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

VA Medical Center in Little Rock, Arkansas
March 15, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated pursuant to information received from a whistleblower complaint to the Office of Special Counsel, alleging inappropriate scheduling practices at the Department of Veterans Affairs Medical Center (VAMC), Little Rock, AR.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** We interviewed 13 VAMC employees.

- **Records Reviewed:** We reviewed Department of Veterans Affairs (VA) employee training records (Talent Management System (TMS) modules pertaining to patient scheduling), VA employee emails, and VA scheduling policy.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A Primary Care medical support assistant (MSA1) stated that a fellow MSA taught him to manipulate the "desired date," and that all MSAs in Primary Care were trained to "zero out" the wait time because it was how they were supposed to schedule. MSA1 further stated that he even taught new MSAs to manipulate the desired date; that the practice was still ongoing; and, that no one had advised him or other MSAs he had spoken with to enter the desired date correctly, as defined by policy. MSA1 advised that in 2011, he did not understand why his department was manipulating or altering the desired date, because he understood it to be the date requested by the patient. Once he began inputting the correct desired date, per policy, 28 patients showed extended wait times. He then received an email from MSA Supervisor 1 instructing him to reset those 28 appointments, and advising him that he had scheduled them incorrectly. MSA1 stated that this was a reprimand from his supervisor for scheduling appointments correctly and in accordance with VA policy.

- Primary Care MSA2 stated that a fellow MSA taught him to manipulate the desired date, and that he was told that this was how appointments were scheduled at VAMC Little Rock. The MSA stated that MSA Supervisor 1 instructed him to change the desired date to the next available appointment date, in order to reflect zero days for wait times. This happened not long after he started due to him inputting the correct desired dates. MSA2 believes this was a numbers' game and was done to make the facility look good by showing no wait times for veterans, but he provided no evidence to support this belief. As of the date of the interview, MSA2 had not been instructed by MSA Supervisor 1 to

properly input the correct desired date in accordance with Veterans Health Administration (VHA) policy.

- MSA Supervisor 1 initially explained to VA Office of Inspector General (OIG) staff the proper way to establish the desired date, but stated that they were not trained that way in the past. She admitted that they were trained to always zero out the wait times by making the desired date the same as the next available appointment date. She said she was taught that way when she began working at the VAMC, and that it was taught that way for years. In approximately 2012, MSA Supervisor 1 was advised by Manager 1 of the correct way to schedule, who also told her that that the current (incorrect) method of scheduling would zero out wait times. MSA Supervisor 1 told VA OIG staff that she disseminated this new information to employees via email; however, no one followed up to ensure everyone understood the change. She also reported that a recent internal audit determined that her section appeared now to be scheduling correctly. She estimated that her employees had been scheduling correctly for the previous 6 months, and that she advised her employees how to schedule correctly at least 6 months prior to the date of the interview. MSA Supervisor 1 stated that she was aware of the 2010 VA policy that regulated patient scheduling procedures, but advised that she had just seen it for the first time approximately 2 weeks prior to the date of the interview.

- Primary Care MSA3 named a different fellow employee as the individual who taught her how to zero out wait times, and who told her that this was the proper method for scheduling appointments at VAMC Little Rock. She identified a Supervisory Health Systems Specialist assigned to the chief of staff's office as the person she was instructed to call if she had a problem regarding scheduling, and that this person had instructed her to continue scheduling appointments the way she always had (meaning, zeroing out wait times,) even after media reports of the allegations at VAMC Phoenix[*] began to surface. MSA3 received instructions to zero out wait times as recently as the morning when she was interviewed by VA OIG staff.

- Primary Care Supervisor 2 stated that she was an MSA for 4 years and reported directly to the Supervisory Health Systems Specialist during that time. The Supervisory Health Systems Specialist taught her and the other MSAs to zero out the wait times when scheduling appointments, and if wait times were over 30 days, he instructed them to remake the desired date to zero out the wait time. Supervisor 2 knew they were manipulating the system, but stated it was what they were trained to do, and that this was also how she taught others to schedule. Approximately 2 years preceding the date of the interview, Supervisor 2 was informed by Manager 1 that she and others were not scheduling in accordance with VA policy, so she immediately began training her employees to schedule in the correct manner. Because MSAs had been accustomed to improperly manipulating the desired date for so long, many were confused as to the meaning of the term, so implementing change in their scheduling practices was difficult. In May 2014, Manager 2 held training for the facility's management on inputting the correct desired date, as defined by the patient. Supervisor 2 said that the Supervisory

