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

VA Medical Center in Portland, Oregon
November 8, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based upon information received on August 5, 2014 from the newly appointed VA Portland Healthcare System (VAPORHCS) Director. The director stated that a VAPORHCS Operative Care Division (OCD) employee alleged that hospital management created lists of veteran appointments with a greater than 30-day wait time. The complainant was interviewed by a Department of Veterans Affairs (VA) Office of Inspector General (OIG) employee. The complainant also provided documents and specifically alleged the following:

- VAPORHCS management regularly provided staff with lists consisting of patient appointments that were more than 30 days from the patient's "desired date." Supervisors provided the lists to medical scheduling assistants (MSAs) and asked them to reschedule the appointments by canceling the appointment, then rescheduling it for the same date. The only changes made were for new patient appointments.

- Appointments not scheduled to reflect a wait time shorter than 30 days were referred to as a "scheduling error."

    - MSAs were only authorized five scheduling errors per year. When errors exceeded five, schedulers performance was generally rated lower.

- The "scrubbing" of lists was a regular practice at VAPORHCS since approximately 2008.

The practice stopped after reports of scheduling issues at the Phoenix VA were disclosed.[1]

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed the complainant and 12 VA employees working in a range of positions, including managers and schedulers.

- **Records Reviewed:** VA OIG reviewed a sample of patient records to evaluate scheduling and documentation of appointment and desired dates, as well as employees' email messages relevant to the allegations.

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

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant alleged that in about 2008 or 2009, VAPORHCS OCD began scrubbing lists of appointments that were scheduled beyond 30 days of the patients' desired dates. The complainant stated that a scheduling administrator instructed an employee to reschedule appointments beyond 30 days by canceling the appointment then rescheduling the appointment for the same date. The appointment would then be used as the patient's desired date. These changes were made only for new patient appointments. The purpose was to show that OCD complied with the 30-day access requirement. Initially, when the lists began, there were about 400 names on them. The complainant stated that employees questioned the scheduling administrator about making these changes, but the administrator instructed employees to change patient desired dates in the system. The complainant alleged that, when an employee stopped scrubbing lists about 2 years prior to the OIG interview (2012), two other employees were made responsible for scrubbing the lists. The desired date access goal measure changed from 30-day access to 14-day access about 3 years ago (2011) according to the complainant. The complainant also stated that the lists were scrubbed from approximately 2008 to April 2014.

  The complainant believed that "auditors" were going to arrive at VAPORHCS in 2014 to review scheduling procedures. (Note: A VHA Access Audit team conducted a site visit at the facility on May 14, 2014.) The complainant alleged that a scheduling supervisor was asked what an employee should do if an auditor asked the employee to demonstrate how to schedule an appointment. The supervisor instructed the employee to schedule appointments correctly per the policy and not the way the employee was taught, which was by using the appointment date as the desired date. The supervisor said he was not aware that schedulers were scheduling in this incorrect manner and instructed the employee and others to schedule the correct way. This employee reportedly received an unspecified form of counseling from this supervisor and a former OCD supervisor a week later, but the employee said that they were aware that the scheduling of the desired date as the appointment date was occurring before the conversation with the employee's supervisor. The complainant stated that another employee in OCD gave training to schedulers on how to schedule (incorrectly) so the trainer would not have to go back in the system and change appointments. The complainant alleged that the trainer and a former OCD supervisor worked overtime on the weekends to scrub lists. The complainant further alleged that an employee was informed by his/her supervisors that a senior leader for the facility wanted him/her fired for manipulating wait times.

  The complainant also alleged that schedulers were not allowed to have more than five scheduling errors per year for their performance evaluation. If a patient was scheduled beyond the 30-day access measure, it was considered a scheduling error and held against the employee. The complainant was not aware of anyone receiving a negative evaluation because of scheduling errors. The complainant thought that this was a hospital policy, but was uncertain if he/she had seen or read the policy. The complainant alleged that everyone was told that they had to meet access requirements or the director's office would not get their bonus. When asked for the source of this information, the

complainant said he/she did not remember. The complainant provided several emails to support his/her claims. However, the emails were written in 2006, 2007, and 2008, before the publication of the scheduling directive.

