

**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 congressional staffer for the House Committee on Veterans' Affairs and a confidential source that the Department of Veterans Affairs (VA) Medical Center (VAMC) in Manchester, NH, had manipulated wait time data, to include entering the "next available date" as the patient's "desired date," which resulted in the appearance of a zero-day wait time.

New allegations regarding manipulation of the create date, which was the most recent wait time standard, were received during this investigation.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed more than 30 individuals, including physicians, nurses; nurse managers; administrative and scheduling staff; assistants to senior managers; the chief of Medicine; the former acting associate director; the VAMC Manchester Director; and the Veterans Integrated Service Network (VISN) 1 Director.
- **Records Reviewed:** VA OIG reviewed documentation including Veterans Health Administration (VHA) policy, wait time data from 1/1/2009 to 5/1/2014, MUMPS¹ reports, monthly management reports, Quality Executive Board meeting minutes, annual scheduling directive compliance certification, emails obtained from staff, internal memos from VHA and Manchester management, VHA site visit close-out reports, and documents obtained from VISN 1 Director concerning wait time data.

3. Summary of the Evidence Obtained From the Investigation

Issue 1: Wait Time Manipulation Regarding Desired Date

Interviews Conducted

- A confidential source advised that, from approximately late 2009/early 2010 through at least November 2011, desired dates were knowingly manipulated to meet wait time performance measures at this VAMC. The source advised that he/she contacted VHA Support Service Center (VSSC) via telephone, asked how his/her service could improve on wait times, and was told that the source needed to enter a desired date that matched the appointment date. The source would daily check the 14-day list [a computer-generated

¹ MUMPS refers to the Massachusetts General Hospital Utility Multi-Programming System. A routine using MUMPS captures scheduling information and generates a report with specific focus on information regarding desired dates.

report of patients with appointments scheduled more than 14 days past the desired date] and then “. . . have to go in and change that desired date to make it look like the patient wanted to be seen on the date of the appointment.” The source advised that VAMC management was aware of this manipulation, including the assistant to the chief of staff and the quality manager. The source advised that even the VAMC Director at the time remarked on how the wait time numbers for the source’s place of work, which had long-standing access issues, were suddenly in the “green,” and reportedly said he didn’t know how the source did it, but to keep doing it.

- An administrative officer advised that they were never instructed to establish the desired date based on a clinician’s availability. She indicated that in 2011 and earlier, scheduling clerks would say, “I’m calling to schedule you an appointment, this is what I have.” She said this changed in 2011 and now, at the time of the interview, they would say, “I’m calling to schedule you an appointment, when would you like to be seen?” In either late 2011 or early 2012, she noticed that a Mental Health Clinic nurse scheduled appointments the wrong way. She said the nurse told her she was trained by a former administrative officer to give patients an appointment date and if they agreed that was the desired date.²
- A former Mental Health nurse stated that from approximately late 2010 through early 2012, she was entering an incorrect desired date by inputting the appointment date as the desired date rather than the veteran’s actual desired date. She said a former administrative officer told her to do it this way, and she learned later from another Manchester administrative officer that it was wrong. She said, “. . . Basically what it was, was scamming the system and it wasn’t fair to the veterans either . . .”
- An assistant to a senior Manchester manager stated that what “the system found, a number of years ago, probably back around 2009, was that people were gaming the desire[d] date. They were putting the desire[d] date as the same time as the appointment date, and they were getting a zero result.” When asked if that happened at his VAMC, he said, “I’m sure it did. . . . It happened everywhere.” When asked if it happened just in Mental Health, he said, “No, everywhere . . . Everywhere, because the system was based on a desired[d] date.” He said, “. . . It was a result of the way the system was set up, and I don’t think people were gaming that. I think people were . . . that was just the way the system was set up.” He indicated that in 2010–2011, they changed the system so that the scheduler had to ask the patients when they wanted to be seen and that date became the desired date. He later explained that he didn’t consider it to be “gaming” the system, because it was just the way the system was set up.

