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

VA Medical Center in Albuquerque, New Mexico
June 22, 2016

1. Summary of Why the Investigation Was Initiated

On May 20, 2014, Senator Tom Udall shared an article with the Department of Veterans Affairs (VA) Office of Inspector General (OIG), which appeared in a local Albuquerque, NM, newspaper. The article was critical of scheduling practices at the Raymond G. Murphy VA Medical Center (VAMC) in Albuquerque, NM. In response, VA OIG opened this investigation.

A confidential complainant identified the Primary Care Clinic as the place where scheduling was handled incorrectly resulting in delays in care according to a previous VA OIG Hotline contact. This complaint was similar to conditions described in the article, specifically program support assistants (PSAs) were being "forced" to input "desired dates" that were beyond the dates providers recommended or the patients requested. The complaint alluded to the entry of inaccurate desired dates as a manipulation of metrics and was concerned about adverse patient outcomes.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the complainant, VA OIG interviewed 18 current and former employees.

- **Records Reviewed:** VA OIG reviewed VA emails; an Administrative Investigation Board (AIB) concerning Electronic Wait Lists (EWLs); electronic Official Personnel Folders (e-OPFs) for five managers; Senior Executive Performance Plans for fiscal years (FYs) 2010 through 2014; two Established Patient Wait Time Reports covering FYs 2010 through 2014; two New Patient Wait Time Reports for covering FYs 2012 through 2014; documentation related to patients who died while waiting for an appontment in 2009; 21 patients' records; analysis of deceased patients on the newly enrolled appointment requests (NEAR) list; Veterans Health Information Systems and Technology Architecture (VistA) screen captures from the Sleep Clinic; and results of Hotline 2014-01229-HL-0219.

3. Summary of the Evidence Obtained From the Investigation

The complainant initially contacted the VA OIG Hotline on September 19, 2013. This contact resulted in a referral to Veterans Integrated Service Network (VISN) 18 on September 22, 2013, to conduct a review and report back to the VA OIG Hotline. VISN 18 responded to the Hotline referral on November 25, 2013. VISN staff concluded, as the complainant had alleged, that different groups of staff at the VAMC

were, in fact, mis-entering desired dates. VISN staff reported that a New Mexico VA Health Care System (NMVAHCS) business manager had conducted a fact finding in Primary Care Clinic-A, where "It was confirmed that staff had been instructed to discuss available dates when scheduling appointments, and to record these available dates as the Veterans' desired dates." However, VISN staff did not determine how Primary Care Clinic-A PSAs were misinstructed. VISN staff reported they provided training to Clinic-A staff as corrective action and made the assurance that an AIB would be convened to further investigate the issue. The VISN 18 response was provided by the VISN 18 Director, who has since retired. NMVAHCS performed an AIB from December 2013 through April 2014 that was finalized on June 5, 2015, after the commencement of the VA OIG investigation. The finalized AIB also confirmed the mis-entering of desired dates, but did not hold anyone accountable or determine a root cause.

The complainant submitted additional but similar complaints to VA OIG Hotline on January 16, 2014, and April 6, 2014. These submissions were more direct in their accusations of purposeful metric manipulation to give the appearance of better than actual performance.

On June 6, 2014, the investigator received additional correspondence from Senator Tom Udall describing four allegations. The first allegation concerned a complaint from a former employee. The second concerned a veteran patient. These first two complaints concerned personal injustices affecting only the two individuals. The remaining two complaints were previously identified as access-to-care issues.

Interviews Conducted

- The complainant described in detail the practice of entering data into the VistA appointment system at the VAMC. The complainant showed the investigator where Primary Care PSAs would annotate in VistA the desired and actual appointment dates. The complainant showed the two dates to be the same date on several examples he/she pulled up. The complainant stated that he/she believed this inaccurate desired appointment date would result in reported wait times for future appointments for these patients to be zero days. The complainant demonstrated that available appointments for Primary Care appeared to be approximately 60 days out and that patients reporting for appointments on the day of the interview had waited 81 days. The complainant also described how physician panels were assigned to physicians who either did not see patients or were no longer at VA.

- A medical support assistant (MSA1) described a long-standing practice of printing and consolidating Clinic Appointment Availability Reports (CAARs) for management. She described CAARs as consolidated reports about various metrics associated with scheduling. The reports were used to make "correction" to long wait times. She said that she fixed some wait times at the direction of a nurse manager.

- Two PSAs who worked in Primary Care, both stated it was a long-standing practice to enter the same date for "desired" and "actual" appointment dates into VistA. Sometime in late 2013, they were instructed to put true desired appointment dates in VistA. Both

were uncertain if this practice was being fully implemented, but both agreed the reported wait times were now more accurately represented. They pointed to a series of immediate supervisors and a nurse manager as the individuals who instructed them to use this practice. One of the PSAs stated that next available appointments were now 60 days out for Primary Care.

- A former Team Care Manager confirmed the practice of entering a desired date that would result in a zero-day wait time.

- The first-level nurse manager denied any systemic effort to alter or otherwise misreport desired dates. She pointed to a business manager as the person responsible for the MSAs and scheduling. She also identified several efforts she initiated to correct the problem.

