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

VA Medical Center in San Diego, California
March 30, 2016

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) investigation was initiated by a confidential source who alleged that four supervisors at the VA Medical Center (VAMC), San Diego, were pressuring the employee to "fudge the desired date" for veterans appointments.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the complainant, VA OIG investigators interviewed three medical support assistants (MSAs) and the current supervisor[*].

- **Records Reviewed:** VA OIG reviewed a spreadsheet detailing appointments made by MSAs in 2013 and 2014.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant alleged that the supervisors said the proper way to gather the desired date from a veteran was to offer the veteran the next available appointment and then ask, "When would you like to be seen?" The complainant stated this was not how he/she was trained; the complainant was trained to begin by asking the veteran when he/she wanted to be seen.

  The complainant said he/she was repeatedly given this direction verbally, never in writing. The complainant said he/she knew this was not the correct way to schedule patients so he/she refused to schedule that way. The complainant finally gave in to the way the supervisors wanted the staff to schedule patients, after continually being encouraged by management to schedule its way. The complainant noticed he/she received certain benefits, including a higher performance rating, once he/she conformed to management's scheduling practices, and believed this was due to his/her scheduling the way management advised.

[*] We did not interview the other three supervisors because the scheduling instructions they gave the complainant occurred prior to the release of VHA Scheduling Directive 2010-027. Our investigation focused on activities that occurred after the release of this directive.

- MSA1, whose scheduled appointments reflected 70 percent of all appointments had no wait time according to the record review, stated he had been working for VAMC San Diego for a couple of years as an MSA. He stated that he had never been asked to alter wait times or desired dates by any of his superiors. Furthermore, he stated he only recently had heard that there was a "rule" that patients should wait no more than 14 days to be seen by a provider. He stated he discussed this with his supervisor and was told that he shouldn't be concerned with the wait time. He said he was encouraged to ask the patient when he/she would like to be seen. Regarding zero-day wait times for 70 percent of his appointments, he stated that the data more than likely reflected that the appointments the physicians scheduled were set in stone. He said in the specialty clinic where he is assigned, it's not uncommon for the therapists to set appointment dates for their patients. Thus, when he inputs the appointment he already knows what date to schedule it per the physician's order.

- MSA2, whose scheduled appointments reflected 70 percent of all appointments had no wait time based on the record review, stated that he had been working at the VAMC for about a year at the time of the interview. He received his MSA training via Talent Management System (TMS) and by shadowing other MSAs. He stated he had never been asked to alter wait times or "desired dates" in the system. He said, "Once a desired date is in the system, it should not be changed." Regarding canceled and rescheduled desired dates, he stated he did not capture the previous desired date. It was his practice to reschedule a patient as if scheduling an entirely new appointment; thus he did not input the previously requested desired date. He said this was how he was taught to cancel/reschedule appointments.

- MSA3, whose scheduled appointments were identified by the record review as having no wait times 99 percent of the time, stated he was formerly located in Area 1E and had been with VA for many years. He said he worked at several VA facilities, including the facility in Oceanside, CA. He said he had never been told by superiors to alter desired dates or wait times in the system. While working in Area 1E, the majority of the appointments (follow-ups or otherwise) were set by the physician. Thus, when he scheduled an appointment, there was generally no wait time because the doctor had more than likely discussed with the patient when he/she was to come back for a follow-up. When shown the results of the record review, wherein his appointments indicated that he was able to schedule veterans with no wait time 99 percent of the time, he stated the figures were accurate because of the reason he mentioned previously–that physicians usually scheduled the dates when their patients needed to come back for an appointment.

  MSA3 stated he did not always lead with "When would you like to be seen?" when scheduling a veteran for an appointment. He said there were times when he would pull up the calendar and tell the patient when the next available appointment was, then ask when the patient would like to be seen. He said he did not see a problem with scheduling this way when he knew the availability of certain clinics. When asked about his supervisor, he said the individual was a good supervisor and there was never a time when he had asked him to change wait times.

- A supervisory MSA stated that the MSAs he oversaw had received guidance on how to acquire the desired date for veterans by asking, "When would you like to be seen?" He stated the desired date was never to be altered once inputted. He said that the only time a desired date was altered was when a patient canceled an appointment and rescheduled for a different appointment date. At that time, a new desired date would be entered into the system as the patient had essentially canceled his/her former desired date. With clinic cancellations, MSAs could look in the system and capture a patient's original desired date.

  He added that if MSAs were not doing so, then "they are being lazy" as the action requires no inconvenience. Regarding bonuses, he said that MSAs only received bonuses as it related to their work performance; they did not receive bonuses for keeping wait times under a certain number. Similarly, he did not receive bonuses because clinic wait times were below a certain number. He said that he had not given any MSA guidance to alter desired dates or wait times and explained there would have been no point in doing that. He stated that he had discussed with his immediate supervisor the possibility of a training session for the MSAs and that they would initiate said training within the month after the interview.

  He acknowledged there was inconsistency related to appointment scheduling within some of the departments he supervised. This was the result of appointments, either new appointments or follow-ups, being established by the attending physician(s). He further stated that it was also the result of MSAs not asking veterans, "When would you like to be seen?" or stating (for example), "The next available date is September 4th; when would you like to be seen?" to determine a desired date. In response to these issues, the supervisor stated that he would initiate refresher training for all MSAs under his supervision within a month of the interview.

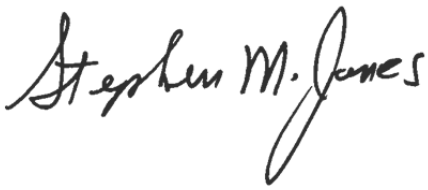
Records Reviewed

A spreadsheet on scheduling trends and the percentage of appointments scheduled as having a zero wait time for 2013 and 2014 showed that one of three MSAs appeared to have zero-day wait times for 99 percent of all appointments scheduled at VAMC San Diego. The other two employees had zero-day wait times for approximately 70 percent of all appointments.

4. Conclusion

The investigation did not substantiate the allegation that employees were being told by their supervisors to alter/manipulate desired dates or wait times.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 27, 2015.



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For more information about this summary, please contact the Office of Inspector General at (202) 461-4720.