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

VA Medical Center in White River Junction, Vermont
April 4, 2016

1. Summary of Why the Investigation Was Initiated

This case was initiated pursuant to information provided by the director of the VA Medical Center (VAMC) in White River Junction, VT, reporting that employees had come forward alleging inappropriate scheduling practices at the facility, to include entering the next available appointment date as the "desired date" resulting in the appearance of a zero-day wait time, and entering an appointment canceled by clinic as canceled by patient, which also resulted in the appearance of a shorter wait time. These allegations were the primary focus of this investigation.

Additional allegations arose during this investigation, which involved consult management in Mental Health and specialty clinics. Generally, it was alleged that the Mental Health Clinic did not use consults, instead steering all new patients to its walk-in clinic, so the 14-day new patient goal was not an issue; thus, giving the appearance that all new Mental Health patients were seen immediately.

In addition, allegations surfaced that there was a "14-day rule" in Medical Service's specialty clinics and Surgical Service, which had caused VA staff to hold onto consults, that is, not schedule appointments until they were within 14 days of the appointment, presumably to improve the wait time based on the create date.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** Department of Veterans Affairs (VA) Office of Inspector General (OIG) interviewed more than 40 current and former employees, including the VAMC White River Junction (VAMC WRJ) director and the Veterans Integrated Service Network (VISN) Director.

- **Records Reviewed:** VA OIG reviewed appointment and wait time data for a 2-year period, monthly management reports, emails, Veterans Health Administration (VHA) policy, internal memos, VAMC's Fact Finding Report, spreadsheets titled "White River Junction VA Data Mine of Risk Management/ Patient Complaint/ Congressional Inquiries Potentially Associated with Delay in Care/ Access," VHA Audit Site Visit notes and close-out report, performance appraisals, award data, and VA Performance and Accountability Reports issued annually from FY 2009–FY 2013.

3. Summary of the Evidence Obtained From the Investigation

Issue 1: Wait Time Manipulation Re: Desired Date

Interviews Conducted

- A medical support assistant (MSA1) stated that she mostly scheduled Primary Care appointments, but also scheduled appointments for Dermatology, Arthritis, and other specialty clinics. Approximately 6 years prior to the investigation, she took the required scheduling training, thought she knew how to do it, and then shortly after was told she was doing it wrong. MSA1 was instructed by both her former and current supervisors to enter the appointment date as the desired date so that it looked like the patient had no wait time. If schedulers did not do it this way, it was brought to their attention and they were told to go back in and fix it. Both supervisors told her the wait time had to be zero. The supervisors told her if she did it incorrectly three times, it would go into her record and affect her performance review; however, she did it the way they wanted so this was not an issue for her. This desired date manipulation applied to both new and established patients.

  MSA1 said that she came forward with these allegations after the Phoenix[1] wait time matter hit the media. She did not come forward earlier because she was afraid she would lose her job. She stated that her current supervisor came up to talk with her and other schedulers on May 22, 2014, in an attempt to convince them that this was all a misunderstanding, as if the schedulers hadn't heard what they had heard. She felt a little intimidated by the visit and believed the director subsequently reassigned the supervisor. Although she didn't know of any examples of patient harm, she thought it hurts the patients because the data manipulation did not give a clear picture of what VAMC WRJ needed: more doctors.

- A former Call Center MSA said that when she first started in her scheduling position, her supervisor told her to enter a desired date that equaled the appointment date so the wait time would be zero. The example she gave was that a patient asked for June 15th, but the next available appointment wasn't until September 1st, so even though ". . . in reality his desire date was actually June 15th . . . we would have to go out of the system, put the desired date in as September 1st, and were instructed to do so, so the wait time on the report would be zero . . ." She said, "I never felt it was the right thing to do . . ." She was trained by other MSAs who told her to do it this way. In June 2012, she questioned her supervisor about this practice because she was uncomfortable with it. When asked if she raised her concerns to anyone else, she said, no, she was worried about retaliation. When asked if she ever did it the right way, she said, yes, and her supervisor brought it to her attention as an error in the system during her performance review in October 2013. The former MSA stated that her supervisor told her that the chief of Primary Care "wanted these numbers to be at zero." She stated that even if the actual wait time was only a couple of days, she was instructed to go back in and make it so it was zero wait time; the

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

example she gave was of a patient who wanted an appointment on June 1st, but because only June 6th was available, she would have to enter June 6th as the desired date.

- MSA2, who scheduled appointments for Primary Care and some consults for Rheumatology, Infectious Disease, Endocrinology, Dermatology, and so forth, stated that when she first started, her immediate supervisor instructed her to enter the appointment date as the desired date, with the goal of a zero-day wait time. MSA2 had felt that this practice hid the actual accessibility of the clinics, and cited Dermatology as having long wait times/poor access. MSA2 advised that both the former and current supervisors had pointed out examples on the MUMPS[2] report of appointments that exceeded the target wait time (previously 30 days, then 14 days) and asked her to correct these "errors." She believed she would enter the appointment date as the desired date for these corrections. MSA2 said too many errors could lower your performance rating but did not provide any evidence that this had occurred.

- A Primary Care registered nurse (RN1), who was involved in scheduling for Urgent Care matters and some follow-up appointments, said both the former and current supervisors for MSAs told her that if she could not get a patient in within 14 days, then she was supposed to enter the actual appointment date as the desired date, even if the patient wanted to be seen sooner, so there was a zero-day wait time. RN1 didn't do it that way and had been told that she took up a lot of one former MSA's administrative time, as one had to "undo and redo" her appointment scheduling. RN1 knew the data were changed, because she noticed her notes weren't in the scheduling package anymore and when she asked about this, the former MSA confirmed she was changing the data. RN1 and another nurse-friend of hers discussed how this is "data manipulation" and they wouldn't do it. RN1 did not have any knowledge that this practice negatively affected patient care, as Primary Care has very good access and Urgent Care cases were seen right away. RN1 said the effect would be more with follow-up and recall appointments. She gave as an example a patient who was sent a recall letter that he/she was due to be seen for his/her annual exam on July 1st, so the patient called on June 1st, but can't be seen until September 30th, so that became the desired date. When asked if a physician was notified of the delay, RN1 said "no, but in a May 22, 2014, meeting they discussed implementing that practice so a doctor could determine if the delay was safe or not."

