If she had known it was wrong, she would not have scheduled that way.

- MSA 3, MAS, VAMC San Antonio, stated she was not capturing a patient's desired date until approximately 6 months prior to the interview. She never asked a patient for their desired date and was not aware of what a desired date was until approximately 6 months prior to the interview.

- MSA 4, MAS, VAMC San Antonio, stated that when he first started as a scheduler, he was recording the desired date from patients correctly. He stated there was a "list" that came out showing that his patient wait times were extended. He stated he was approached by his supervisors regarding his extended wait times. He was not aware if the list he was on was called a scheduling error list. He denied that he was on the list because his create date and desired dates were the same day. He stated he was on the list because of the extended wait times. He began to use the first available date as the patient's desired date because he did not want to be removed from his job.

- MSA 5, MAS, VAMC San Antonio, stated when he first began scheduling, he did not know what a desired date was. He would schedule patients according to when the provider wished to see the patient. He stated he was not adequately trained as a scheduler when he first began scheduling. In 2011, he was scheduling appointments so that the patient's desired date was the first available date. He received a list of appointments that he was instructed to reschedule from his lead clerks. He stated he was instructed to reschedule the appointments on the list, which he had previously scheduled. He did not understand what the problems with the appointments were but claimed the "days don't match." He was unable to explain what he meant by the days don't match, but believed it had something to do with wait times.

- MSA 6, MAS, COPAC Kerrville, stated that when she first began scheduling, she was taught to make the patient's desired date the first available date. She was instructed to zero out her wait times by the lead clerk and her supervisor. She stated her current supervisor has never instructed her to zero out wait times. She stated she understood a scheduling error to be when the wait time did not equal zero. If she were told to correct a scheduling error, she would make the desired date the first available date to correct the error.

- MSA 7, MAS, COPAC Kerrville, stated that she previously did make patients' desired dates the first available dates. She was instructed to do this by her supervisors.

- MSA 8, MAS, COPAC Kerrville, stated she was originally trained to schedule patients by making patients' desired dates the first available date. She was instructed to schedule this way by her supervisor. She was told that the wait time must equal zero. She stated that she received a scheduling error list for the appointments that did not have zero wait times.

- MSA 9, MAS, COPAC Kerrville, stated that he was first trained to schedule patients by making patients' desired dates the first available date. He was instructed that if the wait time for the patient exceeded 10 days, it would be a scheduling error that he would have to fix. Scheduling errors are recorded and counted up at the end of the year to go against a scheduler's performance evaluation.

- An administrative officer at VAMC San Antonio stated that there was a time when the patient's desired date was not the date they wished to be seen, but was the first available date. In 2005, she was originally trained in TMS to make the patient's desired date the first available date. She explained that a scheduling error was when the create date and desired date were the same day. She denied that the scheduling error was based on wait times. She stated that scheduling errors were corrected so that the desired date was equal to the appointment date. She stated she did not believe a scheduler would lose their job if they had multiple scheduling errors; rather that scheduler would be retrained.

- A supervisor at VAMC San Antonio stated she was taught how to schedule by a lead clerk and a supervisor in MAS. When she first learned to schedule, she was taught to make "Wait Time Two" (the amount of time from the patient's desired date to the appointment date) equal zero by scheduling a patient's desired date on the first available date. She explained that if the wait time was too long then her name would be reported on a list and she would be contacted by either the lead clerk or the supervisor to fix the error. In order to make sure her name was not on the list, she stated she would make the wait time equal zero. She explained that desired dates were not an issue when she began scheduling years ago; however, she later learned that she had been incorrectly taught how to schedule.

- A lead clerk at VAMC San Antonio stated she has been a scheduler since April 2000. She recalled a VA training video on scheduling which taught schedulers how to locate and schedule patients on the first available date by going in and out (of the VistA scheduling system). She would enter into the system and input "T" to look up appointments beginning "today." From there, she would locate the first available date

and communicate that to the patient. If the patient were able to come in on that day, she would exit the VistA scheduling system and then log back in. She would then input the first available date, which the patient agreed to, as the patient's desired date. She would then book the appointment on that day. If a scheduler did not make Wait Time Two equal zero, that appointment would appear on a list and supervisors would instruct schedulers to fix the appointment. She was not aware if anyone had been disciplined for not "fixing" the appointments that appeared on the list. She stated that when she became a lead clerk, she taught other clerks how to make the patient's desired date the first available date. She did not know she was doing anything wrong by scheduling that way. The EWL, while frowned upon, is used when necessary.

