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

VA Central Western Massachusetts Healthcare System
Mental Health and Primary Care Services
VA Medical Center in Northampton, Massachusetts
March 22, 2016

1. Summary of Why the Investigation Was Initiated

This case was initiated based on information provided by a Department of Veterans Affairs (VA) National Stand Down Team, which was assembled by the Veterans Health Administration (VHA) to evaluate scheduling practices at VA medical facilities. The VHA National Stand Down Team informed the VA Office of Inspector General (OIG) that an employee alleged that management at the VA Medical Center (VAMC) in Northampton, MA, was "gaming" access numbers in Mental Health by (1) encouraging the entry of inaccurate desired dates, and (2) repetitively creating and canceling clinic appointments to ultimately achieve a "desired date" closer to the actual appointment date.

The VA OIG investigation initially focused on Mental Health but expanded to Primary Care, based on new allegations received from confidential sources regarding concerns about the lack of responsiveness to consults and the failure to use the Electronic Wait List (EWL).

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** More than 20 individuals were interviewed, including scheduling supervisors and employees, quality management staff, nurses, a case manager, psychologists, the former chief of Primary Care, administrative staff for Mental Health and Primary Care, program managers, clinical application coordinators, a health care education officer, the chief of staff for Veterans Integrated Service Network (VISN) 2, and the director of the VA Central Western Massachusetts Healthcare System (VACWMHS).

- **Records Reviewed:** Documents and data reviewed included canceled and discontinued consults from January 2012 through August 2014, which included a comments field with narrative related to the reason for cancellation or discontinuation, and relevant emails and records provided by staff and confidential sources.

3. Summary of the Evidence Obtained From the Investigation

The VHA National Stand Down Team disclosed that an employee had concerns management was gaming access numbers in the Mental Health Clinic by allegedly repetitively creating and canceling clinic appointments to ultimately achieve a desired date closer to the actual appointment date. The complainant had also reported that management was encouraging the entry of inaccurate desired dates and did not wish to have the conversation disclosed to either the Medical Center Director or the Quality Management Manager.

Issue 1: Entry of Inaccurate Desired Dates (Mental Health Clinic)

Interviews Conducted

- A medical support assistant (MSA1) whose responsibilities included scheduling in the Mental Health Clinic at VAMC Northampton reported that consults for Mental Health services go to the nurse who discusses them with a Mental Health team on Tuesday afternoons to identify the provider who will see the patient. She stated that another employee is involved with scheduling new patients. She stated that the desired date is what the veteran wants. When asked if it has always been that way, she said, "Yes." She was unaware of any "secret" wait list and, when asked if she had ever received pressure from management to do anything unethical related to wait times or scheduling, she said, "No."

- MSA2, another scheduling employee in the Mental Health Clinic at VAMC Northampton, reported that a nurse reviewed all the consults that came into Mental Health. She reported that the majority of the consults were scheduled by a nurse due to her large workload. She said that the desired date is the date that the veteran really wants to be seen, but she would usually tell the patient when the physician's next available appointment was, because it was easier that way. When asked if she had ever received pressure from management to do anything unethical related to wait times or scheduling, she said, "No."

- A nurse in Mental Health at VAMC Northampton reported that he managed consults for new patients. He was trained by another nurse and received online training related to scheduling. He had managed consults on his own for several months. He demonstrated how he used the desired date in the process of scheduling a patient in Veterans Health Information Systems and Technology Architecture (VistA) or "VistA Web." Using a hypothetical situation when a provider's schedule was full, he showed how the initial schedule displayed in VistA Web would go through July 3, 2014. He said, "I would then back out, and I would reenter the clinic and reenter—and then I would say no, not next available, and I would put in a desired date as the first day that I haven't checked already." He said, "I've been doing this for 7 months. I haven't figured out any other way to see that doctor's schedule except by putting the desired date in the future." He said, "Yeah, and then I put in 7/4 [July 4, 2014] because I want to see further ahead . . . if there's another way to advance this schedule other than saying desired date, I would do it." When asked whether the schedule would extend without changing the desired date field, he said, "Not that I know of. I haven't been trained to do that." When asked if he ever canceled or denied a consult due to lack of availability, he said, "No, never." When asked if he had ever heard of anything like that happening, he said, "No, not at all. . . . We have no reason to do anything like that."

