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

VA Medical Center in Los Angeles, California March 30, 2016

1. Summary of Why the Investigation Was Initiated

A House Committee on Veterans' Affairs staffer referred a complaint from an employee at the Los Angeles Ambulatory Care Center (LAACC) who reported that a medical support assistant (MSA) supervisor was involved in inappropriate scheduling practices. The employee alleged that the supervisor printed out a list of patient appointments and was in the habit of rescheduling any appointment with a wait time exceeding 14 days, in a systemic effort to misrepresent wait times by making them appear lower.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** The Department of Veterans Affairs (VA) Office of Inspector General (OIG) interviewed, in addition to the complainant, 21 current and former employees.

- **Records Reviewed:** VA OIG reviewed emails from the complainant, the supervisor, and other employees, and applicable policies.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant stated that she noticed her comments in the Veterans Health Information Systems and Technology Architecture (VistA) were being deleted for appointments she had scheduled. She also noticed that her supervisor was rescheduling patient appointments but not carrying the patient's "desired date" forward, which caused the desired date to become the new appointment date and made the wait time zero. She believed this was done to lower patient wait times, but did not provide any specific evidence that this was the intent. She reported that other MSAs noticed the same thing and all the MSAs who reported to the supervisor knew that he was doing it. She stated that the supervisory program specialist (SPS1) never told her she was scheduling appointments incorrectly and that he had told her that the comments he was deleting were not necessary.

- A senior management official for the facility reported that the Veterans Integrated Service Network (VISN) 22 System Redesign staff investigated the complainant's allegations and found they were true and that SPS1 had been improperly trained. The senior manager also reported that audit teams were analyzing other VA clinics for similar issues.

During a subsequent in-person interview, he stated that he was notified by the complainant in January or February 2014 about alleged improper scheduling practices by SPS1. He said that his audit tool did not show any concerns and he did not meet with the complainant at that time. He also did not report the complainant's concerns to anyone at that time. He stated that he was again made aware of complainant's concerns in April 2014. A manager in Ambulatory Care stated the allegation was that SPS1 was rescheduling patient appointments and deleting comments in VistA. He stated the VISN 22 System Redesign office staff investigated and found that SPS1 had changed approximately 680 out of the 750 appointments reviewed. The review concluded that SPS1 was improperly trained by his former supervisor and there was no intent to manipulate scheduling numbers; he was changing patient appointments in order to get patient appointments scheduled quicker. The senior manager said that administrative action had been taken in response to the VISN 22 investigation.

He also revealed that issues with improper scheduling practices had been uncovered by auditors at the Oxnard and Lancaster Community Based Outpatient Clinics. Instead of asking patients when they wanted their appointments, schedulers were telling patients what the first available appointment was and asking if the patients wanted that date. He reported that he had just learned that another employee was alleging inappropriate scheduling practices at the VAMC West Los Angeles (WLA).

- The VISN 22 Director confirmed that his staff had investigated allegations of inappropriate scheduling practices at LAACC and found them to be true. He stated that it was a training issue and there was no intent to manipulate numbers. He also provided a copy of the report of their investigation.

- A manager at LAACC reported that approximately 1 year prior to the interview, the complainant had raised concerns about scheduling issues related to her supervisor, SPS1. The manager believed that SPS1 did not instruct MSA clerks on the proper way to change patient appointments if a provider called in sick. Although it was improper, SPS1 was trying to change patient appointments by moving them up when they were not scheduled correctly. They determined that it was a training issue that led SPS1 to improperly rescheduling patient appointments. She noted that SPS1 was trained by a prior supervisor who had since retired. She thought that a Health System Specialist had looked into the complainant's concerns regarding patient scheduling about a year before the VA OIG investigation and did not find any issues. She did not recall a specific conversation but believed she would have reported this to the senior management official at the time. SPS1 had eight MSA clerks who reported to him.

  The manager also stated a former WLA scheduler had reported to her that there were improper scheduling problems at VAMC WLA. The former scheduler alleged that schedulers were instructed to overbook patient appointments. Schedulers would then call the patient back at a later time, cancel the appointment, and reschedule a new appointment. The new appointment date would then be entered as the patient's desired date. The former scheduler also reported to her that sometimes schedulers would be unable to notify patients who would then show up at their original appointment time.

- A former Mental Health scheduler stated that when a management analyst started working in Mental Health, schedulers were instructed to overbook patient appointments. Schedulers were then instructed to call the patients back at a later time and reschedule their appointments. The new appointment dates were entered as the patient's desired date. This was done to reduce patient wait times. He was told that employees would be disciplined if they failed to follow this scheduling procedure.

