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

VA Medical Center in Manchester, New Hampshire
March 31, 2016

1. Summary of Why the Investigation Was Initiated

This case was initiated pursuant to information provided by a complainant that (1) the Pain Management Clinic (Pain Clinic) at the Department of Veterans Affairs (VA) Medical Center (VAMC) in Manchester, NH, had "secret" wait lists; (2) the Pain Clinic had excessive wait times; (3) unidentified VAMC administrators secretly installed cameras in the Pain Clinic office and patient areas; and (4) unidentified VAMC administrators worked only 4 days per week.

The investigation disclosed that the complainant had first-hand knowledge of the excessive wait time allegation only; he received information concerning the other allegations from another source. This source also expressed a concern that the Pain Clinic might have manipulated wait time data that resulted in bonuses being paid to VAMC administrators.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed the complainant, a confidential source identified by the complainant as having knowledge of the issues, Pain Clinic nurses, and the VAMC Manchester Director.

- **Records Reviewed:** VA OIG reviewed documentation provided by the VAMC Director regarding the VA Real Time Location System (RTLS) and Action Plans; patient medical records; a VAMC internal audit of all Pain Clinic visits from January 1 to April 25, 2014; Pain Clinic Access Data from January 2013 through June 2014; monthly management reports; documentation provided by the complainant; and reports provided by the confidential source relating to tracking "next available dates."

3. Summary of the Evidence Obtained From the Investigation

Issue 1: Secret Wait Lists in the Pain Clinic

Interviews Conducted

- A confidential source identified by the complainant as having first-hand knowledge of the alleged "secret wait lists" was interviewed. This source had knowledge of "call back" lists, which were used to call patients in the event of a cancellation. The source advised he/she kept these lists: as well, that the patients on these lists already had appointments in the system (though far into the future), and described these lists as "above-board." The source said VA management did suddenly instruct staff that they can no longer have handwritten paper lists; however, the source said that these lists were not secret and not off-the-books.

- The VAMC Director initiated an internal review in April 2014, as a result of media reports about the VAMC Phoenix* allegations, which verified that the VAMC had no "secret lists." This internal review involved a team of inspectors who physically walked into each clinic to discuss their scheduling processes and asked if they had any secret lists or unauthorized paper lists. The director advised that this review did identify that clinics had paper lists called "Wait Lists," which were actually cancellation lists [as the above-referenced source confirmed]. The director explained that if veterans wanted an earlier appointment than what was scheduled, they were placed on this list in case a cancellation opened up an earlier spot. The director advised that her staff verified that 100 percent of the veterans on this list had scheduled appointments in the electronic system, and they changed the name of this list to "Cancellation List."

- A nurse with responsibilities that included Pain Clinic consults advised that she had no knowledge of secret lists, paper lists, or unauthorized lists being maintained in support of scheduling.

Records Reviewed

- An email written by the complainant stated that the Pain Clinic "has a secret waiting list causing long delays in access to pain management procedures such as spinal epidurals."

- The complainant's letter to the OIG Hotline, which focused on his own VAMC and non-VA medical care, explicitly stated that his complaints did not pertain to secret waiting lists:

> Pages 20–21: ". . . By the way, hopefully as you can see by now, my lack of pain management care access for chiropractic and acupuncture was not due to any 'secret waiting list.' I was already receiving the care I needed when it was illegally taken away apparently for budgetary reasons. This complaint is in an entirely different category than secret waiting lists and is about conspiratorial actions designed to prevent veterans from getting the care their PCP [Primary Care provider] ordered . . ."

Issue 2: Excessive Wait Times at the Pain Clinic

Interviews Conducted

- The complainant advised that he personally experienced long wait times in the Pain Clinic at VAMC Manchester. He said he had to wait more than 9 months to get an injection procedure.

- A nurse in the Pain Clinic advised that access had been a problem for the Pain Clinic since January or February 2013. She advised that they were able to make their wait time performance measures prior to January/February 2013 only because the Pain Clinic had just opened on September 17, 2012 [and the clinics/appointment slots had not yet been

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

filled]. She estimated that the Pain Clinic had not met its wait time goals over the past year and a half, prior to the interview. She said that the only possible exception to that would be around June–September 2013, when Veterans Integrated Service Network (VISN) 1 gave the Pain Clinic additional funding to help improve access, by getting the patients pain care in the community through the non-VA Coordinated Care Program [formerly known as Fee Basis]. One hundred fifty-four patients were provided with non-VA care. She advised that, as of the June 2014 interview, Pain Clinic providers showed the following next available slots for consults (new patients): 53 days, 67 days, and 84 days. At the time of the interview, she said the Pain Clinic had 6–8 pending consults.

