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

VA Medical Center in Tucson, Arizona
November 8, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated following the receipt of information from the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline. The complainant, a former Southern Arizona VA Health Care System (SAVAHCS) employee, alleged that she became aware of a number of "game playing techniques" by SAVAHCS to improve the appearance of appointment access. The complainant alleged: (a) that in 2012, more than 400 Orthopedic appointment requests were on individual pieces of paper instead of being placed on the Electronic Wait List (EWL); (b) that, between 2008 and 2009, approximately 600 Urology appointments were on individual pieces of paper instead of the EWL; (c) that Palliative Care consults were placed in Veterans Health Information Systems and Technology Architecture (VistA) with the statements, "This consult placed for performance measures only. Do not take action on this consult"; and (d) that consults were discontinued with the comments, "Consult being discontinued because 30-day metric could not be met. Please resubmit consult." The complainant further alleged that she had reported these concerns to SAVAHCS management, but senior leader 1 dismissed her findings. The complainant also alleged that she reported the matters in 2010 to two senior leaders, who substantiated her complaints. The complainant added that she wanted to make the OIG aware of the ways SAVAHCS "gamed" the system and was concerned patient care may have been delayed and patient harm may have occurred.

In May 2014, an anonymous source also contacted the OIG Hotline and alleged that the Veterans Affairs Medical Center (VAMC) in Tucson had been under investigation 6 years ago for instructing scheduling clerks to falsify veteran "desired dates" in order to meet requirements. The anonymous source alleged that schedulers were now receiving training, but managers who previously told them to falsify desired dates were denying they instructed scheduling clerks to falsify the appointment dates. The anonymous source stated that managers were "once again throwing the clerks under the bus as if they came up with this idea [to falsify the desired dates] themselves." The anonymous source further stated that senior leader 1 "created a culture where he doesn't communicate with most of the hospital staff, remains very isolated, rarely if ever leaves his office during weekdays and has created a culture of intimidation where employees are deathly afraid to bring him bad news or tell him the truth."

In July 2014, VA OIG received a copy of an anonymous complaint routed from U.S. Representative Ron Barber's office. The anonymous complainant stated that he/she was an employee at the Tucson VA and that the clinical nurse manager (CNM) praised nurses who entered a patient's appointment dates as being 14 days or less. The anonymous complainant also stated that the CNM instructed him/her how to misrepresent the patient's desired date to achieve the 14-day metric.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed the complainant and 23 VA employees from both Veterans Integrated Service Network (VISN) 18 and VAMC Tucson.

- **Records Reviewed:** VA OIG reviewed VA emails, a report of contact, a report regarding the 2010 VISN Unannounced Site Visit, the facility's response to the unannounced site visit, VA memos, training materials, pending consults, Electrophysiology documentation, monthly appointment and consult audit reports, as well as a Veterans Health Administration (VHA) issue brief.

3. Summary of the Evidence Obtained From the Investigation

Complainant Interview

Interviews Conducted

- The complainant stated that she believed the issues she referred to the VA OIG were criminal and added that the SAVAHCS "staff were directed by [senior leader 1] and his underlings to do exactly what they did and game the system." The complainant stated that, in February 2010, she went to multiple SAVAHCS employees, including two senior leaders, in an effort to address her concerns of SAVAHCS employees gaming the system. The complainant stated that in her discussion with a specific senior leader about gaming, it was her impression that he wanted her to lie to the VA OIG and that he disregarded the information she had. After that meeting, she went to VISN management.

  The complainant explained that, at about the time of her reporting to VISN management that gaming activities were taking place, SAVAHCS senior leader 2 and senior leader 3 had asked her if she had called the VISN. She had reportedly replied that in fact she had called the VISN. The complainant further explained that senior leader 2 had told her that she should have "come back to me," and that, in response to her affirmative statement, senior leader 3 had "lit into me." The complainant said she believed senior leader 1 and others retaliated against her for bringing the issues to VISN management's attention and that she planned to file a retaliation complaint with the Office of Special Counsel.

2010 Unannounced Site Visit

Records Reviewed

- We reviewed a VISN report, dated March 1, 2010, in which an employee of the SAVAHCS reported her concerns about gaming activities to VISN senior leader 1. The report stated that the employee was concerned about appointment scheduling and consults. The report further stated that the employee wanted someone to review facility data to determine if any adverse patient events had occurred as a result of these practices. The report indicated that VISN senior official 1 and senior official 2 reviewed the issues at SAVAHCS on February 25, 2010, calling it the 2010 VISN Unannounced Site Visit. The report stated that VISN senior official 1 and senior official 2 concluded, "Some

SAVAHCS staff members were practicing in a way that placed a higher priority on the achievement of performance measures versus the achievement of high quality care for patients." The report also stated, "Additionally, findings confirm that scheduling and consult practices did misrepresent facility performance on some performance measures." The report stated that, as a result of the VISN review, SAVAHCS leadership was required to perform a number of tasks, including a full review of all canceled consults entered on or after April 1, 2008, to the present (March 2010). The report specifically identified the following:

- A practice existed whereby Cardiology staff members, for example, Fellows, canceled pre-surgery Cardiology consults and notated that only an EKG [electrocardiogram] was performed and as such was not a risk stratified assessment for surgical purposes.

- A practice existed whereby a Dermatologist responded to consults without actually seeing the patients in question. Occasionally the Dermatologist recommended topical chemotherapeutic agents for patients based only on a description of a lesion and not based on an actual face-to-face evaluation of the patient.

- A practice existed whereby Women's Clinic staff members told consulting staff that Pap smear consults were not needed; that a telephone call requesting a consult was all that is needed. Patients had been lost to follow-up as a result of canceled consults.

- A practice existed whereby administrative clerks routinely, and presumably without clinical oversight, canceled consults for patients if the patients had been seen by the consulted service within the last 24 months.

- Evidence existed that consults were being canceled and then rescheduled after the 30-day mark had been reached in order to prevent the consults from showing up as not completed within the 30-day goal.

- Evidence existed indicating that administrative clerks were determining desired dates for next appointments rather than patients and providers.

- Service agreements between Primary Care and Specialty Care Services did not exist in all areas.

- The SAVAHCS leadership recently learned that Palliative Care consults were being placed and the consulting service was documenting that, in essence, the consult was not a true consult, but instead was a consult written to meet a performance measure. Leadership took immediate action ordering that this practice cease and desist.

- No direct harm to a patient was identified in this initial review.

- The facility provided a copy of a memo dated October 1, 2010, that addressed senior leader 1's "Final Response to Staff Member Allegation and Subsequent VISN Unannounced Site Visit." The memo and attachment stated that a review of more than 21,000 consults canceled from April 1, 2008, to March 1, 2010, identified one potential

adverse outcome involving a delay in diagnosis and treatment that resulted in a patient's death from advanced lung cancer. The memo stated that because of the VISN review, senior leader 1 implemented the following:

- One hundred percent retraining of the scheduling clerks and supervisors to ensure compliance with VHA directives on scheduling and consult practices;
- Inappropriate handling of consults addressed through development of procedures, process improvements, and training;
- Adverse events discovered disclosed to patients; and
- Consult monitoring established to ensure appropriate practices were sustained

Orthopedics

Interviews Conducted

- The complainant stated that SAVAHCS participated in a national collaboration effort regarding Orthopedics services, and that during this initiative, she had learned that schedulers were scheduling patients' desired date incorrectly. She explained that she told service chief 2 that he needed to retrain the schedulers. The complainant said that is when she learned that Orthopedics had a backlog of more than 400 cases. The complainant added that when she tried to identify where the patients were in the process, she discovered that "they weren't on a wait list of any sort. They were on little pieces of paper on the tech's desk, who is responsible for trying to get them scheduled according to the orthopedist's prioritization."