- The former supervisor for schedulers stated that he trained several SPSs but he never heard anyone at VA talk about manipulating data to make wait times appear better. He said that when a new appointment was made for a patient, the scheduler needed to carry forward MSA comments. He stated that he always trained his employees to carry forward comments. He denied that he ever trained anyone to rebook patient appointment dates and list the patient's desired date as the new appointment date. If patient appointments were overbooked, they would not be canceled, but would be absorbed by available providers.

- An LAACC administrative employee stated she first heard about scheduling issues at the clinic in April 2014 from an onsite manager. She reported that SPS1 was correcting MSA scheduling errors by changing appointments and desired dates. She stated that SPS1 reported that he was trained to do this. He told her that he would remove MSA comments that he felt had nothing to do with patient care and she responded that he was never to remove MSA comments. She denied that she told SPS1 to lower appointment wait times.

- MSA1 reported that it was common knowledge among the MSAs that SPS1 was deleting comments and changing desired dates to reduce patient wait times. She said there was no valid reason for him to be deleting MSA comments from VistA.

- MSA2 reported that he had heard that patient appointments were being overbooked at VAMC WLA. When patients showed up for their appointment, they were told there was no appointment in the system.

- MSA3 reported that when patients came to VA and wanted to schedule an appointment as soon as possible, a "T" was entered into VistA. MSAs would bring up the scheduling tool to find the next available appointment date and offer that to the patient. The MSA would then completely exit out of VistA, go back into VistA and schedule the appointment on the next available date, while making the desired date the same as the appointment date. This made the patient wait time zero. At a staff meeting in September or November 2013, SPS1 told MSAs this was how he wanted appointments scheduled and that was how management was telling him they wanted it done. MSA3 added that this was not the way he was trained to schedule appointments. He stated that walk-in patients would be entered into the system as unscheduled appointments. Walk-ins were now entered as an appointment for that day. This was done to make the wait time zero. This happened even if a patient only saw a nurse and not a doctor. He said MSAs never used the Electronic Wait List (EWL) and added that it was an unspoken thing that if a scheduler didn't schedule using these techniques, it would influence his/her review.

However, he did not provide any evidence that his or anyone else's review had been affected.

- A System Redesign manager reported he was given 1 day to look into the allegation regarding inappropriate scheduling practices at LAACC. He ran several reports regarding scheduling and reviewed the numbers, and he determined the scheduling of appointments was being done incorrectly at LAACC. He also reviewed providers' third next available appointment dates, as well as how far out providers were scheduling on average. He then compared those numbers with the number of days beyond the patient's desired date (which was usually 0) that appointments were being scheduled. He determined that, based upon the 3rd next available appointment dates for providers and the average number of days out that appointments were being scheduled, zero-day wait times did not seem appropriate. He concluded that scheduling data were not being recorded correctly.

  He then looked at scheduling numbers for SPS1 and the three other supervisors at the clinic and determined that SPS1 was not scheduling appropriately and not supervising his MSAs correctly. He asked all the supervisors if they ever told employees to "zero out" wait times and they all denied it. He also asked several MSAs if they were ever asked to zero out wait times. All said no, except one who asked if his answer was off the record. When he told the MSA "No," the MSA then said, "Well then, no, I was never asked to zero out wait times." He could not remember the names of the MSAs he spoke to. He stated he did not have the time or experience to determine intent or if anyone was told to zero out wait times; he just reviewed the numbers and determined that scheduling was not being done correctly.

  He stated he did not write the Veterans Health Administration (VHA) Issue Brief, dated April 15, 2014, and updated on May 29, 2014. Based on his review, he determined that SPS1was zeroing out patients' desired dates, but he did not know if patient comments were being deleted because, "we never tracked for that." He could not prove if any intentional manipulation of desired dates to improve access did or did not take place. That was put in by whoever wrote the brief.

- A lead Patient Services assistant, who did not work in Primary Care, reported that the original patient's desired date always remained the same in VistA. She would never delete patient comments, but she heard that SPS1 was deleting MSA comments from VistA and fixing errors in original appointments. She said that SPS1 should not have changed the patient's desired date in VistA, and she did not know a legitimate reason to change it. She added that changing desired dates was not consistent with the way she was trained.

- SPS1 stated that he was using the Clinic Access Availability Report (CAAR) to look for scheduling errors in VistA. He explained that he would then go into VistA and reschedule patient appointments. He would not reenter the MSA comments into the new appointment if he did not feel they were important. He stated that while this would cause lower wait times, he was not doing it to manipulate data; he was only trying to do the right thing. He stated that he was trained by his former supervisor to do this. He knew

that the practice went against the national scheduling policy and what was taught in the Training Management System Scheduling Training. He denied telling MSAs to offer patients the next available appointment date and use that as the desired date. He stated that he did tell MSAs to negotiate desired appointment dates with patients. He denied that he was rescheduling appointments in order to reduce wait times, receive a better performance rating, or to receive cash awards. He did admit that what he had done was wrong and was very sorry for the way he was doing things.

