VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Delay of Care and Scheduling Issues at the VA Medical Center in West Palm Beach, Florida

August 9, 2017
15-02583-256

ACRONYMS

CBOC	Community Based Outpatient Clinic
FTE	Full-Time Equivalent
FY	Fiscal Year
MAS	Medical Administration Service
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Highlights: Review of Alleged Delay of Care and Scheduling Issues at the VAMC in West Palm Beach, FL

Why We Did This Review

The Office of Inspector General received two separate anonymous complaints in October 2014 and February 2015 alleging delay of care and potential manipulation of wait-time statistics at the VA Medical Center (VAMC) in West Palm Beach, Florida. The first complaint alleged that the VAMC and its outlying clinics were using patient cancellations to manipulate wait times. This complaint also contained allegations pertaining to unrelated human resources matters that included promotion and hiring decisions, which we did not review. The second anonymous complaint alleged that canceled cardiology appointments delayed cardiology patient care.

What We Found

This VAMC had a higher than average rate of clinic-canceled cardiology appointments with some patients experiencing multiple cancellations. Clinic scheduling staff canceled approximately 15 percent of cardiology appointments scheduled from October 1, 2014 through February 26, 2016. The VA national average for clinic-canceled cardiology appointments for the same period was 11 percent. These canceled appointments resulted in delayed care for many veterans, with at least 971 veterans incurring multiple cancellations.

In addition, scheduling staff incorrectly recorded wait times when rescheduling 125 of 160 clinic-canceled appointments (78 percent) and 13 of 120 patient-canceled appointments (11 percent).

We did not substantiate the allegation that VAMC scheduling staff manipulated wait times by scheduling appointments within wait-time goals, improperly marking them canceled by patient, and then rescheduling the appointments in the future.

These issues occurred because the VAMC did not fully staff the cardiology clinic due to unexpected staff departures and challenges in recruiting cardiologists, and facility scheduler training and supervision were inadequate. Moreover, supervisors did not complete required scheduler audits, which inhibited the detection of scheduling errors.

As a result, the VAMC understated patient wait times, delayed patient care, and did not offer eligible patients care through the Veterans Choice Program.

What We Recommended

We recommended the Director fill cardiology vacancies, provide effective training to schedulers, and perform required scheduling audits.

Agency Comments

The Director of the West Palm Beach VAMC concurred with the report recommendations and provided appropriate action plans. The Director reported Recommendations 1, 3, and 4 will be implemented by October 1, 2017. She also reported the VAMC had completed actions to address Recommendation 2. The Director's full response is included as Appendix B.

The Director's planned corrective actions are acceptable. We will monitor the facility's progress and follow up on the implementation of our recommendations until all proposed actions are completed. As of July 2017, VAMC management had not provided us with the evidence necessary to close Recommendation 2. Once we receive such evidence, we will determine whether the actions taken are sufficient to close the recommendation.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Allegations

The Office of Inspector General received two separate anonymous complaints in October 2014 and February 2015 alleging delays of care and potential manipulation of wait times at the VA Medical Center (VAMC) in West Palm Beach, Florida. The first complaint alleged that staff at the VAMC and its outlying clinics were manipulating wait times by scheduling patients into unavailable appointment slots within wait-time targets, then marking these appointments as canceled by patient and rescheduling into available slots further into the future. This anonymous complaint also included allegations pertaining to unrelated human resources matters that included promotion and hiring decisions, which we did not review. The second anonymous complaint alleged that canceled cardiology appointments delayed cardiology patient care.

West Palm Beach VA Medical Center

This VAMC is part of the Veterans Health Administration (VHA) Veterans Integrated Service Network (VISN) 8 VA Sunshine Healthcare Network. The facility provides veterans with primary, specialty, and long-term care services in conjunction with six community based outpatient clinics (CBOC) and two vet centers.

Cancellation Procedures and Wait Time Calculation

VHA requires facilities to capture a patient's wait time as the number of days elapsed between the clinically indicated or preferred date and the actual appointment date.[1] For established patients, the clinician or licensed provider must record the appointment's clinically indicated date by specifying when the patient needs to return to the clinic. For new appointment requests or appointments without a clinically indicated date, the scheduler must use the preferred date, which is the date the patient would like the appointment to occur.