- An employee in Quality Management at VAMC Northampton reported she provided "targeted" training to employees related to scheduling if they were having challenges and problems. For example, Mental Health recently found that they had a scheduler who apparently "wasn't quite getting it right." They took away his access to the scheduling system and requested a meeting to make sure that he understood what he was doing. She

said that he did not understand desired date. When asked if there were anything else other than desired date that he was doing wrong, she said that she could not remember anything specifically. She said that she made him verbalize what he was doing and demonstrate on a fake patient that he knew what he was doing. She said that the individual did not have a lot of VA experience. She also explained that, as a nurse, the issues of appointments and scheduling are challenging, especially considering that VA's system was old. She also was not aware of any schemes regarding creating and canceling clinic appointments or anything unethical related to wait times or performance measures.

- Another employee in Mental Health at VAMC Northampton reported that, lately, they were reinforcing the definitions of desired date and trying to understand what "create date" means. But it was a pretty complicated system. She did not have any specific examples of the desired date being misused.

- An employee who previously worked in Mental Health at VAMC Northampton reported that she learned during a phone call with another nurse in Mental Health at Northampton that, "I should have been hitting 'M' when I didn't see the slot." According to this nurse, she was told by a coworker that this feature brings up more dates. She said, "and the truth is, it's like so blocked there to meet with a psychiatrist or trying to get the psychiatrist who should be seeing the veteran." When asked if she would match up the desired date with the "next available date," she said, "I was." When asked if she made mistakes looking back, she said, "Yeah, maybe I didn't put the right date in. . . . The desired date, yeah." She added, "I never got trained." When asked if she ever felt pressure from management to do anything unethical with regard to wait times, she said, "Absolutely never. No." When asked if she ever felt like she was doing something to satisfy a performance measure, she said, "No, absolutely not." When asked if she ever canceled or discontinued consults because there was no availability, she said, "No." When asked if there was any instruction to cancel or discontinue consults based on availability, she said, "Absolutely not."

- A VAMC Northampton Health Education staff member provided information showing she had scheduled and completed training related to scheduling with the Northampton and Springfield nurses who were interviewed.

- A Mental Health Program Manager indicated that he was unaware of exactly how a nurse misused the desired date until VA OIG investigators explained it to him. He said that the desired date should be patient directed. He did not give any training to nurses related to the desired date. He was unaware of anyone from management pressuring the Mental Health nurse or clerks to misuse the desired date. He said, "All our clerks have the best intentions in mind and if there were desired date issues; it was through poor training or ignorance, not through a desire to manipulate the system in anyway. They all have a lot of integrity and passion in terms of helping vets." He was unaware of any pressure given from management to staff to misuse desired dates or do anything unethical and has never felt pressure from management do to anything unethical or do something outside the rules and regulations related to wait time. He said that it never got to that point, but if it ever did, it would be an issue of needing more resources. His response would have been to take it up the chain of command and ask for more resources. He was also unaware of any

schemes related to canceling or discontinuing consults to meet performance measures. He said there were times when they couldn't get someone in within 14 days and that performance measures make some allowance for that. When asked if patient care has ever been sacrificed to meet performance measures, he said "No, never," and added that it would upset him. He is proud that the Mental Health Clinic is a patient-centered clinic. He is unaware of any secret waiting list. He is unaware of any manipulation of data.

Issue 2: Repetitively Creating and Canceling Clinic Appointments (Mental Health Clinic)

Interviews Conducted

- Employees who managed the consults in the Mental Health Clinic denied being aware of any schemes regarding creating and canceling appointments. They also denied ever canceling or denying a consult due to lack of availability.

- Quality Assurance Management Specialists were not aware of any schemes regarding the creation or cancellation of clinic appointments. They also denied knowledge of anything unethical relating to wait time or performance measures.

- Clinical application coordinators stated that they were not aware of any templates within the Computerized Patient Record System that were built to manipulate wait times or performance measures, nor were they aware of anything unethical related to wait times or performance measures.

- A case manager in Mental Health did not have concerns regarding the discontinuation or cancellation of consults. She reported seeing consults discontinued or canceled in Mental Health for reasons that were justified. When asked if there was a scheme to discontinue consults due to lack of access, she said she has "no knowledge of people doing that; zip, zero." She had not experienced anything unethical related to wait times or scheduling.

- An administrative employee in the Mental Health Clinic stated that she was not aware of any manipulation related to the 14-day access performance measure. She had not heard of any manipulation related to desired dates or consults and was unaware of consults being canceled or discontinued for reasons that are not right. She clarified that mistakes were made, but they were not intentional. She also had not received any complaints from staff regarding manipulation of wait times nor had she received pressure from management to do anything unethical.