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

Health Systems Specialist was present for the training. Supervisor 2 also worked with the New Enrollee Appointment Request (NEAR) List, which consists of names of veterans who requested an appointment during their enrollment process at VAMC Little Rock. She explained that VA policy mandates that the VA must attempt to call these veterans on three separate occasions. If all three calls were unsuccessful, VAMC staff must send a certified letter to the veterans advising them to call the VAMC to schedule their appointment. Around May 2014, another supervisor officially began oversight of the NEAR List, and advised Supervisor 2 to call the veterans on the NEAR List only once. If there was no answer, his instructions were to leave a message and send a certified letter to the veteran. The other supervisors allegedly told Supervisor 2 that the reason for this was to "hurry up and get through and move on to the next one." Supervisor 2 knew that this was a violation of policy, so she continued to call three times before she sent letters to veterans. Supervisor 2 sent the other the Supervisory Health Systems Specialist an email requesting clarification of his instructions, and the Supervisory Health Systems Specialist reaffirmed them. The email string was provided to VAOIG staff.

- The Supervisory Health Systems Specialist told VA OIG staff that he had never instructed anyone to zero out wait times, and that he was also unaware of anyone instructing others to schedule inappropriately. The Supervisory Health Systems Specialist specified that he had never scheduled appointments by inputting the "appointment date" as the desired date, and that no one had told him they were scheduling incorrectly at VAMC Little Rock over the last couple of years. He said that if he saw an MSA zeroing out a wait time, he corrected them and told them it was inappropriate. The Supervisory Health Systems Specialist advised that he sends the NEAR List to Supervisor 2, and she and other MSAs call the veterans on the list to negotiate appointments. The Supervisory Health Systems Specialist described the current practice for contacting veterans on the NEAR List as: "call them three times and then send them a certified letter." He stated that this ensures that VAMC has exhausted all means to contact the veterans. He stated that he has never told anyone to call the veterans only once. He also stated that he did not attend the May 2014 training in which Manager 2 instructed management on the appropriate use of the desired date.

- VAMC Little Rock Senior Leader 1 correctly described to investigators how appointments should be scheduled in regard to what the desired date was versus the next available appointment date. She stated that the first time she heard about MSAs manipulating the desired date was during a May 2014 meeting with other members of the VAMC's leadership. That was also the first time she had heard the phrase zeroing out wait times. Senior Leader 1 said that neither she, nor anyone else at the meeting, had any idea that MSAs were scheduling in that fashion; she stated the practice was absolutely wrong. When they learned that this was actually taking place, they wanted to retrain the MSAs, but the Veterans Integrated Service Network (VISN) advised them not to conduct any training until further notice. The thought was that VA Central Office was going to send out a new scheduling package or change how appointments were to be scheduled.

  Senior Leader 1 stated that she did not know why MSAs manipulated the desired date, and added that there is no benefit at all to doing so, emphasizing that management did not

receive bonuses for minimal wait times. She was not aware of MSA supervisors instructing their MSAs to schedule this way. She stated that newly hired MSAs must successfully complete training modules in the VA's TMS before being granted the ability to schedule appointments. Once they obtain this ability, the MSAs are mentored in the Primary Care Call Center where they receive additional experience. Senior Leader 1 also said that zeroing out wait times was never officially taught at the VAMC. The message from VAMC leadership has always been to do what is right for the patient. If they could not get a patient scheduled to be seen in a clinic in a timely manner, they would outsource medical services to ensure timely care. She also stated that VA's 2010 scheduling policy is difficult, as it contains different definitions of desired date at different places within the document. In one instance, desired date is defined as the date on which the patient or provider wants the patient to be seen. In another instance, it is defined as the date requested by the patient, without regard to scheduled capacity. There was no mention of the provider in this second definition. Senior Leader 1 described the correct procedures for removing a veteran from the NEAR List, and stated that she would be very surprised to learn that the Supervisory Health Systems Specialist instructed someone to call veterans only once before removing them from the list.

- VAMC Little Rock Manager 1 stated that her position required her to run access reports, which showed the wait times for patients outside of 14 days. She audited scheduling data for outliers at least every month, which identified scheduling errors or whether the VAMC needed to devote resources to patients' access to care. She reported her findings to VAMC senior leadership and the administrative officers of the various departments to identify the number of patients who were not being seen in a timely manner, or what errors the schedulers had committed.

