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

VA Medical Center in Alexandria, Louisiana
May 4, 2017

1. Summary of Why the Investigation Was Initiated

This investigation was initiated pursuant to allegations concerning several violations of Veterans Health Administration (VHA) policy in 2014 with regard to scheduling of patient appointments. Specifically, it was alleged that a service chief instructed staff to use the Electronic Wait List (EWL) for new enrollees only, and not for existing patients. The complainant further alleged that most of the established patients were seen within 14 days of their "desired date," and that patient care was never affected.[1] The complainant reported that, in her opinion, the EWL was not being properly used. After talking with the complainant, VA Office of Inspector General (OIG) conducted a preliminary review of appointment data. The review disclosed that VAMC Alexandria was averaging a zero-day wait time for 80 percent of all appointments. VA OIG then conducted an investigation into the apparent wait time manipulation.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed the complainant and 13 VA employees, including schedulers and supervisors.

- **Records Reviewed:** VA OIG reviewed VA emails, a VHA audit, and scheduling data.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant stated that VAMC Alexandria was using the EWL primarily for new enrollees who could not be seen within a 14-day time frame. According to the complainant, the EWL was rarely being used for existing or established patients. She stated that the service chief instructed staff to schedule this way. She further stated that most established patients were seen within 14 days of their desired date.

- A program assistant in Primary Care stated that she scheduled established patients only for the Primary Care Clinic. New patients were scheduled by a scheduler assigned to the

[1] The Electronic Wait List (EWL) is used to better understand and manage the number of new patients waiting for care. A new patient is a veteran who has not been seen in the corresponding stop code within the past 24 months or is an established patient in a stop code, but being seen for a new problem. New patients who request an appointment anytime within the following 90 days, but cannot be scheduled because of unavailable clinic capacity, will be placed on the EWL.

VAMC's Call Center. She added that she was aware of the EWL; however, she did not need to use it. She stated that she scheduled patients according to their desired date. She also stated that after patients were seen, the Primary Care providers annotated their desire to see the patients in 6 months through the Computerized Patient Records System (CPRS). After reviewing CPRS, the schedulers placed the patient's name on a Recall List because the provider's desired date exceeded 90 days. Once a patient was on the Recall List, she and other schedulers checked the list on a regular basis. When the patient was contacted, if there were no available appointments on the patient's desired date, she offered the "next available" appointment until the patient agreed upon a date.

She added that the VAMC has been dealing with a deficit in providers for years. As a short-term solution to deal with patient care, a Primary Care provider was moved from the Community Based Out Patient Clinic (CBOC) in Lafayette, LA, to the main VAMC campus. The program assistant stated that when the service chief assumed the position, she (service chief) reviewed the scheduling process, and realized that scheduling was not performed according to VHA policy. The program assistant further stated that the service chief implemented formal scheduling training, which was administered via classroom and computer-based training. She also stated that before the service chief's implementation of training, schedulers "had to train themselves."

- A medical service assistant at the Call Center stated that he was responsible for scheduling certain new patients [enrollees] for the main VAMC campus. He said he received formal scheduling training in early 2014. The training was conducted at the main VAMC campus and the outlying CBOCs [via video teleconferencing]. During the training, he opened an electronic spreadsheet that was stored on the VAMC's shared drive. The Microsoft Excel spreadsheet contained a list of new patients requesting appointments. He explained that the document was used by the VAMC and its CBOCs located in Lafayette, Lake Charles, Jennings, and Fort Polk, LA. The scheduler at each location monitored the spreadsheet daily. If a patient desired to receive services at a particular location, the scheduler responsible for that location was also responsible for contacting the patient to schedule the initial appointment.

  The spreadsheet was originally created to track new patients who arrived at the VAMC after duty hours or on weekends. He stated that the clerks inserted the names on the spreadsheet, which was reviewed by the schedulers on the following day. Since its inception, the spreadsheet evolved from an after-hour notification to the primary tracking document for all new patients. He added that the spreadsheet was used in concert with the Veterans Health Information Systems and Technology Architecture (VistA) database. He explained that the names were not deleted from the document. Once the patient had been scheduled, his or her case was closed out on the form by listing the appointment date and the clinic to which he or she would be assigned. He provided a screenshot of the spreadsheet. He reported that a Veterans Integrated Service Network (VISN) 16 representative was made aware of the spreadsheet during a recent visit (May 2014), and she had no issue with the document stating that she understood why the VAMC used it.

