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

This investigation was based on two complaints filed with the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline in May 2014 alleging misconduct and manipulation of the "desired dates" by medical support assistants (MSAs) at the VA Medical Center (VAMC) in San Diego and its Community Based Outpatient Clinics (CBOCs). OIG investigated both allegations simultaneously as they related to the same issues.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed both complainants, the VAMC Director, 16 current and former MSAs, a program analyst, a former senior manager for the Mental Health Clinic, an employee in Systems Redesign, two employees who conducted an internal inquiry of the complaints received in 2013, and a medical administrative officer (MAO).

- **Records Reviewed:** VA OIG reviewed scheduling data for fiscal years (FYs) 2012 and 2013 in the Mental Health Department. We also reviewed VA emails for an MAO and other key employees, as well as Veterans Health Information Systems and Technology Architecture (VistA) mailman* messages.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- Complainant 1 stated in the complaint provided to the VA OIG Hotline, "It has been extremely troubling to see the clerks around me being trained inappropriately to show a zero desire date or just knowing better and directly lying about the dates and times the patient is requesting to be seen when creating appointments." The complainant's [supervisor had] "made it clear to all clerical staff; he is requiring zero desire dates and those who will not comply with the fraudulent scheduling practices, then evaluations will reflect marginal performance preventing promotions and bonuses." In the first interview, Complainant 1 reiterated the complaints previously provided to the OIG Hotline. In a second interview conducted, a few days later, Complainant 1 provided additional documentation and further explained the VistA scheduling system.

- The VAMC San Diego Director advised that the complaint filed by Complainant 1 had been received by the VA Secretary and he had just been designated to conduct a

* This is a messaging system within the VistA scheduling program.

fact-finding inquiry of the complaint. He provided the emails and Fact Finding Investigation Memorandum regarding the above-referenced complaint to the Secretary's Office. He stated that he was concerned as one of the emails alleged that the complainant first reported the manipulation of desired dates back in March 2013, but he had not seen that email until earlier the day of the interview.

- Complainant 2 alleged he was told or trained by his supervisor, an MAO, to "zero out" desired dates when scheduling or rescheduling patient appointments.

- Both complainants indicated that when the recent Veterans Health Administration (VHA) Inspection Team, sent by the VA Secretary, came to VAMC San Diego and CBOC Mission Valley on May 19–20, 2014, the MSAs interviewed were handpicked and coached by the MAO on what to say to the inspection team. The complainants identified three MSAs who reportedly were selected to speak to the inspection team. Reportedly MSA1 told another MSA he didn't want to say anything to the inspectors because the MAO was sitting in the interview with him. Because MSA1 declined to be interviewed during the investigation, we were unable to explore this allegation. The other two MSAs, MSA2 and MSA3, denied being directed on what to say to the Inspection Team.

- A total of 16 more MSAs were interviewed in the week following the interview of Complainant 2; many of them confirmed that they were told to schedule by directing the veteran to the next available appointment or to later zero out the desired date by canceling/rescheduling appointments. Some MSAs reported being told they had too many appointments scheduled with desired dates exceeding 14 days, so they were told to change them. If they didn't, many noted, other MSAs or the MAO would change their appointment desired dates anyway. Other MSAs reported being "hounded" by the MAO to zero out desired dates so, even though they knew it was against the 2010 VHA policy, they did it because of the continual pressure. Several other MSAs declined to be interviewed when contacted by OIG special agents.

- A former lead MSA stated that another MSA was once tasked to change all desired dates that exceeded 14 days. He recalled having to find a dedicated room/computer so the MSA would not be disturbed while he made these adjustments. According to the former lead MSA, this instruction came straight from the MAO around November/December 2012. Furthermore, he routinely received emails from the MAO identifying scheduling clerks who needed to adjust their desired dates to reflect a shorter waiting time. He said that the MAO continued to send these email reports until the waiting times were to his satisfaction, even if that meant the desired dates were altered. Because he no longer worked for VA at the time of the investigation, he did not have any emails showing the direction by the MAO.