² In 2012, OIG reported that VHA did not have a reliable and accurate method of determining whether VHA provided patients timely access to Mental Health Care services. OIG found Mental Health schedulers did not consistently follow procedures when establishing desired dates resulting in inaccurate and unreliable wait time data. See [Review of Veterans’ Access to Mental Health Care](#) (April 23, 2012). In 2012, OIG testified in front of the Senate ([VA Mental Health Care: Evaluating and Assessing Care](#)) (April 25, 2012) and House ([Hearing on VA Mental Health Care Staffing: Ensuring Quality and Quantity](#)) (May 8, 2012) Committees on Veterans’ Affairs on the results of the review.

- A former Manchester Mental Health manager said that a former administrative officer used to go back into the VA system and alter the desired date for follow-up appointments, because he said the schedulers entered it incorrectly. She said he changed the desired date from “T” to something closer, but didn’t know what he was changing it to. She told the staff member, “. . . You should really be looking at the records as well to correlate what you’re doing so you know that if you’re altering that you have the support to do that. . . .”
- A former acting associate director for the VAMC said that under the former director, performance measures were discussed on a regular basis, at least weekly. He said the former director emphasized performance measures, to include wait times, more than the current director. The former director would tell people to “get into the green” [referencing the green/red performance measure report]. He said that, at morning meetings, the former director and Service Line managers would review the MUMPS list, which is a list from the scheduling package used to monitor 14-day wait times on a weekly basis, and discuss why a service would have “x” number of patients on that list. He said, “It’s just back then, we were always told, ‘Work your MUMPS list to make sure that you don’t have erroneous data on your MUMPS-on your MUMPS list . . .’ . . . because if you work that list and get that number down, then your performance measure improves.” The former acting associate director said that sometimes clerks got into bad habits of giving the patient the soonest available appointment date and then entering that as the desired date, but he described this practice as “errors” identified through audits and would not describe it as the standard practice at the time. The former acting associate director stated that if high-volume clinics, such as Audiology, Optometry, and Mental Health, reported wait times that indicated they were seeing 100 percent of their patients under 14 days of the desired date, he would say there was a problem because it just wouldn’t make any sense.
- A quality care manager—when asked if it was a common practice at VAMC Manchester to enter the next available appointment date as the desired date—said she had heard that too, but because she was not directly involved with scheduling, she didn’t know if that’s what they did. She later said if that was the practice, she thought that was the people’s understanding of it. She said that now, at the time of the interview, schedulers were not giving patients the appointment date. She was not sure when it changed, but the new way was to ask the veteran, “When do you want to be seen?” rather than offering the veteran the next available appointment date.
- A Manchester nurse manager for a specialty clinic advised that back in or around 2009, she noticed that Cardiology had many pending consults and only one cardiologist; yet, Cardiology’s access numbers were good. She said this was a red flag and she knew something was wrong. She asked a former nursing staff member about it and was told the former staff member entered the appointment date as the desired date for everything, because she was trying to make a particular physician look good. When the nurse manager explained to the former nursing staff member that Cardiology wouldn’t get additional FTEs that way, because it didn’t look like Cardiology had an access problem, the former nursing staff member responded, “We’ll get in trouble otherwise.”