- A program analyst stated that the employee referred to by the complainant told her that, before the VA Phoenix scheduling issues became public, the employee was asked how she scheduled appointments. The program analyst added that the complainant told her that an employee had been asked by her supervisor how she scheduled appointments and that the employee had gotten into "trouble." The program analyst stated that she told the complainant that she had emails from her management and the complainant's management that showed there was pressure to change desired dates. The complainant informed her that these were the same emails he/she had already sent to OIG agents. The program analyst stated that after VHA Directive 2010-027 was published in 2010, she scheduled appointments correctly and in accordance with the directive. She also stated that supervisors in Department of Hospital and Specialty Medicine (DHSM) were clear to schedule appointments per the directive. She said that the employee did not receive the same guidance and continued to schedule patient desired date information incorrectly. The program analyst stated that appointments scheduled outside of the 14-day access goal, but in accordance with the directive, were not counted against schedulers as a scheduling error for performance evaluations purposes.

- A nurse manager stated that he knew there was a push to get patients scheduled for appointments within 14 days of the patient's request per a senior leader between mid-2012 and August 2014. He explained that patient access data were reviewed every 2 weeks. Although he was not familiar with the scrubbing of the lists, the guidance was to get patients appointments sooner or to outsource the appointment. He stated that there were many patients on the lists who had been scheduled inappropriately, such as cases in which the MSA used the "T" and "T+1" function[2] without comments in the record, which, he added, were probably "erroneous" dates. He stated that no one ever instructed him to change desired dates. The nurse manager further stated that, when scheduling issues arose, he informed his facilitators they should not be changing desired dates. He stated that the complainant informed him sometime between mid-2012 and August 2014 that an employee had been instructed by a scheduling administrator to make the desired date and the appointment date the same. He further stated that he immediately instructed this employee to stop scheduling appointments in this manner. When asked if he ever asked his employees to change, manipulate, or use arbitrary dates in the system to make access numbers look good, he stated, "I do not believe I ever said that, correct." He also stated that not meeting the 14-day patient access goal was not considered an error in MSA performance evaluations.

- A former OCD supervisor stated that supervisors pulled patient lists and reviewed them for scheduling errors to determine if MSAs were eliciting a desired date, and to see if

[2] MSA(s) use VHA's Veterans Health Information Systems and Technology Architecture computerized healthcare 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. "T+1" equals today's date plus 1 day.

they could get patients in sooner for treatment. The former OCD supervisor was unable to provide a definite time period for when this occurred. She stated that an employee scheduled the appointment date as the desired date and claimed to have been taught to schedule in this manner years ago. The former supervisor did not know of any other employees scheduling in this manner. She noted that the employee stopped scheduling incorrectly after they had a conversation about scheduling practices several years prior to August 2014. The former supervisor stated that she never instructed anyone to use the desired date as the appointment date, and she never heard anyone else tell schedulers to schedule in this manner. The former OCD supervisor stated that the lists were not scrubbed for appointments beyond 14 days, but for scheduling errors. She further stated that in the event they were unable to determine the patient's desired date, an arbitrary date was sometimes used as the desired date; for example, when the scheduler may have used the "T" function. In these situations, the use of the "T" function was considered a scheduling error. Using a random date to fix scheduling errors may have occurred about 20 or 25 percent of the time. The former OCD supervisor was unable to provide a definitive time period for when this occurred. The former OCD supervisor stated that she received guidance to review patient appointment lists from a scheduling administrator.

The former OCD supervisor further stated that a senior facility leader led the access group meetings to review lists to meet the 14-day access goal. She added that the purpose of reviewing the lists was to fix scheduling errors and to meet the 14-day patient access goal. The former supervisor reiterated that they only changed scheduling errors; in cases in which there was a desired date with a comment, no information was changed in the patient's appointment record. She further noted that employees were allowed only so many scheduling errors each year for their performance plan, but this policy had nothing to do with meeting the 14-day access goal.

- An OCD Medical Scheduling Assistant (MSA1) stated that she received annual training and special training for scheduling at an unspecified time before the 2014 interview. She added that she followed the scheduling directive, but that there were situations when patients would be asked for their desired date and the patients responded that they did not care and wanted the "next available" appointment. In those cases, the next available appointment would become the desired date.

