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

Community Based Outpatient Clinic in Rochester, New York March 15, 2016

1. Summary of Why the Investigation Was Initiated

The investigation was initiated based on information provided by a confidential complainant (CC). The CC alleged that a former medical support assistant (MSA) supervisor (MSA Supervisor 1) at the Department of Veterans Affairs (VA) Community Based Outpatient Clinic (CBOC), in Rochester, NY, instructed CBOC Rochester Primary Care Clinic MSAs to make veterans' desired dates for appointments at the CBOC to be the same date as the scheduled appointment date or first available date. The CC stated this has resulted in the appearance of a zero-day wait time for veterans seeking Primary Care appointments at the CBOC and created the perception that there was adequate staffing at the CBOC when that was not the case.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the complainant, VA Office of Inspector General (OIG) agents interviewed 16 VA employees during the course of this investigation.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- An administrative officer stated that she has always known the proper way to use the "desired date" and believed she had conveyed that message to the CBOC employees in the past. However, she realized there might have been some confusion on the interpretation of the scheduling policy causing her to send an email to her supervisory staff on or around March 1, 2014, to reiterate the policy. The email was sent to two MSA supervisors (MSA Supervisor 1 and MSA Supervisor 2) and a health technician. MSA Supervisor 2 had begun her role in a supervisory capacity at the CBOC only shortly before this email message.

  The administrative officer mentioned during her interview that she previously had discussions with MSA Supervisor 1 about their differences in interpretation of the proper use of the desired date versus the first available date. At one time, MSA Supervisor 1 believed that the first available date should be the desired date. The administrative officer believed that MSA Supervisor 1 was currently properly following VA policy.

- Five MSAs and one health technician all conveyed during the investigation that they were currently using the proper scheduling directive or procedure, but advised that that was not always the case. All of them mentioned that they had previously been directed to use the first available date as the desired date. Three MSAs and one health care technician mentioned receiving this information from MSA Supervisor 1. Only one

MSA scheduler stated that she always used the proper scheduling procedure, but this was the case because she does not schedule new appointments; she only handles consults and recall list appointments.

- An MSA/health technician and an MSA stated that they were still currently inputting the patient's first available date as the desired date. They were not familiar with the 2010 directive or any guidance that was provided by the administrative officer via email on or around March 1, 2014.

- MSA Supervisor 1 stated that his/her current understanding of the desired date and first available date is that the desired date is the date on which the patient wants to be seen. He/she admitted to misunderstanding the correct procedure or protocol and previously, but unintentionally, trained his/her staff to use the first available as the desired date.

- A former MSA Supervisor (MSA Supervisor 3) stated that he/she previously understood the desired date to be the same as the first available date. MSA Supervisor 3 thought this issue was brought up in an email from the Medical VA Care Line Manager (CLM), but he/she said he/she had been confused or misinterpreted the scheduling directive regarding the relationship of the desired date, the first available date, and the negotiated appointment date. MSA Supervisor 3 said he/she had no malicious intent to manipulate patient wait times.

- The CLM stated that her interpretation of the use of the patient's desired date when making an appointment has always been correct and explained that the desired date is the date initially requested by the veteran even if it was not available. It was her responsibility to ensure MSAs correctly understood and applied VA policy relative to the patient's desired date and she was presently clearing up any misunderstandings. The CLM was aware that there may have been an issue with the desired date prior to any of the Phoenix[*] issues coming to light. At that time, she began having discussions with some of the staff and realized her staff was misinterpreting the meaning of desired date. Also, after speaking with MSA Supervisor 1 and MSA Supervisor 3, she realized that they, too, misinterpreted desired date indicating they may not have been properly trained. She stated that she should have been more specific and thorough in their training and in explaining VA policy.

- VA OIG agents interviewed the VAMC Canandaigua Director (the VAMC has oversight responsibility for the CBOC), who stated that his interpretation of the use of the patient's desired date when making an appointment had always been correct and explained that the desired date is the appointment date initially requested by a veteran even if it was not available; it was not the first available date, which is what the CBOC was previously using. He emphasized the definition of desired date by saying, [it's] "whatever [date] is being requested by the veteran," and "what they say, not what may be available." This is the policy and directive that is currently in place. However, he was aware of some recent

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

confusion or misinterpretation of the directive. He conveyed that it was their objective at VAMC Canandaigua to try to identify issues or problems before they become a concern.

The VAMC Canandaigua Director stated he was never informed by anyone not to cooperate with auditors or investigators regarding any inquiry made about the CBOC related to patient wait times or patient waiting lists. He agreed that the zero-day wait time created a misconception that the schedulers were not handling their workload in an appropriate manner. He always advised staff just to be honest if they had to answer any questions.

The VAMC Canandaigua Director was not aware of any computerized, hard copy, or separate patient waiting lists and he was never directed to destroy or shred any illicit or other documents pertaining to patient waiting lists, wait times other than what is destroyed during the normal course of business. He was never told of any monetary gain [bonuses] for anyone relating to patient wait times. He was not aware of any managerial changes or disciplinary actions relating to this issue.

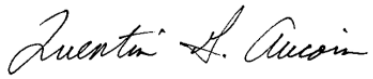
4. Conclusion

The investigation revealed that several schedulers at the CBOC were routinely using the first available appointment date as the desired date. This was likely due to erroneous information provided by MSA supervisors who stated that they trained staff to use the first available date as the desired date because they misunderstood the correct procedure. This issue was being corrected by management through the issuance of additional guidance and oversight and other corrective actions.

The VA employees interviewed advised that management never provided instruction intended to limit cooperation with OIG auditors or investigators for any inquiry into the CBOC patient wait time issue. They were advised just to be honest if they had to answer any questions. No one was aware of any computerized, hard copy, or separate patient waiting lists. In addition, the employees interviewed were never directed to destroy or shred any documents pertaining to patient waiting lists or wait times other than what was destroyed during the normal course of business. They were never informed that there was any monetary gain for anyone relating specifically to patient wait times. In addition, they were not aware of any managerial changes that occurred recently because of disciplinary actions relative to the wait times. Many of the employees voiced their opinion that there was no malicious intent by any employee to defraud or mislead anyone regarding wait times.

They commented that the zero-day wait time created a misconception that the schedulers were handling their workload in an appropriate manner.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 22, 2014.



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