- MSA3, who scheduled appointments for Primary Care, mostly, and some specialty clinics such as Dermatology, advised that she came forward to the VAMC Director with scheduling allegations because "I feel like we are trying to cover up patient wait times." She stated that her coworkers, who trained her, as well as her current supervisor, instructed her to enter the appointment date as the desired date so it resulted in zero wait days. This process was used for both new and established patients. Her supervisor specifically told her that there needed to be zero wait days on the report for every patient. She only had one or two errors that caused her supervisor to contact her and have her redo them. She had a 45-minute discussion with her supervisor on May 22, 2014, during

[2] MUMPS refers to the Massachusetts General Hospital Utility Multi Programming System. A query using MUMPS captures Veterans Health Information Systems and Technology Architecture (VistA) scheduling information and generates a report with specific focus on desired dates and actual appointment dates.

which she was told she only ever had one mistake that she'd been asked to correct. MSA3 said that three errors would count against her on her performance review. She saw the desired date manipulation as a particular problem with recall appointments, because a doctor might want to see a patient for a June 15th recall appointment, but she could not get him/her in until October or November, and the system still showed a zero-day wait time, which covered up the 4-month wait period. Until the day before the OIG interview, if she entered June 15th as the desired date, it would have counted as an error. She stated that on May 20th or May 21st, 2014, she and other schedulers had a meeting with the facility director, chief of Primary Care, and all the other Primary Care leadership, during which the chief of Primary Care said, when discussing this recall appointment issue, that he was comfortable if patients could be seen within 2 weeks, before or after, the recall date.

- MSA4, who scheduled for Primary Care and some specialty clinics, stated that she took the required training modules for scheduling and it was clear from this mandatory training how scheduling should be done. However, her supervisor interpreted the training differently and instructed her to find the next available appointment and then enter that appointment date as the desired date so it showed a zero-day wait time. MSA4 said this was mandatory. During her first week, her supervisor told her she has a really hard time explaining the desired date and why they did what they did. MSA4 said she felt like she was "lying" by putting down, for example, July 23rd as the desired date when the veteran really wanted July 1st. Patients with urgent concerns could be seen within a week or two, but regular MSAs didn't have access to those emergency slots. MSA4 advised there was an access problem in Dermatology, where the soonest appointment was not for another 3 months, but the access reports based on desired date are not accurate.

  During a recent mandatory meeting held by the director and the Business Office, which both MSA4 and her supervisor attended, it was clear to MSA4 that what they had been doing with the desired date was incorrect. After the meeting, MSA4 emailed her supervisor and asked her how they should proceed with scheduling and her supervisor came up to talk to her. When MSA4 told her supervisor her understanding of how things should be done, her supervisor said, ". . . no, continue as is. I've talked to [a former MSA supervisor]. We're not doing anything wrong. Continue backing out . . ." There was a subsequent meeting held by the director, attended by MSA4, her current supervisor, a former MSA supervisor, and other MSAs. During the meeting, MSA4 spoke up and explained how they were being told to do things. The current MSA supervisor said nothing, but the former supervisor spoke up and said it's "clearly a misunderstanding," that the MSAs have misunderstood. MSA4 was upset by this, because the former MSA supervisor was never her supervisor or worked with her, so how would she know if there was a misunderstanding?

  MSA4 said that another MSA was told the same thing–find an appointment date, back out, and enter that exact appointment date as the desired date so there was no misunderstanding. A few days before MSA4's interview, the chief of Primary Care sent out an email and now the desired date was the date desired and what her supervisor had told her was no longer in place. The chief of Primary Care was also creating a physician notification process so if a patient couldn't be seen within 2 weeks of the recall date, then

the Call Center can notify the physician so he/she can make a clinical decision on whether the delay is acceptable.

MSA4 gave as an example that if she were scheduling an appointment for an established patient who needed to be seen in 3 months, she would enter either today plus 3 months or the date that's 3 month's out [for example, if today were April 1, 2014, she might enter T+3 or July 1, 2014]. However, if an appointment weren't available until September 1, 2014, this would show a 60-day wait time, so in this example, she's instructed to back out of the system and then go back in and enter the appointment date, September 1, 2014, as the desired date. She stated that Primary Care runs reports, and "we get called on the carpet hard if our name shows up on that. Of that desired date, I think they allow us two days on either side… We're allowed three mistakes a year. Go pull my personnel file. Those are my mistakes . . ."

- MSA5, who worked in the Scheduling Office, advised that she created clinics, schedules consults for some of the specialty clinics (Arthritis and Endocrine, Infectious Disease), and so forth. She was trained to ask the patient what his/her desired date was, then go in and find the soonest available appointment near the desired date and offer it to the patient, negotiate a mutually agreed upon date, and then use that appointment date as the desired date. She took the online training module and was trained by another MSA, MSA2. She said she didn't believe this process was in the module. She said her supervisor and another MSA were "there with us" helping train them. She gave an example of clinic cancellations that were months away, when she would enter the next available appointment date as the desired date, even though it wasn't negotiated with the veteran. When asked if her supervisor ever told her the reason to do it this way, she said it had to do with wait times and "zero days." When asked if anyone else besides her supervisor told her they needed to have zero-day wait times, she said, ". . . Not that I recall, as far as I know. It was just the way we were trained to do it; that using mutually agreed date as the desired date . . ." She added that if the patient agreed to it, then it worked.

- Another registered nurse (RN2) who did scheduling stated that she was asked to enter the appointment date as the desired date. Some of the instruction came from the former MSA supervisor, but less directly because she was not her immediate supervisor. Her immediate supervisor would say during nurse staff meetings, as a reminder to the whole group, please remember to do this. RN2 believed her supervisor was just passing on what she was asked to pass on, but didn't think her supervisor really cared one way or the other, because she never enforced it.

