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

VA Medical Center in Philadelphia, Pennsylvania
March 8, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated pursuant to information provided on May 30, 2014, by an employee (complainant) at the Veterans Affairs Medical Center (VAMC) in Philadelphia, PA, who had information relative to allegations of wrongdoing in the Audiology and Vascular Departments and the Eye Clinic of the VAMC. The complainant claimed that a former manager in Audiology was allegedly keeping a password-protected Microsoft Excel spreadsheet on his Department of Veterans Affairs (VA) computer that identified and was used to track patients who required consults for non-VA care at the Pennsylvania Ear Institute (PEI), Elkins Park, PA. The complainant also alleged appointments were not appropriately being made for veterans in the Vascular Department, and possibly other departments, during a period a Health Administration Services (HAS) clerk went on leave and was out for an extended period. Lastly, a manager in the Eye Clinic was allegedly "cooking the books" in that clinic by manipulating consults. During the investigation, another issue surfaced that consults in Physical Medicine and Rehabilitation (PMR) were being canceled and rebooked within Veterans Information Systems and Technology Architecture (VistA) for unknown reasons.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed 19 current and former VAMC employees during the course of this investigation.

- **Records Reviewed:** VA OIG reviewed wait list data for Audiology for the period ranging from November 15, 2011, through June 1, 2014. The hard drive for the former manager in Audiology was also sent to VA OIG's Computer Forensics Lab for analysis.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant stated that in approximately September 2013, it was discovered that a former manager in Audiology was allegedly keeping a password-protected Microsoft Excel spreadsheet on his VA computer that identified and was used to track patients who required consults for non-VA care at the Pennsylvania Ear Institute (PEI), Elkins Park, PA. When asked, PEI identified approximately 900 patients for whom no information was documented in any VA system regarding the consults. Supposedly, the former manager had commented that his "bonus" was dependent on his compliance with wait time standards. The complainant stated that VAMC management took appropriate corrective actions regarding this issue following discovery.

The complainant also stated that an issue surfaced in the Vascular Department involving a clerk in HAS who had gone on leave and, for an extended period, appointments were not being appropriately made in Vascular and possibly other services for which the clerk was responsible. The complainant was unable to identify the other services the clerk covered and she could not identify the clerk. The clerk's position was backfilled in February 2014.

Sometime before June 2013, an issue was brought to the complainant's attention that a manager in the Eye Clinic was "cooking the books" in that clinic. At the time, the clinic was experiencing a long wait list and to reduce the wait list, she allegedly canceled and remade consults, or just canceled them. The complainant had no information regarding whether or not patients were properly seen by VA.

During a subsequent interview, another issue was raised regarding scheduling patient consults in PMR. It was alleged that consults were being canceled and rebooked within VistA, but the complainant had no other information regarding why this was being done.

Issue 1: Audiology Wait Times

Interviews Conducted

- On June 3, 2014, three VAMC employees assigned to Audiology stated that the former VAMC Director wanted a reduction of the patients being maintained on wait lists, which was the cause, in part, for the VAMC losing a patient care award. According to two of the three interviewees, after losing the patient care award, the former director stated that his bonuses, along with others, were affected and he didn't want to be in that position again. Accordingly, consults were being closed within VistA when a patient was referred to PEI. Though PEI wasn't able to keep up with the volume of VA patients, the former manager continued to send patients to PEI. He kept a spreadsheet supposedly containing all VA patient Audiology consult referrals, not just those referred to PEI. The former manager used this spreadsheet to keep track of patients being seen at the VAMC—those who had been seen at PEI and those waiting to be seen at PEI.

- The manager for Clinical Operations stated that she did not become aware of the Microsoft Excel spreadsheet being maintained by the former manager in Audiology until after the manager went out on extended leave. She had never seen the spreadsheet but advised they took measures to ensure all veterans needing to be seen by PEI were seen. She also stated that neither she nor the former manager received bonuses based solely on the wait listing of patients.

