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 Chattanooga, Tennessee March 10, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated following receipt of a report from the Veterans Health Administration (VHA) National Stand Down Team (NSDT) and containing allegations from three medical support assistants (MSAs). The MSAs alleged that Chattanooga, TN, Community Based Outpatient Clinic (CBOC) employees were being directed by the Business Office to change patient "desired dates" to the actual appointment dates patients were seen, even when the providers clearly wanted the patients to be seen sooner. The NSDT report also relays the MSAs allegation that employees were being placed on a "bad boy" list if they did not comply with this direction.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted ten interviews with CBOC employees, as well as VA Tennessee Valley Healthcare System (TVHCS) and Veterans Integrated Service Network (VISN) managers.

- **Records Reviewed:** VA OIG reviewed Clinic Appointment Availability Reports (CAAR), job specific competencies; emails sent out by the CBOC Chattanooga Business Office; and other records.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The TVHS Director and two managers in the Business Office stated they were familiar with the April 26, 2010, Schoenhard Memo[1] and VHA Directive 2010-027[2]. When asked how the scheduling process within VA could be improved, one of the Business Office managers pointed out more training and better clarification of expectations. The director acknowledged that he now realizes the CBOCs did not have adequate oversight from the VA TVHS Business Office. The director also advised that a former Business Office manager for the CBOC had previously identified issues at CBOC Chattanooga.

  The TVHC Director advised that during a meeting with four schedulers at VAMC Murfreesboro (TN) the schedulers voiced concern that they were inappropriately scheduling appointments based on supervisors' instruction. (Note: This information led

[1] Memorandum from William Schoenhard, VA Deputy Under Secretary for Health for Operations and Management, titled: *Inappropriate Scheduling Practices*.
[2] *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010).

to the initiation of a separate investigation at VAMC Murfreesboro and is documented in a separate report.) The director further noted that he identified scheduler training as inconsistent across VA TVHC campuses and CBOCs, and that standardized retraining of all schedulers was under way. The director later stated that all individuals with scheduling privileges had received the initial block of VA TVHS training and that follow-up training would continue on a monthly basis.

- VISN 9 Director and Deputy Director were interviewed. The director stated he had been informed of the NSDT findings at CBOC Chattanooga by the deputy director. The deputy director stated that he was part of the NSDT and had access to all reports, including VISN 9. Once he saw the issue at CBOC Chattanooga, he talked with both the VISN 9 and TVHS Directors. The director also pointed out that he had notified the OIG as soon as he received the additional allegation. Both individuals stated they had no prior information regarding this issue.

- A medical support assistant (MSA1) at CBOC Chattanooga advised that she was not aware of any scheduling issues in the Mental Health Clinic. Her understanding of desired date was the date the patient desired to be seen. A report called the AEG[3] Report was once circulated for review. MSA1 advised that schedulers would sign the AEG Report after they reviewed it and understood any errors they made. She viewed the AEG Report review as a learning tool to help identify errors and keep them from being repeated. She was never told to go back and change dates. She, along with the other schedulers at CBOC Chattanooga, had recently received standardized scheduler training but noted that she was already scheduling appointments in the manner being taught.

- MSA2 stated that approximately 1 or 2 years prior to the investigation, the former Business Office manager assigned her to take a report around to all MSAs who scheduled appointments. The report was to be reviewed by the MSAs and they had to initial it if their desired dates and appointment dates did not match or show zero-day wait time. She did not think the former manager was very knowledgeable of the scheduling process, and at that time a gray area existed as to what the definition of a desired date actually was. When she started working as a scheduler, there was no training provided; she would sit with different people to learn, but each person did the job differently. They now have weekly meetings and she has received training on scheduling provided by VA TVHS.

- MSA3 stated that the former Business Office manager had sent emails instructing MSAs to change desired dates if the desired date by the patient was outside the 14-day wait period. She further stated that she was "written up" because she had scheduled appointments outside the date range desired by the doctor and because she used the correct desired date. However, she could not produce any documentation showing that she was written up or had received a negative review due to these issues. She stated she was told to go back into Veterans Health Information Systems and Technology Architecture (VistA) and make wait times equal zero days. MSA3 added that schedulers

[3] The AEG Report lists appointments with desired dates, creation dates, and has a comments section. The report is used to review the return to clinic or consult dates to assist in ensuring accuracy in scheduling and is sent out as a training tool to assist schedulers as well as point out potential errors. The acronym "AEG" comprises the initials for the individual who first developed the template for this report and has no specific meaning.

at the CBOC have recently received training. At the end of the interview, MSA3 provided two emails authored by the former Business Office manager that offered scheduling guidance.