- The chief of Medicine at VAMC Manchester denied instructing Cardiology or scheduling staff to manipulate the desired date in this way; specifically, he said that if anyone at this facility was “zeroing out” the desired date wait time, it was not at his instruction. He said he had given pressure to his staff to “get patients in,” but he hoped it wasn’t misconstrued as, “make it look good.” He said he’d probably said it on numerous occasions, “Let’s get them in within 14 days.” He advised that desired date was a less exact term than create date, because desired date is “. . . based on a negotiation between the clerk and the patient.” He said it was his understanding that the conversation between the clerk and the patient had only recently, and in retrospect, been worked out, but he admitted this was only hearsay and he hadn’t witnessed it. He said now, at the time of the interview, it was made very clear that the conversation was supposed to be the clerk asking the patient in a cold-calling mode, “When do you want to be seen?” He believed this was only made clear after the process was already abandoned, which he found ironic. Before that, it was his understanding that the standard conversation was to advise patients that they had an opening on Day X, and to ask patients if that worked for them. If a patient said, “Well, that’s a Monday; I’d like to be seen on a Tuesday,” then the wait time would be one day [desired date plus one]. He said, “. . . That was generally the accepted norm throughout the system. . . .” He also voiced his opinion that setting an arbitrary date of a 14-day wait time goal across all specialties made no sense whatsoever since not all specialties had a medical need to be seen within that time frame.
- With respect to the annual scheduling compliance certification, a former Systems Redesign employee advised that in 2010 she was assigned to review scheduling policy, training, and meet with Service Line managers and other personnel to collect data necessary for the VHA Directive 2010-027 certification—which calls for the director to submit an annual certification of full compliance with the content of this scheduling directive certification through the VISN Director to the director, Systems Redesign, in the Office of the Deputy Under Secretary for Health for Operations and Management. She said she developed a grid of the scheduling directive. When asked about desired date manipulation, she said she was not sure if that was the biggest gap identified, though she did believe it was part of her initial review. During this review of scheduling practices, she recalled that there were a couple of “ah-ha” moments, when the review seemed to give the VAMC some clarity on scheduling practices, but she couldn’t recall specifics. She said the directive was not very concise and that, at least initially, she found that VAMC managers did not have the same understanding of acceptable scheduling practices. When it was pointed out that an August 2011 scheduling audit continued to identify inappropriate scheduling practices at the facility, she said that it took the VAMC a little bit of time to understand how appropriate scheduling should be done. She said her access review involved a little “reverse engineering,” during which they started with a list of what not to do, and from that had to extract how to do what is right. She said she did not see evidence of data manipulation to improve the wait time performance measures.
- The confidential source was contacted via telephone to specifically ask about the annual certification. The source did not remember the former Systems Redesign employee handling the scheduling compliance certification and identified another individual, an assistant to a senior Manchester manager. The source recalled that assistant bringing the certification up at a morning meeting and saying, “We’re not doing any of this, right?”

and everyone answering “No,” and then the individual saying, “Okay, we’re good.” The source guessed that the former Systems Redesign employee wasn’t familiar with the manipulation of the desired date.

Records Reviewed

- A review of Quality Executive Board (QEB) meeting minutes stated that on May 17, 2012, an administrative officer reported on scheduling compliance. Among other issues, it was stated that currently a nurse in Mental Health scheduled all consults and it was recommended that the medical support assistants in Specialty and Acute Care schedule the Mental Health consults. As a result, the director requested the scheduling workload be removed from the Mental Health nurse.
- The acting associate director identified Audiology as a high-volume clinic. A review of Audiology wait time data was conducted, which showed that from 2010–2012, when the desired date was the wait time goal, the vast majority of months indicated that most Audiology patients were seen within 14 days of the desired date. Alternatively, the data for these same months for wait times based on create date suggested a possible access problem (the annual averages for new patients being seen within 14 days of create date were: 15 percent in 2010, 26 percent in 2011, and 22 percent in 2012).
- Because Cardiology was identified as a clinic that was backlogged but still had good access numbers, a review of Cardiology wait time data was conducted and appeared to substantiate statements regarding desired data manipulation. The average percentage of patients who were seen within 14 days of create date was 37 percent while the average percentage of patients who were seen within 14 days of the desired date was 99 percent, with 10 out of the 12 months being recorded as 100 percent. Years 2010–2011 were a little more varied, but calendar year (CY) 2012 data indicated that 100 percent of new patients in Cardiology were seen within 14 days of their desired date for 11 of the 12 months. A staff cardiologist agreed that Cardiology access was historically poor because the service was understaffed.
- A review of VHA Directive 2010-027 disclosed that the director was required to submit an annual certification of full compliance with the content of this Directive through the VISN Director to the Systems Redesign Director, in the Office of the Deputy Under Secretary for Health Operations and Management.
- The investigation identified that in December 2010, the director was asked to certify that his facility was in compliance with VHA Directive 2010-027. A review of the facility’s response, in January 2011, disclosed that the former director certified that his schedulers were trained and effectively supervised to ensure the correct entry of the desired date, and that the desired date was being defined by the patient without regard to schedule capacity. No signature was required for this certification; it involved an upload of data to the national Systems Redesign SharePoint portal. It was handled by the former Systems Redesign employee who was interviewed. A June 16, 2011, email from the Systems Redesign coordinator to the former VAMC Director, with the subject line: *CBI visit: Scheduling Directive*, and which described her meeting with the VISN Compliance

