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



VA Medical Center in Loma Linda, California December 20, 2016

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) initiated an investigation in response to a complaint received in February 2015 alleging that electronic wait-list and wait-time manipulation activities were occurring at the VA Medical Center (VAMC) in Loma Linda, CA.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed 21 VA employees, including schedulers, supervisors, and senior leaders.
- **Records Reviewed:** VA OIG reviewed appointment scheduling data, VA emails, and a Veterans Health Administration (VHA) fact-finding report.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

• The complainant stated that a former VA employee had told him "zeroing" practices had occurred at VAMC Loma Linda, as it pertained to the zeroing of appointment desired dates to meet the 2-week previous performance measure. He explained that the former VA employee cited 2010 and 2011 as the time frame when zeroing practices occurred. The complainant stated that he had no firsthand knowledge of this, but other employees who worked at the VAMC could provide additional information. He identified the following people: a registered nurse, a licensed vocational nurse, a supervisory medical support assistant (SMSA), a Specialty Clinic employee, a medical support assistant (identified as MSA3), a Primary Care physician, and a VA employee. When asked if there had been recent examples within the last 2 years (prior to March 2015), when zeroing practices occurred, as directed by VAMC senior leader 1, the complainant insisted that the employees listed above had knowledge of recent occurrences of these practices.

The complainant stated that he believed hidden lists were being used in the Primary Care Clinic, as well as in the Mental Health Department. He reported that he had gathered data suggesting hidden lists were specifically being used in the Intake Clinic (IC), which is part of Primary Care. The complainant stated that the IC is reserved for patients who need immediate care while a doctor is unavailable. Thus, they are seen by a nurse in the IC. The complainant stated that IC patients are primarily walk-in patients so appointments should not exist. He stated that the data he pulled revealed there were

several patients scheduled for future appointments, adding that "hidden lists must be in use."

The complainant also stated that "resetting consults" is similar to zeroing appointments. He used the Echocardiography (Echo) Clinic as the primary example and explained that following a consult in the Echo Clinic, the majority of veterans would have to return to the clinic to be monitored. He said that in the case in which patients were returning, schedulers were closing the consultation so it appeared the consult was complete. The complainant stated that this practice was incorrect as these consults should be coded as "pending" because they are technically not closed as the patient would be returning for follow-up. He also referenced an email from the Cardiology former service chief that was sent in 2013 to various employees telling them not to reset consults.

- The licensed vocational nurse (LVN) and the registered nurse identified by the complainant were interviewed jointly. They both stated that the inaccurate capture of desired dates ("zeroing out") occurred approximately 4 to 5 years ago (prior to March 2015). They added that they were told by the SMSA to "zero out" dates/appointments. The LVN stated that this practice occurred sometime in 2010–2011. They both said that they were not receiving any current guidance to zero out appointments or "fudge numbers." They also stated that they did not use hidden lists and they were unaware of others' use of any hidden lists. Regarding the resetting of consults, they both reported that they did not make appointments for consults and they had no knowledge of the alleged resetting of consults.
- The SMSA stated that, before 2008 and possibly as early as 2005, appointmentscheduling instructions came from VAMC senior leader 1. She further stated that she recalled attending meetings with VAMC senior leader 1 in which he said that he wanted no wait time between the appointment date and the desired date the patient had chosen. She stated that they were "gaming the system" and even questioned VAMC senior leader 1 on this practice. She identified administrative employee 1 as another VA employee who did not agree with VAMC senior leader 1's instructions to zero out wait times and who had challenged him as well. She explained that VAMC senior leader 1 responded to their concerns by saying this was how it was going to be. She said that she knew the guidance from VAMC senior leader 1 to change appointment wait times was wrong but he was the boss, and "if you challenged [VAMC senior leader 1] things would be hard for you." When asked what this meant, she replied that your job position would be in jeopardy if you didn't follow VAMC senior leader 1's instructions. She stated that other VA employees would tell her that changing the wait time was wrong and inaccurate. She added that she would tell them she knew this, but her guidance came from VAMC senior leader 1. She said she had suggested to the other employees that they talk to VAMC senior leader 1 if they were concerned. She stated that having no wait time made the facility's numbers look good. She also stated that Washington, DC, cared about the numbers, and that VAMC senior leader 1 was a "numbers guy."
- The specialty clinic employee stated that she had no knowledge of any "indecent practices," specifically wait-time manipulation and the use of hidden lists, by personnel in her clinic. She added that she was not aware of any hidden lists being used by the