- The former manager in Audiology stated at the time of the interview that it had been several years, maybe 4 to 5 years or longer, since he kept any spreadsheet identifying referrals to PEI. He said he did this during a period that it was permitted and stopped when that changed. After that, he only kept consult sheets for referrals to PEI arranged by service-connected priority. He said that because every veteran eligible for VA care was eligible for an Audiology consult and due to limited staff, this caused a continuing problem for Audiology to see patients in a timely manner. PEI was contracted on a fee

basis approximately 10 years before (in the early 2000s) to provide services that mirrored those done within VA; they conducted hearing aid evaluations. He was unsure of the size of the wait list for Audiology as that was something managed by the HAS. In seeking information on the size of the wait list for Audiology, the former manager was advised that wait lists were specifically mentioned in his 2012 performance evaluation. He said that there was moderate pressure to reduce the size of the wait lists; however, he was never advised to do anything outside of VA policy. To reduce the size of the wait list, he made efforts to triage the list for higher-priority veterans; authorized staff overtime; worked to recruit new fee basis vendors; pleaded for additional staff; and placed two audiologists at Community Based Outpatient Clinics in Horsham, PA, and Gloucester, NJ, respectively.

The former manager could not offer an explanation as to why the audiology electronic wait list (EWL) went from more than 200 to about zero during the period of March 2012 through March 2013 and then back up to more than 200 since then. He suggested contacting the HAS for additional information. He also identified a Medical Administration Service (MAS) clerk who may have more information regarding the EWL. He described the former director as the most collaborative director, stressing his sense that issues were addressed under his leadership from a team perspective. He never recalled hearing of any awards being lost due to wait list issues nor being told that bonuses were dependent on this specific performance standard.

- The MAS clerk identified by the former manager in Audiology explained that the Audiology wait list during the period March 2012 through March 2013 decreased because veteran patients from the VAMC started to be sent to PEI for appointments. Approximately 14 months later, the wait list increased because PEI wasn't seeing patients in a timely fashion, so their appointments were once again being scheduled at the VAMC. In addition, an audiologist who was hired for the Saracini Community Based Outpatient Clinic in Horsham, PA left after only being with VA for about a year and a half. She also stated that the spreadsheet the former manager in Audiology maintained was for determining what follow-on services patients might need when they came back from PEI or after receiving services at the VAMC.

- The service chief stated that the changes to the EWL during the March 2012 through March 2013 time frame most likely reflected that the VAMC patients were being sent to PEI on fee basis as opposed to being treated at the VAMC where capacity was a continuing issue. Accordingly, these patients would have been monitored by non-VA care or fee basis instead of within Audiology. As time passed, however, it became apparent that PEI was unable to see patients any sooner than at the VAMC, so patients were pulled back into the VAMC and added to the EWL, which explained the increase. When asked, PEI identified approximately 900 patients for whom no information was documented in any VA system regarding the consults.

Records Reviewed

- A review of wait list data for Audiology for the period from November 15, 2011, through June 1, 2014, revealed that the Audiology Department regularly experienced a large

number of veterans on the wait list, often numbering several hundreds, except for the period of about March 1, 2012, through about March 1, 2013, when there were no veterans identified on the Audiology wait list. After March 1, 2013, the list reappeared and gradually grew to its pre-March 2012 levels.

- The hard drive for the former manager in Audiology was sent to VA OIG's Computer Forensics Lab to be analyzed. The analysis of the hard drive did not identify any spreadsheet file that approximated the type he allegedly kept relative to referrals to PEI.

Issue 2: Vascular Clinic Scheduling

Interviews Conducted

- A VAMC supervisor and two medical support assistants were interviewed. Their statements showed that an employee who went out on extended leave primarily scheduled appointments for the Podiatry and Ear, Nose & Throat Departments. She also assisted in scheduling appointments for the Spine, Vascular, and Plastic Surgery Departments. In regard to making patient appointments during this employee's absence, at least five different VAMC employees were identified as being tasked with providing assistance and that appointments were being made appropriately and in a timely fashion. The employees stated that her absence did not affect patient appointments or patient care.

Issue 3: Manipulation of Eye Clinic Consults

Interviews Conducted

- A manager in the Eye Clinic described the "manipulation of consults" as being necessary because of the archaic nature of VistA, which does not provide a true reflection of wait times without the manipulation of the data. She explained that the vascular ultrasound machine used within the eye clinic only interfaces with the consult section in VistA. Accordingly, staff input a consult and schedule a patient's appointment. If the appointment is requested by the provider within 90 days, no manipulation of the consult is needed. However, if the appointment requested by the provider is over 90 days out, the consult is made for scheduling purposes but immediately canceled. However, the scheduled appointment remains in the system. The consult is later reinstated 1 to 5 days before the appointment so the vascular ultrasound machine can interface with VistA and generate a patient list for the work to be done on a particular date. The reason for this manipulation is because the vascular ultrasound machine does not interface with all parts of VistA and reads only consults. The consults that are more than 90 days out are canceled because if they were left within VistA, it would make it appear that there were delays in the clinic when that is not the case. The clinic has no delays and if a provider requests an ultrasound for the next or same day, it can be accommodated.