- Another former MSA stated that the former MSA supervisor was her supervisor when she was in an MSA position. She said that 90–95 percent of the time she could get patients in when they wanted to be seen, because Primary Care had great access for new patients. She stated that desired date was based on what the veterans said when they wanted to be seen. She said if a patient's preference was to be seen on a Friday, but the next available Friday wasn't for some time, she'd still put down this coming Friday as the desired date. She didn't schedule new patients back then. She could not remember how she scheduled established patients back then. Back then, they used the "MUMPS report"

to identify wait time errors. She didn't really know what the "MUMPS report" was, but she knew it wasn't good to be on it.

- A quality officer advised that in regard to the desired date, it had always been her understanding that it was "the date that the veteran desires to be seen . . . as negotiated with the provider." She understood why MSAs were going in and coming back out and she thought that was misunderstood for the most part. She said if a veteran asked to be seen July 1st and no appointment was available until July 15th, the desired date would be July 1st and the wait time would thereby show 15 days—even if the veteran agreed to the July 15th appointment date. She said she had recently learned, as a result of allegations pertinent to this investigation, that some MSAs were scheduling the desired date as July 15th.

  She had not observed that in the clinics back in 2008 through early 2010, but if that's the way it was being done, it was incorrect. If there were a drastic difference [between appointment and desired date], the scheduler needed to get up and go have a conversation with the provider. She said a zero-day wait time is a great goal, but you get there the correct way, and that didn't mean manipulating the numbers. She said she was not aware of any instances of the desired date being manipulated, not for new or established patients. She conducted a Fact Finding Report, in response to these allegations, in which she documented the results of her interviews with the current and former MSA supervisors and an MSA [MSA6]. The quality officer concluded in her report that it was her impression that schedulers who made errors and were told to go back in and fix the errors may not have been given sufficient supervisory feedback to explain why these were considered errors, etc.

- A former administrative assistant in Primary Care said that back when she worked for Primary Care, there was an access issue, as they had more than 400 patients on the new enrollee appointment request (NEAR) list. She told the second-level supervisor that she was unable to get the patients booked within the 14-day limit because there was no availability. The second-level supervisor told her, in front of the current and former MSA supervisors, that whatever date she could get an appointment would be the desired date.

- The manager for Primary Care described scheduling errors that involved a scheduler mistakenly entering "today" (the default entry) as the desired date, which would result in a lengthy wait time/show a delay when there was none. He said no one was encouraged to go back in and change dates to hide wait times. He said the supervisors [the current and former MSA supervisors and the second-level supervisor] were shocked people felt they were being told to always put the appointment date as the desired date. He also advised that access at VAMC WRJ's Primary Care was unbelievably good for new patients and said they can get 95 percent of them in when they want to be seen and that the desired date is based on when they want to be seen. He suggested that confusion amongst MSAs existed and was the result of the Same Day Access Report. He indicated the report looked at wait times for those seeking same day access such as for acute needs [that is, appointments for which the create date equaled the desired date, which indicates "Today" was entered for the desired date]. He said if the list showed a patient was

waiting 6 months, it was clearly a mistake, because VAMC WRJ's Primary Care staff were able to see a patient with an acute need that same day.

- MSA6 stated that in 2009 she was trained by two coworkers/MSAs at the desk to schedule appointments by reviewing clinic availability and then entering that specific date, which made it look like the clinic wait time was zero. When asked if the goal was zero-day wait time, she explained that the goal changed from less than 14 days, to 7 days, then to 1 or 0 day. Her wait times were always zero days because she entered the appointment date in the desired date field. The MSAs were instructed by their supervisors to do it this way. If an appointment wasn't scheduled within the goal (for example, 14 days, 7 days, or 0–1 days), they showed up on the MUMPs report and were told to remake the appointment for the exact same date and time, which removed the clinic wait time, bringing it down to zero. She referred to the MUMPS report as "the Naughty List," because it was part of their performance evaluation and they couldn't be on the list more than three times. Her perception was that it was all about performance measures and goals. In or around early 2014, her supervisor specifically told the MSAs in the Call Center, either in an email or a meeting, that the wait time had to be either one or zero days. She didn't think this was done to deny a patient care, because a patient was still going to get the same appointment date, regardless of what the desired date was changed to. She had no knowledge of patient harm resulting from this conduct.

  Note: MSA6's statement to the investigators was contradicted by the VAMC's internal Fact Finding Report, which stated that on May 21, 2014, when MSA6 was asked by a quality officer if she ever entered a desired date, which matched the appointment for the purpose of deliberately making the gap a zero, MSA 6 responded "absolutely not."

- A third former MSA initially became involved in scheduling mainly Primary Care and Dermatology appointments, and later was tasked by the Primary Care's administrative officer [also referred to as the second-level supervisor] to remake appointments. The current MSA supervisor and another employee trained her to find the appointment, back out, and then move forward with the appointment date that was agreed upon with the veteran. In or around February 2013, her second-level supervisor brought her a task stating that the appointments were made incorrectly and she needed to go back in and remake them. The second-level supervisor explained that these were part of the reason they were not passing their access measure and that they needed to be remade because they were errors in the way they made appointments. She was shown how to cancel and remake the appointment so it was the same exact appointment, just entered differently, so the wait time appeared to be shorter. The second-level supervisor and the former MSA supervisor were standing there with a report that showed wait times. She stated that she was told to cancel and remake appointments that were originally made by several different schedulers.

  She also said there were some frequent fliers, but it was for any of the Primary Care Clinics and then some new patients and community based outpatient clinics. It was almost every day that they brought her a list of appointments that needed changing. She was initially told to cancel and reschedule them. What she didn't know how to do, was to go in and write over the appointment, so the original appointment that was outside the

wait time measure would no longer exist. At some point at the end of 2013 or early 2014, she attended part of a Thursday morning meeting with the chief of Primary Care, another physician, the second-level supervisor, the former MSA supervisor, the current MSA supervisor, and another scheduler [the second former MSA]. During this meeting, she asked the chief of Primary Care if he wanted her changing the appointments "carte blanche," and he said, "No . . . that is not what you're supposed to be doing . . . We're looking for things that were done in error . . . we're not helping anyone, including ourselves, if we, if we make up those. No. Don't do that." She said this was in absolute contradiction with what the second-level supervisor had told her. After that meeting, she started looking at the appointments for real errors. Subsequently, one of the supervisors said, "Well, we are starting to slip on our access again." She also said there was a real resistance to getting some assistance on new patients. So they would get this giant group of them, this was before it was handed to telephone triage and then back, and the new patients would just "collect and collect and collect and then try to do a mass scheduling."