The manner in which VHA calculates a patient's wait time for a rescheduled appointment varies depending upon whether the clinic or the patient initiated the cancellation.

- If a clinic cancels an appointment, the scheduling staff must input the cancellation as a clinic cancellation. Under such circumstances, VHA calculates the patient's wait time by comparing the actual appointment date with the original clinically indicated or preferred date. VHA Directive 1230, July 15, 2016, and VHA Directive 2010-027, June 9, 2010, were in effect throughout the periods we reviewed.

[1] See *Correction: Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance (June 8, 2015)*

Although VHA revised the applicable guidance during the reviewed periods, the changes are not material to the matters examined by this review.

- If a patient cancels an appointment, the scheduling staff must input the cancellation as a patient cancellation. Under such circumstances, the wait time is recalculated by comparing the actual appointment date with the patient's newly indicated preferred date.

VAMC policy requires that when a clinic cancels an appointment, the patient must be given the choice of rescheduling with another provider or with his or her original provider within 14 days of the original appointment date. The facility directed this requirement in VAMC Memorandum 548-05-38, dated March 20, 2012, and VAMC Memorandum: *Cancellation of Patient Care Activities,* dated April 1, 2016.

RESULTS AND RECOMMENDATIONS

Finding

West Palm Beach VA Medical Center Needed To Fully Staff Its Cardiology Clinic and Ensure Staff Follow Local and National Scheduling Policies

The West Palm Beach VAMC (the VAMC) had a higher than average rate of canceled cardiology appointments, with some patients experiencing multiple cancellations. Cardiology clinic staff canceled approximately 15 percent of cardiology appointments scheduled from October 1, 2014 through February 26, 2016, which was about 4 percent higher than the VA national average for the same period. In total, at least 971 veterans from this VAMC incurred multiple cardiology appointment cancellations during this period.

We also found that the VAMC scheduling staff incorrectly recorded clinically indicated or preferred appointment dates when rescheduling canceled appointments. Scheduling staff incorrectly recorded wait times when rescheduling 125 of 160 clinic-canceled appointments (78 percent) and when rescheduling 13 of 120 patient-canceled appointments (11 percent).

We did not substantiate that staff were manipulating wait times by scheduling appointments within wait-time goals, marking them as canceled by the patient, and rescheduling them further in the future. From 4,957 appointments, we reviewed a statistical sample of 120 and only identified four that were originally scheduled within 30 days, then canceled by patient and rescheduled beyond the 30-day wait-time goal. These cancellations were appropriate, based on the comments in the electronic scheduling system and additional information provided by VAMC staff. In addition, none of the 32 staff members interviewed were aware of any manipulative scheduling activity.

These conditions occurred because the VAMC did not fully staff the Cardiology clinic, and facility scheduler training and audits were not adequate. As a result, West Palm Beach VAMC management understated patient wait times, delayed patient care, and did not offer eligible patients care through the Veterans Choice Program.

VAMC Cardiology Clinic Rate of Clinic-Canceled Appointments Was Higher Than National Average

The VAMC had a higher than average rate of clinic-canceled cardiology appointments, with some patients experiencing multiple cancellations. Of the nearly 32,000 cardiology appointments created by the facility from October 1, 2014 through February 26, 2016, there were 4,660 (about 15 percent) canceled by the clinic, which was about 4 percent higher than the national average for VA cardiology clinics. Within the 4,660 clinic-canceled cardiology appointments, at least 971 veterans incurred multiple cancellations, ranging from 2 to 16 appointments canceled for each veteran.