  When reinterviewed, the medical services assistant confirmed that Medical Administration Service (MAS) supervisor 1 was aware of the Microsoft Excel

spreadsheet. He provided copies of email communications sent to him by MAS supervisor 1 and containing attached copies of the spreadsheet. He stated that, in April 2014, the service chief brought him a printout containing a list of patients who were scheduled for appointments exceeding 14 days. He recalled the service chief inquiring as to why patients were scheduled over 14 days. He stated that he and a patient service assistant were confused as to what the service chief wanted them to do about the patients' scheduled appointments. He said the patient service assistant approached the service chief for clarification on the issue but was told by the service chief, "Don't worry about it." He stated that shortly after this occurred, MAS supervisor 1 came to the Call Center and asked for the patient printout the service chief had left behind. He added that in April 2014, MAS supervisor 1 then distributed the list to several schedulers and instructed them to rebook the appointment for the same date, creating a shorter wait time from the create date.

- A health benefits advisor confirmed that when a new enrollee requested an appointment, the veteran's name and information were entered onto the New Enrollee Appointment Request (NEAR) list. Once the veteran's information was inserted, a scheduler from the Call Center or the CBOC contacted the veteran to schedule an appointment.

- Medical support assistant 1 (MSA1) stated that she was responsible for scheduling appointments for established patients in a specialty clinic. She was the "back-up" scheduler for new enrollees. She explained that the clinic had 7 days to contact all new enrollees referred from Fort Polk, LA. The clinic received new enrollees from "walk-ups" and the NEAR call list. She explained that the NEAR list and the EWL were maintained in the VHA Support Service Center (VSSC) database. She stated that she and another scheduler made three attempts to contact new patients to schedule an appointment. After the third attempt, a letter was sent to the veteran's home of record listed in the VHA database. All contacts or attempted contacts were annotated in the veteran's medical records. She further stated that although the clinic had one provider, it did not have a backlog of patients and had no reason to use the EWL. She added that she was not aware of, and did not use, the NEAR list on the VAMC's shared drive.

- MAS supervisor 1 stated that she was the direct supervisor for schedulers assigned to the Call Center and Primary Care Clinic. She added that she also provided follow-up training to schedulers once they received classroom instruction and/or computer-based training. She stated that all schedulers adhered to VHA policy concerning the EWL; she also confirmed the use of the electronic Microsoft Excel spreadsheet to track new patients requesting appointments. She further stated that, after the scandal at VAMC Phoenix, AZ,[2] broke, she questioned the service chief about the use of the spreadsheet. She said the service chief told her that the list could be used by the VAMC. She stated that personnel in the Admitting Section inserted the names on the list, and the medical services assistant was responsible for reviewing the list and contacting the veterans to schedule appointments. She added that because the medical service assistant was able to schedule patients within 30 days, there was no need for the EWL. She explained that the

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

Microsoft Excel spreadsheet streamlined the process and functioned as an equalizer when scheduling patients. If the VAMC used the EWL, patients with more severe disabilities would be pushed to the front of the list, while patients with less severe disabilities would be pushed to the bottom, and patient care would be affected. She said the spreadsheet ensured that everyone was scheduled in a timely manner, regardless of his or her condition. She stated that, at the beginning of 2014, the service chief had brought a printed list of patients to the Call Center. The list contained patient appointments that exceeded a 14-day wait time. She further stated that the patients had been scheduled incorrectly because the "Wait Time 1" and the "Wait Time 2" equated to the same number of days. She explained that the schedulers in the Call Center were not asked to manipulate the wait times; however, they were asked to fix the scheduling errors. She did not provide a direct answer as to how the schedulers were expected to fix the patients' schedules.

