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

## Multi-Specialty Outpatient Clinic, Fort Collins, Colorado and VA Medical Center, Cheyenne, Wyoming April 1, 2016

### 1. Summary of Why the Investigation Was Initiated

This investigation was initiated in June 2014 based upon information received via media reports, congressional staff, and other sources regarding allegations of the manipulation of patient appointments and wait times at the Multi-Specialty Outpatient Clinic (MSOC) in Fort Collins, CO. MSOC Fort Collins is administered by the Department of Veterans Affairs (VA) Medical Center (VAMC) Cheyenne, WY. Of particular concern at the outset of this investigation was an email dated June 19, 2013, written by a program coordinator that appeared to articulate a method of "gaming" the scheduling system in order to meet a VA metric in which veterans' appointments were ideally to be scheduled within 14 days of the veterans' "desired dates."

The initial investigation into the allegations relating to Fort Collins developed additional information implicating a VAMC Cheyenne supervisor for engaging in canceling the medical appointments of veterans and rescheduling them, thereby making the reported wait times of veterans to appear to be less than they actually were. This resulted in the opening of a supplemental investigation. The results of both investigations are summarized below.

### 2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the three subjects, the VA Office of Inspector General (OIG) interviewed three employees who were subordinate to the manager in the Business Office.

- **Records Reviewed:** VA OIG reviewed performance standards and performance ratings for the three individuals who were the subjects of the allegations.

### 3. Summary of the Evidence Obtained From the Investigation

**Interviews Conducted**

- A program coordinator acknowledged writing the aforementioned June 19, 2013, email. He articulated that his intent in writing the email was to get medical support assistants (MSAs) to "engage" with veterans when making appointments; in other words, to talk to the veterans to find out what days they really wanted to be seen. Instead, what he observed was that MSAs were simply entering a "T" into the scheduling system when they were scheduling an appointment with the veteran. A T refers to "today," which is the default for the appointment date in the scheduling system. This would mean that the veteran wanted the appointment that day (today). By entering a T, MSAs were not

appropriately determining when the veterans really wanted to be seen or when the veterans' providers really wanted them to be seen.

The employee also stated that he would receive notifications from the VAMC Business Office about patients who were exceeding the 14-day metric. A manager in the Business Office would instruct him to cancel the existing appointments and reschedule them for the exact same date and time. The effect of this action was to make it appear as if the 14-day metric was being met. The employee stated that this did not cause a delay in care to veterans as they had the same appointment and received the same care they would have otherwise received.

When asked if he felt the Veterans Health Administration (VHA) scheduling policy was clear, he said he did not think it was. He was also asked if anyone other than the manager in the Business Office had instructed him to alter records, specifically the VAMC Director, the Veterans Integrated Services Network (VISN) Director, or anyone from VA'S Central Office (VACO). The employee denied that any of these individuals or anyone from VACO had instructed him to falsify records. He also said that it was not his intent to falsify records. He reiterated that his intent in sending the email was to help the schedulers better understand how measures applied to them.

- During interviews of three employees who were subordinate to a manager in the Business Office, two stated that the manager directed them to alter the previous month's Clinic Utilization Summary Statistics (CUSS) reports to make the clinic appear as if it was being used at an 85 percent rate. The "utilization rate" is the appointment usage versus appointment capacity of the clinic. The 85 percent rate was articulated as a goal set by VACO. The third employee stated he/she was aware of the practice as being directed by the manager.

- The manager in the Business Office denied that any manipulation occurred. She stated that she understood the clinic utilization goal of 85 percent was set by VACO and that it was to reflect the actual clinic utilization rate. She stated repeatedly that the intention was to make the clinic utilization rates match what was actually occurring so that adjustments could be made moving forward. When asked if she had instructed staff to modify the historical CUSS reports, she said she did not remember doing so, but added later, "I'm not going to tell you that it might not have happened." In a subsequent interview, the manager was once again asked about the CUSS report issue. She denied having any memory of telling staff to change the prior month's data, but acknowledged that it was possible she did so.

  The manager was also questioned about the issue of changing appointment dates. She articulated that the goal was to get the proper "desired date" of the veteran. She explained that when the business office became aware that appointments were scheduled with a desired date of "today," it was an indication that the schedulers were not using the correct desired date. She would then provide instructions to the schedulers to "correct" the appointment. She said that the intention of her instructions to the clinics was for them to put in the appropriate desired date of the appointment.

The manager denied that she had received instructions to alter records from the VAMC Director or the VISN Director, nor had she received such instructions from VACO or another VAMC.

In a subsequent interview, the manager was asked again to clarify issues related to scheduling appointments in light of an email written by the former lead medical support assistant (LMSA) in August of 2012 and forwarded to several MSAs, in which it was noted that there were "2700 incorrect entries" with regard to scheduling and that a scheduling supervisor and the manager revised the desired dates to get the list down to about 100. The email further stated that the list was back up to about 200 appointments, and the manager "has already corrected most." The email went on to articulate that schedulers should inform the veterans calling in when the "next available date" is [for an appointment] and to use that date as the desired date. When asked how these entries were "corrected," she explained that the appointments would be remade for the same date and time as they were originally scheduled to occur. When asked if she thought this was a manipulation done solely for the sake of getting to the 14-day number, she responded, "Yes."

When asked if instructions to take this action were given to her by someone in the front office, or by the chief of staff, the manager replied that she did not remember getting specific instruction from anyone. When asked to explain in detail how the "corrections" were made, she explained again that the appointments were remade (essentially overwritten) and that the appointments would be made again for the same date and time, but with a new desired date. As a result, the desired date of the appointment became the same date as the original appointment. She added that this had no effect on the veterans because they received the same appointment they otherwise would have received. When asked if she thought this action was "gaming" the system, she replied, "Yes."