- The chief medical officer stated that she was not aware of any of the items mentioned in the NSDT report. She had some understanding of scheduling and believed the desired date could be determined by the provider but is mostly up to the patient. She further described how the providers have at least four "flex spots" available per day in order to fit patients in, as needed. She did not know of any bonuses being given based on wait times. She noted that wait times were a monthly performance measure and a monthly meeting was held with the VISN to go over these measures.

- The former Business Office manager stated that he understood there were two different meanings for the term desired date. The first was the date a patient requested to be seen and the second was the date the provider wanted the patient to be seen. He was not aware of any "secret" wait list, manipulation of the system to make wait times appear better, or any bad boy list associated with wait times while he was at CBOC Chattanooga. He set a 7-day requirement to attempt to get patients scheduled. By setting this 7-day time period, the CBOC staff were allowed enough time to follow up in case there were problems contacting the veterans and still get the veterans in to be seen within the prescribed VHA time frame. He also advised some of the confusion regarding wait times stemmed from an issue with VistA.

  He explained that when one is on the provider screen in VistA and the enter key is depressed, VistA automatically populates the next available appointment as the desired date for the veteran. The issue comes in if/when the veteran does not want or need to be seen for a few months. This was the only reason he could think of why schedulers would change the desired date in the system. He emphasized that any changes to a desired date were in an effort to accurately reflect what the veteran and provider wanted. He added that a lack of proper training for schedulers also caused a lot of confusion. He acknowledged using an error list sent from the TVHC Business Office to counsel and train employees on how to properly schedule veterans. He denied ever directing or being directed to manipulate wait times.

Records Reviewed

- OIG staff reviewed the June 30, 2013, through May 31, 2014, CAAR reports. The data showed that a large number of patients were seen within 1 day of their desired appointment date. A request was then made for the June 2014 CAAR report to determine whether there was a change due to the fact that standardized scheduler training began at CBOC Chattanooga in June 2014. Subsequent review of the June 2014 CAAR report revealed a noticeable difference and more accurate reflection of scheduling data after the standardized scheduler training was implemented, compared with the reports that were completed prior to this training.

- A review of a spreadsheet of disciplinary actions taken against CBOC Chattanooga employees with scheduling privileges showed that from May 2011 through February

2013, nine individuals with scheduling privileges were disciplined, but none of the actions related to scheduling issues.

- An OIG special agent and a supervisory Healthcare Inspector from the OIG Atlanta Field Office reviewed the emails provided by MSA3. Although not worded exactly, the emails/scheduling guidance appeared to be an attempt to follow VHA directives or policies, specifically VHA Directive 2010-027.

- VA OIG staff reviewed emails and a document provided by the former Business Office manager. The document was titled "Processing Flow" and outlined the manager's processes for new patients, phone calls, emails, and returning patients while he was the Business Office manager at CBOC Chattanooga. Review of this information disclosed that it appeared that he attempted to follow VHA directives and policies and did not indicate that CBOC Chattanooga or the former Business Office manager were manipulating scheduling in order to "game the system."

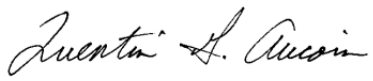
- The job-specific competencies for MSAs 1, 2, and 3, as well as for the former Business Office manager, were reviewed. Of the four, MSA1 was the only one who had a specific amendment to her core-specific competencies, titled "Amendment to Competency Assessment on Outpatient Scheduling." This was completed in 2007. The record also outlined training and specific scheduling tasks that MSA1 had to demonstrate in order to be considered proficient in scheduling. MSA2 and MSA3 had no job-specific competencies in their files related to scheduling. The former Business Office manager had no job-specific competencies in his file related to scheduling.

4. Conclusion

The investigation did not substantiate that a bad boy list existed or that MSAs were written up for entering the correct desired date. No evidence of any effects on patient care was identified during this investigation, and no wait time manipulation intended to "game the system" was discovered. A need for standardized scheduler training was identified. This need was also independently identified by the director of TVHCS, who initiated a standardized training program for all of TVHCS. As of August 27, 2014, all CBOC Chattanooga schedulers had attended this training.

Although the investigation could not rule out the possibility that schedule manipulation occurred in the past, the evidence showed that once formalized scheduler training began at the CBOC in June 2014, any indications that schedule manipulation may have been taking place no longer existed.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 4, 2015.



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