- schedulers. She also stated that her responsibility was administrative duties and so she didn't schedule patients.
- MSA3 stated that she had not been recently directed by anyone to alter desired dates but that, in the past, approximately 3 to 5 years ago (prior to June 2015), she had been directed to alter desired dates. She stated that she was uncomfortable sharing with VA OIG the name of the individual who had told her to alter desired dates for fear of losing her job. When asked about VAMC senior leader 1, MSA3 said that she would not be surprised if VAMC senior leader 1 had told individuals to alter dates or if he had told people to keep hidden lists. She also stated that VAMC senior leader 1 rarely sent out guidance via email. MSA3 stated that she did not have any knowledge of individuals using hidden lists and that she did not use hidden lists.
- The Primary Care physician identified by the complainant stated that he did not have any firsthand knowledge about the complainant's claims. He speculated that if there had been guidance for staff to manipulate wait times or use hidden lists, the guidance would come from VAMC senior leader 1. He said that he did not recall any emails sent by VAMC senior leader 1 or any supervisory staff with guidance to manipulate wait times or use hidden lists.
- The final VA employee identified by the complainant stated that she had no firsthand information regarding his claims.
- VA OIG received a list of 16 employees, both MSAs and program support assistants (PSAs), who scheduled appointments for the Mental Health Department from VAMC Loma Linda supervisory staff. We interviewed 14 employees from that list. Five employees interviewed stated that they rarely used Electronic Wait Lists (EWL) since those were reserved for new patients. Consensus among the five employees was that for the Mental Health Department, many of the doctors had a set schedule when making follow-up appointments. Because of the patient and doctor agreeing on a specific date, appointments having a zero-wait time were accurate and "hidden lists weren't necessary." One MSA (MSA2) stated that he had been instructed by a supervisor at another VAMC to alter desired dates so there would appear to be no wait time, a practice he continued at VAMC Loma Linda. One MSA (MSA1) told VA OIG there was a "rumor" that some PSAs used hidden lists. No other MSAs or PSAs reported this kind of information during the interviews. The remaining employees stated that they had no knowledge of wait-time manipulation or use of hidden lists.
- MSA1stated that "rumor has it" some PSAs used hidden lists although she did not specify who. When asked where she had heard that rumor, MSA1 said that a PSA had told her they were keeping hidden lists. She stated that she and the PSA were casually talking about work one day and he brought it up. She said that the PSA was formerly an MSA and he recently began working in the Mental Health Department. She stated that she believed the PSA because she had noticed several veterans attempting to check in for appointments on the kiosk in the lobby of the clinic without success. She said that she attempted to help the veterans check in, but there was no appointment showing in the Veterans Health Information Systems and Technology Architecture or the Computerized

Patient Record System. She stated that she would ask the veteran if he/she was sure he/she had an appointment and the veteran would say, "Yes, someone called me and told me I have an appointment today." She stated that this had happened to at least four to five veterans a week.

- The PSA stated that he never told anyone hidden lists were being used. He said that he did not use them and didn't know of anyone in the department using them, so there would be no basis for him telling someone else they were in use.
- MSA2 stated that he worked at a different VAMC during parts of 2013 and 2014 and that he had been told by his supervisor at the other medical center to alter desired dates so there would appear to be no wait time. He said that he was explicitly told by this supervisor the wait time should always be zero. He stated that he continued to schedule appointments in this manner while at VAMC Loma Linda. He added that he never received this guidance from anyone at VAMC Loma Linda.
- Administrative employee 1 stated that, back in 2008–2010, she worked in the Mental Health Department. She said that she didn't directly supervise anyone at that point in time and although she had scheduling access she did not regularly use it. She said that she recalled attending regular meetings with VAMC senior leader 1 but didn't specifically recall discussions in which he directed schedulers to alter the desired dates when scheduling patients or to go back and change the desired dates after appointments were made. She said that she knew that prior to the Scheduling Directive of 2010, patients were scheduled differently. She added that VAMC senior leader 1 was a numbers guy as he came from a "data" background and was always concerned about what the numbers reflected.
- Administrative employee 2 stated that she recalled meetings discussing clinic access and scheduling; however, she had no specific recollection of any meetings in which VAMC senior leader 1 had directed her or others to alter/manipulate patient desired dates to reflect a zero desired date. She said that before the June 2010 Scheduling Directive, appointments were scheduled in this fashion; however, after this directive was issued, she did not recall being directed to have schedulers make appointments contrary to the directive.
- A former program manager for a specialty clinic stated that for the period 2008–2010, he did not recall specifically being directed to schedule contrary to the official guidance at the time. He said that he did vaguely recall there were times he didn't agree with the way he was being directed to schedule patients, but he could not specifically recall an example of what facet of scheduling he disagreed with.
- A former service chief stated that when he arrived at VAMC Loma Linda, the June 2010 Scheduling Directive was already in place and he was adamant that all appointment scheduling should be done in accordance with the outlined directive. He said that he received push-back from VAMC senior leader 1 at the onset because VAMC senior leader 1 didn't think scheduling needed to be changed. He stated that he did not specifically remember VAMC senior leader 1 or anyone else directing people to schedule

