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

VA Medical Center in Phoenix, Arizona
Community Based Outpatient Clinic Southeast, Gilbert, AZ
May 4, 2017

1. Summary of Why the Investigation Was Initiated

VA Office of Inspector General (OIG) initiated an investigation in May 2014 upon receipt of information provided to the OIG Hotline. The complainant, a VA employee, alleged that from late 2008 through May 2014, management at the Community Based Outpatient Clinic (CBOC) Southeast, located in Gilbert, AZ, including supervisory CBOC employee 1, instructed staff to alter scheduling dates so the appointment dates would "coincide" with veterans' desired appointment dates.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed 10 VA employees, including the complainant, schedulers, and two supervisors.

- **Records Reviewed:** VA OIG reviewed a VA email provided by the complainant.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant stated that she used the date of the next available appointment as the "desired date," which significantly shortened the wait time or even reduced it to zero. She explained that she was told by her former supervisor (now deceased) to do it that way or face discipline. She stated that the medical support assistants (MSA) were told to keep the wait times to less than 14 days unless there was a valid reason to be over, such as showing no availability. She said she understood it to mean that if a scheduled appointment was 14 days past the desired date, "you fix it" by going into the system, canceling the appointment, and rescheduling the same day with a new desired date. She added that it was easier for her to bring up the appointment date and make it the desired date, which would make the wait time zero. She stated that as of this week (at the time of the interview in May 2014), she now made the desired date the date the veteran wanted, not the scheduled date. She further stated that she was concerned management would take action should this be discovered. She said she was aware of the "Widely Important Goal" (sic)[1] (something the former director implemented), which required offering new patients an appointment within 14 days of their desired date with follow-up appointments within 7 days. She stated that they had lost many providers over the past year but were still required to maintain the 14-day scheduling goal.

[1] The actual phrase is "Wildly Important Goal" from *The 4 Disciplines of Execution: Achieving Your Wildly Important Goals* by Chris McChesney, Sean Covey, and Jim Huling.

In a follow-up interview conducted 4 days after the original interview, VA OIG investigators asked the complainant if her current supervisor had spoken to her regarding scheduling veterans for appointments that were more than 14 days past their desired date. She replied that supervisory CBOC employee 1 had not. She stated that she had expected supervisory CBOC employee 1 to confront her regarding her current lack of adherence to the 14-day scheduling goal but no such conversation had occurred to date.

- A registered nurse stated that supervisory CBOC employee 2 told her in 2012 during staff meetings to have 100 percent compliance in the desired date area. She explained that supervisory CBOC employee 2 told her to make the desired date the appointment date to ensure the wait times were zero. She added that she complied with these instructions starting in 2012.

- MSA1stated that approximately 3 years ago (in 2011, prior to the time of the interview), the individual who was then his supervisor (now deceased) told him the desired date had to be within 2 days of the appointment date. He further stated that the deceased former supervisor told the MSAs these instructions were coming from upper management. MSA1 stated that he would run a daily Clinic Appointment Availability Report (CAAR) to make sure the wait times were no more than 2 days apart. If the wait time were over 2 days, he would back out of the system and make the appointment date the desired date. He also stated that the MSAs thought it was cheating because it looked like a veteran could be seen whenever he/she wanted.

- MSA2 stated that the clinic was expected to have zero-day wait times. She explained that these orders came from "downtown," specifically from VA Medical Center (VAMC) service chief 1 to the clinic's supervisor, supervisory CBOC employee 1. She further stated that supervisory CBOC employee 1 instructed her to "zero out" the wait times. She added that if the corrections were not made, she would be reprimanded. She stated that after an appointment was made, she would exit the system and make the appointment date the desired date. She said she printed the CAAR report every morning and corrected it; this meant that if the CAAR report had a wait time of over 3 days, she would go into the computer and zero out the wait time by entering into the system, canceling the appointment, and rescheduling for the same date.

- MSA3 stated that he used to schedule appointments by entering "T" for "Today" as the desired date and then schedule the appointment. Subsequently, he would just make the date of the appointment the desired date. He added that this would reduce the wait time to zero. He further stated that supervisory CBOC employee 1 required each Patient Aligned Care Team (PACT) to print its CAAR reports every morning. If the report showed an unacceptable wait time, he would go back in, cancel the appointment, reschedule it, and that action would zero out the wait time.

- MSA4 said that supervisory CBOC employee 1 gave him a copy of the Veterans Health Administration directive on scheduling. He stated that she expected the MSAs to schedule veterans in a reasonable amount of time. He also stated that he was aware the

Pentad[2] wanted veterans seen within 14 days. He explained that supervisory CBOC employee 1 had told him to correct the dates if there were more than 14 days between the appointment date and the desired date. He stated that he complied with these instructions by rescheduling the appointments and changing the desired date. He added that when he stopped printing CAAR reports and changing desired dates, he received a verbal warning from supervisory CBOC employee 1, nothing more. He did not give a date for when this incident occurred.

