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

VA Medical Center in Tuscaloosa, Alabama
March 16, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based on allegations received through the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline from an anonymous source claiming that clerks in the Primary Care Clinics at the VA Medical Center (VAMC) in Tuscaloosa, AL, were being instructed to contact veterans to cancel and reschedule appointments in order to improve the appearance of access to care.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** We interviewed the director and associate director, VAMC Tuscaloosa; a medical support assistant; a supervisory medical administration specialist; and several employees from the Health Administration Service (HAS).

- **Records Reviewed:** We reviewed the fact-finding inquiry conducted by VAMC Tuscaloosa.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A senior leadership official, VAMC Tuscaloosa, stated that the media attention into VAMC Phoenix[1] caused the medical center leadership at Tuscaloosa to conduct an internal review of their scheduling protocol. During their internal review, employees provided varying explanations regarding the use of the Electronic Waiting List (EWL) process. The official explained that it became clear to senior management that employees were not familiar with the proper scheduling procedures, due to a lack of knowledge and/or training. As a result, senior leadership established a training regimen for all employees, to include Webinar training.

  The official also stated that improper scheduling activity was uncovered in the Mental Health Clinic, adding that sometime on February 6, 2014, VAMC Tuscaloosa closed the general Mental Health Outpatient (MHOP) Clinic and transitioned those patients to a post-traumatic stress disorder (PTSD) clinical team. When the transition occurred, the system created a new stop code and treated the MHOP patients as new patients when, in fact, they were established patients. Rather than place the patients on the EWL, a medical support assistant (MSA) created a separate list of patients from MHOP. The MSA then used this list to re-enter the scheduled follow-up appointments in the PTSD

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

Clinic. The official further stated that VAMC Tuscaloosa management had conducted a fact-finding inquiry that discovered a supervisory medical administration specialist (MAS) had reported to management that the only wait list used during the transition between the two clinics was the EWL—when, in fact, the supervisory MAS knew the MSA had a separate list of patient names.

- The MSA explained that the "desired date" is obtained following a discussion between the doctor and patient about the best date to pick for a return visit. The MSA added that the EWL is only for new patients to be placed on if there are no appointments available within 90 days. She noted that she has never been instructed to change desired dates. When asked about a Report of Contact completed by the chief of the HAS on May 20, 2014, and stating that the MSA maintained a list of patients as a way to ensure they received timely follow-up appointments, she denied that she kept a paper list.

- A supervisory MAS stated the desired date is the date the provider orders or the date the veteran requests as his/her appointment date. She stated it is their goal to have the veteran seen by a provider within 14 days, even if the schedulers have to overbook a provider. She said if a scheduler had to change an appointment, he/she would note the reason in the remarks section. When questioned regarding her knowledge of paper wait lists, she stated she was not aware of a paper list of veterans' names waiting to be scheduled. She added that there was a misunderstanding on the matter of a scheduler keeping a paper list, as the list was actually a printout of patients who were waiting to be transferred over to the new clinic. At the end of the interview, she left the room but returned within the next 5 minutes to state that she did not advise the MSA to keep a paper list. She said that the MSA had initiated this on her own to keep track of the emails she received from a provider.

- HAS employee 1 stated she received annual training and, in addition, she relied on management to address daily scheduling issues. She said the VAMC runs a report, the Massachusetts General Hospital Utility Multi-Programming System (MUMPS[2]) report. This report is returned to the scheduler to make the necessary corrections where the desired appointment date is determined to be incorrect. If the desired appointment date is scheduled past 30 days, it will show up on the MUMPS report. She stated that the supervisor in Clinical Administration would speak with the scheduler regarding the MUMPS report, which could result in a negative performance evaluation. She denied having any knowledge of anyone keeping a paper list of patients waiting to be scheduled.

- HAS employee 2 stated the desired date is the date the patient desires to come back to the clinic in collaboration with the provider. She stated new patients are typically scheduled within 14 days; if not, they can be scheduled within 90 days. After those 90 days, the patient will be placed on the EWL. She stated the EWL is frequently used at VAMC Tuscaloosa. She added that the EWL was currently being used only for home-based Primary Care. She stated that she was not familiar with the *Inappropriate Scheduling*

[2] MUMPS refers to the Massachusetts General Hospital Utility Multi-Programming System. A query using MUMPS captures Veterans Health Information Systems and Technology Architecture (VistA) scheduling information and generates a report with specific focus on desired dates and actual appointment dates.

Practices memo, issued by William Schoenard, Deputy Under Secretary for Health Operations and Management on April 26, 2010, regarding "gaming" strategies that VA employees use to try to circumvent the system and create certain dates to prevent a delay in patient care.