- A second-level nurse manager stated she started to get involved with scheduling in May 2013, because there was a lot of confusion at the time about how to enter the desired date. She tried to correct the problem but was told by her superiors not to get involved. She provided documentation she had accumulated about scheduling practices and training given to the staff. She pointed to a business manager as the person responsible for the situation.

- A former administrative officer stated he performed an AIB about the desired date issue in Primary Care. He confirmed the improper use of the VistA field but did not identify a responsible party. The AIB results went to the VAMC Director for signature. He provided an unsigned copy of the AIB.

- The identified business manager stated she was not in charge of the MSAs and could not be held responsible for their behavior. She pointed to the first-level nurse manager as the person responsible for them. She denied giving any directions regarding how the desired date field should be filled or otherwise corrected. She pointed to several efforts she made to correct the problem to include responding to and substantiating the OIG Hotline complaint about the issue.

- A service chief stated that he appointed the business manager to investigate the Hotline complaint and she substantiated the allegations. In response to her findings, an AIB was started. He never received the results of the AIB, but he did start a re-engineering effort for scheduling and started other initiatives to reduce wait times and improve service. He identified both the first-level nurse manager and the business manager as the managers in charge of the MSAs. He stated that scheduling is a business office issue. He was in receipt of current measurements concerning wait times from a statistician who indicated a significant failure to meet VA goals. He was unaware of any effort to alter wait time data to improve the measures.

- A supervisor in a Primary Care clinic stated it was a decades-long practice to alter or otherwise enter an incorrect desired date for appointments in an effort to underreport wait times. She described an all-hands meeting 2 years prior to the interview, during which the former director told everyone to properly enter the desired date. Clerks in the past were taught to back out of the system and change the desired date. She identified the

business manager as the individual who pressured her to make "corrections" to the desired date after the all-hands meeting. She also identified a period of time in which a "KAPLO[1]" report would be distributed twice a day to facilitate correcting long wait times.

- A former nurse manager in Primary Care stated that during her tenure as manager, she received complaints from MSAs about ethics issues involving the desired date. She identified the business manager as the person in charge of metrics.

- A provider in Primary Care stated that he was not familiar with the scheduling directive and did not know about the desired date issue. He denied having given instruction or passing down reports needed for corrections by the MSAs. He identified the business manager as a person being interested in the access measures for the outlying community clinics.

- The acting director of the VAMC reported to the investigators that a neurosurgeon alleged she was being asked to operate and "make the numbers" and she didn't have the equipment she needed. He also believed the service chief's actions concerning the panels, such as his assignment of a panel to himself, was appropriate considering the circumstances. He also stated there might be 21 identified patients from the Sleep Clinic affected by wait times.

- A manager in Patient Care Service described wait times in Audiology, Orthopedics, Dental, and Neurosurgery. She stated that her primary responsibility was focused on inpatients. She keeps a vigorous surgical schedule and cancellation rates were low. Her quality control focused on readmission issues. At the time of the interview in June 2014, there was a 350-patient backlog for Orthopedics. She participated in a quality board that met quarterly. The service chief, the first-level nurse manager, and the business manager participated as a team in the meetings in which access measures were discussed.

- A service chief for Medicine explained the compensation system and described the performance measures for himself and the service chief in Primary Care. He further explained that access measures were incorporated into the service chief's appraisal, but he did not think the incentive was there for the service chief to alter metrics. He offered no explanation for the apparent discrepancy between actual wait times and reported wait times. He stated that he and the management staff were not particularly engaged in the process by which the metrics are derived.

- A facility manager confirmed that the service chief, the first-level nurse manager, and the business manager were all aware of the wait time issue/policy. She stated that she

[1] The investigation was unable to determine what the term "KAPLO" represented. Other witnesses testified that the KAPLO report was superseded by the AEG report. The AEG report lists appointments with desired dates, creation dates, and has a comments section. The report is used to review the return to clinic or consult dates to assist in ensuring accuracy in scheduling and is sent out as a training tool to assist schedulers, as well as to point out potential errors. The acronym "AEG" comprises the initials for the individual who first developed the template for this report and has no specific meaning.

overheard the business manager tell the service chief that she was not the appropriate person to further investigate the desired date issue because she would be implicated in it.

Following her interview, the facility manager provided photocopies of part 2 of the attachments for the AIB report. She provided the Senior Executive Performance Plans for the FYs 2010, 2011, 2012, 2013, and 2014. She also provided two Established Patient Wait Time Reports, both containing information for FYs 2012, 2013 and 2014, along with two New Patient Wait Times Reports from Create Date reports, both containing information for FYs 2012, 2013, and 2014.