- VISN senior official 1 stated that she was aware of the 400 Orthopedic appointments on individual pieces of paper that someone found in a cast technician's desk. She further stated that she believed the scheduler simply printed the consult and placed the paper in a drawer. She added, "Especially if it's a cast tech, because sometimes they'll send a consult to prosthetics for the casting, and that's how they actually order the cast to be done. So if that person's getting them on the printer and just putting them in a drawer, ideally they wouldn't do that."

- Service chief 3 stated that Orthopedics had 400 handwritten consults on paper that were not in the electronic scheduling system. He added that he was aware of the backlog for some time and knew that people were working with paper. He also said that now they scan paper into the electronic charts and then destroy the paper copy.

- Medical staff assistant (MSA) 1 stated that she had worked as an advanced MSA at VAMC Tucson for approximately 10 years. MSA1 stated that after someone determined that 400 Orthopedic cases were not on a wait list, this might have started the surgical wait list. MSA1 stated that about 2 years prior to the interview, Orthopedics was "very, very far behind. They created an Excel work list to work from and it was only to make sure that the patient still wanted the surgery or they had the surgery and for some reason the request was still there. I did help on that for a little bit."

- A manager for a specialty service stated that he was aware the Orthopedics Department had several hundred scheduling requests that piled up about a year prior to the interview. He said he believed it was very difficult to manage patients by papers. He added that he and others decided to start placing the patients into a Microsoft Excel spreadsheet so the department could track its patients. He said he was not aware of any patient harm due to delays in care. He stated that Orthopedics now used the EWL, but they also used a Microsoft Outlook calendar for scheduling.

- Service chief 2 stated that he recalled 400 Orthopedic appointment requests on individual pieces of paper placed in a desk; however, he could not recall any details.

- Senior leader 3 stated that she did not have any knowledge of 400 Orthopedic requests on individual pieces of paper that someone placed in a desk.

- Service chief 1 said she was not aware of 400 Orthopedic appointment requests on individual pieces of paper found in a desk.

- Based on the aforementioned interviews, we established a timeline and attempted to interview a former VAMC employee in connection with the 400 Orthopedic appointment requests found in the desk. When approached by OIG, the former VAMC employee declined to be interviewed.

Records Reviewed

- We reviewed an email provided by the complainant regarding Orthopedic collaborative meeting minutes from August 17, 2012. One email discussion item stated:

  > **Wait List for Patients:** Since these patients are backlogged for procedures and not visits, [name removed] stated the Electronic Wait List does not need to be used. Rather, there is a backlog package within the surgery scheduling package that will be used. This package is managed jointly between SCL [Surgical Care Line] and BSL [Business Service Line].

Urology

Interviews Conducted

- The complainant stated that, in the late summer of 2012, the Urology clinic found shoved into a drawer more than 600 paper Urology consults that were not scheduled. The complainant said the urologists used paper forms to identify patients who needed follow-up appointments as well as their diagnoses.

- VISN senior official 1 stated she believed the 600 Urology consults that were stuffed into a drawer might have been printouts of patients who were already scheduled.

- Service chief 3 stated that Urology had been chronically understaffed for a long time and SAVAHCS had difficulty recruiting urologists. He said they had some problems seeing

patients within the 14-day requirement. He further stated that at one point Urology had around 600 handwritten consults on paper that were not in the scheduling system. He stated that he was "aware of the backlog for some time" and "knew that people were working with paper" and "even now it's an issue because we still have some bit of paper around, but we try to be more electronic." He said he received complaints about delays for surgeries, but that most patients were seen within a month.

- MSA 1 stated the Urology Department at VAMC Tucson was currently "very understaffed." She further stated that another employee had placed 600 Urology appointments into a drawer but did not recall any names. She added that she addressed the stack of appointments four times by scheduling an appointment for each patient. She stated that at one point employees had to come in on Saturdays to do flow studies for patients. She said she remembered a former VAMC Tucson employee, whose name she did not recall, who was scheduling patients by service-connected disability and not by diagnosis. For example, she learned that the former employee would schedule a veteran who only had urinary issues, but was service-connected, before a veteran who had bladder cancer, but was not service-connected. She stated that the service chief was very upset when he learned about this. She added that another former VA employee, whose name she did not recall, contributed to the same problem, "because that's how she was being trained." She stated that three former employees were involved with the Urology backlog and this occurred about 5 or 6 years before the June 2014 interview.

- Licensed Practical Nurse (LPN) 1 stated that she once had more than 400 unscheduled Urology appointments; a fact she brought to the attention of management. She said that, at that time, Urology did not have enough staff; there were no appointments available; and management did not allow non-VA care as an option.

- A manager of a specialty service stated that he was aware of Urology having 600 scheduling requests pile up 4 or 5 years ago (prior to 2014). He added that he continued to have an ongoing concern about urologists using paperwork to schedule patients.

- A Business Service Line (BSL) employee stated that a scheduling backlog of a couple hundred patients in Urology was discovered after an MSA resigned. The BSL employee said the MSA placed the names of veterans who needed consults on paper scheduling sheets. She stated that when a patient checked into the clinic, the clinic created the paper scheduling sheets. She added that she reported this to her supervisor. She said they worked on the backlog and got the patients into the system as quickly as possible. She stated that MSA1 helped in scheduling the patients. She said she did not recall any patient harm due to the MSA not properly scheduling patients. She stated that she was unaware of any gaming of the metrics at SAVAHCS.

- Service chief 2 said he recalled Urology appointments being in a drawer of a BSL clerk, but was not sure there were 600 appointments. He stated that an MSA resigned and a new MSA was moved in and discovered the Urology orders that needed to be scheduled. He said the MSA who left VA was supposed to schedule the Urology appointments but did not.

- Service chief 1 stated that she was unaware of the existence of 600 Urology appointments being stuffed into a drawer by a BSL clerk at SAVAHCS.

- Senior leader 3 said she did not know anything about 600 unscheduled Urology appointments found stuffed into a BSL clerk's drawer.

Records Reviewed

- We reviewed an email provided by a complainant. The email was from service chief 3, who wrote, "It seems that BSL had been taking the paper request and squirreling the paperwork in various spots. We investigated and there were more than 600 actionable requests for services unattended."

Palliative Care

Interviews Conducted

- A complainant stated that, in February 2010, she learned about Palliative Care consults that employees entered into VistA with the explanation that they were for performance measures only and that no one should take action. The complainant said she identified 17 patient consults with these notes and met with a senior leader and told him it was "criminal at best." She said senior leader 2 appeared shocked that this was occurring and issued a cease and desist order.