When reinterviewed, MAS supervisor 1 attempted to define the scheduling errors; however, she eventually recanted her statements. MAS supervisor 1 stated that, sometime around April 2014, under the direction of the service chief, she had instructed the schedulers in the Call Center and in a specialty clinic to rebook scheduled appointments for the same date and time. She confirmed that the schedulers in the Call Center manipulated the wait times; however, according to her, the schedulers in the specialty clinic did not manipulate wait times.

- The patient service assistant stated that, in April 2014, the service chief brought a printout containing a list of patients who had been scheduled in February 2014 for appointments exceeding 70- to 100-day wait times. She further stated that the service chief instructed Call Center personnel to rebook the appointments for the same date and time, and then to change the desired date to the same date as the appointment date. She explained that this action did not affect patient care; however, it did change the wait time to "0." She stated that MAS supervisor 1 divided the list between several Call Center schedulers, adding that the schedulers were able to change the wait time dates over the course of 2 days. She also indicated that none of the schedulers received awards or recognition for accomplishing this task. She did not know if the service chief or MAS supervisor 1 received awards for adjusting the wait times. She said she attempted to meet with the service chief once the task was completed; however, the chief avoided her. She stated that the VISN 16 representative was informed of the situation during a May 2014 visit to VAMC Alexandria.

- MSA2 stated that, in April 2014, the service chief provided a list of patients with appointments exceeding 90 days. She further stated that the service chief directed the schedulers to rebook patients for the same appointment. At that time, MSA2 was not aware that the service chief was directing schedulers to violate VA scheduling policies. MSA2 explained that she changed the desired date to the same date as the appointment date for approximately 10 patients. MSA2 added that the majority of the patients' appointments had passed, so staff concentrated on the remainder. She said that once the list of wait times had been changed, it was returned to the service chief. MSA2 did not keep a copy of the list. She stated that she, the patient service assistant, MSA3, and another scheduler changed the wait times per the service chief's instructions.

- MSA3 stated that, in March or April 2014, she, the patient service assistant, MSA2, and another scheduler changed the desired date to the appointment date for patients scheduled over 90 days. She said they did so per the service chief's instructions that were relayed via MAS supervisor 1. MSA3 explained that MSA supervisor 1 brought the list to the Call Center and instructed the schedulers to manipulate the wait list. When the patient service assistant and the other schedulers initially did not complete the list, MAS supervisor 1 came to the Call Center and told the schedulers, "Mother is asking if y'all are working on the list." She stated that MAS supervisor 1 referred to the service chief as "Mother." MSA3 reported that she had changed the dates for approximately 10 to 20 patients. She stated that they did not file a complaint with the VAMC director because they felt that nothing would be done. She added that MAS supervisor 2 had ordered a specialty clinic's schedulers to manipulate the wait times as well, but the schedulers had refused and contacted their labor union—the American Federation of Government Employees (AFGE).

- MSA4 stated that before the service chief assumed the position, MAS required that schedulers rebook appointments exceeding 30 days; this action was performed on a weekly basis and decreased the wait time in the scheduling system. She stated that the service chief ended this practice once appointed to the position. MSA4 explained that the service chief initiated formal training, which included classroom and computer-based training. MSA4 confirmed that in April 2014 she had received an email from MAS supervisor 1 instructing her and other schedulers to rebook appointments in the form of an attached spreadsheet. She said that when she inquired about these instructions, MAS supervisor 1 emailed back with the instruction to "rebook the patient for the same date and time." On another occasion, MAS supervisor 2 provided another spreadsheet containing appointments exceeding 30 days. MSA4 stated that she and other schedulers refused to rebook the appointments and reported the unlawful request to AFGE, which then contacted VISN 16. MSA4 further stated that VISN 16 sent a representative to the VAMC. She added that the representative interviewed her and other schedulers, and that during her interview, MSA4 reported the manipulation of wait times.

