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

VA Medical Center in Murfreesboro, Tennessee
March 10, 2016

1. Summary of Why the Investigation Was Initiated

The director, VA Tennessee Valley Health System (TVHS), notified the Department of Veterans Affairs (VA) Office of Inspector General (OIG) that four schedulers at the Central Scheduling Unit (CSU) at the Alvin C. York VA Medical Center (VAMC) had expressed concern that they either had or were presently inappropriately scheduling appointments based on supervisor instruction. The schedulers were not identified by name. The medical support assistants (MSAs) self-reported manipulating the patient "desired date" for appointments in the Veterans Health Information Systems and Technology Architecture (VistA) to reflect the date for which appointments were actually set.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed eight employees at the VAMC Murfreesboro.

- **Records Reviewed:** Personnel records and 4 months of scheduling audits for the CSU were reviewed.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- An advanced medical support assistant (AMSA1) who was assigned to the CSU, said when he was trained to schedule appointments, he was taught to go into VistA to find an available appointment date. Once the veteran agreed to the appointment date, he would exit VistA before scheduling the appointment. He would then re-enter VistA, put the desired date of the appointment as the date he was scheduling the actual appointment, and make the appointment. In doing so, this creates a zero in the column for the wait time. Anything other than a zero would show on an "error list" and have to be corrected. He stated that there was still confusion among schedulers about how to schedule appointments.

- AMSA2 stated that she did schedule appointments for patients but she mostly dealt with the doctors and clinics more than patients and that most of her communication was done through email. She was unable to provide any information related to the manipulation of

wait times in VistA and noted that she was required to watch a training video after the allegations in Phoenix[1], AZ, were reported.

- AMSA3 stated that, in February 2009, he was trained to look in VistA when scheduling appointments to find an appointment suitable for the veteran before actually scheduling the appointment. To schedule the appointment, he was to "back out" of VistA, then re-enter VistA to make the appointment. He stated the desired date needed to reflect the actual appointment date to make the wait time zero. If the wait time were not a zero, the error would appear on an AEG[2] Report. Supervisors gave the list to the lead clerks and the scheduling employee was forced to correct the "error" and make the wait time zero. If the AMSA did not follow the procedure and make the wait times zero, they could have their schedule access taken away, be considered insubordinate, or written up for dereliction of duties. AMSA3 stated that the assistant chief of the TVHS Business Office in Nashville sent out a module for employees to view on the proper procedure for scheduling appointments after the allegations in Phoenix were reported; however, no staff meeting was held to discuss the proper procedures.

- AMSA4 stated that her daily responsibilities included answering the phone and scheduling patient appointments. She was trained that the desired date was ultimately whatever the date the patient agreed upon for the appointment; it was the date that the appointment was actually scheduled. She was trained to put a comment in the "other info" section that states, "DD=date of appointment per consult or RTC (return to clinic), date of order." She had always put the date of the actual appointment as the desired date so she never had to correct errors. However, she advised that a Schedule Lead recently brought her an error list that had five appointments that needed correcting. She was busy when he mentioned it to her and she had not had a chance to discuss it with the Schedule Lead or correct the errors and did not know what she did wrong. AMSA4 said this was the first time since she started her job that she had an error.

- AMSA5 stated that his daily responsibilities included scheduling patient appointments. He was trained that when making appointments he was to enter VistA and find an appointment date suitable for the veteran. Once the veteran agreed upon the date, he "backs out" and then re-enters VistA to schedule the appointment. According to AMSA5, the desired date in VistA was the date of the actual appointment. If the dates were different, an error was created and had to be corrected. He also advised that the same Schedule Lead referenced by ASMA4 recently brought him an error list that had approximately 70 appointments that needed correcting. It took him approximately 1 week, working overtime and between assignments, to correct the errors. He said that he had never been told why the desired date was put in as the date of the appointment. He did report that VistA has the option to select the next available appointment. By selecting "Yes," it will create an error and put you on the "bad boy" list. He no longer backs out of

[1] Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.
[2] 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" is the initials of the individual who first developed the template for this report and has no specific meaning.

VistA. Instead, he selects "No" for first available appointment and can see all the available appointments. Once an appointment is selected, the desired date is still the date of the appointment.