- VISN senior official 1 said she recalled the Palliative Care consult issue, adding that "Somebody was putting in consults, because they thought it was the right thing to do. They said well, we're supposed to have consults on all these people. But they knew that the family didn't necessarily want palliative care, and they would put the consult in anyway, because they felt they were required to have the consult in for the metric. So to not offend the family, they would put that in, which I find offensive." She also said that it appeared that SAVAHCS was "totally gaming, because you're talking about a metric." However, she stated that she understood it was one employee who believed he or she was supposed to put the consult in for metric purposes, even though the patient's family may not have wanted palliative care. She said, "This was a localized finding that we saw no direction from leadership to do. It was stopped when leadership in the facility was made aware." She stated that this was an old issue, which had already been addressed during a 2010 consult lookback.

- Service chief 2 said he did not know about consults that stated the consult was placed for performance measures only and not to take action on the consults.

- Service chief 1 said she did not know anything about consults being placed for performance measures only.

Records Reviewed

- A complainant provided a Report of Contact (ROC) she authored in February 2010.

Review of the ROC showed it recorded the timeline of events surrounding the Palliative Care consult manipulation. The ROC indicated that a physician identified a Palliative Care consult as something created solely for the purpose of a performance measure. The ROC showed that, on February 5, 2010, the complainant reviewed the records of 19 patients assigned to the intensive care unit (ICU) and found that three of the patients had these inappropriate consults placed in their records. The ROC showed the complainant then reviewed 150 Palliative Care consults and found a "significant number of them to be placed solely for purposes of meeting the performance measures."

- We reviewed a February 2010 email string between senior leader 2, senior leader 3, and the complainant about 3 ICU patients out of 19 consults placed to meet a performance measure. Senior leader 2 and senior leader 3 supported the cease and desist order and believed social workers were responsible.

Consult Discontinuations

Interviews Conducted

- The complainant stated that she believed "there was at least one patient that died due to the gaming of the consults" that involved a pulmonary embolism. The complainant said she did not think senior leader 1 was aware of the deceased veteran until an unidentified VISN employee informed the front office staff.

- VISN senior official 1 said that in 2012 (approximately), a review of Gastroenterology consults determined that a patient died while there was an open consult. She said SAVAHCS had contacted the family of the veteran and the veteran's family explained that the veteran did not want the care—which is the reason he did not go to VA. She stated that in either 2009 or 2010, SAVAHCS conducted a 100 percent review of consults at VAMC Tucson as the result of concerns brought forward by a VAMC Tucson employee, later identified as the complainant. When she was requested to provide copies of the consults that were discontinued because they did not meet the 30-day metric, she said she could not locate the source documents or a list of the patients. She stated, "I observed CPRS (Computerized Patient Record System) records where a consult was canceled with a statement saying the reason was that it was going to extend beyond the 30-days target. The care would be delivered despite that. I observed that this didn't change the delivery of care to the veteran, but changed the assessment of the timeliness of that care in some cases. This was immediately halted when leadership in the facility was made aware. This also was the evidence for our statement that staff were valuing performance on a metric more than the accurate reflection of the delivery of care. We did not find any evidence that leadership directed this to happen and it only appeared to have been at a very front line level in certain areas that it happened."

- A BSL employee said she was aware employees canceled consults because they did not meet the metric. She stated that she could recall one instance in cardiology when the consult was closed, even though it should have remained open; however, she could not remember specifics regarding this consult. She further stated that although she could only think of that one consult, she believed there were "probably various ones throughout

the facility." She said she was aware a 30-day metric had to be met because it was a national metric. She said she never received counseling by management regarding not meeting a metric. She stated that she thought Neurosurgery had consults canceled after 30 days, which made the provider resubmit the consult. She added, "it's like the provider, they didn't follow the service agreements and I know that Neurosurgery had done that and said resubmit when everything is completed."

- Service chief 2 stated that he recalled hearing in 2009 or 2010 about consults that contained a comment about the consult being discontinued because a 30-day metric could not be met. He explained that he was in a different role at that time. He said there could be several reasons to close a consult: a clinical reason, which meant the care was completed; or an administrative closure, which meant there was no need to see the patient. He stated that a consult could also be discontinued, which meant you were "unable to resurrect the consult."

- Service chief 1 said she was not aware of consults being discontinued because a 30-day metric could not be met.

- Senior leader 3 stated that she had no knowledge of someone discontinuing a consult because a 30-day metric could not be met.

Records Reviewed

- A complainant provided an email from a Compliance and Business Integrity Office employee, dated March 2, 2010, in which the employee stated that he reviewed 1,301 Dermatology consults between October 1, 2009, and January 31, 2010. The email showed the employee found that 45.27 percent of all consults were canceled. The employee had written, "The number of cancelled consultations seems excessively high."

- VISN senior official 1 provided an email that stated that one result of the consult review included prohibiting SAVAHCS clerks from canceling consults for any reason, effective March 4, 2010.

Scheduling

Interviews Conducted

- VISN senior official 1 stated that VA recently completed an internal audit of scheduling in facilities. She said the auditors identified a problem with a clerk's supervisor; she did not know this person's name, but indicated a review of VAMC Tucson concerning the desired date and other issues determined that clerks "felt a general pressure from their supervisor - that they should use the "next available" date instead of the [patient's] desired date." She further stated, "So the best I can tell is that there was an educational document that had gotten into the National Systems Redesign Web site, that talked about how you book the desired date, and it erroneously had in there that you use the next available. That's part of the confusion in this, is if I were a clerk, entry level position here to a clinic, and I went to a National System Redesign site, that are supposed to be the

experts, and I download this thing and it says this, I can understand how they do it wrong. That's been taken down. We made sure of that. But there was misinformation, and it could have been that the supervisor was looking at this and saying no, this is what you're supposed to do, and that they felt pressure."

- Service chief 3 stated that he recognized there were problems seeing patients within the 14-day requirement. He said he had complaints about delays for surgeries, but providers saw most patients usually within a month. He added, "You have to see a new patient within 14 days; but nobody has gone beyond that."

- MSA1 stated that the only "game-playing" technique that she knew about involved the desired date. She said there was an instance in Orthopedics about 2 years ago. She also said that scheduling for operating rooms was so far behind, they created a Microsoft Excel spreadsheet to determine whether each patient still wanted the surgery or whether the veterans had the surgery and for some reason the surgery request was still in the system. She stated, "I do know that we have been told to tell the patient when our next available is and use that as a desired date."

- LPN1 stated that she was previously an MSA in a specialty clinic, where she experienced problems getting veterans care. She said she met with the manager of the specialty clinic and Urology staff because Urology was behind about 150 appointments in scheduling and the appointments were on paper forms. She stated that she recalled veterans would "come up to the front desk and say, you know, 'am I going to die before I get this exam done?'" She added that she kept Urology staff up to date about the backlog of paper schedules. When asked if the paper list was a copy of what would be considered the EWL, she said the "Business Service Line was very careful never to call it a wait list […] We don't have a wait list. We don't have a reminder list. We don't have anything like that." She stated that no one trained her on the EWL and BSL management told her and others that there was no such thing as the EWL.