- A senior leader stated that he was unaware of the electronic spreadsheet and the manipulation of wait times directed by the service chief. He further stated that he considered the service chief the subject matter expert on scheduling and that any advice he received from her was sound. He said he was aware that VISN 16 had sent a representative to the VAMC to investigate allegations of manipulation of wait times; however, he stated that he could not recall ever being briefed by the VISN on the results of the investigation. He stated that he did not direct the service chief to manipulate wait times for scheduled patients at the VAMC. He said he understood that his questions and comments could be taken out of context; however, he instructed his staff to ask questions if they believed his directives violated policy, were illegal, or unclear. He added that he did not receive nor did he authorize any cash awards to any of his staff for meeting the wait time goals.

  During a telephone conversation about an unrelated matter, the senior leader mentioned that he had contacted other VAMCs concerning the Microsoft Excel spreadsheet. He stated that until they could find a solid solution, the VAMC would continue to use the

spreadsheet as a means to track new patients requesting appointments through the admission desk.

- The VISN 16 representative confirmed that she had traveled to VAMC Alexandria in early to mid-2014 to investigate allegations of manipulation of patient wait times. She stated that during the course of her inquiry, she had concluded that the schedulers misunderstood instructions to manipulate the wait times issued by the service chief and MAS supervisor 1. She reportedly relayed her findings to the VISN director and provided a report—a copy of which she gave to the OIG.

- The service chief stated that she assumed the position in July 2012. She said she supervised clerks and administrative personnel assigned to the Call Center, Intake and Eligibility Section, Non VA and Purchase Care Section, Health Information Management, Primary Care, and Specialty Care at VAMC Alexandria's main campus. She stated that MAS supervisor 1 supervised the Call Center staff as well as clerks assigned to the Primary Care Clinic. MAS supervisor 2 supervises the clerks assigned to the specialty care clinics.

  The service chief explained that, in or around April 2014, she had conducted a random audit of scheduled appointments for established patients. As a result of the audit, she discovered that the majority of the appointments listed the same date for the create date and the desired date. Corresponding dates are an indicator that the schedulers were not scheduling patients "appropriately." She explained that a list containing more than 600 patients who had been scheduled inappropriately was provided to the clerks in the Call Center by MAS supervisor 1. She stated that she had met with the schedulers in the VAMC's Call Center to discuss the scheduling errors on the list. She added that the medical service assistant and the patient service assistant were among the clerks present at the time. She remembered explaining to the clerks that they needed to review the list; access the patient's medical records to identify the "return to clinic date" or the provider's desired date, then access the scheduling system to change the desired date to the provider's desired date. This change did not involve contacting the patient about his or her true desired date. [This conflicts with VHA Directive 2010-027, dated June 9, 2010, Paragraph 4c (4) (b), which states, "For Established Patient's Return Appointments: A specific or a general timeframe is communicated by the provider and the actual desired date is established by the patient."]

  When told that the clerks in the Call Center and MAS supervisor 1 had reported that they were not provided clear directions on how to fix the "inappropriate[ly]" scheduled appointments, the service chief blamed MAS supervisor 1, claiming she had poor communication skills and was unable to pass on her guidance in a clear and concise manner. She further stated that the patient service assistant was the only clerk who came to her and asked for clear directions on how to correct the scheduling errors. She stated that she and the patient service assistant met in her office where they discussed what actions needed to be taken to correct the scheduling errors. [The patient service assistant denied this occurred.]

  The service chief stated that she was unaware that the clerks in the specialty clinic had

refused to make corrections to their scheduling errors. She said she was also unaware that the clerks had involved AFGE. After being read an excerpt from one of the emails sent to the clerks in the specialty clinic instructing them to correct the wait times due to "inappropriate scheduling," the service chief stated that the list sent to the specialty clinic contained the name of patients who were not scheduled for appointments and were part of the delinquent recall list.

The service chief was shown an email with the attached spreadsheet containing patients with established appointments scheduled over 90 days. The service chief was also shown the email from MAS supervisor 1 instructing the clerks to rebook the appointments for the same time and date. The emails also contained direct orders from MAS supervisor 2 telling the clerks to reschedule the appointments for the same date and time. In the emails, the employees stated that what was being asked of them was wrong, and similar to what happened at the VAMC in Arizona. After reading the emails, the service chief continued to claim that she was not asking the clerks to manipulate the scheduled appointments and continued to deny knowledge of the clerks' refusal to comply.