- The confidential source said that the Pain Clinic went from having zero patients, upon opening in September 2012, to more than 1,600 patients. About 3 to 4 months after the clinic opened [or in approximately December 2012/January 2013], the wait times got longer, and veterans were waiting 3 to 4 months for injections. As time went on in 2013, wait times were "longer and longer and longer" and veterans were waiting 7 to 8 months, and at times 12 months, for injections. The Pain Clinic providers are at 135 percent utilization rates, but still booking out 9 to 12 months for injections. At the time of the VA OIG interview, two main providers were booking out to December 2014 and February 2015 for injections [so approximately 3 months and 5 months out]. Botox injections to treat headaches for Traumatic Brain Injury (TBI) patients are required every 3 months, so staff had to schedule these during what should have been their lunch break. In February/March 2014, Pain Clinic staff presented a white paper on needed improvements.

  The VAMC recently spent half a million dollars to outsource [through the Non-VA Care Program] more than 253 Pain Clinic patients waiting more than 30 days for pain management care. That money dried up in October 2014, so the Pain Clinic was expecting those 250+ patients to try to access the Pain Clinic's services in another 3 to 4 months, which would lengthen wait times again. One Pain Clinic nurse was so overwhelmed because she had piles of consults—100+ patients waiting to be processed. This pile of consults had not been formally accepted or reviewed by her and appointments had not yet been booked. The source estimated the time frames of these big piles of consults were in early 2013 and 2014, before the Pain Clinic was given money to outsource patients. The source also indicated that procedures were being overbooked, and explained how they were overbooked using one procedure as an example. The source also said if VA OIG interviewed Pain Clinic patients, they would hear "wait time horrors" and stories of multiple cancellations.

  The confidential source subsequently contacted the investigators and asked VA OIG not to go any further with this investigation regarding excessive wait times in the Pain Clinic and alleged wait time data manipulation. The source advised that VAMC administrators had taken positive steps toward solving the Pain Clinic's wait time issue, to include: (1) Hiring an additional provider in Pain Clinic/Anesthesia; (2) Hiring a medical assistant to help with scheduling; and (3) Giving the Pain Clinic more equipment and space. The source thought for the OIG to go to VAMC management at this point was unnecessary, and might result in retaliation against the source because the source thought it would be

obvious to management who made the allegations.

- Another nurse in the Pain Clinic (who originally was planning to speak with VA OIG) advised he/she did not feel he/she needed to meet with VA OIG because of the positive changes, also described by the confidential source, that VAMC administrators were making to improve the Pain Clinic's wait times. He/she said things at the Pain Clinic are "on the right track" and expects they "will improve dramatically."

Records Reviewed

A review of the complainant's medical records specific to the Pain Clinic substantiated long wait times, which included an almost 3-month (new patient) wait, from the time the complainant requested a referral to the Pain Clinic in 2012 to the time he was actually seen in 2013. From early 2013 through late 2014, the complainant received various injections/procedures, with an average wait time of 7- and 8-months.

Issue 3: Cameras Secretly Installed in the Pain Clinic

Interviews Conducted

- The complainant stated that a VA employee advised him that VAMC management secretly installed cameras in the Pain Clinic, specifically, the offices, the patient service area where they do the procedures, and in the operating room.

- Regarding the allegation that cameras were secretly installed in the Pain Clinic, the confidential source described disc-like devices that were installed in the corners of each room in the Pain Clinic, to include where they did procedures and the operating room. The source believed these devices had the capability of audio and video recording and the "word on the street" was that these devices could track equipment and possibly personnel via laser IDs built into employee nametags. The source put a piece of paper over the devices, since the source did not know what they were. The source called the device vendor who confirmed that these devices could be used to track personnel and had audio/video recording capabilities. The source concluded by saying that the source was "pretty assured now that they're for tracking equipment." The source faulted VAMC management for not having better communication when installing such new devices.