  She added that patients would ask her to call them if someone canceled, but she had to tell the patients she was not allowed to do that. She explained that she could not write down patient names and numbers because management did not want any lists around with patient names. She stated that, just before this interview, she heard a patient say he was supposed to come back for an appointment in 6 months, the patient forgot, and it was 10 months later before the patient had his appointment. She said there was no list or anything to remind the patient. She added that she recognized that many of the veterans suffered from memory problems and putting the responsibility on them to remember to call back months later to make an appointment was a systemic problem. She stated that some patients would complain about their appointment being 'canceled by patient' when the veteran claimed that to be untrue. She said that recently she had had a patient who said he needed to see the hematologist-oncologist because he found out his platelet count was still low. She stated that no one had told the veteran his platelet count was low; he had learned about it by reviewing his own test results.

- A nurse manager stated that the 14-day metric involving the desired date was manipulated by going in the system, learning the next available appointment date,

backing out of the scheduling system, and changing the desired date so it looked like the date the veteran wanted to have the appointment. She further stated that if she and others did not do that, the system would show a 60-day wait list. When asked who gave her the instructions to do the scheduling that way, she said the chief over her Patient Aligned Care Team (PACT) passed down all the metrics and that they received training from BSL leadership. She stated that senior leader 1 put pressure to meet metrics down the chain of command. She added that they were trained to alter desired dates by making the desired date the date of the next available appointment, not the patient's actual desired date.

- MSA2 stated MSA3 sent daily emails to MSAs in Primary Care that listed each provider's next available date, which was no more than 2 weeks away. She added that the emails were never accurate and believed it was an effort to try to make the appointment access numbers look good. She stated that the next available appointments were at least 2 months away and that she was currently scheduling patients for appointments between 60 and 90 days in the future. She said, "They want to make it seem like we're actually scheduling the patients in a timely manner, but it's not really accurate." She stated that she placed a patient's desired date in the system as the desired date; however, she was trained to tell the veteran the next available appointment date, ask the veteran if that is when he would like to be seen, and use the appointment date as the desired date. She added, "The desired date is the date that we're actually scheduling their appointment." She said the desired date was whatever the veteran was requesting and if the veteran wanted to be seen today, that would be the desired date. She further stated that if the veteran asked for one appointment date and she gave him the next available date and the veteran acquiesced to that date, the desired date would match the next available appointment date.

- MSA3 stated that approximately 2 months ago (from June 2014), physician 2 told him to switch from looking at a Primary Care doctor's next available appointment, to also look at triage appointments with nurses as the next available appointment for patients. He said this change improved the appointment access numbers dramatically but required some patients to seen by a nurse instead of a doctor, in some cases. He stated that only a few doctors used the recall reminder. He estimated that 8 out of 10 patients forgot to call and make their appointment. He said most physicians he worked with have next available appointments about 60 to 90 days out. He stated that he used the date the patient wanted to be seen as the desired date and felt no pressure to change it; however, he told the patient when the next available date was and would "massage the patient" in order to find a common date, which was used as the official desired date.

- MSA4 stated that the desired date was the date the veteran wanted to see the provider. She said that before SAVAHCS implemented PACT in 2011, she would change the desired date to match the next available date. She said with PACT, the veteran's requested date was the desired date. She stated that, in some cases, veterans called in every single day to see if there was a cancellation.

- Physician 3 stated that her MSA was "reprimanded several times" because she did not go back into medical records and change the desired date to the date of the scheduled appointment.

- A business manager stated that he and others performed audits of desired dates and talked to MSAs when the MSAs did not enter the desired dates correctly. He explained that after discussion with the MSAs, he found that the MSAs often believed they were supposed to make the desired date the same day as the appointment date. He said he thought desired date was not complicated and stated if the patient agreed with the next available appointment, then that would be the desired date. He said schedulers should not be using "T[1]" as the desired date. He said he never heard about the desired date being blank or skipped over.

- A business manager reported that he had seen consults as old as 180 days, 200 days, and 300 days. He stated that a long time ago, someone had patient information in a drawer that needed to be scheduled for follow-up appointments, but he was not aware of any patient harm involved in that incident.

- A manager in a specialty service stated the desired dates had always been a concern. He said he acquired reports to see if schedulers complied with the 14-day rule. He said he and other schedulers were trained not to guide the patient to where there were appointments available, but instead tried to ask the veteran first when the veteran wanted an appointment. He said there was negotiation between the scheduler and the patient. He said he counseled schedulers when they used T for desired date. He stated that if they used T, that was an error. He said he was aware of the problem with paper scheduling in Orthopedics in the past and initially stated that he had created a Microsoft Excel spreadsheet to keep track of the patients. He later stated that Orthopedics never used a spreadsheet. He said General Surgery, ENT [Ear, Nose, and Throat], Cardiology, and Thoracic used a spreadsheet to schedule patients. He stated that he and others decided to start placing the patients into a Microsoft Excel spreadsheet so the departments could track their patients. He said that at the time of the interview, Orthopedics used the EWL, in addition to a Microsoft Outlook calendar for scheduling.

- MSA5 said that other than a 2-week orientation, she did not receive much training on how to do her job. She stated that when she scheduled patients, she entered the date the patient wanted to be seen as the desired date and then offered the patient the next available date. She said that on multiple occasions, her supervisor reprimanded her orally and via email for not meeting the 7-day access-to-care rule. She stated that she got into the habit of going into the system, finding the next available date the patient could be seen, backing out of the system, and then going back into the system to make the patient's desired date on the same date that she made the appointment. She explained, "I asked why we were gaming the system and I was told that numbers went up to Washington D.C. and we needed to show that we were in compliance as far as seeing veterans in a timely manner." She stated that she asked why they didn't tell the truth so that they would be given more help, and she was told that she needed to continue scheduling patients within the 7-day window rule. She said her last performance

[1] MSA(s) use VHA's VistA computerized health care management system to schedule appointments. Several date input fields are used when scheduling an appointment to include "date of contact," "desired date," and "appointment date." MSA(s) can input the current date into the system by striking the "T" (Today) key.

appraisal did not include a reference to meeting or failing to meet performance metrics.

- A BSL employee said the expectation was that schedulers would hopefully make the desired date within 14 days or 30 days "or whatever the case may be within that desired date." She stated that she was not aware of a former BSL chief giving any guidance to schedulers to manipulate numbers. She said she was not aware of patients having the need to call back daily to try to get an appointment. She said she never gamed the system or told anyone to game the system to meet metrics. She said she recalled that MSA2 had a list of patients who were not scheduled. She stated that the list went back about 1 week for appointments waiting to be scheduled. She said that when MSA2 scheduled all the patients, she told MSA2 that she (MSA2) was not to keep any lists and told MSA2 to destroy the old list. She stated that she was not aware of anybody else destroying, manipulating, or shredding any type of paperwork related to EWL or scheduling. She said she was not aware of any issues at VAMC Tucson similar to what was occurring at VAMC Phoenix.[2]

- Service chief 1 stated that when VA first provided its facilities with guidance regarding the EWL, a scheduler was expected to place a new patient on the EWL if the patient could not be seen within 120 days. She said VA eventually changed this guidance to 90 days. She said she had not seen anything showing a deliberate pattern of someone trying to "circumvent the system" or "work the numbers" in regard to scheduling patients. She stated that supervisors conducted monthly audits and identified errors. She said veterans provided schedulers the dates and times they wanted particular appointments, which were the desired dates. She stated that currently new patients at SAVAHCS waited about 10 days to see a provider from the time they first called to schedule appointments. She said she was not aware of any metric gaming occurring at SAVAHCS. She said she was not aware of any scheduling clerks going in and out of the scheduling system to manipulate data. She stated that she was aware that the chief of a specialty service received permission from senior leader 2 to keep paper copies of everything. She said the specialty service chief kept the copies in a secure cabinet and the copies represented what he had entered into CPRS. She added that metrics were never part of an MSA's performance review. She said she was not aware of patient harm because of schedulers not using the EWL, inappropriate scheduling practices, or a focus on meeting metrics.