contrary to the directive. He said that he hired administrative employee 3 to be in charge of clinic operations and she may have additional information.

• Administrative employee 3 stated that when she worked at VAMC Loma Linda, VAMC senior leader 1 would hold frequent meetings in which scheduling and wait times were discussed. She stated that, in her opinion, VAMC senior leader 1 wanted things to be scheduled a certain way, which was contrary to the way she thought things should be scheduled. She stated that VAMC senior leader 1 made comments that patients' appointments needed to be "fixed," but did not recall specific details. She stated that VAMC senior leader 1 never provided specific directions that these patients' appointments needed to be altered, but she said it was understood that the patients' desired dates needed to be changed so that it did not look like there was any wait time for the patients. She stated that she instructed her staff to never change any appointments. She added that the SMSA was present during the meetings, and that the SMSA also agreed that no appointments should be changed. She identified a section chief as another supervisor who was possibly present at these meetings.

Administrative employee 3 identified one incident when she became aware that VAMC senior leader 1 had allegedly told her employees to change appointments. She added that she went on leave for about a week and a half, and that during her absence, VAMC senior leader 1 told the schedulers they had to "fix" some appointments. She stated that the schedulers informed her of the incident upon her return. She explained that the schedulers were upset that VAMC senior leader 1 had instructed them to change the appointments and added that the employees did not follow VAMC senior leader 1's instructions, that no appointments were changed, and that there was no negative effect on patient care. She did not recall the exact date when this incident occurred, but stated it was probably in early 2011. She also did not recall the names of any of the schedulers who had made the complaint.

- The section chief identified by administrative employee 3 stated that he did not recall ever being directed to schedule veterans contrary to the June 2010 directive. He stated that he did recall being told to change a patient's desired date if the patient desired to be seen on a day other than when the doctor wanted to see him. In other words, he said they would make the desired date the date the patient wanted to be seen, not the date the doctor wanted to see the patient. He stated that he did not recall ever being told by VAMC senior leader 1 to call the patient and verify that they could make their appointment and then change the patient's desired date to the actual appointment date based upon the call.
- VAMC senior leader 1 stated that he never received all the details regarding the complainant's allegations. He said that he asked the complainant to explain his allegations, but he never received an explanation. VAMC senior leader 1 stated that he never directed staff to alter desired dates or use hidden lists. He added that he did not supervise scheduling staff, so guidance to do their job would not come from him anyway. VAMC senior leader 1 stated that the complainant had been passed up for a promotion and that before that occurred, the complainant had told him that if he were not promoted, he would take the information he had gathered to the media and show them that VAMC

Loma Linda was "just as bad as Phoenix." VAMC senior leader 1 said that this discussion came up during a meeting he had on January 20, 2015 with the complainant and the complainant's immediate supervisor. He stated that, after that meeting, he prepared a report of contact documenting the meeting, to include the allegations of VAMC Loma Linda staff being directed to change desired dates. He stated that he also sent a follow-up email to the complainant asking him to provide his specific concerns to the Human Resources office to initiate a formal investigation. He provided copies of the Report of Contact and follow-up email. He stated that he had administrative employee 4 look into the complainant's initial allegations and "overall there were no major issues to address."

