

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



**VA Medical Center in Danville, Illinois
March 3, 2016**

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based upon a report from the Department of Veterans Affairs (VA) Veterans Integrated Service Network (VISN) 11 National Stand Down Team "Heads Up" memo regarding a visit to the VA Medical Center (VAMC) Danville on May 15, 2014. The memo detailed the following:

- One employee indicated that she equated next available appointment to "desired date" based on her understanding.
- A second employee reported she was instructed to make the desired date the same as the appointment date. In other words, use the next available appointment as the desired date (that is, when the patient's original desired date was not available). She was told to follow this procedure or she would be on the "blacklist." The VAMC Danville Stand Down Audit was conducted by the VISN 12 Chief Medical Officer, the VAMC Staff Assistant to the director, and two VISN 12 Health Systems specialists.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the VA's VISN 11 National Stand Down Team, Heads Up memo, VA Office of Inspector General (OIG) interviewed two VISN 12 employees involved in gathering information for the Heads Up memo, as well as a combination of 12 current and former VAMC Danville employees, including the former associate chief of staff.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A VISN 12 Health Systems specialist, who participated in the VAMC Danville audit, stated that during the week of May 12, 2014, the team visited Veterans Health Administration (VHA) facilities in Fort Wayne, IN; Marion, IN; Indianapolis, IN; Danville, IL; and Peoria, IL, as part of the Access Stand Down site visits. At each facility, the team met with leadership for approximately 15 to 20 minutes and was provided a random list of medical support assistants (MSAs) who covered a range of clinics and specialties. The team used two rooms with computer access to conduct interviews. Interviews were scheduled for an hour for each MSA with set questions regarding scheduling. The specialist stated that one member of the team was the interviewer who asked questions and the other member of the team recorded the responses directly into a SharePoint site. The specialist further stated that interviewee names were not recorded, but the facility number and specific work area were recorded.

The specialist did not know which MSA referenced being put on a blacklist and did not hear that statement in the interviews she conducted. The specialist suggested that another Stand Down Team employee may have been in the interview during which the blacklist statement was made by an MSA. The specialist provided a copy of the random list of MSAs provided by VAMC Danville who were interviewed by the Access Stand Down site visit team on May 15, 2014. This list annotated which individuals were interviewed by Team 1 and Team 2.

- Another VISN 12 employee who participated in the Stand Down site visit on Team 1 interviewed MSAs and typed notes directly into the computer, which uploaded to the SharePoint site. In their interview with OIG, the employee recalled that an MSA, whose name she could not remember, made a statement about a blacklist. She recalled that when she heard the phrase blacklist, she wanted to explore that further, but the doctor conducting the interview continued with the set questions.
- MSA1 at the facility stated that when scheduling patients, she used the agreed-upon appointment date as the desired date. MSA1 further stated that if she made any adjustments or changes to the appointment date she changed the desired date as well. Approximately 2 years ago, MSA1 received emails, referred to generally as “nasty-grams,” regarding the access list of patients with waits longer than 30 days. These emails were sent weekly by the former Primary Care coordinator and occasionally from the Surgical Service administrative officer. When MSA1 received these lists, she matched the desired date and appointment date in VistA to reduce the wait time to zero. Nobody told MSA1 to do this; she just assumed that it should be done. MSA1 called this the blacklist because she felt if the changes were not made there would be repercussions by management. MSA1 said there never were any reprisals of any sort in her performance evaluations or work environment. MSA1 stated that two other MSAs and an MSA supervisor also received these emails.

In a second interview, MSA1 further explained that she was trained to follow this practice: when a veteran requested a specific appointment date and a different appointment date was scheduled, the scheduled date was entered as his/her desired date. MSA1 stated that if a veteran called with no requested appointment date and the next available appointment date was offered and agreed upon, that appointment date would be the desired date. The former Primary Care coordinator sent the access list emails. When MSA1 questioned the coordinator about the list, the coordinator replied that the numbers were not good and needed to be better. MSA1 stated that her supervisor never told her to change dates or to clean up the list.

- MSA2 stated that her clinic did not have a long wait. MSA2 stated she was never told by management to change the desired date to match the appointment date. She further stated that she never received any emails regarding an access list.
- MSA3 stated that her clinic had appointment times available with no long wait lists and great access. She further stated that she did not receive any emails regarding wait times nor had any knowledge of any lists.

- MSA4 stated that her clinic had a 1- to 2-day wait, but did have some same-day availability. She was not aware of any emails regarding any patient wait lists.
- An MSA supervisor stated she received the emails regarding patient wait times from a former Primary Care coordinator. The MSAs were instructed to reschedule the appointment date earlier if the desired date difference was over 30 days, but to keep the original desired date unchanged. The MSA supervisor stated that there was a lack of access due to the lack of providers at VAMC Danville at that time. The MSA supervisor stated she did not feel that MSAs were threatened, but that availability was the issue.

When interviewed a second time, she further explained that she never asked MSAs to switch desired or appointment dates. She explained that the date initially expressed by the veteran was the desired date and any changing of the dates was “gaming” the system. When the MSA supervisor started as an MSA, training and methods of scheduling were not standardized and she was told appointments had to be scheduled in a way that reflected a wait time of zero days. She admitted that when she became a supervisor, she was aware some MSAs scheduled or “fixed” existing appointments by manipulating the desired dates to reflect zero-day wait times. The MSA supervisor denied knowledge of the continued “fixing” of appointments by manipulation of the desired date as standard practice among MSAs following the 2010 VA Central Office scheduling directive. Since the issuance of the directive, MSAs fixed appointments by either correcting legitimate errors to reflect a patient-driven desired date or by working with medical staff to see patients within the accepted wait time measure. This includes the overbooking of appointments or creation of clinic time. On one recent occasion when the supervisor identified an inappropriately scheduled appointment, she counseled the MSA to ensure compliance with the 2010 directive to use a patient-driven desired date. She stated that the former Primary Care coordinator wanted patients to be seen and the numbers to look good.