- The current MSA supervisor described legitimate scheduling errors as occasions when a scheduler entered "T" for today in the desired date field or "Yes" to the question "Is this Next Available?" (which defaulted to a "T" in the desired date field) but then just accepted an appointment from there, forgetting to back out and re-enter the system with the correct desired date. She said it was evident to her upon reviewing reports that these were errors, because if a veteran truly wanted to be seen the same day as his/her phone call, the veteran would be given one of the Urgent Care slots or advised to come into the Emergency Room. She agreed, however, that in most cases no one knew what the true desired date was at the time of correction, because the scheduler would not have noted anywhere when the veteran asked to be seen and, for established patient appointments, the routing slip that contained the physician's return to care date would have been thrown away. She pointed out that two of her MSAs were consistently on the Same Day Access report, every week. When she asked her MSAs to fix an error, she said, "I don't say that the desired date has to match the appointment, but it wasn't today . . ."

  She stated that the wait times for established patients were not monitored, that she didn't look at the wait times between desired date and appointment date for follow-up appointments, that she didn't know what the performance measure was [for established patients], that she was not familiar with any report that would show these data, and that she "doesn't even care frankly what the desired date is . . ." Her focus was on new patients and same-day access. The current MSA supervisor denied training MSAs to follow a process that resulted in the appointment date being entered as the desired date. She said, "Absolutely not."

  She further stated that soon after the schedulers came forward with these allegations, a meeting was held by management, which she and schedulers attended, among others. The MSAs provided feedback at this meeting that they were doing it wrong. When an MSA asked her if this was how she should schedule now, she told the MSA that nothing had changed, that they should be doing it how they'd always been doing it. She said the presentations at that meeting were the same scheduling modules that they were all trained on. She told OIG agents that she thought the national press about VA had made some of her MSAs think they're doing something wrong, but nothing had changed. It was

literally a refresher of the same scheduling modules. When asked what specifically led the schedulers to think they were not doing it properly, she said, "I'm not sure." The current MSA supervisor also told OIG agents that performance measures related to wait times were not part of her performance appraisal.

When re-interviewed, the current MSA supervisor again denied instructing MSAs to follow a process so that it looked like the appointment date was the desired date. She also denied having knowledge of anyone else instructing the MSAs to enter a desired date that equaled the appointment date so that the clinic wait time was less than 14 days. She said she didn't know that it was her MSAs' standard practice to enter the appointment date as the desired date. Later in the interview, she advised that she instructed them to go in and look at what's available, pick a date, ask the patients if it works for them, make sure it was reasonable with what the provider's guidelines were, and most likely that selected appointment date would be the desired date. The current MSA supervisor said she would be willing to take a polygraph examination and provided a signed, sworn statement. When asked if the dozen or so schedulers, MSAs, and nurses alike, were lying when they made these allegations, the current MSA supervisor said, "no." She described how she thought it was a misunderstanding or confusion that came from correcting scheduling errors. She said this was the first she was hearing about these concerns.

- The former MSA supervisor indicated she did not have a hand in training the MSAs initially (she said, "No, not really . . ."); she was not familiar with occasions when MSAs said they were going to put the desired date as the actual appointment date to show a zero-day wait time, even if different from what the veteran wants; she cited policy that once the desired date was established, it shouldn't be changed based on the availability in the clinic; she said the common response from veterans to the question when they'd like to be seen is "today or as soon as possible," so that determined the desired date, and she would record it as "today," and that was how she would have instructed her employees to do it as a 10-year supervisor; when asked if that's how everyone in Primary Care was doing it, she said she didn't know, and she had no direct knowledge of how the current MSA supervisor trained them; and when asked if anyone would have a reason to change the desired date to the actual appointment date, the former MSA supervisor said not for a new patient, but they may do that for a follow-up patient [presumably because the desired date was the method of calculating wait times for follow-up patients only].

  The former MSA supervisor agreed that she had brought errors, such as mistakenly leaving the desired date as today, to her MSAs' attention and said it was part of their performance, but that none of the employees she supervised have ever received a rating of not fully successful. When asked if a scheme to change the desired date to make it within 14 days of the appointment happened at VAMC WRJ, the former MSA supervisor said, "I, I, I don't see it at the CBOCs . . ." When asked if it happened back when she was an MSA supervisor, she said, "No, I mean, I, I, no, I, I don't . . . and it was long enough ago, I, I truly don't remember . . . But I don't think that was ever an intentional . . . no, I don't think it was intentional . . ." At the end of the interview, the former MSA supervisor said, "And did we maybe not do it the right way years and years ago? I'd say maybe that's true. . . . But I think it was . . . innocently. We thought we were doing what was right."

- A second-level supervisor explained that Primary Care MSAs might work for the Green Mountain Firm (downstairs), the White Mountain Firm (upstairs), or Desk 90 (which scheduled for Medical Service's specialty clinics). There was only one MSA [MSA7] who worked at Desk 90. The Surgical Service MSAs came under a different administrative officer. The Primary Care MSAs took the required training modules for scheduling and then the current MSA supervisor trains them. She said she's never watched an actual training session. Regarding the desired date, she said she disagreed that it was always equal to the appointment date. She thought the MSAs were being trained to negotiate the desired date with the veterans. When asked if she believed that schedulers might be trained that the desired date should always be the appointment date so there's a zero-day difference, she said, "No, I don't believe they're trained that way," but agreed she didn't observe their training or staff meetings.

- MSA1, MSA3, MSA5, MSA7, the current MSA supervisor, RN2, a quality officer, Primary Care's administrative officer, and the chief of Primary Care all denied knowledge of a systemic practice of canceling appointments "by patient" when they were actually canceled "by clinic" to improve wait times. RN2 indicated she was initially trained to cancel by patient when the appointment was actually canceled by clinic, but could not recall who trained her this way or when such training occurred. RN2 stated that this was no longer the practice. A quality officer advised that back in late 2009/early 2010, VA recommended that errors be rescheduled by canceling the appointment "by patient" so that the original appointment's tracking record was not lost. She said this was a short-lived practice.