  Service chief 1 stated that VA Central Office (VACO) conducted the VA Access Audit review from May 12, 2014, through June 3, 2014. She explained that there was confusion with the schedulers at the time of rescheduling when a clinic canceled appointments. She stated that when clerks called veterans to inform them of a clinic cancellation, they were sometimes changing the desired date to the new desired date instead of holding the original desired date. She said that VA did not clearly define how to handle clinic cancellations in the standard operating procedure.

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

- Service chief 2 stated that, as of May 2014, the average wait time for a veteran at VAMC Tucson was from 20 through 30 days. He further stated that he held training sessions as recently as October 2013 and even February 2014 to ensure employees understood how to schedule veterans, identify the desired date, properly identify what the patient wanted, and how to identify what information VACO looked at nationally. He declared, "We wanted to make sure that people understood how to select the desired date and that the veteran determines the desired date every time." He said he had no knowledge of metric gaming at VAMC Tucson, adding, "We do not want to fudge anything, we don't want to game anything, we don't want to present something that's not true." He said he did not feel any unnecessary pressure from his supervisor to meet a certain metric or goal.

- Senior leader 3 said she had no knowledge of any metric gaming occurring at SAVAHCS. She stated that the desired date was the patient's requested date to be seen by a provider. She also stated that the veteran should be the one to initiate the desired date, not the scheduler. She stated that service chief 1 was ultimately responsible for ensuring schedulers received proper training. She continued that she would not know about an MSA changing a desired date to meet a metric. She stated that the 14-day metric was not realistic. She said she was not aware of any patients harmed because of inappropriate scheduling practices or of a focus on meeting metrics at SAVAHCS. She added that she was not aware of any destruction of documents or falsification of data related to metric gaming.

Records Reviewed

- A complainant forwarded an email, dated December 16, 2009, from a BSL employee, who stated that there was a new performance measure: "appointments are measured 14 days from desired date." The BSL employee went on to state, "WE control the desired date, keeping within the time frame requested by the provider."

- The facility provided a copy of the VISN 18 Appointment Scheduling Audit Report, V18-022011, dated January 7, 2012. The audit identified the following:

    - VISN-completed appointments averaged 60-percent where desired date equaled appointment date and VISN 18 believed this was artificially high;

    - Big Spring and Prescott were the only two VISN facilities that routinely used the EWL while the three largest facilities had the lowest volume use of the EWL;

    - Tucson was identified as having the appearance of appointments showing canceled by patient when it appeared they were canceled by clinic, noting "the frequency and back-to-back occurrences of these events indicated that the appropriate status should have been cancelled by clinic and not cancelled by patient;"

    - Sixteen percent of Tucson's clinics scheduled appointments without desired dates;

    - Fifty-seven percent of Tucson's appointments had desired dates that equaled the appointment date; and

- "It appears Tucson was not appropriately placing patients on the EWL."

- We reviewed a June 7, 2010 memo from an MSA supervisor involving a Scheduling Practices Assessment in which a SAVAHCS workgroup found that, in most clinics, the schedulers were basing the desired date on clinic availability and not including the patient in the scheduling process. The memo stated that SAVAHCS also found that other prohibited scheduling practices were occurring.

- We reviewed the 2010 to 2014 monthly appointment and consult audit reports from BSL management. The audits revealed schedulers appeared to be making a multitude of errors each month. Examples of the comments on the errors included, ">14 days past desired date, no justification" and "15 days from desired date."

- MSA1 provided a copy of her appointment management training materials. A review of the documents disclosed that a veteran could state his/her desired date and this date should be used in VistA or if the veteran asked when the next available date was, the date the scheduler found was then the desired date.

- We reviewed an email string from the business manager to a BSL employee in which the business manager asked, "With the lack of access in Audiology and Dermatology do you think patients that no-show their consults appointment could be completed after 1 no-show?" The BSL employee responded, "My concern is an audit of appointments/consults that could reveal cx [cancel] after 1 NS which is not in accordance with VHA policy. We would be up a creek."

- We reviewed a VHA Issue Brief dated May 14, 2014. The review disclosed that many MSAs did not use the EWL and could not articulate the use of the EWL; some staff members were not asking the veteran for his/her desired date, and some scheduling staff felt pressured by their supervisor to have the desired date closest to the first available appointment date.

EWL

Interviews Conducted

- VISN senior official 3 said her only concern with VAMC Tucson was that they were underutilized and they did not have many patients on the EWL, when compared with others in the same network. She stated that she was not aware of any gaming in SAVAHCS. She added that VAMC Tucson had been one of the better performers.

- MSA2 said supervisors prohibited her and other MSAs from keeping a waiting list or setting a reminder to call a patient if they had a cancellation. She said MSAs in Primary Care use the recall reminder, but many veterans do not remember to call VA to make the appointment. She said she had never seen the EWL. She stated that there had been times she had to reschedule patient appointments at least four times because a provider was not available. She said cancellations by clinic were frequent.

- Service chief 3 said he was not aware of any metric gaming, but said the rules for appointments had been difficult to understand and had been changing. He said they had a couple of issues a few years ago because they kept their wait list on paper and the paper logs should be electronic because of HIPAA[3] issues and the possibility of losing the papers. He stated that he did not understand the wait list because he just considered it a backlog.

- A nurse manager said Primary Care had never used the EWL, but that there was enough demand to use it. She said Primary Care previously used the callback list, but did not use it anymore. She stated that patients have had to call in every day to try to get an appointment. She said management disciplined providers for sending patients to the Emergency Department (ED). She said management wanted primary care to see all patients, even when the patient was ED-appropriate. She stated that if the patients went to the ED, a metric went down and someone got into trouble.

- MSA4 stated that she had never seen or used the EWL. She said that when VAMC Phoenix received media attention, a business manager told her that if she had any unofficial wait list that she must get rid of it.

- MSA3 said that when issues with VAMC Phoenix became a media headline, the BSL employee went to each scheduler and asked each whether they had any unofficial wait lists and if the scheduler had one, to throw it away.

- An administrative employee said his duties included being in charge of the scheduling keys and the scheduling application. He said he believed all clinics used the EWL. He stated that he ensured all schedulers completed the three modules of online training. He said supervisors decided who needed access to the EWL. He also stated that he was not aware of any scheduling manipulation or other metric gaming.