- MSA4 reported that he was not aware of any improper scheduling issues or practices in the Mental Health Department. He stated that patient appointments were never overbooked in Mental Health and that wait times were not an issue. When he worked in Primary Care several years before, MSA supervisors would instruct schedulers to enter a T in VistA when a patient wanted an appointment right away. Schedulers would then find the next available appointment, exit out of VistA, reenter the system, and schedule the next available appointment. The patient's desired date would then be the same as the appointment date. He said that supervisors would go back and forth using this scheduling method. He identified an MSA supervisor who would have information related to this.

- MSA5 reported no overbooking or patient scheduling issues in Mental Health. He also had no knowledge of anyone changing desired dates or taking steps to manipulate patient wait times. He had previously worked as a scheduler in Primary Care. He stated that at times, supervisors would direct schedulers to enter a T in VistA when a patient wanted an appointment right away. Schedulers would then find the next available appointment, exit out of VistA, reenter the system, and schedule the next available appointment. The patient's desired date would then be the same as the appointment date.

- An MSA supervisor identified by MSA4 reported there was no overbooking in Mental Health and appointments were not overbooked to reduce patient wait times. He could see someone overbooking appointments and then rescheduling them to reduce wait times, but this did not happen in Mental Health. He noted that his supervisor wanted him to start using patient wait lists, but he did not believe in them and reported they are not necessary in Mental Health and noted that these wait lists could be useful in walk-in clinics. He did have knowledge of schedulers entering a T in VistA when a patient wanted an appointment right away, finding the next available appointment in VistA, exiting out of the system, going back in, and scheduling the next available appointment. In the past, upper management wanted appointments scheduled this way. He believed that another MSA supervisor taught him this method of scheduling, but he had never used it or directed his schedulers to do this.

- SPS2 reported that the biggest problem he encountered with MSA schedulers was when they told patients what the next available appointment date was, rather than asking the patient when they wanted to be seen by a provider. He denied that he ever directed schedulers to change desired dates, to change scheduled appointments, or to delete scheduler comments in VistA.

- A manager for Outpatient Clinic operations reported that she never taught her schedulers to ask patients if they wanted the next available appointment date, then use that date as

both the appointment date and the patient's desired date. She refused to do this when she was a supervisor in Primary Care, which caused her wait times to be higher. She heard that she was moved out of Primary Care because of this. She stated that she also heard that SPS1 in Primary Care told his schedulers to make patient appointments this way. She heard that SPS1 was changing desired dates. She provided a copy of an email she sent to a senior facility manager in June 2013, in which she informed him that a preliminary look at the patients' waiting report showed that there were 2,845 patients waiting for appointments downtown in Primary Care, and 2,215 of them (78 percent) had a zero-day wait (meaning that the desired date is the same as the appointment date.) She stated, "That's a glaring red flag that the clerks are not entering the true desired date, but instead, they are finding the next available appointment and making the desired date the same as the appointment date instead of asking the patient when they want to be seen."

- A former employee had reported to VA that he sometimes worked at the reception desk within the Cardiology Department and observed an employee canceling patient appointments all day long and rebooking them. When interviewed, he said that he did not know why appointments were being canceled and did not know if anything improper was being done. He also reported that an employee in the Pre-Op Clinic would do the same thing.

- The employee in Pre-Op reported that she would cancel and reschedule appointments only when a provider called in sick or equipment was broken or overscheduled. She would not overbook appointments or reschedule appointments in order to reduce wait time or manipulate desired dates. She had no knowledge of patient wait times being manipulated.

- MSA6 who worked in Cardiology had no knowledge of patient wait times being manipulated. She would only reschedule appointments when providers were sick, never to reduce wait times.

- The former Greater Los Angeles Healthcare System (GLA) Director reported that she became aware of allegations that SPS1 was manipulating patient wait times when she received an email from the complainant around April 2014. She recalled that employees were not complying with the VA scheduling policy regarding desired dates. She identified another senior management official who was the executive in charge of overseeing this issue. After she was notified of this issue, the senior management official admitted to her that he was notified about it in 2013, by the complainant or another employee, but did not take any action. At the time, the senior management official felt it was an employee dispute between the complainant and her supervisor, SPS1. The former GLA Director stated that if the senior management official had addressed the issue in 2013, it could have been corrected then. She and the senior management official discussed the importance of investigating issues in a timely manner and she had him use this as a teaching point with another manager.