Officer was reviewed. Under the section, “Ensuring Appropriate Scheduling Practices,” she wrote that an issue came up that “Per directive - can’t change the desired date while scheduling appointments. While VistA³ will not allow you to change desired date, you cancel and rebook the appointment this will allow you to change the desired date (this would be an inappropriate scheduling practice)..May need to find a way to monitor . . .”

Issue 2: Failure To Use the Electronic Wait List (EWL)

Interviews Conducted

- A confidential source advised that “the Electronic Wait List was strictly forbidden,” and at least through late 2011, VAMC staff were told in many meetings that “You will not put anyone on the electronic wait list without the entire Quadrad⁴ knowing.” The source advised the reason they were given was that the EWL “is reported directly to Central Office about why we have people on it.” The source said the scheduling system had a prompt that asked, “Do you want to add this person to the electronic wait list?” They were trained to always answer no.
- An assistant to a senior Manchester manager stated his opinion that he did not find the Electronic Wait List (EWL) to be very useful. He advised that, pursuant to the Phoenix⁵ issue in the media, VAMC management did a physical inventory of the entire facility to identify if there were any wait lists, “secret” lists or paper lists, and this review had negative results. VAMC management had even sent out a certification to the departments for them to sign. He said they came across lists used for tracking purposes and cancellation lists, but no wait lists. It was his opinion that patients shouldn’t be managed on the EWL; they should be managed with cancellation lists. He said VA should schedule the appointment and then tell veterans that they’ll be placed on a cancellation list and if they can get them in sooner, then they will. He described the EWL as bureaucratic and taking significant administrative time to manage.
- A former acting senior leader advised that the EWL was “relatively new for us.”

Records Reviewed

- A review of QEB meeting minutes disclosed that on July 16, 2009, an assistant to a senior Manchester manager discussed the VHA Scheduling Directive 2006-055 and business rules regarding the EWL to the QEB and then recommended that new patients not be put on the EWL. The VAMC Director at the time was present at this meeting and suggested an evaluation of the EWL be conducted.
- The assistant to a senior Manchester manager provided a copy of a memo dated March 15, 2013, from the former Deputy Under Secretary for Health Administration

³ Veterans Health Information Systems and Technology Architecture.

⁴ Quadrad is a term used by VAMC Manchester to refer to the four senior leaders: VAMC Director, associate director, chief of staff, and the chief nurse (whose official title is associate director for Nursing/Patient Services).

⁵ Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

Operations (10N) to Network Directors, whose subject line read: *Electronic Wait List (EWL) and Wait Time Measure Changes*, and stated its purpose as making two important changes that standardize the use of VHA's EWL and convey changes in timeliness measurement methods. This new change was to take effect April 8, 2013. The memo specified that only NEW patients who requested an appointment anytime within the next 90 days, but cannot be scheduled due to unavailable clinic capacity, would be placed on the EWL. This memo conceded that "use time" up until that point varied.

- A review of VAMC Manchester's June 2013 response titled "Scheduling Process Checklist" stated that the "EWL is not currently being used consistently but will be activated for use by September 30, 2013.
- A review of the VHA Stand Down Team's Site Visit report found, "... in general staff did not use the EWL or was able to convey an understanding of the EWL."