We reviewed 187 of the 4,660 clinic-canceled cardiology appointments and found that scheduling staff did not reschedule 27 appointments because the patient declined care or clinical staff appropriately determined that the appointment was no longer medically necessary. Of the remaining 160 canceled cardiology appointments, scheduling staff rescheduled 127 appointments to occur within 14 days of the original appointment date. Scheduling staff did not reschedule 33 appointments within 14 days of the original appointment date, as required by local policy.[2]

Incorrect Dates Used To Reschedule Clinic-Canceled Appointments

Schedulers entered incorrect clinically indicated or preferred appointment dates when rescheduling clinic-canceled cardiology appointments. Due to the frequency of clinic cancellations in cardiology at the facility, we reviewed the first completed appointment following a cancellation for the 160 canceled cardiology appointments. Of the 160, schedulers only recorded 35 completed appointments (22 percent) using the correct clinically indicated or preferred dates. The wait times for the remaining 125 completed appointments (78 percent) were incorrect because schedulers did not follow established policies when rescheduling clinic-canceled appointments.[3] These policies required schedulers to maintain the original clinically indicated or preferred appointment date when rescheduling a clinic-canceled appointment. Instead, schedulers incorrectly input the next available appointment date or a later preferred appointment date.

These 125 appointments resulted in an average wait time of 29 days, whereas the electronic scheduling system reported an average wait time of only 6 days due to the use of the incorrect dates. Of the 125 appointments, scheduling staff rescheduled 78 appointments (62 percent) to occur within 30 days. Scheduling staff rescheduled the remaining 47 appointments (38 percent) to occur more than 30 days from the correct preferred date, resulting in an average wait time of 63 days. In addition to understating the facility's wait time, the incorrect date entries prevented scheduling staff from offering patients access to the Veterans Choice Program, which is available when a patient's wait time will exceed 30 days.

Wait Times Were Not Intentionally Manipulated Through Patient Cancellations

We did not substantiate the allegation that staff manipulated wait times by scheduling an appointment within wait-time goals, falsely marking the appointment as patient-canceled, and then rescheduling the appointment further in the future. We interviewed 32 staff members concerning these alleged scheduling practices. All denied any awareness of an effort to manipulate wait times using patient cancellations.

[2] See *VAMC Memorandum 548-05-38 (March 20, 2012)*
[3] See *VHA Directive 2010-27 (June 9, 2010), VHA Directive 1230 (July 15, 2016), and West Palm Beach VAMC Scheduling Guide (August 10, 2015)*

From April 1 through September 30, 2015, the VAMC recorded 65,424 patient-canceled appointments across all of its outpatient clinics. From these, we identified a subset of 4,957 outpatient clinic appointments in which the record reflected that an appointment was patient-canceled and rescheduled on the same day. These appointments represented the greatest likelihood of identifying improper scheduling conduct because the alleged practice would most likely occur by scheduling staff canceling the original appointment and immediately rescheduling it for the future date. We reviewed a statistical sample of 120 of these 4,957 appointments. Because we sampled appointments throughout the system rather than any one clinic, our results do not reflect the practices of any one specific clinic.

Of the 120 patient-canceled appointments reviewed, we only identified four that were originally scheduled within 30 days, then canceled by patient and rescheduled beyond the 30-day wait-time goal. These cancellations were appropriate, based on the comments in the electronic scheduling system and additional information provided by VAMC staff.

Incorrect Dates Used To Reschedule Patient-Canceled Appointments

Of the 120 patient-canceled appointments we reviewed, we found that scheduling staff entered incorrect dates for 13 of the rescheduled appointments (11 percent), which understated patient wait times. Similar to the incorrectly rescheduled cardiology appointments, scheduling staff often used the rescheduled appointment date in place of the patient's newly indicated preferred date, which resulted in an incorrect wait time of zero days. Only 2 of the 13 patient-canceled appointments were rescheduled to occur within 30 days of the patient's newly indicated preferred date. The remaining 11 appointments occurred at least 30 days later, resulting in an average wait time of 49 days whereas the electronic scheduling system reported an average wait time of 2 days for these same appointments. In addition to understating the facility's wait time, the incorrect date entries prevented scheduling staff from offering these patients access to the Veterans Choice Program, which is available when a patient's wait time will exceed 30 days.

Inadequate Staffing, Training, and Oversight

The VAMC canceled appointments because it did not fully staff the cardiology clinic. The inappropriate scheduling practices occurred because the VAMC did not train staff on local policies to reschedule clinic-canceled appointments within 14 days, staff did not follow national scheduling policies, and supervisors did not complete required scheduler audits.