  She also provided oversight for MSA training, and she personally received access training and learned scheduling as part of her duties for oversight. She stated that after MSAs are hired, they are required to complete VA TMS training modules, which instruct them how to properly schedule appointments. VA Central Office standardized this training nationwide. Successful completion of these TMS modules is required before MSAs can gain access to VAMC systems for scheduling patients for appointments. Manager 1 stated that MSAs were not trained to zero out wait times. She said that they were confused as to what the desired date was supposed to be because it was difficult getting a patient to request an actual desired date. She explained that she thought this confusion and interpretation of the desired date was shared with other MSAs, which created an inconsistency in scheduling at the VAMC. She also felt that local training within each of the VAMC's individual departments was also inconsistent.

  In 2009, she told VAMC senior leadership that MSAs did not understand what the desired date was. She made a request to centralize scheduling training for all MSAs and their supervisors at the facility, which she would conduct face-to-face. The leadership supported this and told her to set up the training. She also created the Super Schedulers, which consisted of MSA supervisors and those with scheduling experience to standardize the training. All MSAs and their supervisors attended this training. This training emphasized the desired date as the date requested by the provider or the patient.

In 2013, she found that many MSAs were still confused as to what the desired date was. Manager 1 again advised senior leadership and again requested to conduct face-to-face training with all MSAs and their supervisors at VAMC Little Rock. The leadership again supported her and advised her to set up the training. Manager 1 provided VA OIG staff with two reference cards that she normally provided to MSAs, consisting of 2007 and 2010 versions. Both cards referenced the desired date as the date the patient or provider requests. The November 2010 card contained the statement in large bold letters, "**Desired date is not determined by appointment availability**." Manager 1 never thought that anyone was purposely manipulating scheduling data. She never saw or heard anybody instructing MSAs to manipulate wait times, nor did she ever get the impression from any of the VAMC senior leadership that they had to fix data to make the facility look like they were meeting national performance measures. Manager 1 stated that the culture among the senior leadership at VAMC Little Rock was to do what was right for the veterans, and to fix what was broken.

- VAMC Little Rock Manager 2 stated that his department determined whether or not to place new enrollees on the NEAR List. If they did, Primary Care staff processed the patient from that list. He stated that on at least a weekly basis, VAMC senior leadership and Primary Care management reviewed the report to ensure patients were not left on the report for very long. This was part of the access review process. He stated that this same group also reviewed the Electronic Wait List. The purpose of the reviews was to ensure that the VAMC had adequate resources to address whatever backlogs that occurred in a particular area.

  He explained to VA OIG staff the correct procedures for removing a patient from the NEAR List, as directed by VA policy. He said three attempts must be made to call the veteran. If they cannot contact the veteran by telephone, they must send the veteran a certified letter. He was not aware of a policy that allows them to deviate from that process. He routinely trained schedulers as national policies changed and evolved. He also stated that all schedulers received proper training, to include their supervisors. Part of the training he performed addressed desired dates, and he correctly articulated VA's definition of desired date as the date the patient requests for an appointment. He was not aware of anybody being taught in the training to make the desired date the same as the next available appointment date.

  He also attended Manager 1's training, the first time being in 2004 or 2005, and added that he would be shocked if an MSA supervisor who had been at the facility for several years justified manipulating scheduling data by saying that this is how it has always been done, or that they did not know the proper procedures for scheduling. Manager 2 had recently heard the term zeroing out wait times in the media, but had not heard that this practice was occurring at VAMC Little Rock. He also stated that VAMC senior leadership recently asked for scheduling audits to be conducted more frequently, and that they also recently decided that they needed to start from scratch and retrain supervisors and front-line schedulers to ensure everyone was operating consistently.

  He stated that for as long as he had been employed at VAMC Little Rock, the senior leadership's primary concern was the patient, and added that one senior leader coined the

phrase, "But What About the Patient?" The management team had always tried to impress upon others to treat the patients as if they were a member of their own family. He never heard anyone at a higher level say they did not want anyone on a wait list. What he stated he heard was, "What is the plan to take care of these patients in the most expeditious manner possible?" He also added that department heads were held accountable and required to develop action plans to get patients seen sooner, and they had to report to senior management several times a week to discuss individual patients.

- An acting manager at the VA Community Based Outpatient Clinic (CBOC) in Hot Springs, AR, stated that there were six people at the CBOC who schedule patients—four MSAs for Primary Care, one for Mental Health—as well as a clerk at the front desk. She was not aware of any issues with scheduling or any backlogs at the clinic and added that when she needed patients to see their providers, the patients appeared to be seen in a timely manner. She stated that the CBOC recently began using the Electronic Wait List.