Issue 3: Inappropriate Discontinuance of Consults To Meet 14-Day Benchmark

Interviews Conducted

- A quality care manager advised that it was recently discovered that there was inappropriate discontinuance of consults to meet the 14-day access goal. VAMC management reportedly learned of this on or about May 21, 2014. When describing how the Cardiology Clinic discontinued consult(s) because a patient could not be seen within 14 days and asked the requesting provider to resubmit the consult at a later date, she said, "... That to me is kind of concerning because how is Primary Care going to remember to do that ...". She said Cardiology was told they're not supposed to do that.
- A Cardiology nurse stated that a cardiologist told her to stop scheduling appointments that far out, that she needed to cancel the consults and have Primary Care resubmit when it was closer to when the patient needed to be seen. The cardiologist told her this was per administration, which she assumed was the service chief. This scenario took place only for a short period of time because, once Primary Care raised the issue, a nurse manager told the nurse she did not have to handle consults in that way. There were a total of four consults that she discontinued in January 2014 because of the 14-day goal. She indicated that for a much longer time period, she had been canceling or discontinuing consults when the patient didn't need to be seen for 6–12 months out.
- The physician whose Cardiology consult was discontinued with a comment to resubmit in 4 weeks [which was when she wanted the patient to have a follow-up appointment] "per access agreement and administration," was interviewed. She advised that she brought this issue to management, to wit: the chief of Primary Care and Primary Care's nurse manager. She saw this as a potential safety issue because the patient(s) "might fall through the cracks," but had no knowledge of patient harm. She said no one advised her of a process that would prevent patients from falling through the cracks, and when she asked Cardiology Clinic staff if they would remind her to resubmit it, they said no. When she asked how she was supposed to track it, she was told to write it down. She said Primary Care staff at VAMC Manchester did not have access issues and could see new

patients within 14 days and sometimes within 24 hours. She was not aware of Primary Care discontinuing or canceling consults to meet performance measures.

- A cardiologist recalled having a specific conversation with the service chief in which the service chief discussed discontinuing consults to keep access open for patients who need to be seen more timely. When the service chief learned of a physician's objection, he said they needed to ask Primary Care to resubmit the consult because of the 14-day goal. The cardiologist said he believed the service chief did this as a result of pressures from the VISN, but he didn't know specifics or provide any supporting evidence.
- The service chief admitted to instructing Cardiology to discontinue consults so they can be resubmitted within 14 days of the appointment date. He said he had no knowledge of the practice resulting in patient harm. He advised that back in September or October 2013, VISN 1 had him sign an agreement, which he referred to as a "charter," that he would work to meet the 14-day access goal, specifically for Neurology and Dermatology. This was his first assignment when he became an acting VISN manager for a specialty service, and it received the sponsorship of the VISN 1 Director. When asked if it was possible that because he signed the VISN access charter for the other two clinics, he, in his mind, applied it across the board to the other clinics, he said, "Conceivably, yes . . . I will concede that that's a possibility . . ."

When discussing pressures from above, the service chief suggested that the VAMC Director had placed pressure on him to meet the 14-day access goal. When asked if the director ever asked him to discontinue consults to meet the 14-day benchmark, he said that it was not in one statement. He said, over time in different statements, she would tell him to review his consults for appropriateness, and then another day she might tell him that they were trying to meet a benchmark. During monthly meetings referred to as "Super Tuesday," the VISN 1 Director went through performance measures page by page if there was a problem. The former VISN 1 Service Line Manager for Specialty Care did bring up the 14-day benchmark at monthly teleconference meetings. He later said that "pressure" was probably the wrong word. It was more about trying to succeed for the team—this is what we're trying to do, so do your part. He said, "I will say that [the Medical Center Director] was probably more concerned with performance measures than the previous directors."

Regarding bonuses, the service chief said his Executive Career Field (ECF) performance plan probably did include wait time goals, but he didn't remember. He said he had never been denied an ECF bonus because wait times were poor. He said one-tenth of the Pay for Performance (PFP) bonus was based on the 14-day benchmark. He said if staff's clinic access was not good, he didn't recall giving staff less of a proficiency rating, but it had affected the PFP bonuses he had given out. He said he didn't think the facility director knew about this issue back in the early 2014 time frame. He didn't think anyone higher than a nurse manager knew about it.