  When re-interviewed, he was shown the three emails the program analyst had sent in 2014 directing desired date changes. He said that he recalled getting similar emails from her before he retired in mid- 2013. He mostly recalled receiving emails from the MAO telling him to check his VistA mailman messages. When he would check the VistA mailman messages, he would have lists of veterans and a message from the MAO saying the veterans' desired dates were too high and they needed to be changed.

- On June 25, 2014, OIG received information from a VA employee that a veteran had attempted suicide at a CBOC located in San Diego, due to his frustration with his canceled appointments. OIG staff reviewed the veteran's historical appointments in VistA, which showed that the veteran's appointments had been canceled since early 2014, and the desired dates of his rescheduled appointments were captured incorrectly. The veteran last saw his Mental Health provider in early 2014. He then had an appointment scheduled for several months later, which was also canceled by the clinic. The veteran was then scheduled to see his Mental Health provider near the date OIG learned of the suicide attempt, but that appointment was canceled by the clinic, as well. Ultimately, the veteran was scheduled in advance to see the provider the following month, but by the time the data was reviewed, the appointment had already been canceled by the clinic. The veteran was not scheduled to see his provider until 1 month later. The veteran was admitted to the VAMC after his suicide attempt.

  When interviewed by OIG staff, the veteran stated he used the cancellation of his appointments as an excuse to act out and attempted to harm himself. He said he regrets his actions and that he received help and now has follow-up appointments. He had been seeing the same provider since 2009 and never had an appointment canceled until 2014. He estimated that his appointments were canceled four times in a row, which triggered his behavior. In addition, an OIG auditor reviewed and reported VistA scheduling data showing that, in FY 2013, the veteran's provider canceled 13 to 14 percent of his appointments with less than a day's notice and, in FY 2014, that number rose to between 24 and 27 percent for his various clinics.

- A VAMC San Diego Mental Health program analyst sent three emails, dated April 15, 22; and 30, 2014, and identified during an OIG email search, in which she appeared to direct MSAs to alter desired dates incorrectly. The emails stated that MSAs should call the veterans appearing on an attached list of patients who had wait times exceeding 14 days past their desired dates and offer them earlier available appointments. If the veteran declined the earlier appointment date for any reason, the MSA should then change the veteran's desired date to the original appointment date as the veteran was now saying that is when he/she desired to be seen. The employee stated that, at the time, she thought that she was correct, but had now come to understand it is not the proper way to capture desired dates. She did not recall why she felt that she was right at the time or who told her it was okay, but she had since learned that the original desired date should not be altered unless the veteran changes the appointment.

  Regarding other emails she sent, the program analyst stated that the emails were for the Executive Leadership Team (ELT) and were part of her regular responsibilities as a program analyst. She said the emails contained several charts, graphs, and statistics regarding Mental Health access at VAMC San Diego. OIG staff specifically drew her attention to an email dated May 19, 2014, and another dated June 2, 2014, which showed graphs reflecting the number of veterans waiting more than 14 days for a Mental Health appointment. When asked if she could explain the significant decrease in the number of veterans waiting more than 14 days, she said she knew that the department had received more resources and had reorganized how they did things, thus creating the changes.

When re-interviewed, the program analyst stated that she did not specifically recall being given the direction about changing the desired dates from an employee in the Systems Redesign division. She didn't recall specifically who told her but didn't recall it taking place on a conference call, as reported by the MAO.

- A medical provider was interviewed regarding an email, dated July 8, 2013, he had received from a former VA employee, a registered nurse in a specialty clinic, in which the former employee directed the provider to contact his veteran patients who have a wait time exceeding 14 days; if he made telephonic contact with them lasting for more than 11 minutes, he could "modify the desire date." The provider stated that he really didn't recall the nature of the emails or the reason the former employee would have said that.

