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

VA Medical Center in San Juan, Puerto Rico
March 21, 2016

1. Summary of Why the Investigation Was Initiated

The investigation was initiated based upon a Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline complaint alleging multiple issues that involved mismanagement by the director, VA Medical Center (VAMC) in San Juan, PR. These issues included "gaming" wait lists in Primary Care and specialty clinics by Health Administration Service (HAS) staff under the direction of the chief of staff (COS), and the associate director (AD).

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG agents interviewed HAS schedulers and supervisors in Primary Care, as well as a specialty clinic and the director, VAMC San Juan.

- **Records Reviewed:** VA OIG reviewed Clinic Appointment Availability Reports (CAARs) for VAMC San Juan; emails of the VAMC Director, AD, and COS; and performance appraisals and award documentation for the VAMC Director and AD

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- HAS Clerk1 stated that he is responsible for scheduling veterans for appointments within Primary Care. He stated that clerks scheduled appointments by checking the "desired date" of the veteran based upon the providers' follow-up orders. If a veteran cannot be scheduled within 14 days of his/her desired date, the clerk looked for the "next available date," asked the veteran if that date was acceptable, scheduled the appointment, and entered the appointment date as the veteran's desired date.

- An HAS manager stated that clerks schedule veterans' appointments by asking the veterans for their desired date, then inputting that date, then checking for availability, and scheduling the appointment within 14 days of the desired date. She stated that this process was how clerks were trained to schedule appointments. She also stated that when the scheduling directive came out, they scripted how schedulers were to make appointments and provided the scripts to the clerks. She denied that clerks used the next available appointment date instead of the veterans' desired date to meet the 14-day goal. She further denied that the AD ever told her to "game" the system to meet Veterans Integrated Service Network (VISN) goals. In addition, she said that the COS never mandated any follow-up criteria for Primary Care.

- HAS Clerk 2 in a specialty clinic stated that he was responsible for scheduling veterans for appointments within the specialty clinic. He stated that clerks scheduled veterans for their appointments by checking the desired date of the veterans based upon the providers' follow-up orders. If a veteran cannot be scheduled within 14-days of his/her desired date, the clerk looked for the next available date, asked the veteran if that date was acceptable, scheduled the appointment, and entered the appointment date as the desired date of the veteran. He stated that his supervisor would "be all over [him]" if he scheduled a veteran beyond the 14-day desired date. He related a situation when he could not schedule veterans for appointments after a doctor had to cancel appointments due to a leave of absence. He stated that he tried to reschedule as many veterans as he could; however, once all the slots were filled, he had to provide the remaining list of veterans to an HAS Supervisor for action. He stated that he did not know what the supervisor did with the remaining veterans. He stated that HAS supervisors typically told them not to exceed the 14 days. He further stated that HAS supervisors also told schedulers that their performance appraisal was based upon scheduling veterans within 14 days of their desired date. He added that he was unaware of any shredding of patient lists.

- HAS Supervisor 1 denied ever telling anyone to change veterans' desired date to the next available appointment date. She stated that management wanted to meet the 14-day desired date goal of 99 percent. She did not recall ever telling any of her employees that there were issues with scheduling veterans within 14 days of their desired date. She stated that if HAS staff cannot contact a veteran, they would send a letter to the veteran with an appointment date selected.

- HAS Supervisor 2 of a specialty clinic stated that there was a lot of pressure to meet the 14-day desired date requested by veterans. Scheduling appointments within 14 days of desired dates was mandatory. He stated that he routinely stressed the need to meet the 14-day policy to his subordinates. He stated that if his clinic did not meet the 14-day appointment window within 98 percent of the time, he received a report from his supervisor and was asked to determine whether there were scheduling errors or if there were an access problem. He stated that if his clinic met the 98 percent scheduling rate, he did not hear from his supervisor. He stated that he received scheduling training in 2009, and was taught to manipulate and game the system by looking up appointment availability; telling the veteran what was available; and scheduling the available date as the veteran's desired date. He stated that there was an access problem and the numbers did not reflect the fact that he did not have enough HAS staff nor did the specialty clinic have sufficient provider staff.

- The director of VAMC San Juan stated that he was unaware of any inappropriate scheduling at VAMC San Juan and never condoned it. He stated he did not order, nor did anyone in management ever direct, VAMC staff to game or manipulate veterans' appointments in order to the meet the 14-day desired date policy.

Records Reviewed

- A review of CAARs for VAMC San Juan, from October 2012 through June 2014, corroborated that HAS schedulers in Primary Care and a specialty clinic used the clinic's

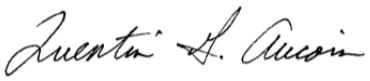
available date instead of the veterans' desired date.

- A review of emails belonging to the VAMC San Juan Director, AD, and COS (that is, 140,056 emails with 154,084 attachments) did not identify any emails from VAMC San Juan senior management directing staff to manipulate scheduling in order to meet veterans' desired date within14 days. The review did identify emails that corroborated access issues, including staffing shortages and delays in scheduling veterans within the specialty clinic.
- A review of the VAMC Director's performance appraisals and performance award documentation did not disclose any evidence that he received bonuses or performance ratings solely based upon facility access levels.
- A review of the VAMC AD's performance appraisals and performance award documentation did not disclose any evidence that she received bonuses or performance ratings solely based upon facility access levels.

4. Conclusion

The investigation found that VAMC San Juan HAS schedulers in Primary Care and a specialty clinic used the clinics' next available date as the veterans' desired date and changed appointments that fell outside of the 14-day desired date policy to be within 14 days. Schedulers stated that there was no senior management direction to manipulate wait times; however, pressure from first-level supervisors to meet the 14-day goal was clearly evident. The manipulation of wait times appeared to be an unintended consequence of this pressure combined with limited availability of appointments within 14 days of the desired dates. The investigation did not identify any inappropriate destruction of records by VAMC San Juan staff related to scheduling outpatient appointments. A review of the director's and the AD's personnel files did not identify any bonuses or appraisal ratings solely tied to patient access levels at the facility. The employee who taught the staff in 2009 was retired at the time of the investigation and the current manager confirmed that HAS staff were being trained the proper way to schedule appointments. As for the statement made by HAS Clerk 2 about the list provided to a supervisor of veterans he/she could not schedule, the investigation was unable to corroborate this claim.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 29, 2014.



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