  She stated that a nurse in the Purchase Care Department (PCD) reviewed the lists and fixed the errors. The lists had been circulated for several years before the OI interview in 2014. She stated that she was sometimes asked to correct appointments that had been inadvertently scheduled incorrectly. She was not aware of ever entering arbitrary or inaccurate desired dates in the patient record to meet 14- or 30-day access goals. When asked if the main objective of supervision was to ensure patients were scheduled to meet the 14- or 30-day access goals, she said yes, but the objective at her level was to fix scheduling errors. She stated that she was not instructed to use the appointment date as the desired date. She added that, per the performance plan, schedulers were not allowed to have more than five scheduling errors per year. She further stated that not meeting 14-day access would not be considered a scheduling error.

- Another OCD Medical Scheduling Assistant (MSA2) stated that approximately 5 years

prior to the OIG interview, in 2009, schedulers were asked by either the scheduling administrator or the former supervisor to schedule appointments by going into the system to look for the first available appointment, then using that date as the desired date. There was a lot of resistance to this instruction, and her initial thinking was "I'm not going to do that." When prompted to explain her reaction, she said because it was "fudging the numbers." When asked to elaborate, she said they were always told they had to show wait times to get help for their clinics and "fudging numbers" made it appear that they had availability for patients even though they did not actually have available appointments. In addition, scheduling this way doubled the work because they had to go into the system, find dates, and then back out, which was cumbersome and time consuming. When asked if there was ever a time she was instructed to change the desired date for veteran appointments scheduled correctly, but outside the 14 days, she said, "I would say yes." She further stated that it did not seem like the fudging of the numbers stopped until the "mess with Phoenix came out." Since then, she has scheduled per the directive, but no one directed her to stop what she was doing previously. She said that the scheduling policy was "vague" as there were people instructing to schedule different ways. Her understanding was that they had to have less than five scheduling errors per year, but she was uncertain what defined a scheduling error.

- The scheduling administrator—a former OCD supervisor until late 2012—stated that she received an access list every 2 weeks to obtain a true measure of wait times and to fix scheduling errors. She explained that only scheduling errors were changed. She stated that she and another supervisor also led scheduling training. She further stated that she did not give guidance to change dates if appointments were beyond the 14-day access goals, nor did she recall having ever instructed any of her managers or staff to change dates if appointments were beyond the 14-day access goals. The purpose of the access lists was not to meet the 14-day access requirement. She stated that schedulers did not manipulate a number to meet a measure. She also denied that she or others verbally instructed MSAs to change numbers to meet the 14-day access requirement.

- An administrator in OCD stated that she had received patient access lists for several years. The lists were used to identify and change scheduling errors, which consisted of schedulers using the T and T+1 functions. These errors were fixed by rescheduling the appointment for the date and time the patient was scheduled. She added that the former OCD supervisor and the scheduling administrator gave the guidance on fixing the scheduling errors several years prior to 2014. Originally, schedulers fixed their own errors, but more recently that task was given to designated staff. She stated that she never directed anyone to make changes to meet the 14- or 30-day access measure. When asked how they would determine the desired date with T and T+1 errors, she said they would not always know the desired date. In the event there was no documentation to determine a desired date, the appointment date would become the desired date. These were classified as scheduling errors and would be noted as "scheduling error fixed." She noticed that the lists had fewer errors over time.

- A supervisor, who did not schedule appointments, stated that the lists contained names of patients who may have been inappropriately scheduled into clinics. The lists showed appointments that had been made using the T and T+1 functions and were considered

scheduling errors. She said an appointment made with T and T+1 without a comment was considered a scheduling error. When asked if any other errors were reviewed, she said no.

- A former OCD employee stated that the previous OCD supervisor gave access lists to her and others. The lists were reviewed for scheduling errors, such as schedulers using the T+1 or T+2 function to enter the desired dates. There were also other scheduling errors; however, desired dates were not the main issue because they could not be changed, having been selected by the patient. The employee was not instructed to make changes in order to meet 14- or 30-day access measures. Appointments scheduled correctly but outside the 14- or 30-day access measure were left alone.