- The VAMC Director advised she had no knowledge of the inappropriate discontinuance/cancellation of consults or inappropriate consult template language until May 21, 2014, at which point she directed her staff to cease the practice. She said that

during a morning meeting on May 21, 2014, she learned that the Specialty & Acute Care team was canceling or discontinuing consults “. . . because they weren’t meeting the 14-day rule.” She said, “. . . they were changing them to quote meet the 14-day measure . . .” She said she didn’t think she was pressuring the chief of the service to meet that measure, but said the way the chief is paid, “. . . and the way his contract is written, whether it’s 14 days or anything else, is based on performance measures. I mean we need to be open and honest, that is the way it is, whether it’s about access or other things . . .” She said she would guess that most physicians would feel pressure to meet those particular standards. She also advised that the chief of the service had a collateral role, in which he worked for the VISN Director, overseeing the services for all of VISN 1; so, she suggested, the chief of the service probably felt an extra weight in that regard.

Records Reviewed

- A review of an email message string disclosed that, on January 29, 2014, a Primary Care provider requested a Cardiology consult for a patient, new to the VAMC’s Cardiology clinic, who had recently had bypass surgery elsewhere. She requested a 4-week follow-up. On January 30, 2014, a Cardiology nurse discontinued the consult with the following comment: “Unfortunately, per access agreement and administration I am not able to schedule Veterans out further than 14 days, so please re-submit consult in 4 weeks. . . .”
- A manager in Primary Care provided an email string from the January–February 2014 time frame about a discontinued consult. The service chief responded to the Primary Care manager with a copy to a cardiologist stating, “We are asking that consults be placed when patients are to be seen within 14 days which is the benchmark . . .” A second email string shows that the Primary Care manager responded by asking if this was agreed upon anywhere by all stakeholders, and identified this as a “safety issue for the PCP [Primary Care provider], with the potential to have [it] fall thru the cracks.” The service chief reportedly responded, “The 14 day access issue is a charter coming from the network director.”

Issue 4: Inappropriate 14-Day Language Placed Into the Dermatology Consult Template

Interviews Conducted

- A Dermatology staff member understood that the consult language, which stated, “Is patient willing to be seen within 14 days of submitting this request? Yes. No-If NO, please reconsider and resubmit when request at that time,” was put into the Dermatology consult template because patients who didn’t want to be seen until much later than 14 days were considered outside the 14-day measure. He said he attended a staff meeting a couple of years prior to the interview during which it was discussed that a new wait time measure (consults needing to be seen within 14 days) was put in place because previous measures were being manipulated in other VA facilities. He said when the wait time measure was based on the desired date that language was not in the consult template. He said when the performance measure was changed to patients needing to be seen

within 14 days of being contacted by a clerk to make the appointment, that's when the language was put in and he didn't know how it was put in or who requested it to be put in.

- A nurse who had been responsible for handling Dermatology consults was shown language in the "Comments" field of a Dermatology consult that said "No contact with Veteran via phone or letter; consult discontinued, please reconsult." She said she wrote that in the comments section because that's just the way they've done it, not because they were ever denying a patient service. If a patient wanted to be booked past the 14 days, they would book it. She indicated that she got that 14-day language from a document called "key response terms" that the former nurse shared with her.
- The service chief admitted that the Dermatology consult template was revised with his knowledge. He said it was suggested by staff, he didn't recall who, and he agreed to it. He didn't recall if he contacted the Clinical Application Coordinators to add the language to the template, but it was added approximately a year prior to the time of the interview. When asked what happened a year before that made him do this, he said there were probably a lot of no-shows and cancellations. He said to his knowledge this practice did not result in patient harm, and believed it to be a benefit. He said it was his understanding that the 14-day language was removed from the Dermatology consult template because the director insisted upon it, but he still stood by it and thought it was good patient care.