- MSA5 stated that Phoenix VA Healthcare System management officials were looking for wait times under 3 days when reviewing CAAR reports. She stated that if the CAAR report showed a wait time exceeding 3 days, she was expected to reschedule the appointment and change the desired date. She added that she complied with these instructions, which came from supervisory CBOC employee 1.

- Supervisory CBOC employee 1 stated that, over time, a program analyst gave her varying instruction on the handling of the desired date. She said that initially the program analyst instructed the staff to use Today as the desired date. She stated that the program analyst later met with each of the MSAs at the CBOC individually. She explained that she was not with the program analyst when the program analyst spoke to the MSAs, but she believed the program analyst told them to use the appointment date as the desired date, which would result in zero-day wait times. She stated that in 2013, the program analyst began emailing her a report known as the "MUMPS Report."[3] The report is similar to the daily CAAR report for individual schedulers. She stated that the MUMPS report provided a list of all appointments scheduled beyond 14 days of the veteran's desired date for all schedulers. She reportedly was told by the program analyst to speak with the MSAs to correct any mistakes. She stated that MSA6 complained to her about changing the desired dates to meet the metrics. She further stated that she called the program analyst about the matter and was told that if the dates were correct to leave them alone. She said that the MSAs then had to pull a daily CAAR report and check any appointments outside 14 days to correct any errors.

  Supervisory CBOC employee 1 also stated that she instructed the MSAs to print the CAAR report, to circle wait times exceeding 14 days and then to note whether it was scheduled correctly or not. She explained how she clarified this point with her MSAs in an October 4, 2013 email that read: "Please note not all appointments with a greater than 14 day wait time is (sic) made in error. The true wait time must remain untouched, just annotate that it is correct." [Agent's Note: This email was obtained by OIG email reviewers from the VA Exchange System.] When asked when the CBOC began using the Electronic Wait List (EWL), she replied that the clinic did not begin using the EWL until after the OIG began investigating allegations of wait-time manipulation at VAMC Phoenix in April 2014. Before that, all patients were placed on the VAMC Phoenix EWL. She said she was able to access that EWL and sort patients by zip code; she would then distribute the names to the MSAs at the CBOC to schedule appointments. She stated

[2] The Pentad is the medical center's five-member executive management team.
[3] MUMPS refers to the Massachusetts General Hospital Utility Multi-Programming System. A routine using MUMPS captures scheduling information and generates a report with specific focus on information regarding desired dates.

that a VAMC employee would sometimes send her an email with a list of veterans to schedule at the CBOC. She explained how she would divide the list evenly among the PACTs at the CBOC so they could be scheduled.

- Supervisory CBOC employee 2 stated that he never saw any instances of any staff "gaming the system." He was asked multiple times during the interview whether he had directed others to manipulate the desired date metric. He responded that he did not fully understand the scheduling package. He stated that he had a conversation with VAMC service chief 2 in approximately February 2013 about the proper use of the desired date. He further stated that, subsequent to this conversation, he requested formal training for the employees of the CBOC. He added that around the beginning of 2013, a VAMC service chief 1 asked the program analyst to provide the requested scheduling training.

- The program analyst, who now works at another VA facility, stated that she did not recall providing one-on-one training with employees at the CBOC. She said she did recall sitting down with one MSA at the clinic because of concerns supervisory CBOC employee 2 had with him scheduling correctly. She stated that she spoke to the MSA, whose name she did not recall, regarding scheduling same date appointments. She said that the MSA was entering T for Today to view availability in the calendar but was not backing out of the system before scheduling the appointment, thus making the desired date the day the appointment was scheduled—which often was incorrect. She said that she visited the CBOC approximately three to four times during her tenure in Phoenix. One of her visits was dedicated to training the new clinic supervisor, supervisory CBOC employee 1. She stated that she went over pulling up reports, workloads, and clinic utilization. She further stated that she could not recall emailing supervisory CBOC employee 1 a copy of the MUMPS list. However, she did remember telling supervisory CBOC employee 1 that she was to have her employees pull reports daily, correct any mistakes or sign off on any appointments over 14 days that had been scheduled correctly. She stated that she did not instruct supervisory CBOC employee 1 to change desired dates to meet the 14-day scheduling goal. She said that she believed an EWL was in place at the CBOC in 2013, but was not sure if it was used in 2014.

Records Reviewed

- VA OIG reviewed an email provided by the complainant that was sent to her (and all MSAs at the CBOC) by supervisory CBOC employee 1 in October 2013; it was titled PROJECT CAAR REPORT. The email explained how to review CAAR reports to ensure an appointment was made correctly. The email stated, "Please note not all appointments with a greater than 14 day wait time is (sic) made in error. The true wait time must remain untouched, just annotate that it is correct."

4. Conclusion

The investigation determined that scheduling staff at the CBOC were instructed by several supervisors to manipulate wait-time data from 2011 to 2014. Several employees reported that they were instructed to manipulate wait times by a former supervisor, who is now deceased. The investigation also disclosed that several employees said they were instructed to manipulate wait times by their current supervisor, supervisory CBOC

employee 1. The investigation further disclosed that one employee reported that she was instructed by supervisory CBOC employee 2 to manipulate wait times.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on October 12, 2016.

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