- The VAMC Director provided documentation that showed these devices, which were part of the RTLS, were for the express purpose of "asset management, cath lab supply management, sterile processing workflow, and automated temperature monitoring," and did not contain cameras or microphones. The director also provided documentation that showed VAMC staff were notified of this RTLS program and were afforded an opportunity to attend the RTLS Information Session in February 2014. Because of staff concerns, the associate director provided a brief overview of the aforementioned capabilities and directed supervisors to help mitigate these concerns with their staff during their huddles/ meetings.

Issue 4: Unidentified VAMC Administrators Work Only 4 Days Per Week

Interviews Conducted

- The complainant stated that a VA employee advised him that the VAMC administrators only worked 4 days per week. When asked to elaborate on this issue, the complainant did not provide further details.

- The confidential source, who was thought to be the source of this complaint, advised that if he/she ever said that VAMC administrators were working 4-day weeks, it was because he/she was referring to legitimate, compressed work schedules, which not everyone was allowed to work.

Issue 5: Concern That the Pain Clinic May Have Manipulated Wait Time Data Resulting in Bonuses Being Paid to VAMC Administrators

Interviews Conducted

- The confidential source advised that the Pain Clinic kept open one or two next available appointment slots within 30 days so the Pain Clinic's access appeared better than it was. The source provided some reports, which appeared to substantiate what the source said about slots being held (though the reason for this practice was not confirmed). The source also provided an anonymous summary of wait time manipulation allegations. The source advised in this summary that the wait time sample reports provided to OIG ". . . represent new patients who access the pain clinic for the first time. They represent approximately 10–15% of the total patients who are seen in the pain clinic. Waits for these appointments are significantly abbreviated as compared to the 85–90% of pain patients who are seen in the PAIN CARE CRNA F/U [Certified Registered Nurse Anesthetist Follow/Up] 30 min category. The PAIN CARE CRNA F/U 30 min category is not included in the Specialty Medicine 14-day wait and next available data.xlsx document. So the data reported does not reflect the vast majority of pain patients who are seen and the long wait times patients have had to endure until recently . . ." In this excerpt, the source was stating that wait times for new patients were shorter and the only category of patients being tracked. Established patients, also referred to as follow-up patients, were not being tracked. OIG's review of monthly management reports supports this contention that only new patient wait time data were tracked.

- A nurse in the Pain Clinic estimated that the Pain Clinic had not met its wait time goals over the past year and a half prior to the interview. She said that the only exception would be around June–September 2013, when VISN 1 gave money to the Pain Clinic to help improve access, by getting the patients pain care in the community through the non-VA [formerly known as Fee Basis] program. She provided Pain Clinic access data from January 2013 through June 2014, which showed that in those 18 months, the Pain Clinic was in the green for only 3 months, indicating that the Pain Clinic was below the VA goal (or in the red) for the other 15 months. She advised that these poor access reports are a good indicator that she's not "gaming" the system. She had no knowledge of anyone at the VAMC gaming the system, or manipulating data to improve wait times.

Records Reviewed

- Although the reports provided by the confidential source showed that VAMC management tracked these next available dates, VA-wide wait time performance measures and consequently performance bonuses were not based on these next available dates.

- A review of monthly management reports, issued from December 2012 through May 2014, showed that the wait time performance measure was "New SC Appt in 14 Days of Create Date," that is, it involved the wait time performance of all the combined specialty clinics for new patients (not established patients). This wait time measure included access data for more than 40 different specialty clinic stop codes, of which Pain Clinic was only one. Out of the 18 reports reviewed, 7 were in the green (met the goal) and 11 were in the red (did not meet the goal). A review of monthly management reports, issued from June through September 2014, showed that the 14-day wait time goal was removed from VA's performance plans on June 9, 2014, and wait times specific to the Pain Clinic continued to be in the red.

4. Conclusion

- The allegation that the Pain Clinic had secret wait lists was unsubstantiated.
- The allegation of excessive wait times at the Pain Clinic was substantiated, but positive changes had been implemented prior to the investigation to alleviate the problem.
- The allegation regarding cameras being secretly installed in the Pain Clinic was unsubstantiated.
- The allegation that management worked only 4-day weeks was unsubstantiated.
- The allegation that the Pain Clinic might have manipulated wait time data that resulted in bonuses being paid to VAMC administrators was unsubstantiated.

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

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