- A senior leader for VISN 2, who served as the lead on the VHA Audit Team that reviewed wait times at VAMC Northampton in May 2014, provided a list of 10 employees who were interviewed. He said that their review did not identify any significant issues based on these interviews. He subsequently provided data showing that the performance for Primary Care and Specialty Care was poor related to VHA's target goal. For the same time period, Mental Health's performance exceeded the target (70 percent) by seeing 93.97 percent of the patients within 14 days.

- A program manager stated that information related to performance measures was communicated with staff at forums such as weekly and monthly meetings. The program manager said that they brainstormed ways to improve on performance measures, to the extent that they had control over them. He was unaware of any pressure given from management to staff to misuse desired dates or do anything unethical. The program manager had reportedly never felt pressure from management to do anything unethical or do something outside the rules and regulations related to wait time. He stated that it never got to that point, but if it ever did, it would be an issue of needing more resources. His response would have been to take it up the chain of command and ask for more resources.

  He was unaware of any schemes related to canceling or discontinuing consults to meet performance measures. When given the hypothetical scenario of consults being discontinued due to lack of access to the clinic, he said that did not happen. He explained that there was the occasional situation when they couldn't get someone in within 14 days but performance measures make some allowance for that. When asked if patient care has ever been sacrificed to meet performance measures, he said, "no, never," and added that it would upset him. He is proud that the Mental Health Clinic is a patient-centered clinic. He was unaware of any secret waiting list or any manipulation of data.

- Another Mental Health provider and program manager who worked on the performance measure committee for the Mental Health Clinic was interviewed. When asked if any processes proposed or implemented by the committee were unethical, he said, "No." He was unaware of any schemes or processes that were implemented or proposed that sacrificed patient care. He was unaware of any schemes related to manipulating wait times by overbooking and then canceling consults or any scheme involving consults being canceled or discontinued due to lack of access. He identified three strategies that improved meeting the performance measure related to access: (1) protected slots for new patients, (2) having a person whose role was to be responsive to consults, and (3) staffing.

Records Reviewed

Captured data of canceled and discontinued consults from January 1, 2012, through August 5, 2014, within the Mental Health Clinic at VAMC Northampton were reviewed and analyzed. The reports also included a comments field with narrative related to the reason for cancellation or discontinuation. The review of the data identified the following:

Canceled Consults

- There were 787 unique entries for canceled consults, which is an average of approximately 25 consults being canceled per month.

- A query of the following search terms in the comments field revealed that:
  - There were zero entries for the following search terms: "performance," "reconsult," "manipulate," "template," "creative," "unethical," "gaming," "patient harm," or "poor care."

- There was one entry associated with search term "overbooked." The narrative indicated that the appointment was canceled by the clinic due to being overbooked.
- There were 18 patients associated with the search term "access." The narrative appeared to be unrelated to lack of access or wait times.

Discontinued Consults

- There were 1,300 unique entries for discontinued consults, which is an average of approximately 42 consults being discontinued per month.

- A query of the following search terms in the comments field identified that:
  - There were zero entries for the following search terms: "performance," "manipulate," "overbooked," "creative," "gaming," "unethical," "patient harm," or "poor care."
  - There was one entry associated with the search term "reconsult." The narrative appeared to be unrelated to manipulation or wait times.
  - There was one entry associated with the search team "template." The narrative appeared to be unrelated to manipulation of wait times.
  - There were 35 entries associated with the search term "access." The narrative appeared to be unrelated to manipulation of wait times.

Issue 3: Additional Information: Lack of Access and Use of the Electronic Wait List

Interviews Conducted

- Confidential sources were interviewed regarding gaming the system by repetitively creating and canceling appointments and concerns of lack of access to primary care. The confidential sources provided records showing that a patient seeking primary care services did not receive an appointment for more than 7 months because it was reportedly "lost in the system."

- A supervisory MSA for Northampton Primary Care and Specialty Care stated that Primary Care had not used the EWL because, to her knowledge, they had never needed to use the EWL. She said they try to get patients in within 30 days. She also stated that she was not aware of anything unethical in Primary Care or Specialty Care related to wait times or scheduling.

- Another MSA employee whose responsibilities included scheduling new patients who showed up on the New Enrollee Appointment Request (NEAR) list stated that she had not used the EWL because she had not needed to use it. When asked if she were aware of anything unethical related to wait times, she said, "No." When asked if she were aware of any secret waiting list, she said, "No." She added that she is proud of the work that they do at the VAMC.