- MSA5 stated that she was trained that the desired date was veteran-driven. MSA5 received weekly emails from the former Primary Care coordinator regarding the access list of patients with over 14-day wait times. MSA5 was instructed to cancel the original appointment date, thereby canceling the original desired date, and to reschedule the same appointment, making the desired date the same. MSA5 could not recall who instructed her on this practice. She stated that she trained with another MSA who also received the same emails and followed the same practice.
- A former MSA stated that she trained to be an MSA with a current MSA and was trained that the desired date would always match the appointment date. Her supervisor at that time told her that the desired date should always match the appointment date. Because she scheduled that way, none of the patients were on the access list.
- A former associate chief of staff stated she wanted excellent health care access for veterans. There was an access list on SharePoint and it was the responsibility for all MSAs to check it for their patients waiting more than 14 days and then to see if the patient could be seen sooner. She further stated that the desired date was patient-driven and any fixing of the dates to reduce wait times was gaming the system, which was not

the practice at VAMC Danville. She did not tell a VAMC Danville employee to fix the appointment dates by cancellations, rescheduling, or any other type of date manipulation. She stated that there was no pressure from higher management to game the system, but she wanted to improve access to care for the veterans. She did not see the former Primary Care coordinator's emails to the MSAs, but the employee was vigilant to ensure access and care for the veterans. Each week, she looked at the access list to improve care.

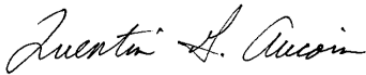
- A Surgical Service administrative officer stated that her responsibilities were in the Surgical Service and that she never scheduled patients nor was she an MSA. She stated that there was no pressure to get patient wait times down. The access list was a tool to track patients who were not scheduled within the specified time frame. The lists were sent out and it was each service's job to, in the administrative officer's words, "clean up the list" (that is, to see if the patient could be seen sooner or to correct errors made by MSAs). She received the list from the former Primary Care coordinator and she sent it to the MSAs in her specialties within the Surgical Service. The former Primary Care coordinator asked the MSAs to correct errors or to try to schedule patients for earlier appointments. She did not really feel that there was any pressure from management regarding the list or a focus on the numbers.
- MSA6 stated that she was trained (and scheduled) based on a patient-driven desired date. MSA6 did receive the access list emails from the former Primary Care coordinator to check them for errors but there was no pressure to change the dates or wait times. MSA6 noted to the former Primary Care coordinator the reasons that patients had such waits and never adjusted the dates.
- A former Primary Care coordinator stated that she felt confident that VAMC Danville did not game the system or misrepresent wait time numbers. She stated that there was pressure to decrease wait times for veterans but not in any manipulative way. The access list was accessible by all MSAs and reviewed daily. She explained that the desired date concept was very difficult as veterans could be steered toward a date that was not really their desired date. She also said that the desired date was to be patient-driven even if the desired date was not available, and if the veteran had no preference and seemed happy with the next available date, then that would be the desired date. She believed that fixing of the dates occurred, but she would go back to make sure the desired dates were not changed. She never told MSAs or management to make desired date and appointment date the same. She felt that VAMC Danville would not get the resources it needed to increase access and reduce wait times if wait times were manipulated.
- A Medical Administration Services supervisor stated that there were two ways to schedule: use of desired date based on patient request or, if a patient was indifferent regarding a desired date, an agreed-upon appointment date was the desired date. If an MSA scheduled an appointment with a wait time of greater than 14 days, they were required to enter a note explaining the reason in VistA. Once an appointment was made in VistA, notes could not be added. The supervisor was aware of the access list for patients with a greater than 14-day wait. This list was emailed to MSAs by the former Primary Care coordinator and these emails were referred to as nasty-grams. If an

appointment was on the access list and the MSA failed to put notes in VistA, they would cancel and rebook the appointment to add notes. She and the MSA supervisor never told MSAs to intentionally make the desired date and appointment date the same. MSAs were tired of the nasty-grams and made the desired date and appointment date the same to avoid being on the access list and receiving the nasty-gram emails. She did not know who told MSAs to reduce wait times or to zero out the desired date and appointment date.

4. Conclusion

Our investigation revealed that a list was emailed weekly by the former Primary Care coordinator to MSAs containing patients with wait times greater than 14 or 30 days between the desired dates and the actual appointment dates. Upon receiving such lists, one MSA changed dates within VistA to reduce wait times to zero. Nobody told her to do this; she just assumed that it should be done. That MSA felt if such changes were not made, there would be repercussions by management against those which she deemed to be on a black list. Another MSA said she was instructed to change dates within the system to zero out wait times greater than 14 days, but she could not remember who told her to do so. Yet another MSA said a supervisor told her that desired dates should always match appointment dates. This supervisor denied ever giving such instructions.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 19, 2015.



QUENTIN G. AUCOIN
Assistant Inspector General
for Investigations

For more information about this summary, please contact the
Office of Inspector General at (202) 461-4720.