- MSA2 had previously said she was never directed to change/alter desired dates. She recalled receiving several lists from a program analyst and the MAO. When she received the lists, she understood she was supposed to call the veterans on the list and offer them an earlier available appointment. The veterans usually took the earlier appointment but if they didn't, she didn't change their desired dates; she merely left their original appointment as is. After reading the email from the program analyst during the interview, she realized that what the program analyst was telling the MSAs to do was wrong. She added that she never really read the email content at the time; she merely went to the list and started calling veterans.

  She denied allegations that she was provided a special room to contact veterans and offer them new appointments or change their desired dates. She also denied ever blind scheduling any veterans or changing appointments without contacting the veterans first. As for the room she was working in, she said since she often floated between various clinics, covering for MSAs on leave, she would sometimes sit in the room with the "researchers" and make phone calls from the list because she didn't have a set office or workspace.

- A former senior manager for the Mental Health Clinic at VAMC San Diego stated that he requested that a service chief look into the manipulation of desired dates for Mental Health in 2013. This request followed a complaint received by VA in February/March 2013. His recollection was that there were no significant findings to support the allegation but some changes were made based upon recommendations in the report. He stated that he had never directed desired dates to be changed and he had always felt that using the create date was a more true measure of patient access to care. He added that he would be surprised to hear that anyone in his department maliciously manipulated the desired dates.

  He was shown two ELT updates sent by the program analyst on May 19, 2014, and June 2, 2014, and was asked if he could explain the drastic decrease in the number of veterans waiting more than 14 days for a Mental Health appointment. He said he attributed it to an increase in resources and a redesign in how veterans were seen, thus causing less of a backlog. He further stated he had no reason to believe the change was due to anyone manipulating the data.

- The two employees who investigated the 2013 complaints regarding allegations of manipulation of Mental Health desired dates stated that they conducted their investigation in May/June 2013 and presented their report to the former senior manager for the Mental Health Clinic. Both the MAO's supervisor and the MAO were briefed on the investigative findings. They recommended that Mental Health provide scheduling training to its MSAs to comply with VHA Scheduling Directive 2010-027, because they found discrepancies in the MSAs' scheduling practices. In addition to training, it was also recommended that the Mental Health Clinic monitor its MSAs for consistency and compliance. They did not know who the program analyst was, and why she was sending Mental Health Clinic MSAs emails telling them to change desired dates contrary to the VHA Directive. One witness said she had hoped that the MAO would have emailed the Mental Health MSAs to tell them that the program analyst's instructions were wrong. The other witness said she is skeptical of how the MSAs were arriving at the desired dates because, when they interviewed the MSAs and Mental Health Clinic leadership, they all seemed to disregard the necessity to ask the veterans when they wanted to be seen and just used the "mutually agreed upon date."

  When shown the Scheduler's Audit Tool report—which indicated that several MSAs in the Mental Health Clinic had scheduled more than 700 appointments and had a 98 to100 percent rate of zero-day wait times for those appointments—one of the witnesses said there should be concern because that rate of "accuracy" when scheduling appointments with zero-day wait times was impossible.

  The other witness stated that the MAO had supervised MSAs in various positions. She noted that the MAO was responsible for running the Scheduling Audit Tool to monitor his employees (MSAs) at one of the MAO's prior positions; he was also responsible for properly training them if they were not in compliance. The witness was adamant that all of the supervisors who reported to her, including the MAO, understood the importance of the Scheduling Directive and that the MSAs should not deviate from the policy. She stated she held weekly meetings with the supervisors under her and went line-by-line over the Scheduling Directive and they knew how important it was to be in compliance. Her instructions to the supervisors were to watch for trends when analyzing the auditing reports (that is, look for high percentage of zero-day wait times).