Records Reviewed

- Data for all appointments made at VAMC WRJ over the 2 years prior to the investigation [which involved more than 700,000 records], were reviewed. From these records the percentage of appointments that were made with a zero-day wait time from the desired date, per month, by each scheduler were identified. A review of the data substantiated that some MSAs entered the appointment date as the desired date 100 percent of the time. In fact, more than half of the total schedulers (152 out of 293) on this list entered the appointment date as the desired date 100 percent of the time. Some MSAs entered the appointment date as the desired date almost all of the time.

- A review of Monthly Management Reports posted on the VISN 1 intranet showed an increase in 2013 for the performance measure titled "Same Day Access With PCP." From January 2012 through April 2013, VAMC WRJ did not meet this performance measure (it was in the red). In January 2013, this performance measure was 49.2 percent, when the goal was 66 percent. In April 2013, the measure was 56.99 percent. From

May–December 2013, the facility met the 66 percent goal with a steady increase to 95.7 percent, as follows:

- May 2013 – 69.4%
- June 2013 – 81.5%
- July 2013 – 96.3%
- Aug. 2013 – 96.4%
- Sept. 2013 – 95.7%
- Oct. 2013 (End of fiscal year (FY) 13) – 95.7%

This goal/measure was removed from the FY 14 Monthly Management Report, so it could not be determined whether the measure dropped in late 2013/early 2014, when the third former MSA advised she stopped changing the data "carte blanche."

- A review of wait time data showed that over the past 2 years, two MSAs identified as fixing "errors" [the second and third former MSAs] scheduled 100 percent of their appointments with a zero-day wait time.

- Files obtained from the current MSA supervisor included a file with an email from the current supervisor to an MSA employee, dated April 4, 2014, stating, in part, "Please remake the following appointments not next available . . . please be sure to back [out] of the appointments after you find a date and go back in to make the appointment not next available." This is an example of what appears to be a legitimate error as described by the current supervisor.

Issue 2: Wait Time Manipulation in the Mental Health Service Through Use of Walk-in Clinic.

Interviews Conducted

A confidential source alleged that at least through late 2011, VAMC WRJ blocked the ability to enter consults for Mental Health in its system and steered all new patients to its walk-in clinic in Primary Mental Health Clinic (PMHC), so that the 14-day metric for new patients in Mental Health was not a concern.

We interviewed a manager in Mental Health who confirmed that consults were generally not used in Mental Health at VAMC WRJ, because Mental Health used an open-access model for new and established patients alike, and consults were considered unnecessary.

Records Reviewed

Review of *Consult Management Frequently Asked Questions* narrative dated October 16, 2013, found that Mental Health was required to use consults when crossing programs; for example, from Primary Care to Mental Health, or from one Mental Health specialty to another; however, consults were not required when patients were seen in a walk-in clinic or when there was a "warm handoff" between providers on the same team.

Review of emails from the chief of Mental Health confirmed that consults were generally not

used in Mental Health at VAMC WRJ, because Mental Health used an open-access model for new and established patients alike, and consults were considered unnecessary.

Issue 3: Wait Time Manipulation Re: Create Date Through "14-Day Rule"

Interviews Conducted

- A quality officer advised that the only way to manipulate the data [based on the create date] would be not to schedule the consult until it was within the 14-day window, which she was not aware of occurring at VAMC WRJ. She said that for the 2 years prior to the investigation, VAMC WRJ had failed the create date wait time measure for specialty care, so she didn't believe the data were manipulated.

  Medical Service

- A Medical Service administrative employee advised that over the last couple of years, he would periodically check the pending consult list and ask MSA7, who did most of the scheduling for Medical Service's specialty clinics, why the consults were pending. MSA7 advised him that she was told to wait to schedule the appointment within 14 days of scheduling due to wait times. He said this type of conversation may have occurred a couple of times between himself and MSA7. He told MSA7 just to schedule the consult and that she did not have to wait. He speculated that scheduling supervisors may have thought this system would allow for good performance measures with no harm to patients as they would not be seen quicker either way. He said that, according to MSA7, both her current and former MSA supervisors told her to do it this way.

- MSA7, a scheduler for Medical Service/Specialty Clinics, advised that for new consults and established patients alike (though she primarily just scheduled new consults), when booking non-urgent Sleep, Pulmonology, and Neurology appointments, there was typically no appointment availability within 90 days. She said she, therefore, placed the new consult (hard copy) in its respective folder without scheduling an appointment for the patient. She advised that she created this folder system, without instruction from others, to help ensure no patients fell "through the cracks." She doubted most consults were filled within 14 days as every time she scheduled an appointment, several other new consults came in. She said this was never meant to mask wait times but that she did not know how else she was supposed to keep track of the patients as she had never been trained in the use of the EWL or Recall system. She conceded that while providers and supervisors, such as her current and former MSA supervisors and the second-level supervisor, knew she kept folders with consults in them, they were probably unaware the consults therein had not yet been scheduled. Her scheduling supervisors relied on a random audit in the Veterans Health Information Systems and Technology Architecture (VistA) for reviewing appointments that had been scheduled. She said that in an effort to keep track of those patients awaiting appointments, and to accurately show the backlog, the Medical Service's administrative officer told her to start putting those patients in VistA or the Computerized Patient Record System (CPRS) as Future Care Consults.

Note: It was evident from the interview that MSA7 was unaware that Future Care Consults were only intended for established patients. As of July 14, 2014, she said she was still receiving new consults for Neurology and was still putting them in a folder without scheduling them.

