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

VA Medical Center in Augusta, Georgia
April 7, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated pursuant to information developed during a proactive review of wait time issues at various Department of Veterans Affairs (VA) facilities, including VA Medical Center (VAMC) Augusta. During the review, a service chief told investigators that she had discontinued 321 ultrasound consults for Non-VA Care Coordination (NVCC) because she thought they could be addressed in-house, rather than being delivered through fee basing or NVCC. A subsequent referral from another VAMC employee alleged that employees within the Primary Care Department at VAMC Augusta were intentionally manipulating waiting times in order to meet VA wait time standards.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed seven Augusta VAMC employees, including the director.

- **Records Reviewed:** VA OIG reviewed a PowerPoint presentation by the program support clerk (PSC).

3. Summary of the Evidence Obtained From the Investigation

Issue 1: Cancellation of NVCC Consults

Interviews Conducted

- The service chief (SC1) was interviewed as part of a proactive effort regarding scheduling and consult issues within VA. When asked if she had ever participated in a group closure of consults, scheduling manipulation, or any similar action, she stated that approximately 1 month prior to the interview, she discontinued 321 NVCC consults for imaging (ultrasounds). All of the discontinued consults were annual screenings and not new screenings or for any other urgent purpose. She stated she initially discontinued the consults because she thought they would be able to address them in-house as opposed to sending them outside VA to be performed for a fee. However, she subsequently learned that her facility was only able to schedule approximately 61 of the 321 consults. She stated it was a "misunderstanding" because she initially spoke with another service chief (SC2), VAMC Augusta, who gave her the initial approval. However, after discontinuing the consults, SC2 later explained to her that he misunderstood her intention and said they would not be able to handle all the consults in-house.

- SC2 stated there was an ultrasound backlog because of limited staffing and a large number of ultrasound consults. SC2 stated that around February 2014, following an

increase in Radiology staff, he informed SC1 that he could begin to do some of the ultrasound consult referrals in-house. SC2 stated that SC1 misinterpreted his offer to help with some of the referrals as his department was unable to handle all 321 exams, which allowed her to remove the consults from the pending fee-basis consults. SC2 stated that "it was an honest mistake by [SC1]" and he "didn't think anyone meant any harm." It was his understanding that 51 of the 321 discontinued consults were pending new appointments and the others were completed. However, he said that he did not manage scheduling matters and could not comment on the specifics. He explained that all of the canceled consults were proactive aortic abdominal screenings for patients over the age of 50 who had a history of smoking even a single cigarette. Since the consults were first entered, he received permission from the Veterans Integrated Service Network (VISN) 7 office to adjust the requirements for these types of screenings because of the broad screening requirements, which likely resulted in the large amount of delinquent consults.

- The VAMC Augusta Director stated that he was aware of the consults that had been discontinued. His own inquiry into the matter revealed there had been a misunderstanding between SC1 and SC2 about VAMC Augusta's ability to adequately service the imaging consults; however, he felt there were no bad intentions to discontinue the consults. He also stated that a 100 percent review was requested of all the discontinued consults.

Issue 2: Wait Time Manipulation

Interviews Conducted

- The employee who alleged that patient wait times were manipulated stated that around May 2014, she discovered that a VAMC Augusta PSC manipulated patients' "desired dates" after she became suspicious once the department quickly went from "red to green." The employee stated that the PSC was not a scheduler. The PSC reportedly pulled a daily list of patients with future appointments and identified those patients with appointments exceeding 14 days and changed the desired date to make the desired date "zero." The PSC created a PowerPoint presentation on how to manipulate the desired date. This presentation was subsequently emailed to the scheduling staff and SC1.