- The MAO was provided copies of the program analyst's 2014 emails and asked if he had ever heard that this was an appropriate way to change the desire dates. He recalled that he and the program analyst were told this while on a conference call with a Systems Redesign employee. OIG staff also showed the MAO a report from the Scheduler's Audit Tool, which indicated that several of his MSAs in Mental Health had scheduled more than 700 appointments and had a 98–100 percent rate of zero-day wait times for those appointments. He looked at the numbers and questioned their origin. He didn't acknowledge the fact that it seemed like an inordinately high rate of zero-day wait times. When told the numbers came from a report in the Schedulers Audit Tool, he did not have an answer for how or why MSAs could legitimately schedule with such "accuracy." He stated during the interview that he had never directed anyone to change patients' desired dates.

- An employee in Systems Redesign was asked if he had ever been part of a conference call in which he explained a legitimate way desired dates could be changed. He adamantly said no. He stated repeatedly he was responsible for training all of the scheduling supervisors in the Veterans Integrated Service Networks (VISN 22) and he had never told them the desired date could be changed. Most specifically, he said he never directed the program analyst or the MAO to change the desired dates. We also showed him a report from the Scheduler's Audit Tool, which indicated that several MSAs in Mental Health had scheduled more than 700 appointments and had a 98–100 percent rate of zero-day wait times for those appointments. He said he was paid to review these kinds of data and it was just not statistically possible for MSAs to schedule with this level of "accuracy." If he were given this report to review, the high numbers of zero-day wait times would be a red flag. He added that having a rate of zero-day wait times higher than 70–80 percent was questionable and uncommon.

- The VAMC San Diego Director was briefed on the results of this investigation. He said he was very surprised at our findings as he had spoken to the former provider, the MAO, and the MAO's supervisor regarding the initial allegations and was told there was no altering of desired dates happening in the Mental Health Department. He further stated he specifically showed the MAO the allegation that had been reported to the OIG and the VA Secretary's Office in May 2014. When he had asked if the allegation had any merit, the MAO reportedly told the director there was no merit to the allegations. The director acknowledged concerns about the high percentage of zero-day wait times based upon the data OIG presented him. He was also surprised to see the emails in which the program analyst directed the altering of desired dates with instructions that explicitly violated VHA Scheduling Directive 2010-027.

Records Reviewed

- VA OIG reviewed a report showing a list of the VA San Diego Healthcare System employees who had scheduled patient appointments in the Mental Health Department in 2014. The list reflected the overall number of appointments that were scheduled, the number of appointments with zero-day wait times, and the overall percentage of zero-day wait time appointments for each employee. The Mental Health MSAs who had higher than an 80 percent zero-day wait times were identified for interviews.

- VA OIG reviewed scheduling data for the Mental Health Clinic, VAMC San Diego. Our review found that in FY 2013, 32 percent of all appointments rescheduled after being canceled by the clinic had altered desire dates. In FY 2014, it was 33 percent.

- VA OIG searched 11,599 emails for the MAO and other key VA employees. This review revealed several relevant emails that were addressed with various witnesses.

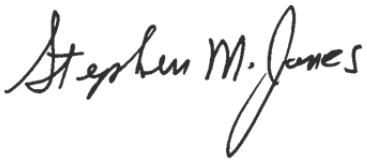
- VA OIG reviewed records in VistA mailman for "G.PSYCH CLINIC SCHED" back to January 2012. This is a messaging system within the VistA scheduling program that allowed the MAO and other employees to send a mass email to all of the MSAs in the VA San Diego Mental Health Department. The request was revised to include any VistA

mailman messages sent by the MAO from September 2012 through April 2013. The review did not reveal any emails directing MSAs to manipulate desire dates.

4. Conclusion

Interviews, along with the analysis of scheduling data pulled from VistA, revealed many MSAs were initially altering the desired dates of patients or scheduling veteran appointments with zero-day wait times. Testimonial evidence from multiple MSAs regarding the MAO's involvement in directing manipulation of wait times and analysis results from scheduling reports contrasted sharply with the MAO's denials of responsibility. In addition, emails from a Health Program analyst sent to MSAs included specific instructions to zero out wait times if patients did not wish to change to an earlier appointment. These instructions explicitly violated VHA Scheduling Directive 2010-027.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on March 18, 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.