- A former supervisor of the CSU stated that if an employee were to respond to the "first available?" prompt when scheduling an appointment in VistA with a "Yes" response and select an appointment without backing out of VistA, that would be "gaming the system" and would be wrong. He explained that if "Yes" were selected to respond to the "first available" prompt, then the wait time would be calculated from the first available appointment that arose, and this could cause a potentially incorrect wait time. The desired date the scheduler used was the date the patient chose and agreed to, not the date the provider chose. When questioned about the AEG Reports, which show errors created by the scheduler when making appointments for a veteran's doctor's visits, the former supervisor advised that the AEG Report showed errors and was used as a training tool. He said employees were not required to correct the report, but if an employee did correct the report, it had no effect on wait times. He stated that he had never "knowingly or purposefully instructed people to manipulate any wait times."

- The director of the VA TVHS reviewed the memo he provided OIG on July 17, 2014, detailing the allegations and confirmed the memo was true and accurate. He had no additional information to add to the memo. The director also advised he had been doing reviews of the scheduling process and found that most schedulers did not understand what was considered the desired date as it related to scheduling appointments. He also found that VA providers were not using the return to clinic (RTC) software. He stated that schedulers reported they did not feel comfortable because providers were not putting a date in the order they want the veteran to RTC. As a result of his findings, the director instituted a program to train MSAs in the appropriate way to schedule appointments. He stated that a medical administration specialist, TVHS, Nashville, had been assigned as a dedicated trainer to work with and train schedulers. The director felt confident that implementing the training program was a helpful and beneficial step in correcting this problem at TVHS.

- The Veterans Integrated Support Network (VISN) 9 Director stated that he did not know anything about scheduling issues until the TVHS Director contacted him and told him about the conversation he had with schedulers. The VISN 9 Director held a voluntary luncheon with schedulers at VAMC Murfreesboro to discuss their challenges and issues. During this luncheon, no schedulers discussed any issues related to wait times or manipulation of scheduling appointments in a manner inconsistent with the directive. He stated he was looking into having a certified trainer in each VAMC to provide training to schedulers.

Records Reviewed

- OIG staff obtained a copy of the AEG Report for July 10–16, 2014. This report identified errors on 853 appointments scheduled, or 3.79 percent. The errors were made by approximately 113 different schedulers. While the majority of the schedulers made fewer

than 5 errors each, one individual made 58 errors. Our review found that the errors were broken down into these categories:

- 519— Incorrect desired date
- 144— No comment while making the appointment
- 0—No RTC found for this appointment
- 190—No desired date entered in comments

A second portion of the report was a TVHS Scheduler Re-Training sheet. This document is what some of the schedulers reported as the "bad boy" list and the threat of having scheduling privileges revoked.

- A senior management official, TVHS, Nashville, provided job- specific competencies and performance appraisals for the CSU employees interviewed during the course of the investigation. A review of the documents showed that only one of the employee's personnel records contained job-specific competencies. However, the employee's name was not on the form and the form was not signed, indicating the performance was never evaluated.

- A spreadsheet of all disciplinary actions taken against employees of the TVHS Business Office for the period March 2009 through the present was reviewed. None of the employees interviewed were found to have been disciplined for scheduling or wait list issues.

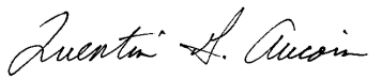
- OIG staff reviewed the sign-in sheet for the "Refresher CSU Scheduling Training Consults." This training was conducted on August 22, 2014. Of the CSU staff interviewed as part of this investigation, all but one of the employees interviewed had attended the training.

- A supervisory Healthcare inspector from the VA OIG, Office of Healthcare Investigations, Atlanta, GA, reviewed audit reports from VAMC Murfreesboro. The inspector advised that it did not appear that VAMC Murfreesboro schedulers were intentionally manipulating wait times.

4. Conclusion

The investigation found that scheduling was not done properly, which may have skewed wait times for the CSU. However, no evidence was found during this investigation indicating that the improper scheduling was an effort to intentionally manipulate wait times to "game the system." Upon learning that the appointments were not being properly scheduled, management implemented a corrective training program to ensure compliance with Veterans Health Administration scheduling policies.

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



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