- The manager of a specialty service stated he was aware of Orthopedics having scheduling issues about a year ago. He said it was very difficult to manage patients by papers. He stated that he was not aware of any patient harm because of delays in care. He said that today (July 2014), Orthopedics used the EWL, but they also used a Microsoft Outlook calendar for scheduling. He said Urology might have used something other than the EWL. He stated that the EWL or surgical wait list showed names primarily, but the Microsoft Outlook calendar showed more details about the patient, doctor, and procedure. He said that there were times when a doctor had notes on a piece of paper for dictation purposes and later brought the paper back to the scheduler and asked the scheduler to give the patient a follow-up appointment. He said Vascular Clinic and sometimes Neurosurgery used paper copies with patient information for scheduling. He stated that this methodology could cause patients to fall through the cracks. He added that SAVAHCS had not used the EWL, but recently started using it for colonoscopies and a couple of other areas.

[3] Health Insurance Portability and Accountability Act

- The BSL employee stated that she was unaware of patient harm because of the lack of EWL use at SAVAHCS.

- Service chief 2 stated that there were no issues with the EWL. He added that wait lists were currently in use in Electrophysiology, Home-Based Primary Care, and the Pain Clinic. He said that recently there was an EWL established in Sleep Study. He said he was not aware of any patient harm because of delays in care. He stated that several years ago (from 2014), the pain clinic at VAMC Tucson created a list other than the EWL. He explained: "we sounded the alarm, we said no, that's not going to happen, we created a wait list, they got in, they were able to clean everybody, clean the wait list out by scheduling them appropriately and we were able to eliminate the wait list."

- Service chief 1 stated that she was aware that a clerk in the Electrophysiology section at VAMC Tucson kept a list of patients, whom he had not placed on the EWL. She said the patients were now on the EWL. She further stated that Home-Based Primary Care was also maintaining a list of patients who needed an appointment scheduled. She stated that some of the patients were on the list, but many patients were not appropriately scheduled for Home-Based Primary Care.

- Senior leader 3 said the Pain Clinic, Home-Based Primary Care, and Electrophysiology currently (at the time of the interview) used the EWL. She said there were daily meetings to discuss the EWL. She stated that she was not aware of other areas that needed to use the EWL at VAMC Tucson.

Records Reviewed

- VISN senior official 1 provided an email (May 2014) with an EWL chart that revealed VAMC Tucson currently had 34 electrophysiology patients on the EWL with 18 days as the average wait time; home-based primary care had 59 patients waiting an average of 59 days for an appointment; and Sleep Study had 13 veterans on the EWL, waiting an average of 30 days.

- We reviewed emails that the BSL employee sent to supervisors on October 11, 2013, February 12, 2014, and April 23, 2014. These emails revealed that there were many EWL entries entered in error and EWL entries had to be approved.

Electrophysiology

Interviews Conducted

- Physician 4 and a nurse practitioner (NP) were interviewed together. The NP stated that electrophysiology involved implanting pacemakers, defibrillators, and ablation procedures for cardiac rhythm problems, and that SAVAHCS had only one cardiologist that specialized in electrophysiology. The NP said Cardiology "never had an official electronic waitlist until a few weeks ago [prior to June 2014] when all the stuff [about VAMC Phoenix] started coming out in the press." The NP stated that there were many complaints from patients, unhappy patients, and referring providers. The NP also stated

that there was only one scheduler and that there was no official list or anything to track patients until a few weeks prior. The NP said there had been delays and SAVAHCS may have compromised care. The NP said she was aware of two patient deaths (Patient 1 and Patient 2) that she associated with delays in care before Electrophysiology began using the EWL and she identified those patients. The NP stated both patients died while on the paper waiting list for their electrophysiology procedures. The NP stated that the electrophysiology scheduler scheduled patients 3 to 4 months out based on paper lists. Physician 4 said Cardiology was an in-demand service and received very little support or increase in providers, even though management knew of the need.

The NP stated that 3 to 4 weeks ago [prior to June 2014], management allowed patients waiting for electrophysiology procedures to be sent outside VA to a private provider for fee based medical treatment because the lack of access to these procedures "could adversely affect a patient's life." The NP stated that of the recent patients sent outside VA for care, one was seen by the outside provider within 4 days, another saw the outside provider within approximately 1 week, and the third patient waited 2 weeks. The NP stated that when the program support assistant (PSA) recently attempted to call two patients, he learned they had died. Physician 4 stated, "I think it's fair for us to say that patients on a waitlist for a device, these patients are old, they have a lot of comorbidities, and it's very difficult for somebody to assume or to figure out whether they died because they didn't get the device." The NP stated that one of the two patients who died, and who had been on the paper wait list for 3 months, had a stroke, died from complications of the stroke, and the defibrillator would not have prevented the stroke. The NP added that the other patient "died of congestive heart failure and the device for which he was referred to was a treatment for congestive heart failure."

The NP stated that Electrophysiology used a one-page worksheet that the clinicians wrote on and provided to the scheduler. The NP further stated that clinicians gave this handwritten page to the PSA in order to schedule the patients. The NP added that she had performed this work for 15 years and that multiple times she and others had raised their concern to upper management about getting behind.

- The PSA in Cardiology stated that he scheduled patients for electrophysiology procedures. He stated, "[The NP] does the work-up for me and I have a folder of the cases to be scheduled and so when I get a new case I just put them on the bottom of the pile because, uh, I schedule the cases in the order in which they come in to me." He further stated that he used the paper for each patient and scheduled a month or two in advance. He said he always had a stack of patients waiting to be scheduled their procedures in Electrophysiology; at one point, he had 40 to 50 patients on his paper wait list. He said, "If I were to go down the pile and get them all scheduled right away, I would be scheduling out 4 months in advance." He added that there were times when someone misplaced one of the paper schedule requests because it was accidentally paper-clipped to another case. He also stated that there were a couple cases for which he should have received a paper to schedule a patient, but did not and the patient began calling him, asking about the procedure.

  The PSA said he believed a patient was harmed due to the delay in care and had to show

up in the ED while waiting for the electrophysiology procedure to be scheduled. He did not recall the patient's name. He stated that at some point, he began considering patient prioritization instead of first come, first served. He said he recently discovered that a patient died while waiting for a defibrillator implant. He thought that occurred about a year ago [prior to July 2014] and he may not have scheduled the patient for his procedure. He stated that the NP told him a patient died while waiting for a procedure and the procedure could have prevented the death. He said there were "a couple patients that died waiting for a defibrillator device […] within the last 3 months, 2 months or so." He could not recall the patients' names. He stated this caused Cardiology to start looking at prioritizing more and getting defibrillator cases accomplished within 6 weeks. The PSA recalled a time when he attempted to contact a patient approximately 5 years ago to schedule his procedure and while talking to the patient's wife, the wife discovered that her husband had died.

The PSA said that after the findings came out about VAMC Phoenix, in approximately May 2014, his supervisor came and told him he needed to put the Electrophysiology patients on the EWL. He stated that from 2007 until recently, he never used the EWL and there was always a paper waiting list for Electrophysiology because VAMC Tucson had only one provider. The PSA said he received a briefing on the EWL when he first started, but he never received training to use it and never had the scheduling key needed to access the EWL. He further stated that he recently began using the EWL; however, none of the patients received their care any sooner.

