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

VA Medical Center in Spokane, Washington
March 25, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based upon information received by the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline from a former VA employee who alleged that the VA Medical Center (VAMC) Spokane, WA, used unauthorized methods to manually track Behavioral Health Services (BHS) patient appointments.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed the complainant, VAMC Spokane scheduling staff, a Mental Health employee, the VAMC Spokane Director, and the Veterans Integrated Service Network (VISN) 20 Director.

- **Records Reviewed:** VA OIG reviewed records including a report documenting all Mental Health appointment cancellations, which included psychiatry, individual and group psychotherapy, by reason listed for each month from January 2012 through May 2014 (for example, *cancelled by clinic*, *no show*, or *cancelled by patient*); Veterans Health Information Systems and Technology Architecture (VistA) data concerning unique patients for three BHS providers, and Spokane VA Scheduling Management Business Rules, Memo 136-56-12, dated June 6, 2012.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant, a former employee at VAMC Spokane, advised that due to low staffing levels and high turnover of mental health providers, VAMC Spokane staff used paper slips to queue appointments for new or incoming Mental Health providers.

- A medical support assistant (MSA1) stated that Primary Care Services (PCS) appointments were entered and tracked using the authorized VistA electronic waiting list functions.

- MSA2 advised that VAMC Spokane BHS schedulers had maintained paper appointment slips for patients of retiring BHS providers that would be entered into VistA once a new BHS doctor had been identified and loaded into VistA. As a result of provider turnover or sick leave taken by current providers, some existing patients were waiting extended periods of time for appointments. The scheduling staff member stated that some patients were rescheduled multiple times while waiting 3 to 4 months between appointments. She further explained that VAMC Spokane inpatient Mental Health clinicians were

prescribing medication renewals for outpatient veterans who were waiting for appointments.

- A Mental Health employee advised that the VAMC Spokane BHS was generally successful at scheduling appointments for new patients within the Veterans Health Administration (VHA) goal of 14 days. She acknowledged wait times extended beyond 30 days for established patients. For these patients, BHS staff triaged some appointments and referred some of them to social workers or to the VAMC Spokane Emergency Department if the patient's presentation warranted immediate treatment. BHS staff maintained paper appointment slips when transitioning patients from a former provider to a new provider. The appointment would subsequently be entered into VistA once the new BHS provider joined the department.

  When re-interviewed, the Mental Health employee clarified that, prior to BHS' deployment of the VA Primary Care Management Module (PCMM), BHS staff had no viable option to identify all of the patients on a medical provider's panel. BHS staff used the search functions in VistA to develop a list that included all patients seen by a particular former provider. This was an ineffective tool for determining which patients needed future care. She reported that this issue made it extremely difficult for schedulers to make future appointments for patients of a retiring provider as there was no panel to transfer the patient's future appointments to within the system. She explained that many of the patients identified while searching VistA were not active patients being seen by a provider, or the patients were not in need of upcoming appointments. In order to assign patients needing future appointments with a new provider, BHS staff placed paper appointment slips in envelopes that were later used to build the new provider's panel. She understood that VA employees were not to maintain waiting lists or spreadsheets per policy, but she felt that this paper-based method was the most efficient option to ensure that patient appointments were scheduled. She understood that only new patient appointments were to be placed on the Electronic Waiting List (EWL). She expressly denied the use of "gaming" strategies to improve the appearance of efficiency of the BHS.

- The VAMC Spokane Director advised OIG that the facility recognized the fact that there was a lack of BHS physicians and that the facility has been successful in their efforts to recruit and retain more Mental Health professionals. She was not aware of the use of paper appointment slips in the BHS Clinic prior to the OIG's investigation.

- The VISN 20 Network Director advised that he was not aware that paper slips were being used to schedule VAMC Spokane BHS patient appointments prior to the OIG's investigation.

Records Reviewed

- A review of a report documenting all Mental Health appointment cancellations from January 2012 through May 2014 showed that 40,012 appointments were canceled during this period. The data indicate that 36 percent of the appointments were *cancelled by clinic*, 44 percent were *cancelled by patient* and patients did not attend their appointment

for the remaining 20 percent of cancellations (*no show*). The facility noted that a significant portion of the cancellations *by clinic* was due to staff absences because of illness. This data indicate that 14,076 VAMC Spokane Mental Health patients had appointments canceled by the clinic during the 32-month period.

- A review of VistA data concerning unique patients for three BHS providers showed that VistA data did not delineate between active and former patients of the treating clinician, but included all patients seen by the provider at VAMC Spokane. These data were consistent with the claim that schedulers could not determine which patients should be rescheduled using VistA.

- In the Spokane VA Scheduling Management Business Rules, Memo 136-56-12, dated June 6, 2012, Item 1 states:

  > *Every clinic will utilize the authorized, official outpatient scheduling package. The use of informal scheduling systems will not be tolerated. Every clinic at Spokane VAMC will only utilize the VISTA software for scheduling of outpatient clinic appointments.*

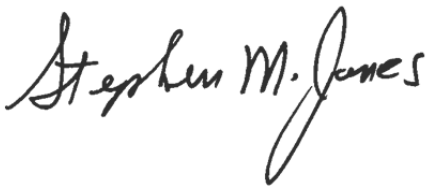
4. Conclusion

The investigation determined that VAMC Spokane BHS scheduling employees used manually printed appointments slips while transitioning patients between medical providers, and that the facility was not in full compliance with the VHA policy for scheduling.

BHS employees advised that they maintained manual paper appointment slips due to BHS provider turnover and limitations within the VA scheduling system used in 2013–2014. The VAMC Spokane BHS scheduling supervisor advised VA OIG that because of VistA's technical limitations, VAMC Spokane scheduling employees were unable to electronically schedule appointments when there was no provider to which to assign the future patient appointment within VistA. The supervisor stated that her understanding of the VA scheduling policy indicated that the EWL should be used for new patients awaiting appointments. The patients involved in this situation were primarily existing patients.

As a result of this situation, the supervisor felt the best solution for this particular situation was to have BHS schedulers place paper appointment slips into a folder system for future patient appointments in anticipation of new BHS clinicians being assigned to the department. Once the new BHS clinicians arrived at VAMC Spokane, schedulers used the appointment slips previously placed in the folder to schedule patient appointments in VistA. This situation regarding future appointment scheduling for patients assigned to providers who had retired was resolved with BHS's deployment of the VA PCMM in late 2014.

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



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