- A former scheduler at a specialty clinic at VAMC San Antonio stated he was shown how to make Wait Time Two equal zero by "going in and going out" by another former VA employee. He could not recall the former employee's name. He stated that if Wait Time Two did not equal zero, your name would be on a "hit list." If your name showed up on the list, you had to fix the appointment by making Wait Time Two equal zero. He never knew that he was scheduling inappropriately. He thought he was scheduling the right way and taught others to schedule the way he scheduled.

- A program analyst, MAS, VAMC San Antonio, stated he has served as a scheduler, lead clerk, and supervisor. He stated that back in 2009, to schedule a patient, he would locate the first available date for the patient and see if they desired to be seen on that day. If so, he would then go back out of the system and log back in, making the patient's desired date the first available date, and schedule the patient on that day. He stated he would not ask patients when they wished to be seen because that was not how he was trained to schedule. He was trained to tell the patient what the first available date was, and to work to find the patient an appointment day that worked with their schedule. He recalled receiving scheduling error spreadsheets, but denied that they had anything to do with the wait time. He explained that scheduling errors were appointments in which the create date was equal to the desired date. If a scheduler used "T" to search the availability, and did not go back out of VistA once they located the first available date and scheduled the appointment; those appointments would be scheduling errors because searching using "T" would make the desired date equal "today," which would also be the create date of the appointment.

- A lead clerk, MAS, VAMC Kerrville, stated she was taught to schedule so that Wait Time Two would equal zero. If Wait Time Two did not equal zero, the scheduler's name would be on a "scheduling error" list. The scheduler would then have to fix the error by making Wait Time Two equal zero. Schedulers had to fix the errors because having more than three scheduling errors in 1 year could affect their performance evaluation. A scheduling error was any appointment that was beyond the 14-day waiting period. Making Wait Time Two equal zero was always the process, and was just the way schedulers were taught to schedule. She believed she was scheduling correctly.

- A supervisor, MAS, VAMC Kerrville, stated she recalled that in the "Go for the Blue" campaign, there was a push that Wait Time Two had to equal zero. She explained that Wait Time Two was zeroed out by making a patient's desired date equal the first

available date. She stated that scheduling errors are appointment errors when the create date is equal to the desired date. She did not ever recall receiving any list that tracked wait times.

- A former MAS supervisor at VAMC San Antonio denied ever instructing an employee to manipulate patient appointment data.

- An administrative employee at OPC Austin stated that, originally, MAS staff in VAMC Temple supervised the scheduling staff at OPC Austin. In or about 2010, OPC Austin became independent of MAS in VAMC Temple. He believed that not having MAS in VAMC Temple over OPC Austin schedulers was problematic. He believed, in retrospect, that OPC Austin supervisors and lead clerks did not understand all the fine points of scheduling. He stated that there were always training issues with scheduling and that there is traditionally a high turnover rate for schedulers. He stated that another problem was that some schedulers rely on how they have historically scheduled appointments, rather than how they were recently trained.

- An administrative officer, Mental Health Product, VAMC San Antonio, stated that she never knew that her schedulers were making patient wait times equal zero. When she started her position several years ago, she was aware that schedulers were not correctly capturing patients' desired dates. She stated that she held multiple trainings with the employees in an attempt to correct "bad habits". She stated that she never instructed her employees to incorrectly make patient wait times under 14 days. She stated a scheduling error is when the desired date equals the create date. She recalled the scheduling error emails from MAS that referenced the directive. She stated that the concept of scheduling errors seemed to confuse schedulers. She stated that there was pressure to get patients seen in a timely manner but there was no pressure to manipulate the data.

- Another administrative officer, MAS, VAMC Temple, stated that OPC Austin scheduling staff was not trained properly. He was not aware of anyone who specifically instructed OPC Austin schedulers to manipulate patient wait times. He reviewed the historical data for OPC Austin and stated that schedulers were not properly scheduling. There were OPC Austin schedulers who were not even asking patients for their desired date. Some OPC Austin schedulers were just scheduling patients on the first available date, rather than having a discussion with the patient. He does not believe that OPC Austin schedulers were properly trained in scheduling prior to Temple MAS taking over in 2013. He stated that he has knowledge about what occurs with MAS schedulers and how his employees are trained, but he cannot explain about the other services' schedulers, which make up 68 percent of the scheduling staff. At VAMC Temple, there are 735 individuals with scheduling keys, and MAS is responsible for 236 of those individuals. The EWL was not used because MAS always believed that there was sufficient access. If he had known there were access issues, the EWL would have been used. He stated that unfortunately, some employees misunderstood the message and believed that the EWL could not be used for any reason.