In April 2014, VAMC Tuscaloosa organized a meeting to review the confusion the medical center had with the recall/reminder software application used to manage appointments scheduled beyond the 3 to 4 month scheduling window. During that meeting, HAS employee 2 learned that the MHOP was being merged into the PTSD clinical team. The staff was instructed to ensure that the veterans being moved to the PTSD clinical team had the same scheduled date that they had in the MHOP Clinic, since they were dealing with established patients. She explained the new clinic was just a name change and the patient saw the same provider but had a new stop code. The system created a new date because of the new stop code. She was not sure whether there was a manual list, but they had a printout of patients showing how far out a patient was scheduled. At the meeting, the supervisory MAS advised that the MSA had a paper list. HAS employee 2 said the supervisory MAS explained in the meeting that the strategy was to keep patients off the scheduling list because they could not meet the 14-day requirement. When MHOP began using the recall system, there was a lot of confusion about when a patient was put in the recall system. She stated this was the only strategy of which she was aware.

- A HAS manager stated the HAS covers a variety of functions, such as eligibility enrollment for health care, information management for non-VA care, and also clinical administrative support (CAS), comprising the inpatient and outpatient scheduling clerks. Service line supervisors report to the assistant chief of the HAS. She holds weekly informal leadership meetings with supervisors, including the assistant chief, to talk about projects and activities that are going on within their sections. She did not recall if the Schoenard memo as well as Veterans Health Administration (VHA) Directive 2010-027 were shared or not. She stated she was not aware of any gaming strategies being practiced at VAMC Tuscaloosa. She recalled a situation in the MHOP in which it was alleged that an employee maintained a paper list of veterans' names. She said they immediately identified the staff involved and addressed the situation. She explained it was her understanding that when the new clinic was established it created a new stop code, which listed the existing patients as new patients. The list was kept to make sure all of the patients were transferred from the old to the new clinic, and to make sure the veterans who were transferred to the new clinic did not miss their scheduled appointments. When she was made aware of the list, she demanded that the clerk stop using it and schedule the patients immediately.

  The HAS manager stated if a clerk appeared on the MUMPS report, he or she would not be counseled. Supervisors receive the MUMPS report via the Veterans Health Information Systems and Technology Architecture (VistA) computer system; they review the report and send it to the clerk who scheduled the appointment to make sure the desired date is correct. If a clerk's name is on the MUMPS report, that clerk will make the necessary corrections and schedule the appointment within a 30-day period. She added employees are not penalized if their name appears on the MUMPS report.

- A supervisor, whose duties involved training and overseeing the day-to-day activities of MSAs and program support assistants, explained that the MUMPS report is a daily report that supervisors receive and which captures scheduling errors. The supervisors will review the MUMPS report and forward the report to the responsible MSA clerk to make the necessary corrections. He further explained that if an MSA clerk received more than five errors within a performance period, that MSA clerk would come to his office and be instructed that it is important to schedule the patients timely and efficiently. He stated that if an MSA clerk received more than five errors within the performance period, that MSA clerk would receive a "less than successful" rating on his or her evaluation.

- The director, VAMC Tuscaloosa, stated that she was briefed on the situation by an HAS manager. She said the manager informed her about a meeting she had attended in April 2014, and learned that the MSA had a "list of patients" that she worked daily to make sure they were given follow-up appointments. She explained that when the two clinics (Mental Health and PTSD) merged, it created mass confusion. Supervisors and employees at VAMC Tuscaloosa were unclear about the significance of VHA Directive 2010-027 regarding scheduling activities; they did not think the directive was applicable to the merger of the two clinics since the patients were not new patients and already had appointments scheduled. She stated that since this incident the supervisors and employees have had face-to-face, as well as online training.

Records Reviewed

We reviewed the report dated June 12, 2014, regarding the fact-finding inquiry conducted by VAMC Tuscaloosa prior to the OIG investigation. The inquiry found that the MSA had maintained a paper list.

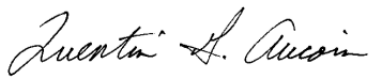
4. Conclusion

The investigation found that several individuals claimed the MSA wrote the names of established veterans who were being transferred from one Mental Health Clinic to another, on a separate paper list, and then scheduled an appointment for a later date—even though the MSA denied maintaining a paper list when interviewed. Prior to VA OIG's involvement, the VAMC Tuscaloosa senior leadership initiated a fact-finding inquiry that confirmed that this had occurred.

The interviews revealed there did not appear to be any kind of guidance from immediate supervisors and service line chiefs/managers to VAMC Tuscaloosa employees regarding VA policies for scheduling. The supervisors could not clearly articulate the scheduling directives outlined in VHA Directive 2010-027, dated June 9, 2010.

The investigation did not find any evidence that senior leadership was aware of the inappropriate scheduling practices.

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



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