Issue 4: Manipulation of Physical Medicine and Rehabilitation Consults

Interviews Conducted

- A manager in PMR reported that he was under the impression that his staff was directed to cancel consult appointments within VistA if they were over 7 days old; but he believes they are canceling consults that are anywhere from just days old to 3 months old. He felt that the consult date was being changed to coincide with a patient's actual appointment date. He stated that if his staff were doing this, the patient's appointment date would not change and the quality of care for the patients would not be affected. He wasn't sure of who informed his staff to follow this procedure although he believed it was a manager in HAS. The manager also believed that the former facility director may have instituted this policy about 3 years ago. It was under the former director's leadership that section chiefs were informed that the VAMC needed to meet the standards set by the Veterans Integrated Service Network (VISN) and at the national level. He also stated that there was no correlation between closing these consults and employee bonuses.

- Three of the PMR manager's employees were interviewed but did not report anything new regarding any issues relative to wait times. They all claimed they were not directed in any way to manipulate wait lists or numbers and had never heard of anyone else doing so. None of the three individuals had any information in regard to consults being canceled and rebooked within VistA and within the PMR Department.

  One of the employees reported that he started a program to increase efficiency; this meant that if a patient were more than 5 minutes late for an appointment, the clinic would cancel the appointment to allow for walk-ins to be seen. At the same time, if the patient showed up later for the appointment, the patient would be added to the schedule and seen nonetheless. This process was instituted 3 months prior to the interview to deal with a 70 percent "no show" rate. He was also on the open consult committee, which looked for ways to administratively or clinically close long-standing open consults. Most of these instances were able to be closed because it was determined that VA had already seen the patient, which was verified through a review of clinical notes.

  The above statement revealed that the PMR manager, who is not directly involved in scheduling, appeared to be confusing the way old consults that were inadvertently left open in VistA were being closed. In these cases, the open consults were actually closed because the services had been verified as having been provided to the applicable patients.

- A manager in Recreation Therapy reported experiencing no scheduling issues. She also reported attending meetings in which the former VAMC Director discussed performance measures, but not in the context of bonuses being directly related to wait times.

Additional Information

- The former VAMC Director stated that he didn't 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 frequently discussed

within VISN 4. He didn't recall ever mentioning to another employee that wait times were part of his rating but they were part of his performance measures, along with 50 to 60 other performance measures. He also didn't 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, not just one or two specific measures, and he did not recall losing an award in or about 2011. He further stated that neither his supervisors nor VA Central Office managers instructed him or provided guidance regarding bonuses or wait times.

- The current director, VAMC Philadelphia, was briefed on these matters. He reported that since the wait time issues have surfaced, he has met with all of his schedulers and advised them to follow all scheduling policies and to do the right thing.

4. Conclusion

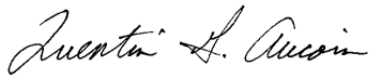
The investigation revealed that a spreadsheet was used by the former manager in Audiology approximately 4 to 5 years ago, when such use was permitted. He said he used the spreadsheet to track patients referred to PEI for hearing aid evaluations. Such patients would not have appeared on any wait list after being referred. According to the complainant, VAMC management took appropriate corrective actions regarding this issue following discovery and contacted all of the veterans (approximately 900) on the spreadsheet.

The investigation also failed to show wrongdoing relating to the scheduling responsibilities of the clerk who went out on leave because coverage was provided during her absence.

With respect to allegations relating to the Eye Clinic, the alleged manipulation had to do with the inability of VistA to properly interface with a particular piece of diagnostic equipment. Any "manipulation" was claimed to have been done so the vascular ultrasound machine could interface with VistA and generate a patient list for the work to be done on a particular date. The investigation revealed that the vascular ultrasound machine does not interface with all parts of VistA and reads only consults. Appointments scheduled for veterans in VistA were not affected in any way by the manner in which consults were handled.

During the investigation, an issue surfaced that consults were being canceled and rebooked within VistA for PMR with the complainant providing no explanation as to why this was being done. The investigation revealed no wrongdoing in PMR and that the complainant, who is not involved in scheduling, was unfamiliar with the process for deleting old consults that were left open in VistA after a patient had been seen.

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