- A supervisor at VAMC Temple stated that she had researched the scheduling directives in 2011. She stated she knew the rules associated with scheduling and followed the scheduling directive. There was a time when the desired date was being recorded as the

first available date, while still taking into account the provider's orders. The scheduler would let the patient know what the first available date was and, if they agreed, that date would be recorded as the desired date. She denied ever instructing her schedulers to manipulate patient wait times. She stated that the scheduling policy was very confusing. She believed that many of the schedulers' mistakes were not intentional and were made because the employee was scheduling too quickly.

- The STVHCS Director stated the STVHCS has MAS schedulers and schedulers that are non-MAS, who report to clinical services. She stated that there has always been some level of confusion regarding how to schedule patients. Scheduling is a complicated and confusing process that is not clear to either the administration or front-line schedulers. She stated she had never been threatened that she could lose her job if the patient wait time metric was not met. For her fiscal year 2013 performance appraisal, the patient wait time metric was such a small portion of the criteria evaluated that not meeting the goal would not have shifted her overall rating. She stated she never instructed anyone to zero out wait times or to make a patient's desired date the first available date. She stated that knowing how far out a clinic is scheduling is a better indicator of access rather than the desired date. The desired date is a movable date, but looking at how far out the first available date is for a clinic is a more reliable gauge for access. She stated she relied on data in order to make decisions about resources. Without accurate data, she was unable to make informed decisions about where the real issues are. She stated she never told anyone that the EWL was not allowed to be used.

Records Reviewed

- VA OIG reviewed multiple performance appraisals, self-assessments, and rating narratives. For a limited number of schedulers, lead clerks, supervisors, and chiefs, there were goals or metrics associated with patient wait times.
- The review of bonuses and awards for multiple VA employees did not reveal any evidence that a VA employee was provided an increased performance rating or a bonus specifically for patient wait times.
- VA OIG reviewed appointment data including scheduler's name, patient's name, clinic name, create date, desired date, and appointment date for COPAC Kerrville. The appointment data contained one appointment day for each month from January 1, 2011, to January 1, 2014. The review revealed that the majority of COPAC Kerrville schedulers had zero wait times. For a wait time to equal zero, the desired date had to be the same date as the appointment date. In multiple instances, for a variety of clinics, almost all COPAC Kerrville schedulers had created dates 1 or 2 months prior to the desired date with a zero wait time.
- VA OIG reviewed appointment data including schedulers' names, patients' names, clinic names, create dates, desired dates, and appointment dates for OPC Austin. The appointment data contained a random selection of days from January 1, 2011, to January 1, 2014. The review disclosed that almost all schedulers and clinics had zero wait times. For a wait time to equal zero, the desired date had to be the same date as the appointment date. In multiple instances, for a variety of clinics, many schedulers had

created dates 1 or 2 months prior to the desired date with a zero wait time.

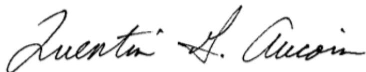
- VA OIG reviewed appointment data including schedulers' names, patients' names, clinic names, create dates, desired dates, and appointment dates for San Antonio VAMC, VAFC North Central, and the Frank Tejeda OPC. The appointment data contained a random selection of days from January 1, 2011, to January 1, 2014. The review disclosed that almost all schedulers and clinics had wait times that equaled zero. In multiple instances, for a variety of clinics, many schedulers had created dates 1 or 2 months prior to the desired date with a zero wait time.

- VA OIG reviewed email related to this investigation. The review did not uncover any emails from any VA employee that indicated an individual or group of individuals were being instructed to manipulate or falsify patient appointment data.

4. Conclusion

Investigation revealed that MAS and non-MAS schedulers were using the first available date as the patients' desired date when making appointments for VA medical care. Review of patient appointment data for facilities in San Antonio, Kerrville, and Austin revealed that the improper scheduling was systemic, and was not limited to a particular clinic or supervisor. The investigation did not reveal any VA employee receiving a bonus or award specifically related to patient wait times. The investigation did not reveal any clinic that was instructed not to use the EWL when it was necessary to use one. Numerous employees opined that there was no malicious intent by any employee to defraud or mislead anyone regarding wait times. Many individuals indicated problems with scheduling ranged from improper training, lack of supervision, to non-centralized scheduling.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on May 6, 2015.



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