In a follow-up interview, MSA7 advised that she was not sure who told her to have new consults scheduled within 2 weeks of the available appointment. She said approximately 1 year prior to the investigation, a nurse practitioner, who triaged consults for a specialty clinic, told her not to schedule appointments for consults until within 2 weeks of the available appointment. She stated that "consults are not supposed to be booked far out." When asked why, she said she assumed because new patients needed to be seen right away. She said that she "could book far out but don't because I was told not to." When asked why she wouldn't book an appointment, even if far out, just to get it in the system and then change it to an earlier appointment when a cancellation occurred, she stated differently—on one occasion, she said she couldn't answer that question, and on another occasion, she said she would be worried it would show 185 days out. She agreed that she understood how holding the consults without scheduling them might improve the wait time numbers. She denied canceling or discontinuing consults to improve wait time numbers. She was never trained to ask patients when they would like to be seen. She said she didn't have time to call her new consult patients; she typically scheduled the appointment and then sent out a letter. As of August 6, 2014, she said she had recently started to schedule new consults as they came in.

- MSA6 advised that Endoscopy consults were held in a folder until they could be booked within 14 days. She said Endoscopy had limited access, perhaps 1 day per week, so appointments were scheduled 2 weeks out. She knew these were set aside and believes another MSA [MSA2] trained her this way.

- The chief of a medical specialty service advised that when he came to the VA several years ago, there were approximately 400 patients waiting 8 months or more to be seen and attributed the backlog to staffing shortages. He was able to get the wait time for new consults down to 4 or 5 weeks but now it was back to about 10 weeks for non-urgent patients, while there was little if any backlog for established patients' follow-up appointments. He was not really involved in scheduling, but it was his understanding MSA7 put the consults in a book after they had been triaged. Since MSA7 could not book more than a month in advance, she called the patients in the book to set up an appointment and did not schedule appointments beforehand.

- The chief of another medical specialty service advised that, as recently as April 2014, new consults awaiting an appointment, which were maintained in folders, used to be triaged on paper instead of in the electronic medical record system. She advised that the current wait time for new, non-urgent consults was generally 90 days.

Surgical Service

- In a follow-up discussion, MSA7 advised that that an employee from Desk 90 advised her that (1) they couldn't schedule consults until they were within 14 days of the appointment date, and (2) they canceled their consults to improve wait times.

  Note: Desk 90 was how VAMC WRJ refers to the scheduling clerks responsible for booking appointments for the specialty clinics within Surgical Service.

- Three current or former MSAs who worked Desk 90, MSA8, MSA9, and MSA10, who handled scheduling for VAMC WRJ's Surgical Service (clinics include Orthopedics, Vascular, Podiatry, Thoracic, and General Surgery), were interviewed regarding an allegation that Desk 90 held consults until they could be scheduled within 14 days of the appointment date. MSA8 and MSA9 agreed that in 2013, physicians who were chiefs of their specialty clinics advised the MSAs of a 14-day rule, that is, they needed to find a spot for the new consults within 14 days of scheduling them. MSA8 said an administrative officer in Surgical Service and a former Desk 90 MSA also told her about the rule. Both MSAs had no knowledge of consults being discontinued or canceled to meet the 14-day wait time goal, but MSA8 indicated that someone other than herself might have held onto consults, since she had been provided with older consults, but this occurrence was described as happening only once in a while.

  Both MSAs agreed that they largely booked consults within 14 days. If they couldn't book the consult within 14 days, then they went back to the provider or health technician in that service, who would often tell them to overbook. When MSA9 was asked if there was any pressure to meet the 14-day goal, she at first said no, and then said everyone knew about the rule and they were "adamant about it." MSA8 said, "If we had the providers we needed for the amount of patients we had, it wouldn't be a problem." When it was suggested that there was no purpose for a 14-day rule except to meet wait time goals, MSA8 said, "Probably," but she didn't know. MSA9 said that Orthopedics had the worst access. Although they were very busy, there were always work-arounds, and Surgical Service physicians saw patients with urgent issues right away, even if they had to stay past their scheduled tour of duty. The former MSA [MSA10], who stopped working at Desk 90 in or around early 2013, had no knowledge of the 14-day rule. No concerns were reported of this 14-day rule negatively affecting patient care.

  In mid to late 2012, Desk 90 was understaffed and former MSA10 found a huge pile of consults, hundreds of them, that hadn't been acted upon. Both MSA8 and MSA10 agreed this occurred, not because consults were held to meet wait time goals, but because Desk 90 was understaffed and staff lacked experience. MSA10 said that in late 2012, there were more than 700 consults not scheduled and were brought to the attention of Surgical Service's Chief and administrative officer who were surprised/"floored." MSA10 had to send a weekly report to Surgical Service leadership until the 700+ consults were scheduled or otherwise properly taken care of. MSA10 said that these consults were usually booked within a couple of weeks of when the appointment was entered. MSA10 had physicians' permission to overbook them, and in at least one case, overbook up to four times clinic capacity. On January 15, 2013, another

76 Podiatry consults were located. By February 2013, MSA10 had the Podiatry consult backlog scheduled.

Records Reviewed

- A review of performance data in VISN 1's Monthly Management Reports disclosed that from July 2011 through October 2013, VAMC WRJ met its wait time goals for Specialty Care. It appears that through October 2012, the wait time goal for new patients in Specialty Care was based on the desired date. From November 2012 through October 2013, the wait time goal for new patients in Specialty Care was that at least 46 percent of scheduled appointments should be within 14 days of the create date. In November 2013, the goal was increased from 46 to 60 percent, and it was only at this time that VAMC WRJ no longer met this goal. This review showed a steady increase from November 2013 through May 2014 over those 7 months–49.7 percent, 50.3 percent, 53.4 percent, 53.8 percent, 58.2 percent, 62.0 percent, and 67.9 percent. In summary, during the 19 months that the VISN 1 reports showed the Specialty Care, new patient wait time goal was based on the create date, VAMC WRJ met the goal during 14 of those months, contrary to what the quality officer advised.

- Review of email communications provided by MSA10 found that on October 18, 2012, "an enormous pile of unscheduled consults" was brought to VA management's attention, and it was later identified that the pile contained 487 Podiatry consults.

Issue 4: Failure To Use Electronic Wait List (EWL) and Use of Ad Hoc Methods To Track Patients in Need of Appointments

EWL

- A quality officer advised that the EWL had not been used or endorsed at VAMC WRJ for at least 8–10 years and that they instead relied on other reports to monitor access and wait times such as the NEAR list. She said they were using it now (at the time of the investigation), and this was prompted by the current Phoenix issue. She said they weren't using the EWL because they didn't want veterans sitting in a queue waiting for an appointment. At the time the decision was made, they thought the better decision was to give the veteran an appointment.