She went on to explain that these actions were taken to address the 14-day policy requirements mandated by VACO. She denied being instructed to do this and explained it was something she knew would occur from her experience with the Veterans Health Information Systems and Technology Architecture (VistA) scheduling package. When asked if she informed anyone of this practice, she said she was sure she had notified her supervisor. That supervisor retired from VA and is now deceased. The manager acknowledged directing the author of the August 2012 email and the individual who forwarded the email to clinic staff to manipulate scheduling data. When asked if she directed a supervisory employee to manipulate scheduling data, she denied doing so, but acknowledged that the individual who authored the email would have forwarded the instructions to supervisors.

The manager was asked if there were disciplinary actions or other repercussions if the 14-day metric was not met. She was not aware of any disciplinary actions or repercussions that were handed out as a result of not meeting the metric. When questioned again as to whether or not she had received instructions from anyone in her management chain to manipulate the data to address the 14-day metric, she said that she did not remember receiving such instructions. When asked if the correct conclusion was that she was the one who came up with the way to manipulate scheduling data, she

replied, "Yes." In a subsequent telephone call, the manager clarified that the time frame in which the appointment manipulation occurred lasted approximately 18 months, from about the end of 2011 until mid-2013, which was about the same time the employee sent out his email.

- A former LMSA at VAMC Cheyenne said the scheduling training he had received was informal, and that his training directed him to use a T as the desired date in the scheduling system and then ask patients what date they wanted for their appointment. He said this practice was still occurring as recently as September 2013. When questioned about the practice of reviewing the 14-day "access list," which identified patients whose desired date exceeded the 14-day metric established by VA, he said that the manager in the Business Office would pull the list and that she and he would "fix" the list. He explained that this was necessary because the appointments had been incorrectly made using a T for the desired date. When this was observed on the access list, it was assumed that the appointment was made incorrectly, although there was no discussion with the veteran to confirm if the appointment was truly incorrect.

  The former LMSA was also asked about 2,700 appointments that were described in an August 26, 2012, email that he had authored. He became aware of these appointments via a list that had been generated by the manager in the Business Office. When asked how these appointments were cleaned up, he said this was accomplished by remaking the appointment. For example, if the appointment was for June 20, he would enter the desired date of the appointment as June 20. The effect of this action would be that the appointment would no longer show up on the [access] list, nor would it show as a cancellation. He said that the manager in the Business Office instructed him on how to perform this action and she also directed him to do so. When asked if he felt pressured to take these actions, he stated that he felt pressured to get the access list under control because the manager told him it was "coming from on high," which he believed to be the "front office," meaning the director's office was aware of their actions. However, he acknowledged that he had no support to substantiate this belief. When asked if this matter ended up being reflected in a negative way on his performance evaluations, he said it did not.

  The former LMSA also stated that in early 2013, he attended a meeting with the VAMC Director at which time she handed out a copy of the VHA scheduling directive and discussed the correct use of the desired date. Despite this discussion with the director, he stated that there was still pressure from the manager and the practice of changing the desired date continued until approximately September or October of 2013. When asked if he felt the director had clarified the use of the desired date in her previous meeting, he stated that she had. However, he said that the practice did not change until after the report, dated December 23, 2013, was issued by the VA Office of the Medical Inspector (OMI). He said that after the OMI report, the director again stressed the importance of the correct use of the desired date. He said that the manager also stressed this point, and that prior to that time, the manager's intent was to get schedulers to use a desired date instead of just using a T. He was also asked about his knowledge of the manipulation of historical CUSS reports. He repeatedly denied any knowledge of this practice.

**Records Reviewed**

The clinic utilization records were reviewed by the OIG Office of Audits and Evaluations. The performance standards and ratings for the three subjects were examined in an effort to determine if the manipulation of the appointments had a material bearing on any ratings or awards they received. The standards and ratings for two of the subjects were reviewed for the time period from November 2011 through September 2013. The final subjects' standards and ratings for the period from October 2011 through September 2013 were reviewed. The review determined that the ratings and bonuses for these employees were not based on meeting standards for scheduling.

## 4. Conclusion

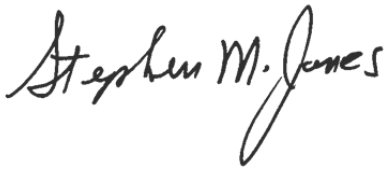
The investigation found that a manager in the Business Office engaged in a practice of canceling the medical appointments of veterans and rescheduling them, thereby making the reported wait times of veterans to appear to be less than they actually were. The manager stated she believed the manipulation occurred from 2011 to mid-2013. She acknowledged directing these actions and denied that she was ordered to do so by anyone else.

In addition, it was also alleged that the manager manipulated the clinic utilization rates to give the appearance that utilization rate for clinics reached the 85 percent goal. Although individuals stated this occurred, the manager did not recall ordering this done. The manager did, however, state that it may have occurred.

The investigation also found that a program coordinator sent an email that appeared to articulate a method of gaming the scheduling system in order to manipulate patient wait times.

The investigation also found that the former LMSA engaged in the practice of canceling the medical appointments of veterans and rescheduling them, thereby making the reported wait times of veterans to appear to be less than they actually were at the direction of the manager in the Business Office.

The OIG referred the Reports of Investigation to VA's Office of Accountability Review on June 18, 2015 and June 24, 2015.



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