- A former Northampton Primary Care senior manager was interviewed. He reported that, until approximately February 2014, there were wait times and they struggled to get veterans seen within 14 days because they lacked physicians or staff. He was unaware of any schemes related to wait time manipulation or scheduling. He was not aware of anything that happened at VAMC Northampton similar to what he heard about in the news related to the VA in Phoenix*, AZ.

- A Northampton Primary Care administrative staff member was unaware of any scheme regarding overbooking or canceling of consults. He was unaware of any scheme used in Primary Care or Specialty Services to manipulate wait times or any secret or hidden lists related to patient appointments.

- A Northampton Primary Care scheduling supervisor reported that they had never met wait time performance measures at the Community Based Outpatient Clinic (CBOC) in Springfield, MA. The employee said that the current access to the Primary Care Clinic at that CBOC started at 52 days and went out to 90 days. The employee also reported that they had not used the EWL.

- An MSA at the same CBOC and responsible for scheduling new patients stated that he had never felt pressure to do anything unethical related to wait times or performance measures. He was not aware of anyone doing anything unethical related to wait times at CBOC Springfield. He was confident that people are doing things the right way.

- A program manager in Mental Health who was also interviewed regarding other issues reported he had never seen the EWL in use or used it. He did not believe clerks had received training related to the EWL until recently. He did not know why the EWL had not been used. If he saw it on a policy and asked about it, he was told that Mental Health didn't use the EWL. He said that a physician told this to him. He reported that the Pain Clinic had access that is beyond 90 days. He later reported that Psychological Testing was an area that was currently over 90 days and had probably been over 90 days in the past.

- A Quality Management staff member who was also interviewed about other issues was interviewed regarding training and the EWL and provided PowerPoint training slides on the correct use of the EWL. She reported that Primary Care scheduling staff were provided training to management regarding use of desired dates, recall software, use of the NEAR list, and correct use of the EWL. She said that the slides were used at training and were provided to the participants. She checked with a few Service Lines and they had been using these as resources for refresher training.

  She also provided data identifying the number of new patients who waited greater than 90 days from January 2012 through July 2014 for services to include Pain Clinic, Podiatry, Optometry, and Neurology, along with Primary Care at CBOC Springfield. In addition, she provided information to identify the number of times the EWL was used for

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

these services. The data for Psychological Testing related to the number of new patients who waited greater than 90 days was inclusive; however, the data did show that the EWL was not used for Psychological Testing.

- The director of VAMC Northampton was interviewed. He explained that he had recently been meeting with scheduling staff to listen to concerns and to further learn about what they do. He had not heard of any complaints about staff being pressured to do anything unethical related to wait times or scheduling. He said that there appeared to be confusion related to desired dates, partially due to the many variances that occur during scheduling. He acknowledged that the facility might have missed opportunities to use the EWL in areas such as Optometry, Podiatry, and Neurology.

  Regarding the misuse of the desired date to expand a provider's schedule, he became aware of this within days after VA OIG interviewed staff and identified the issue. He said that a nurse was retrained on scheduling and the use of the desired date. He said that they were in the process of setting up a position strictly dedicated to training scheduling staff and auditing scheduling practices. He was not aware of any intentional misuse of the desired date.

  Regarding the EWL, he was aware that the EWL was not always used when it could have been. They were pushing hard for staff to use the EWL. He was not aware of staff not using the EWL as a way to manipulate performance measures. When asked when he became aware that EWL was not being fully used, he said, "in June or July 2014." He explained that when a scheduler booked a patient beyond 90 or 120 days of their desired date, there was an alert that would come up regarding the EWL. He said that in the past, schedulers chose to go ahead and just book the patient rather than putting him/her on the EWL.

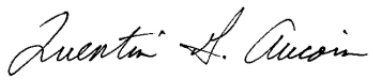
Records Reviewed

The information provided by Northampton Health Education staff showed that one Mental Health nurse completed the mandated module training (Recall Reminder, Make Appointments, Business Rules, and Soft Skills) in 2010. Another Mental Health nurse reportedly completed three of the four modules in 2013 and the remaining module in 2014.

4. Conclusion

The investigation revealed that Mental Health scheduling staff misused the desired date when scheduling in response to consults. Evidence indicates that the misuse was primarily caused by a lack of understanding of the system and not pressure from management to meet performance measures. The investigation also revealed that the EWL was generally not used throughout Service Lines although there were opportunities when it could have been applied. The investigation did not identify any schemes or gaming of the system that was intended to improve performance measures. No specific patient harm was identified as a result of the above allegations.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on October 31, 2014.



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.