  She noted that VISN 22 investigated this issue and after the investigation the retraining of supervisors and MSAs was initiated to ensure all employees were scheduling properly. She stated that she met with the complainant and other MSAs at LAACC to discuss their

concerns. She discovered that many MSAs seemed to have been trained to schedule differently. She denied that she ever directed anyone at VA to manipulate patient wait times or use inappropriate scheduling practices to reduce wait times. She was never directed to do so by anyone at the VISN.

She believed the VistA scheduling program was antiquated and overly complex and said that it would be easier and more efficient for MSAs to schedule patient appointments if better scheduling software were adopted by VA. She also believed that much of the data collected through VistA were not necessarily helpful and did not provide useful information to VA.

Records Reviewed

- VHA Issue Brief, VISN 22: VA Greater Los Angeles Healthcare System, Los Angeles, CA, *Alleged Inappropriate Scheduling Practices*, April 15, 2014, Updated May 29, 2014.

- An EWL, Wait Time Measurement, and Scheduling Guidance PowerPoint presentation, which was provided by VAMC WLA, was identified as a summary of changes outlined in the March 15, 2013, Deputy Under Secretary for Health Administrative Operations memo. The PowerPoint presentation reads, "The scheduler asks the patient when he/she wants to be seen to determine the desired date. . . . The patient's desired date is entered into the computer and is not altered no matter when the appointment is scheduled." Several MSAs at LAACC reported that this was not the process being followed when scheduling patient appointments in Primary Care.

- VHA Directive 2010-027, provided by VAMC WLA, reads on page 7: "1. The scheduler needs to ask the patient, 'What is the first day you would like to be seen?' The date the patient provides is the desired date. . . . 2. The desired date is defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date." These two items are also contained in the GLA Policy 00-10C-10C1- 01, effective February 2012. Several MSAs interviewed at LAACC reported that this was not the way scheduling was being done in Primary Care at LAACC.

- Emails for SPS1 and other VA employees identified the following:

    - An email, dated April 2014, was sent from the complainant to the VA Under Secretary for Health (USH). In the email, the complainant reported inappropriate scheduling practices taking place at LAACC. She informed the USH that she reported the issue to the LAACC Clinic Manager in July or August, 2013, but the issue was still ongoing. In a response, the USH directed the complainant to report the issue to the WLA Director. In April 2014, the complainant reported the inappropriate scheduling practices to the WLA Director. The email chain then included the VISN 22 Director. The next day, another employee emailed the Assistant Deputy Under Secretary for Health Clinical Operations, the Director, Network Support and other officials and reported, "[an employee] ran the data last night and it looks like

[the complainant] is right- there appears to be inappropriate actions by the supervisor." This email chain disclosed that the former director was informed of inappropriate scheduling practices at LAACC in April 2014.

- A memo found in the email review, from the Deputy Under Secretary for Health for Operations and Management, dated April 26, 2010, to all VISN Directors discussed inappropriate scheduling practices. "The purpose of the memorandum is to call for immediate action within every VISN to review current scheduling practices to identify and eliminate all inappropriate practices including but not limited to the practices specified below." The memo continues, "It has come to my attention that in order to improve scores on assorted access measures, certain facilities have adopted use of inappropriate scheduling practices sometimes referred to as gaming strategies." One such "gaming" strategy outlined in the memo was ". . . allowing the Desired Date not to be documented prevents sites from knowing whether the patient was given an appointment within 30 days."

- In April 2014, the complainant emailed the VISN Director and expressed her concern that after [the System Redesign manager] visited LAACC, ". . . their visit seems to focus more on the MSA's and how many errors/mistakes are being made by them, rather than on my initial complaint." The complainant continued, "There is only (one) reason why a supervisor would alter the desired dates of patients appointments, it is being done with intent to give the false impression that there is no wait times for patients."

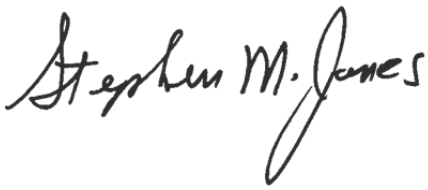
- In May 2014, the complainant emailed the GLA Director and again expressed her concern that, ". . . everyone seems to be focusing their attention in on the MSA's and how they need to be trained/re-trained on scheduling." She added, ". . . my initial complaint was regarding a supervisor intentionally altering patients' desire dates to bring down wait times. It seems that no one has addressed this issue."

The email review did not identify any evidence that SPS1 or anyone else was intentionally manipulating the system to make wait times appear lower.

4. Conclusion

The allegation that SPS1 was accessing the VistA scheduling system and rescheduling patients in violation of VA policy was substantiated. Although this was an intentional deviation from VA policy, the investigation did not substantiate that this was being done specifically to manipulate data in order to artificially lower wait times. VISN 22 investigated the allegations before the VA OIG investigation and took corrective action.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 9, 2015.



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