- A former administrative assistant, who did not schedule appointments but supervised various sub-specialties that scheduled appointments, acknowledged that patient desired dates were changed to meet the 30-day access goal. However, she noted that these desired date changes occurred prior to the VA scheduling directive publication in 2010. She explained that some desired date changes might have been due to a problem with the scheduling software before 2011. She stated that after the scheduling directive was published in 2010, desired dates were not changed.

- A senior facility leader described his involvement with scheduling as "distant." He confirmed that there were performance metrics regarding 14- and 30-day desired dates to appointment date access for veterans that were being measured nationally. He noted that VAPORHCS struggled to meet the national measure, and during the past 5 years, they would "flirt" with making the access goal. Schedulers were provided training that emphasized providing patient access.

  When shown a June 7, 2011 email originated by him and titled, "Access Hot Team Every Thursday," he recalled that there was a focus on clinics with over 20 patients waiting more than 30 days for appointments. He wanted the lists to be used by management to see what was occurring in these areas with access problems and to discuss what these clinics needed to improve patient access. He said there was "no monkey business" in terms of "moving appointments," and he was aware that changing desired dates was prohibited. If a patient was scheduled correctly, but beyond 30 days, staff would attempt to move the patient's appointment forward, provided there was a cancellation.

  The senior facility leader stated that employees were not instructed to manipulate dates to keep access numbers down. There was a specific report to look for schedulers who may have "erroneously" scheduled appointments. He further stated that only scheduling errors were fixed. He also stated that there were about 300 or 400 names on a list to get fixed weekly or biweekly. When asked why schedulers were making the same frequent mistakes, he replied there were many schedulers and that the employees working in these positions were often new employees and employees at a lower pay grade. He stated that the newer employees took longer to learn the scheduling practices and there was also employee turnover. Schedulers did not use arbitrary numbers to meet the measure, and he knew of no reason why a scheduler would say that there was fudging of numbers.

Records Reviewed

- The OI Computer Crimes Unit compiled e-mail conversations among a number of VA employees. Key word searches were conducted and hundreds of emails were reviewed. This review did not find any evidence that VAPORHCS leadership was directing staff to change the desired date to meet national access measures after the VA scheduling directive was published in 2010.

- The OIG Office of Healthcare Inspections conducted a medical record review of 35 randomly selected patients at VAPORHCS for the period from September 1 to December 1, 2013, and found no evidence of irregularities in the scheduling of appointments and desired dates in the sample.

- The OIG Office of Audits and Evaluations provided data from fiscal years 2013 and 2014, which documented a 4.44 percent rate of OCD new patients with zero days between the desired date and appointment date for new patients. The rate of zero-day waits between desired date and appointment date for established patients was 4.8 percent. These data did not support allegations that MSAs routinely used the patient's appointment date as the desired date.

- A review of an employee's performance evaluations from fiscal years 2012 through 2014 found no indication that the employee had been held accountable for scheduling errors or appointments scheduled correctly beyond access timelines for the purposes of performance evaluations.

4. Conclusion

Employees provided various accounts of how patient appointments were scheduled, before and after the VA Scheduling Directive was published in 2010. Employees also provided differing accounts of how patient access lists were reviewed, what comprised a scheduling error, and how scheduling error desired dates were corrected.

The majority of MSAs reported that they followed VA policy when they used the patient's desired date as the date selected by the patient. The majority of supervisors interviewed said that patient lists with greater than 30-day desired date to appointment date wait times were generated and circulated regularly, adding that the purpose of the lists was to allow managers to review and fix scheduling errors. Most of these errors consisted of appointments scheduled incorrectly using the T function on the Veterans Health Information Systems and Technology Architecture (VistA) computerized scheduling system, when the MSA, trying to make the appointment as the desired date, entered the current date instead. Some employees reported that when fixing the T function error, the desired date was changed to the appointment date if there was no documentation to substantiate a desired date. Management acknowledged that lists of appointments were circulated as late as 2014.

Although some instances were found indicating that the next available date was used as the patient's desired date, our review of scheduling data did not not corroborate allegations that MSAs routinely used the patient's appointment date as the desired date.

The evidence did not substantiate the allegation that supervisors, or anyone at the station, instructed schedulers to change appointment data to specifically meet patient access goals. A review of an employee's performance appraisals from 2012 through 2014 did not indicate that the employee was held accountable for failing to schedule appointments within the access measure time lines.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on February 27, 2016.

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