- VAMC Little Rock Senior Leader 2 stated that he was aware of the VHA scheduling directive, but also advised that he was not a subject matter expert on it, and relied upon his subordinates to be the experts. He stated that he was also aware of the Electronic Wait List and the NEAR List, to include the correct procedures for removing a veteran from the NEAR List. He emphatically stated that he had never advised anybody to zero out wait times, and emphasized that he had always advised his subordinates to follow VA policies and procedures. If somebody deviated from the official process, he had not advised them to do so. If any confusion arose regarding those procedures, he always sought clarification from VA Central Office or the VISN.

  He also stated that he did not understand the benefit of manipulating scheduling data, and that simply meeting one element of a performance measure would not guarantee a higher rating or a performance award for an individual or a facility, but that an award would generally be based on meeting several elements of a measure. He also stated that after the VAMC Phoenix allegations surfaced, he started having more conversations with his staff about the Electronic Wait List, and he learned in April 2014 that the list was not turned on at VAMC Little Rock. He described to VA OIG staff the correct method for removing patients from the NEAR List: three attempts must be made to reach the veterans by phone, and if they could still not be reached, then a certified letter must be mailed to them. He advised that VAMC Little Rock's goal was to have veterans seen within 90 days, and many clinics worked very hard to achieve that goal. To accomplish this, they worked overtime, double booked, and even outsourced medical care.

- VAMC Little Rock Senior Leader 3 stated she was responsible for ensuring veterans were seen in a timely fashion, and consequently, responsible for managing the Electronic Wait List, NEAR List, and scheduling. She stated that she delegated these responsibilities to subordinates, but added that she held herself accountable for access to care. She told VA OIG staff that until a focus was placed on whether or not they were using the Electronic Wait List correctly, they generally did not look at it unless there was an issue or problem with it, focusing more on clinic use and management, in terms of appointment times and scheduling. VAMC Little Rock historically used the Electronic Wait List in an intermittent fashion, using it if there was a backlog in a clinic, and if they

could not see patients within a 90-day time frame. She added that her understanding was someone had to turn the Electronic Wait List on, so it is something that was not always accessible.

She stated that she had never instructed anyone to manipulate the system, and never asked anyone to zero out wait times. She also told VA OIG staff that it was unacceptable for anyone to manipulate data in order to look good on a performance measure, and reaffirmed that the desired date should not be altered from what the veteran wishes. She stated that VAMC Little Rock senior leaders regularly stated, "I don't care what the performance measure says, you do it the right way," and she hoped that this sentiment was shared by the people she directly supervised. She did not think schedulers were intentionally or maliciously scheduling improperly, but instead thought that scheduling rules were confusing, and contained conflicting information. She added that the process had become too complex and felt it had been set up for failure.

She also stated that VAMC Little Rock had too many employees with the ability to schedule appointments. She said that providers, to include physicians and nurses, were scheduling their own appointments, which was problematic. They were now managing their own workload. She also said that scheduling was decentralized in 2008 when they established Patient Aligned Care Teams (PACTs). Recently, they significantly reduced the number of employees with the ability to schedule appointments, and continue to do so. They are also in the process of consolidating schedulers so that this was their only function, while being actively supervised by a scheduling supervisor. Regarding removing veterans from the NEAR List, she said that three attempts should be made to call veterans. If they could not reach the veterans by telephone, they would send a certified letter. She stated that she did not care what her performance rating was, and that she was only concerned with doing her best for the veterans.

- A CBOC Hot Springs MSA advised that she determined her clinic had been scheduling appointments incorrectly after she read the recent VA OIG report regarding the VAMC Phoenix allegations. She stated that they were taught to schedule that way, but they never stated that the reason or purpose was to zero out wait times. She said that they were never really concerned with the desired date, and nobody ever said they were doing anything wrong. She did not remember having any scheduling training since taking the VA TMS scheduling modules, and added that MSAs do not undergo enough training to ever really capture what they are expected to do, so MSAs essentially relied on one another when they had questions. She said that she does not consider herself properly trained.

Records Reviewed

- A review of VA TMS training records, which confirmed that VAMC Little Rock employees received instruction in the appropriate methods for scheduling patients.

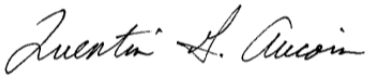
- A review of VA employee emails confirmed that certain supervisors instructed their staff to schedule in a manner inconsistent with the training and VA scheduling policy.

4. Conclusion

The investigation substantiated that both non-supervisory and supervisory VAMC employees were improperly scheduling patient appointments by manipulating the appointment dates in the VA computer system, resulting in the appearance of significantly lower wait times for veterans' clinical appointments.

Two VAMC supervisory employees displayed a lack of candor while making statements to special agents of VA Office of Inspector General regarding their knowledge and/or participation in the manipulation of patient waiting times. This was based on testimonial evidence and a review of email.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 24, 2015.



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