- MSA7, MSA6, and the first former MSA mentioned in this report confirmed they were instructed not to use the EWL.

- MSA7, MSA10, and one chief of service stated that there were backlogged consults in non-urgent Sleep, Pulmonary, Neurology, and Podiatry that had over 90-day wait times.

Ad Hoc Methods

- RN1 advised that Primary Care had a paper list that was kept in the telephone triage room for new patients who needed appointments but couldn't be seen within the 14-day time frame. Even when RN1 told the schedulers to schedule it out further, they would respond

they couldn't do it. She knew the list existed a few years prior to the investigation, and she stopped having any knowledge of the paper list approximately 6–8 months prior to the interview. She said various schedulers used to manage the list, and now a former MSA handled the new patient appointments.

- MSA3 advised that the Call Center had a 3-ring binder, referred to as the "book," that contained new patient consults in need of appointments. This book was rotated among the schedulers, and if it was your day, you went through and called these patients to get them in. Many of them were hard to contact because they were at work, but they would leave messages. Access for these new Primary Care patients usually was not a problem; they could generally get them in the following week. The book was taken away because they were short-staffed. She said around 2 weeks prior to the interview, there was a meeting with Scheduling and a former MSA brought up that she had the new patient spreadsheet and was told to get rid of it.

- RN2 disclosed that several years ago, prior to switching to the patient aligned care team (PACT) model, while performance measures were based on a 30-day wait time for new patients, new patients with non-urgent needs had to wait more than 30 days to see a provider. She indicated that the telephone advice room kept a paper list containing names of patients waiting for appointments, and the patients would not be scheduled until the appointment came up within 30 days. She said the task of scheduling new patients then was given to a former MSA and that this practice no longer occurred. She was not aware of any patient harm in connection with these allegations.

- A former MSA, who at the time of the investigation was in an administrative position for Primary Care, advised that requests for new patient appointments generally came from multiple sources such as Eligibility's NEAR report, consult requests, email, walk-in patients, and telephone calls; she used a spreadsheet to consolidate all of this information to make sure patients were seen and did not fall through the cracks. She said she did not take the patients off the list until she confirmed they were actually seen for their initial appointments. She said her spreadsheet was not replacing anything that could be found elsewhere in the VA system and that she was not taking anyone off the NEAR report.

- A quality officer said she was aware of the former MSA's list and that it was not secret, and that it was easier than logging into the computer for each system in which you were often kicked out for being on too long, and that everything was reconciled in the computer.

- The former administrative assistant advised that when she first started in Primary Care several years before the investigation], the NEAR list had more than 400 new patients on it waiting for appointments, as well as paper consults and that the consults were kept in a book waiting to be scheduled. She said patients could wait months to get an appointment because the NEAR list was not being used properly and Primary Care's objective was to get rid of the list by making one call or sending one letter to the patient and then removing them from the list, even if they did not hear back from the patient. She discussed the push to clean up the NEAR list and said a red flag was created if there was too long of a delay.

- A manager for Primary Care advised that the online spreadsheet and calendar used by the former MSA was not secret and everything on the list could be found in the VA computer system. He explained that some new patients were not on the NEAR list because they did not come through Eligibility; these veterans were not new to the VA but may have been moving to Vermont from another state where they were enrolled. He said that the book was a spreadsheet, keeping track of who needed to be scheduled and that it was a way to make sure no one slipped through the cracks. It was a safety mechanism to ensure new patients were seen and ended up in CPRS. He said Primary Care got approximately 50 new patients a week.

Issue 5: Alleged Patient Harm as a Result of Access Problems

- On May 5, 2014, a VA social worker from a Vet Center contacted the VAMC WRJ director to report that, in 2012, a veteran died of sleep apnea before VA care could be provided due to prolonged wait times at the VA facility. VAMC WRJ initiated a review and a determination was made that there was no significant delay by VA that appeared to have had an effect on the patient's death.

- OIG investigators were provided a spreadsheet titled "White River Junction VA Data Mine of Risk Management/ Patient Complaint/ Congressional Inquiries Potentially Associated with Delay in Care/Access," which contained 10 cases and was later updated. VAMC WRJ conducted a clinical review of all of cases and closed out all but one. This last pending complaint involved an alleged missed diagnosis of cancer, which had been referred for a formal Peer Review.

- The chief of a medical specialty service advised that the pressure of having good access numbers forced past providers in the clinic to schedule patients for just 15–20 minute appointments so that they could see more patients daily. She explained that such short examination times did not permit total body exams, and consequently, some cancer had been missed. She stated that since she first began seeing patients at VAMC WRJ, (3 months prior to the interview), she had found cancer in at least 10 patients whose cancer had not been found during earlier VA visits; she said 10 was a conservative number. During a follow-up interview, she also said she saw 1–2 patients with early [aggressive] cancer. She had no knowledge of bad outcomes such as an invasive [aggressive] cancer or death occurring as a result of a delay in diagnosis/care, but admitted that the potential for that to occur was there. It was her professional opinion that some patients did have slightly larger scars as a result of a delay in diagnosis. This alleged patient harm was not directly connected to any wait time data manipulation. This specialty clinic had a long-recognized backlog; she said there were approximately 200 pending consults in April 2014, and estimated a new (non-urgent) patient's wait time was generally within 90 days of the consult.

- A former MSA alleged that, sometime in 2010–2012, she was aware of at least six patients who died while awaiting care at the VAMC WRJ. This individual could not recall any of the names of the patients who died or any information or circumstances surrounding their condition or deaths. She recounted her attempts to contact veterans to schedule appointments only to be told by their spouses that the veteran had already died.

She indicated, however, that she was unaware if their deaths were actually the result of backlogs in Primary Care.