The PSA said he did not use the desired date function in scheduling and always skipped over it. He said he always offered the patient the next available date and left the desired date blank. He stated that a couple months before the OIG interview, senior leader 1 met with all the schedulers and told them, "We ask the patient, 'What's your desired date?' and if they say, 'Well, I would like to go in tomorrow for my appointment,' and if we don't have any appointments for them for the next month or two, he said it's a negotiation." He said he did not know what senior leader 1 meant by "negotiation." He said, "even if I enter them into the electronic waiting list, they stay, you know, somebody may still have harm waiting for his position, his case."

- A business manager stated that right after the public became aware of problems at VAMC Phoenix, he told the PSA that nobody should have wait lists in which patients were not scheduled. He said that statement prompted the PSA to tell him about a folder he had of patients waiting for electrophysiology procedures. The business manager said that about 3 weeks later, he placed the patients, about 25 or 26, on the EWL. He stated that he was not aware of any patient harm that may have occurred.

- The BSL employee stated that Electrophysiology started using the EWL a few months prior to the OIG interview. She said that one of her supervisors discovered Electrophysiology had a patient list that was in the queue to be scheduled. She said she and others instructed Electrophysiology to create an EWL to get the patients on the list. She said she informed service chief 2 that Electrophysiology was keeping a wait list other than the EWL.

- Service chief 2 said there was an employee assigned to the Cardiology Department at VAMC Tucson who held orders for electrophysiology studies in his desk. He stated that when he and others discovered the issue, all the patients concerned were placed on the EWL.

- Senior leader 3 stated Electrophysiology began to use the EWL within the last few months [prior to July 2014]. She said the cardiac electrophysiologist went on leave and the consult numbers began to increase. She said she was not aware of any patients who died awaiting an Electrophysiology consult.

Records Reviewed

- We reviewed an email, dated May 8, 2014, from the PSA in Cardiology to a VA employee and the business manager indicating that BSL had told him that he needed the EWL option in VistA so he could enter Electrophysiology patients into the EWL.

- We reviewed pending consults for the specialty service. The review disclosed that on May 12, 2014, consult review notes indicated that Electrophysiology needed to have 46 patients on the EWL. On May 16, 2014, consult review notes showed Electrophysiology had 44 patients on the EWL.

- The NP provided examples of one-page forms with handwritten notes for electrophysiology procedure scheduling. Review of these forms disclosed that they listed cases in the queue to be scheduled. The NP also provided the electrophysiology cases that involved deaths, scheduled cases, and fee-based cases. Review of these documents disclosed the names of the two veterans who had died.

- The VA OIG Office of Healthcare Inspections (OHI) sent an email confirming that someone at SAVAHCS should have placed Patient 1, who had died, on the EWL.

Sleep Study

Interviews Conducted

- The business manager stated that if the facility could not get the patient in within 90 days, the scheduler should place the patient on the EWL. He said that even though the Sleep Study Department has had patients scheduled over 90 days, they did not place the patients on the EWL.

Records Reviewed

- We reviewed an email string from April 2014 that identified a 10-month backlog of 126 Sleep Study patients. One of the physicians wanted to send these patients for fee basis, "starting with the old ones from June 2013." Our review also disclosed that Sleep Study began using the EWL on or about February 6, 2014.

Analysis of Alleged Patient Harm

Interviews Conducted

- Interviews of Cardiology staff identified two patients (Patient 1 and Patient 2) who died while waiting for electrophysiology procedures. Another inquiry conducted by OHI (VA OIG Report 14-02603-267), identified an additional patient. None of the three patients were on the EWL because the scheduler did not have access to the EWL and used paper wait lists for scheduling purposes. During the 2010 consult look-back, SAVAHCS reviewers identified one more patient whose death they determined was attributed to a delay in care and diagnosis associated with his canceled consult.

Records Reviewed

- OHI conducted an initial review of the medical records associated with Patient 1 and Patient 2. The OHI employee who conducted the initial review stated, "I did not see any evidence of a delay in care or concerns with the Cardiology consult for either patient." He further stated, "The consult for Patient 1 was acted upon within 5 days of it being placed; however the procedure [w]as canceled because the veteran was hospitalized. Patient 2 had only one consult and one note in the electronic health record. The consult was completed within 12 days."

- Additional review conducted by another OHI employee of the medical records of Patient 1, Patient 2, and the third patient identified by OHI, found that all three were critically ill patients with multiple chronic medical problems, and that all three met criteria for the implantable cardiac devices that were recommended by their cardiologists. The review found that Patient 1 had such significant cardiac disease and was in such an acutely decompensated state—as a result of a stroke requiring urgent vascular surgery—that it is unclear if an implantable cardiac device would have affected the final outcome. The review found that Patient 2 also suffered from severe cardiac disease, but evidence within the electronic health record suggested that the delay in scheduling his device implantation was likely due to noncompliance and/or altered metabolism of his blood thinning medication. The review found that the third patient initially declined an evaluation for the recommended device, but after allergy testing and eventual consent for the procedure, his cardiologist failed to communicate with SAVAHCS providers to coordinate scheduling for the device implantation. The OHI employee also reviewed the medical records of the patient identified during the 2010 consult look-back and concluded, "This unfortunate outcome appears to be the result of an oversight by the Primary Care provider, and not the result of the cancellation of the Inpatient Pulmonary consult."

Senior Leader Interviews

- VISN senior leader 1 stated that she did not have any knowledge of gaming the scheduling system at VAMC Tucson to avoid or alter the EWL in order to maintain a good metric. She said VISN 18 had "a serious issue with wait times for a very long time," and that she had seen the wait times of VAMC Tucson go up and down. She

stated that the patient scheduling process was a very difficult and error-prone task. She added that there was a complaint from a staff member at VAMC Tucson regarding consult closures. She stated that the complaint was about employees closing outstanding consults and that there were patients "falling through the cracks." She also stated that about 2 to 2 1/2 years before the OIG interview, she had instructed VAMC Tucson management to conduct a 100 percent consult review. She said the review substantiated the complainant's allegations.

VISN senior leader 1 said Community Based Outpatient Clinic provider losses have had a drastic effect on wait times at each of the clinics. She stated that staff turnover at VAMC Tucson resulted in increased wait times for veterans. She further stated that the desired date is probably "the thing that gets most easily manipulated." She said that she did not know that a BSL clerk at SAVAHCS had been placing 600 requests for Urology appointments into a drawer. When asked about the 400 Orthopedic cases that VAMC Tucson staff did not place on the EWL, she said that was at a time when "we started doing centralized Ortho out of Phoenix."