  The employee stated that hundreds of Primary Care appointment desired dates were altered to show the desired dated between 0 and 7 days, which improved their performance measures. The PSC would go into appointment management, overwrite the original appointment, change the desired date, but keep the original appointment date and time. Reportedly, Primary Care went from red to green overnight on the dashboard presentation of wait times. According to the employee, Primary Care access became #1 in the VISN, after the PSC's manipulation of the desired dates. The PCS reportedly changed 80 patients' desired dates in 1 day. The employee stated that a manager and SC3 were informed that this could be seen as "gaming the system." The manager's and SC3's responses were that the PSC was correcting scheduling errors.

- The PSC stated she identified scheduling errors in established patients returning to clinic appointments within the Primary Care Department. The errors occurred when the schedulers entered "T" for today as the desired date once the provider and the patient agreed on a return appointment. When the appointment "create date" and the desired date for a future appointment was the same, this would indicate a scheduling error. Once she spoke with the manager and SC3, it was determined the best practice was to change the desired date in order to correct the mistakes made by the schedulers. In May and June 2013, she identified the appointments with scheduling errors and changed the desired dates to reflect a date closer to the return appointment as indicated by the provider. She always notified SC3 when she made changes to the desired dates.

  She created a PowerPoint presentation on how to adjust the desired dates in cases with scheduling errors. The PSC subsequently emailed a copy of that PowerPoint presentation to other schedulers throughout VAMC Augusta. After being shown Veterans of Health Administration (VHA) Directive 2010-027, which read, "once a desired date is established it must not be altered for lack of appointment availability on the desired date," the PSC stated she was not aware she did anything wrong by changing desired dates because she thought she was fixing errors made by other schedulers. It was never her intention to manipulate dates.

- The manager stated she identified scheduling errors in established patients returning to clinic appointments within the Primary Care Department. The errors occurred when the schedulers, including clerks, nurses, and employees from the Call Center incorrectly scheduled appointments by entering "T." When the create date and the desired date for a future appointment was the same, this would indicate a scheduling error. There was never an issue of provider availability. She initially asked the PSC to look into the scheduling issues; however, she never asked her to adjust any of the dates. She thought the PSC had good intentions and said she likely adjusted the dates rather than asked the schedulers to adjust them to ensure it was done. She thought it was likely the PSC also received additional guidance from SC3. When shown VHA Directive 2010-027, and specifically where it is stated that, "once a desired date is established it must not be altered for lack of appointment availability on the desired date," the manager said she was not aware PSC did anything wrong by changing desired dates because she thought she was fixing errors made by other schedulers.

- SC3 stated that despite the fact he hired the PSC along with other providers, wait times did not improve within the Primary Care Department. He requested the PSC to analyze wait times through which they discovered hundreds of scheduling errors. SC1 provided the PSC with program keys and the PSC subsequently made corrections/changes to the appointments with errors. SC3 stated it was not his or the PSC's intent to game the system but only to correct the errors made by the schedulers.

Records Reviewed

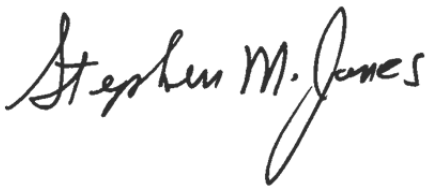
- VA OIG reviewed the PowerPoint presentation provided by the PSC.

4. Conclusion

- During the proactive investigation, SC1 disclosed that she improperly closed 321 NVCC imaging consults after she misinterpreted the facility's ability to address the backlog of imaging consults in-house rather than sending them to outside providers. According to VHA Directive 2010-027, such practice was contrary to policy. The facility identified the problem prior to OIG involvement and took immediate and appropriate action to address the issue with a 100 percent review of all 321 discontinued consults. According to VA OIG Office of Healthcare Inspections, this was an acceptable response by the facility.

- The investigation also found that a PSC changed patients' desired appointment dates in an effort to correct scheduling errors in Primary Care. The PSC's supervisors were aware of the way she was handling the patient information. The decision to change the desired dates was not in compliance with VHA Directive 2010-027.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 25, 2015.



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