Interview With the VISN Director

The VISN 1 Director was interviewed in response to the alleged wait time manipulation schemes involving the desired date, create date, and consult resubmissions in Cardiology and Dermatology. He advised that if they occurred, it was without his knowledge or approval. He also provided the following information:

- The practice of asking consults to be resubmitted to improve wait time goals was not a patient-centered practice, but a performance measure-centered practice. He saw no good, clinical reason to have the 14-day language inserted into the Dermatology consult template. In the allegations involving both Dermatology and Cardiology, he agreed that there was no mechanism to track these patients who needed consults resubmitted, so there was a risk that patients could fall through the cracks. He said that the VAMC Director learned of these practices, stopped them immediately, and then notified him, and he agreed with her actions. This was the first he learned of these practices.
- He said the EWL should be used for new patients who couldn't get an appointment within 90 to 120 days, rather than just give them an appointment somewhere way out in the future, so they can be tracked. He advised that any decision made by VA Manchester not to use the EWL was done without his knowledge or approval.
- He advised that the former Deputy Under Secretary did not give him undue pressure to meet wait times, nor did he believe that he himself passed this down to his staff. He said, upon review of his fiscal year 2014 Senior Executive Service (SES) plan, that wait times

were 2/15 of one element that was weighted as 40 percent of his total rating [or approximately 5 percent of overall rating]. He said, “. . . I think there is a culture in the VA where trying to meet numbers . . . had taken a life of its own and it would lead to unfortunate things. . . . I’ve been very aware of that as something that I’ve been concerned about, and it happens. But to think that these were, you know, people being pressured by leadership to manipulate data, I, you know, I don’t see that. I haven’t seen that. . . .”

VISN 1 Director provided the OIG with copies of two documents he authored concerning wait time issues: (1) A VA blog, titled “Patient Outcomes/Performance Numbers,” which was posted on August 7, 2012, and (2) an April 16, 2014, memo with the subject line “Accuracy in Scheduling Practices,” issued to his service chiefs and staff involved in scheduling, through his chiefs of staff and Service Line leads.

- 8/7/12 Blog: The VISN 1 Director discussed the complexity and confusion around the desired date, and the importance of developing good measures at the national level that can’t be “gamed.”
- 4/16/14 Memo: The VISN 1 Director pointed out “maneuvers,” such as holding onto a consult for several days before creating an appointment, as a way of “gaming” the create date wait time goal. About this maneuver, he said, “. . . That’s a more common thing people may do. They may do it. They may do it innocently or – but that will make even the create date not accurately reflect the experience of the patient . . .” In his memo, he stated, “. . . Over the years, with the complexity of the scheduling process and the pressure to improve reported results, there have been instances across the VA where staff has taken steps like this to make wait times look better. This memo is both a request and a plea that we all do our best in VISN 1 to follow the recommended scheduling practices closely and make sure that our reported wait times reflect as accurately as possible the actual experience of patients . . .”

4. Conclusion

The investigation found that in an unspecified time frame, but possibly through early 2012, it was a well-known and acceptable practice at VAMC Manchester to enter the next available appointment date as the desired date, resulting in the appearance of a zero-day wait time. It appeared that under this practice, the desired date was arrived at by the scheduler identifying the next available appointment in the system, asking the veteran if that date would work, and if the veteran agreed to it, entering it in the system as the desired date.

The investigation substantiated wait time manipulation allegations regarding the desired date through at least 2011 and possibly through early 2012. It was largely described, not as manipulation, but as a standard practice to enter the appointment date as the desired date resulting in the appearance of a zero-day wait time. It appears that under this practice, the desired date was arrived at by the scheduler identifying the next available appointment in the system, asking the veteran if that date would work, and if the veteran agreed to it, entering it in the system as the desired date, though the investigation revealed a few instances of this practice occurring as a result of pressures to improve wait times.

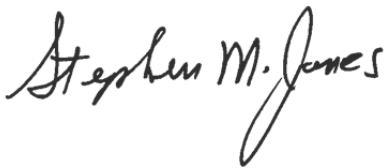
The investigation substantiated that in or around June 2013, at least one service, Dermatology, had language built into its consult template, which instructed the requesting service to resubmit the consult if the patient didn't want to be seen within 14 days of request.

The investigation also substantiated that Cardiology discontinued consults so they could be resubmitted later within the 14-day time frame to meet the then-current 14-day access performance measures, as recently as early 2014. Both of these consult matters occurred pursuant to instruction from a senior physician.

The investigation also disclosed that VAMC Manchester only activated for consistent use the EWL in or around September 2013.

No 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 January 29, 2015.



STEPHEN M. JONES
Deputy Assistant Inspector General
for Investigations

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