VISN senior leader 1 stated that in 2012 one of the issues her office identified was that many facilities were not using the EWL throughout the network. She stated VAMC Tucson did not have an EWL and needed to get one up and operational. She could not tell whether VAMC Tucson worked down the backlog without getting the EWL in place. She explained that the VISN looked at the consults and performance measures, which were the goals for the network. She stated that VISN 18 required facilities to use the EWL for consults that exceeded 90 days. She said she tasked a network team to work with the facilities to establish EWLs in facilities in which EWLs were not used. She stated, "I think that people try very hard to do the best they can for the veteran. And sometimes that means that they're going to do something that's a little bit not following directive, thinking that that's going to help the veteran, or they're going to, you know, take some administrative thing and not do it because they want to focus on the veteran. Well, of course that administrative thing is the way we measure." She said metrics could affect two of five elements in SES performance plans. These include 'Results Driven' and 'Business Acumen.' She stated that she does not always accept what each director says in their self-assessments and narratives. She added that senior leader 1 was highly regarded and that VAMC Tucson was a closely managed organization.

When re-interviewed, VISN senior leader 1 stated that she did not instruct or suggest to anyone that they should manipulate data or metrics. She said she had no knowledge of senior leader 1 being involved in data manipulation. She stated that a SAVAHCS employee in the Quality Department reported an incident wherein the employee felt patients had "fallen through the cracks" because of a cancellation process at SAVAHCS. She further stated that she ordered senior leader 1 to review each canceled consult, regardless of the area, and that he "had to look to see what the status location was, get a patient in for follow-up care if it were needed, and then report back to the network."

About senior leader 1, she said, "I think that there are times in the organization where his enthusiasm may result in people doing stuff that he would not approve of." She also stated, "So it's more like he's got a firmly controlled ship compared to Phoenix chaos,

but it can result in the same misinterpretation and outcome." She stated that senior leader 1 was "a man who has a lot of control over things. I mean, he is a controller." She also stated, "He is also a very brilliant man when it comes to things like numbers, and planning and all of that kind of stuff. But typically, we would see, he would say, boy, my wait times are getting bad. And we would see the same thing happen in our data. So I never got the same feeling he was showing manipulated data." She said she felt senior leader 1 would "distance himself," but not retaliate against people he felt had been disloyal. She recalled one incident: "And I went, [Senior Leader 1], they thought they did come to you. And you didn't respond the way they thought you should. She came once and talked to me once. She never said anything else. And I said, well, [Senior Leader 1], she felt she was turned off, and she needed to come to me. And you cannot hold her [responsible], you know, in any way, for doing it. Well, but she should have trusted me. [Senior Leader 1], you should have listened more."

- Senior leader 1 stated that he was not aware of more than 400 Orthopedic appointment requests placed on individual pieces of paper and put inside a desk instead of on the EWL. He added that he was not aware of 600 Urology appointments placed into a BSL clerk's desk drawer. He recalled consults in the system this way: "This consult is placed for performance measures only. Do not take action." He said that when someone discovered that issue, his staff took care of it immediately. He stated that he was not aware of consults that staff discontinued from 2009 to 2010 at VAMC Tucson because they could not achieve a 30-day metric. He said he never felt any pressure from VISN senior leader 1 to manipulate any data. He stated, "[VISN Senior Leader 1] was absolutely, you know, very clear, we don't game."

  Senior leader 1 said the Pain Clinic, Home-Based Primary Care, and Electrophysiology currently used the EWL. He stated that EWL use fluctuated among areas at VAMC Tucson. He said he recalled Electrophysiology not using the EWL at one point and someone telling him the electrophysiologist went on leave for 2 or 3 weeks and apparently had some appointments "in the desk or something." He added, "The supervisor became aware of it, went and got them, put them in the system, and we moved on it." He said he was not aware of patient harm in Electrophysiology because of a delay in scheduling patients.

  Senior leader 1 stated that he was not aware of any patient harm due to employees not using the EWL, inappropriate scheduling practices, delays in care, or because of a focus on meeting metrics. He said he was not aware of any paper list or Microsoft Outlook calendar usage to schedule veterans at VAMC Tucson. He said he was not aware of any gaming that occurred at VAMC Tucson. He stated there was a shortage of Primary Care physicians and that there had always been enough funds for SAVAHCS to send patients to get non-VA care when needed.

  Senior leader 1 explained the use of the word "negotiation" to SAVAHCS employees during a May 2014 training session. He stated, "You record the desired date and then you say to them, in essence, here's what I have available. So I don't know about the word negotiation, but what I'm saying is here's what I have available. Will that work? But you always record the desired date first and you try to give them some idea of what

you have available and ask is that acceptable. That's all that was meant by it and that's normal." He stated that he and others were responsible in making sure schedulers received adequate training. He said VAMC Tucson did not place its awards before employee needs. He stated that the facility held annual focus groups with employees and that there was an all-employee survey. He added, "Whether I like it or not, I'm responsible for everything here."

4. Conclusion

This investigation confirmed the allegation that approximately 400 Orthopedic appointment requests were on individual pieces of paper in an employee's desk instead of on the EWL. Because of the operating room backlog, the former scheduler, who was identified based on the timeline provided by other interviewees as a former VAMC employee and who also declined to be interviewed, had each unscheduled patient on a piece of paper. The former scheduler did not use the EWL, but had only paper copies of schedule requests, which were later destroyed.

This investigation confirmed the allegation that 600 Urology appointments on pieces of paper were in a clerk's desk drawer and had not been scheduled before the departure of an MSA. The appointments were handwritten consults doctors filled out and provided to an MSA to schedule. The patients to whom these consults applied were not placed on the EWL.

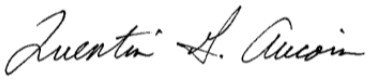
This investigation confirmed the allegation that one or more SAVAHCS employees entered Palliative Care consults into VistA with notes stating that the employee placed the consults for performance measures only and that no action should be taken. The investigation did not identify any managers who knew about, or directed, the gaming of the metrics in this instance. This investigation confirmed the allegation that there were consults that one or more employees discontinued because the 30-day metric could not be met. VISN senior official 1 said she corroborated the allegations when the VISN audited SAVAHCS in 2010. The investigation did not identify any managers who knew about, or directed, the gaming of the metrics in this instance.

In 2010, VISN 18 required SAVAHCS leadership to conduct a consult review based on the complainant's allegation of consult gaming. SAVAHCS's review found that one patient's death was attributed to a delay in care and diagnosis associated with his canceled consult. VA OIG OHI reviewed the patient's records and concluded that the death was the result of oversight by the Primary Care provider, not because of the consult cancellation.

This investigation found the Electrophysiology Section did not use the EWL until approximately May 16, 2014. On May 12, 2014, SAVAHCS identified 46 patients who needed to be placed on the EWL for electrophysiology procedures. We also learned that the Sleep Study/Sleep Clinic did not use the EWL until February 6, 2014. In April 2014, Sleep Study had a 10-month backlog of 126 patients. This investigation discovered that other clinics within SAVAHCS (Orthopedic, General Surgery, ENT, Cardiology, Thoracic, and Urology) also used other scheduling methods, as opposed to only using the approved electronic VistA and EWL tools. Scheduling supervisors condoned these other scheduling methods. In addition, several employees disclosed they scheduled veterans' desired date by

using the next available appointment date. Two scheduling supervisors made statements during our investigation that suggested they trained schedulers to control the desired date in a way that was contrary to VA policy.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on August 10, 2016.



QUENTIN G. AUCOIN
Assistant Inspector General
for Investigations

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