When reinterviewed, VAMC senior leader 1 started by saying he didn't specifically remember 2010 that well. He said that nowhere in a memo or email would we find that he had directed schedulers to change desired dates. He stated that he didn't recall asking MSAs to change desired dates while their supervisor was on leave. He further stated that when the June 2010 Scheduling Directive came out, it caused challenges for VAMC Loma Linda to meet the 14-day scheduling mandate instead of the previous 30-day mandate. He said that he discussed this very issue with clinicians; that is, how could they better meet the 14-day mandate. He said that he couldn't recall a time when he would have met with schedulers, because he typically just oversaw the clinicians. He stated that he never told an MSA to change the desired dates to be the same as the appointment dates. He stated that he created a "working group" to discuss actions to be taken to increase clinic accessibility. He added that he only established that group, but was not an active participant.

• Administrative employee 4 stated that, to his knowledge, hidden lists did not exist. He said that for Mental Health staff, specifically physicians, lists other than EWLs were being used. These lists were created to track patients who possibly wanted to participate in an evidence-based psychotherapy treatment. He stated that these lists were "interest lists" and added that the physicians were not trying to hide anything but that there was no established mechanism to otherwise track this information. He stated that when supervisory staff learned these interest lists were in use, they told staff to use only an EWL to track said interest in treatment by making a column specifically for that type of treatment. When asked if VAMC senior leader 1 sent any emails directing staff to alter dates or use hidden lists, he answered, "No."

He further stated that, as of May 2015, the IC was no longer a separate clinic and both established patients and new patients were being seen within Primary Care. Thus, there was no issue with patients having appointments scheduled within the IC. He stated that, regarding the resetting of Echo consults, there was a programming issue that the "consult management team" attempted to overcome in 2013. However, the procedure that was put in place to overcome the issue was not discussed with the Cardiology Service chief who, as a result, sent an email indicating that manipulation of patient consults was unacceptable. He stated that it was never intended to make it appear that Echo consults were being manipulated, but he stated that the Cardiology Service chief should have been told about the management team's procedure.

• VAMC senior leader 2 stated that, on March 18, 2015, a fact-finding into the complainant's claims that hidden lists were being used in the IC was conducted by VHA staff. She stated that she was not aware of any guidance coming from VAMC senior leader 1 to use hidden lists or manipulate desired dates.

Records Reviewed

- VA OIG reviewed the appointment scheduling data for the Mental Health Department and the Primary Care Clinic at VAMC Loma Linda for 2012 through 2015. The data for the Mental Health Department revealed that between 2014 and April 2015 at least 90 percent of the time, a handful of MSAs and PSAs zeroed out wait times. The data appeared to be consistent with what the MSAs and PSAs claimed in their interviews: there is no wait time since the doctor and patient usually agree on a specified date and time. The Primary Care Clinic data showed several variations as the list of schedulers included more than 200 employees and the total number of appointments made by each scheduler varied significantly. For instance, between 2012 and 2015, some employees made 10 appointments and 8 of them had no wait time while other employees made more than 1,100 appointments and 900 of those appointments had no wait time. Conversely, some employees made 70 appointments and 40 of them had a wait time. Other employees made more than 1,200 appointments and 500 of them had a wait time. For Primary Care, the data did not show a consistent pattern that clearly revealed wait-time manipulation.
- VA OIG reviewed VA emails for administrative and supervisory staff, including VAMC senior leader 1, VAMC senior leader 2, and VAMC senior leader 3. The review did not disclose any evidence that VAMC senior leader 1 or any supervisory staff directed employees to do any of the things the complainant alleged.
- VA OIG reviewed the report of the fact-finding conducted by VHA into the complainant's claims regarding the use of hidden lists. The report stated that no evidence was found of a hidden list being used in the IC.

4. Conclusion

Our investigation found no evidence to support the allegations that VAMC senior leader 1 directed staff to use hidden list mechanisms instead of the EWL. Testimony from two nurses indicated that they were told to zero out dates/appointments approximately 4 to 5 years prior to the investigation by the SMSA. Despite senior leader 1's denial regarding allegations that he directed manipulation of consult dates, when we interviewed the SMSA, she stated that the improper scheduling instructions came from VAMC senior leader 1. The SMSA stated that senior leader 1 told her and others that he wanted a zero-day wait time between the patient's desired date and the appointment date. Other employees said they recalled various meetings with VAMC senior leader 1 during which wait times and patient scheduling were discussed; however, no one else said they heard specific instructions from him to alter wait times or manipulate scheduling. One employee stated that, while VAMC senior leader 1 never provided specific instructions to alter patient appointments, in her opinion, it was understood that the

patient desired dates needed to be changed so that it did not appear as though there was any wait time for the patient.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on October 17, 2016.

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