The facility manager subsequently provided a status update on her review of pending appointments. She provided the following information detailing her staff's attempt to quantify and make contact with all patients who may be in need of an appointment:

- Total Patients Called: 1601
- NEAR List Patients Called: 1030 (19 Deceased)
- EWL Patients Called: 571 (2 Deceased)
- Made Contact: 934
- Worsened Condition: 47
- Prefers VA Care: 684
- Appointed for Care: 697
- Certified Letters Sent: 440

She stated that the VAMC was in the process of contacting patients (as defined by the Accelerated Care Initiative). Their first priority had been the NEAR list. They had more than 1,000 veterans on the NEAR list, and they discovered when trying to contact them that 21 of them had died. After further review, she determined 19 of the 21 deceased patients were not actively seeking care at the VAMC. Of the remaining two, one was waiting for an Audiology appointment and one was waiting for a cardiology diagnostic test.

- A former employee stated he/she was no longer an employee at the VAMC and has litigation pending against it. The former employee complained about redaction of a patient's medical record sometime in 2009 and claimed the medical record was changed to cover up short staffing in the clinic. However, the former employee did not identify the patient by name. He/she also stated that management was getting inappropriate bonuses based on poor metrics. The former employee stated that he/she made an initial complaint in 2009 to the current acting director.

- An employee in the Sleep Clinic stated that she was ordered to cancel out consults older than 1 year. She kept a list of patients who had died while waiting for a consult. She did not make any patient notes about the cancellations, as she was not directed to do so. She has spoken with other nurse managers and said she believes this was a VAMC-wide practice to arbitrarily close old consults. She provided documentation related to

expired-in-waiting patients totaling 21 patients by 2009 (not the same 21 patients identified during a review of the NEAR list). Consults from 2009 and 2010 were involved in this consult purging.

Records Reviewed

- A review of emails obtained from VA's service identified one email of interest sent on May 13, 2013, by an individual who appeared to be the assistant to the business manager. He reported to the business manager and another manager the results of his review of scheduling practices in several clinics. He stated that "ACS" was keeping an unofficial list of patients who requested appointments; "BHCL" PSAs were not inputting desired dates correctly and have not been using the EWL; "Sleep" was not using the EWL; "SCI" was keeping an unofficial wait list on a spreadsheet instead of in the EWL; "Neurology" was mis-entering desired dates and misusing the EWL; and "Endo" was incorrectly using the appointment date as the desired date.

- A review of e-OPFs for five VAMC managers found that while positive performance appraisals and bonuses were generally given to the group, the documents did not attribute the performance ratings or bonuses to access metrics.

- VAMC management initiated an effort to make contact with 1,601 VAMC patients whom it identified as in need of an appointment. During their outreach effort, they discovered 21 patients who were deceased. VAMC staff determined that 19 of the patients were inactive, having signed up for health care benefits but never availing themselves of care. Of the remaining two, one was waiting for an Audiology appointment and one was waiting for a Cardiology appointment when they passed away. VAMC staff determined that no patient harm resulted from a delay of care.

- OIG's Office of Healthcare Inspections (OHI) also reviewed the electronic health records (EHRs) of these 21 patients. There were no non-VA medical records available for review. OHI found that reasonable attempts were made to schedule an appointment with a medical provider for patients or caregivers who requested appointments. OHI concluded that there was no evidence that a delay in the scheduling of an initial encounter with a medical provider resulted in the death of a patient.

- Documentation relating to the Sleep Clinic identified the following.

    - From January 1, 2010, through December 31, 2010, there were 1,922 service requests for Pulmonary Sleep Medicine consults—448 were completed, 121 were discontinued, 10 were canceled and 1,343 were pending resolution.

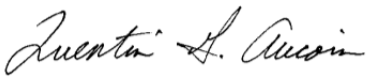
    - From January 1, 2010, through December 31, 2010, there were 12,706 service requests for Sleep Medicine consults—5,828 were completed, 5,613 were discontinued, 967 were canceled, and 298 were pending resolution.

- VistA screen captures provided by the Sleep Clinic employee showed the following.
  - From January 1, 2009, through December 31, 2009, there were 695 discontinued Sleep Medicine consults, 58 canceled Sleep Medicine consults, and 1,389 Sleep Medicine consults.
  - From January 2010 to December 2010, there were 52 canceled Sleep Medicine consults and 1,963 requests for service.
- OIG's OHI reviewed 21 cases involving deceased patients who had one or more sleep studies scheduled, but for whom the sleep studies were not performed by VA. Some or all of these patients may have actually had these studies performed in the private sector, but there was no simple way to determine this. In general, OHI did not believe it possible to assert a nexus or establish causality between sleep apnea and death. While untreated sleep apnea is a recognized risk factor for cardiovascular disease, it would be a "bridge too far" to conclude that sleep apnea caused death even if the patient died of cardiovascular disease. However, since untreated sleep apnea is a cardiovascular disease risk factor, overly delaying diagnosis and not instituting proper treatment would be poor general medical care. OHI did not find that a lack of receiving timely sleep study caused the death of any of the 21 patients.

4. Conclusion

The investigation substantiated the allegation concerning desired dates. A long-standing practice of misreporting desired appointment dates was occurring. Two VA officials—a nurse manager and a business manager—were identified as having played an active role in encouraging this activity. The investigation was not able to substantiate any specific negative patient outcomes related to delays in care.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 21, 2015.



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