Interviews Conducted With the Medical Center and VISN Directors

- The VAMC WRJ director was interviewed by the VA OIG multi-disciplinary team. She became VAMC WRJ's director in January 2013. She indicated that approximately 2 weeks prior, she brought all of the scheduling clerks together to review the scheduling process. She stated that a former Primary Care scheduler alleged that while she was in Primary Care, she was asked to inappropriately remake appointments on a list so that the desired date equaled the existing appointment date. The former scheduler also reported that the former MSA supervisor instructed her that the wait time had to be zero and that was why they were doing this. The VAMC Director subsequently asked her chief of Quality Management to conduct a fact-finding, during which they met with MSA11, who was the union president in addition to being a scheduling clerk.

  MSA11 told them that scheduling clerks were taught to obtain the first available appointment, then go back into the system and enter that appointment date as the desired date and that this had been going on for "quite some time." She also received emails from MSA1 and MSA3 requesting an in-person meeting, during which they confirmed what MSA11 had said. As part of the fact-finding, the chief of Quality Management interviewed the former and current MSA supervisors and second-level supervisor, and told the VAMC Director that they all described the process the same way, but it didn't sound as if their instruction was to do something wrong because they had their reasons for it. The VAMC Director said late that evening (May 20, 2014), she decided to pull in the three supervisors and the chief of Primary Care into a meeting to discuss the issue. During this meeting, they indicated that "there is a misperception of what they are not explaining clearly."

  The following day, VAMC WRJ management held a meeting with the clerks during which the chief of the service apologized if there was a misperception, etc. That same day, MSA4 sent an email stating that there was no misperception, "we are told, taught and trained to find an appointment then back out of the system and put in the exact date. If we make an error and the date we choose is not within 2 days it is printed and put into our records as an error and we also get emails regarding our error. I have been uneasy with this process since I started working here a year ago and have expressed this to [the current MSA supervisor] several times . . ."

  As a result, the director was really alarmed and notified the VISN Director. She was equally concerned about the allegation about clinic cancellations being entered as patient cancellations. She's reviewed the data and found that it was not infrequent for providers at VAMC WRJ to cancel clinics. On May 22, 2014, she brought this to the attention of VA OIG. Also on May 22, 2014, late in the day, she advised two of the supervisors that she had to take them out of their supervisory role and any connection with scheduling at the moment. She further advised that she has reviewed data she referred to as "zeroed out list," which found that out of 600 appointments; approximately 300 had zero-day wait times. She said that the VISN 1 chief medical officer thought that figure was "pretty

high." She also confirmed that VAMC WRJ had not used the EWL and that Primary Care kept a computerized list of new patients whom they schedule off to ensure no one falls through the cracks, and advised that the VHA audit team said they had no problem with that list.

- The VISN 1 Director advised that when the VAMC WRJ Director brought the VAMC WRJ scheduling allegations to his attention, he fully supported her decision to turn this over to the OIG for investigation. He explained that any one performance measure will have a relatively small effect on a VAMC Director's performance evaluation overall. He said the wait time measure for at least the past year or two focused on new patients, who were based on the create date, not the desired date. He said he had no knowledge of (1) consults at VAMC WRJ that were sitting in folders, unscheduled; (2) allegations regarding scheduling, wait times, or delays in care prior to this investigation; (3) adverse events, death, or patient harm as a result of the scheduling practices at VAMC WRJ; and (4) any decision by VAMC WRJ not to use the EWL. He said a new consult should either be booked or placed on the EWL. He said VAMC WRJ was not on his radar as a problematic area regarding access, with the exception of sleep studies and traumatic brain injury evaluations for a period of time. He believes the desired date to be a confusing methodology and was never a proponent of it.

4. Conclusion

- The investigation substantiated that VAMC WRJ schedulers inappropriately entered a desired date that matched the appointment date to obtain a zero-day wait time for both new and established patients. It was largely corroborated that this manipulation was employed by schedulers at the instruction of a former and current supervisor of the MSAs and with the knowledge of the second-level supervisor. The following points are provided as possible mitigating factors to present a balanced, objective report: (1) A few MSAs stated that they were trained to enter into the desired date field the appointment date that was mutually agreed upon with the patient, which agreed with statements made by the current and second-level supervisors. It had been noted, generally, that it can be difficult to obtain a desired date from a patient, and that patients were often very agreeable and will, of course, agree to the soonest appointment available that worked with their own schedule. Whether or not this mutually agreed upon date was within the meaning of VA policy might be a gray area. (2) Another mitigating factor, at least for Primary Care that reportedly had good access, was the overwhelming consensus that this data manipulation resulted in no patient harm because the patient was going to get the same appointment date, regardless of how the desired date was entered. Reportedly, if a new patient called in to the VA Call Center at VAMC WRJ with an urgent matter, there were nurses who triaged these calls, and VAMC WRJ reportedly was able to get these urgent cases in quickly.

- The investigation did not substantiate a systemic practice of canceling appointments "by patient" when they were actually canceled "by clinic." None of the MSAs and supervisors had any knowledge of such a practice. One nurse indicated she was initially trained to cancel by patient when the appointment was actually canceled by clinic, but could not recall who trained her this way or when such training occurred. She also stated

that this was no longer the practice. Another employee stated that back in late 2009/early 2010, VA recommended errors be rescheduled by canceling the appointment "by patient" so that the original appointment's tracking record was not lost. She said this was a short-lived practice.

- The investigation substantiated that Mental Health generally did not use consults, though the service chief indicated this was for good, clinical care, and not to improve wait times.

- The investigation substantiated the existence of a "14-day rule" in Medical Service's specialty clinics and Surgical Service, which caused VA staff to hold onto consults, that is, not to schedule appointments, until they were within 14 days of the appointment, presumably to improve the wait time based on the create date. However, there was conflicting information regarding the extent of this practice and at whose instruction.

- The investigation substantiated that VAMC WRJ has not used the EWL for at least 8 to 10 years, though the investigation was unable to pinpoint exactly when the decision to stop using the EWL was made and who made the decision. The investigation disclosed that within the past few months, the VAMC Director had required VAMC WRJ staff to use the EWL. Investigation also substantiated that VAMC WRJ used ad hoc methods to track patients in need of appointments; for example, Primary Care maintained a spreadsheet, which contained new patients from the NEAR report, consults, phone calls, and walk-ins.

- No specific patient harm had been identified as resulting from the wait time data manipulation allegations.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on December 16, 2014.

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