Records Reviewed

- The OIG Office of Healthcare Inspections reviewed historical patient wait time data and advised that VAMC Alexandria was averaging a zero-day wait time for 80 percent of all appointments.

- We reviewed the VHA audit summary for VAMC Alexandria. According to the summary, the VHA's audit disclosed that "multiple employees reported that they were instructed to change the desired date to meet the 14-day appointment date time frame, or to make the desired date equal to the appointment date, so that it looks like the facility has perfect access."

- We reviewed a spreadsheet provided by the medical services assistant. Our review disclosed that the spreadsheet contained directions for using the document. The directions mention that all appointments should be made within 30 days of the create date. The document does not mention a 14-day scheduling requirement.

- Review of email provided by MSA4 disclosed they were concerned about the rebooking of scheduled appointments:

    - Email sent to MSA4 from MAS supervisor 1 dated April 8, 2014. In the email, MAS supervisor 1 asked MSA4 and other schedulers to reschedule patient appointments for the same date and time, and attached a spreadsheet containing 26 patients with appointments scheduled over 90 days. [Rescheduling patients for the same date and time changes the create date, resulting in a decreased wait time].

    - Email sent to MAS supervisor 1 from MSA4 dated April 16, 2014. In the email, MSA4 confronted MAS supervisor 1 about the rebooking of scheduled appointments.

- Email sent from the service chief to schedulers in MAS dated April 28, 2014. The service chief directed all of the schedulers to "correct their errors" by the following Friday; however, she did not explain what the errors were.

- Email correspondence between the service chief, MSA supervisor 2, MAS supervisor 1, MSA4, and another VAMC employee. The email chain contained MSA4's concerns regarding the rebooking of scheduled appointments. MSA4 explained in the email how she scheduled appointments according to VHA policy.

  MSA4 also inquired as to how the audit was able to determine that the appointments were scheduled incorrectly if the auditors did not converse with the patients to identify their true desired date.

  - Also contained in the email chain was an email dated April 25, 2014 and sent from MSA supervisor 2 to the schedulers. In the email, MAS supervisor 2 explained that the service chief's directive to rebook appointments is "nothing unethical. MAS supervisor 2 reiterated that they are correcting scheduling mistakes."

  - On a separate email within the chain, MAS supervisor 2 states, "I have given you a direct order to complete an assignment and I expect that to happen by the deadline I've given you April 30, 2014."

  - The other VAMC employee responded, "MAS supervisor 2, I am not comfortable doing this list of patients where we cancel them and reschedule them to make the wait time shorter after what I heard on the news that happened at the VA in Arizona but if it is mandatory I will. I just do not want to get in trouble."

- We reviewed a report of the Scheduling Process Consultative Review conducted by the VISN 16 representative. The report documented these conclusions:

  - Scheduling staff believed they were being asked to remake appointments to modify the desired dates in order to ensure a zero-day wait time. The VISN 16 representative attributed this to a lack of clarity in email communications and the absence of standard operating procedures for scheduling processes.

  - The instructions in one email to "reschedule them for the same date and time" in fact referred to remaking the appointment for the same date and time to ensure no delay in care occurred, not to make the desired date the same date as the appointment to obtain a zero-day wait time.

  - The fact that none of the appointment dates or times was modified meant there was no delay in patient care.

  - Challenges in clear communication between supervisors and front-line scheduling staff were evident.

4. Conclusion

The investigation did not substantiate the complainant's allegation that the facility was using the EWL incorrectly. However, the investigation revealed that the service chief created the term "scheduling errors" to conceal her orders to the schedulers in MAS [Call Center and a specialty clinic] to manipulate patient wait times. The investigation also confirmed that she directed personnel to change the desired date to the same date as the appointment date. The investigation disclosed that the service chief used MAS Supervisor 1 to impose her instructions to manipulate the wait times. Finally, the investigation found that MAS Supervisor 2 stated in an email to the schedulers that the service chief's directive to rebook appointments is "nothing unethical." MAS Supervisor 2 reiterated that they were "correcting scheduling mistakes."

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.