Cardiology Clinic Was Not Fully Staffed

The VAMC has not fully staffed the Cardiology clinic since FY 2014. Despite approval for seven full-time equivalent (FTE) cardiologist positions, there were only six cardiologist FTEs onboard in FY 2014, five FTEs onboard in the first 4 months of FY 2015, and six FTEs from February 2015 through FY 2016. In addition, the clinic was one FTE short of its approved authorization of five physician assistant FTEs from June 2015 through FY 2016. A supervisory management analyst from the Cardiology clinic stated

that the facility struggled to staff the clinic fully because it was difficult to recruit cardiology specialists and because two physicians left within a short time frame in FY 2015. The assistant chief of Medical Administration Service (MAS) provided documentation showing the facility was still attempting to fill the vacancies for a cardiologist and a physician assistant. She further stated that the facility had sought help with cardiologist recruitment from VISN recruitment staff and planned to use available recruitment incentives to help with hiring. She also stated that the chief of staff had granted the chief of medicine direct hire authority to simplify the hiring process.

Cardiology clinic staff acknowledged there were many appointments canceled by the clinic. Cardiology schedulers told us that clinic leadership frequently asked them to cancel appointments to accommodate changing clinic schedules, sometimes on short notice. A clinic supervisor explained that the cardiology clinic planned schedules a year in advance and that providers attempted to give adequate notice when requesting leave.[4] The clinic supervisor attributed the volume of clinic cancellations to unexpected cardiology staff absences, such as sick leave or additional necessary absences authorized for education, after the clinic had already established schedules. We asked the clinic supervisor to provide explanations for five dates with unusually high volumes of clinic cancellations.

For all five, the clinic supervisor provided documentation supporting that staff members were out of the clinic for various approved leave and authorized absences for education. The clinic supervisor stated that while they attempted to minimize the number of appointments canceled by the clinic, the clinic's goal when canceling appointments was to absorb as many patients as possible on the same day through other providers or offer a sooner appointment if available. However, this was not always possible due to their current staffing levels.

Recommendation 1 addresses the need to ensure that recruitment efforts continue to fulfill existing cardiology vacancies.

Staff Were Unaware of Timeliness Requirements

Of the 15 schedulers interviewed, 8 told us they were unaware of the requirement for staff to reschedule clinic-canceled appointments within 14 days of the original appointment date. VAMC's Memorandum 548-05-38, dated March 20, 2012, stated that when a clinic cancels an appointment, staff must give the patient the choice of rescheduling with another provider or with the original provider within 14 days of the original appointment date. Following the release of a VHA memo regarding the

[4] We did not evaluate the cardiology clinic's leave approval process or the adequacy of its scheduling assumptions.

cancellation of patient care[5], the VAMC chief of staff on April 1, 2016 issued a memo titled *Cancellation of Patient Care Activities* reiterating the requirement to reschedule canceled patients within 14 days. The assistant chief of MAS told us that, before receiving the April 1, 2016 memo, she too was unaware of the 14-day requirement and that MAS had not trained scheduling staff about this requirement.

Recommendation 2 addresses the need to ensure all scheduling staff are trained on the requirement to reschedule canceled-by-clinic appointments within 14 days of the original appointment date.

Scheduler Supervision Was Not Adequate

Of the 15 schedulers interviewed, seven provided responses indicating they were not using the correct clinically indicated or preferred date when scheduling appointments. These schedulers stated that they were using the actual appointment date or leading patients to select later preferred dates or some other unsupported start date when rescheduling a clinic-canceled appointment. One scheduler stated that several years earlier, a former supervisor[6] trained the scheduler to use the appointment date in place of a clinically indicated or preferred date when making an appointment. This scheduler had more recently completed VAMC-scheduler training based on national guidance that showed how to schedule correctly, but was still scheduling appointments inconsistent with the training. The scheduler was still under the impression that this method was acceptable. Using the appointment date as the clinically indicated or preferred date is incorrect because it records a zero-day wait time regardless of how far into the future the appointment is scheduled.

Recommendation 3 addresses the need to ensure that schedulers are scheduling appointments in accordance with scheduling policies.

Supervisors Did Not Audit Scheduler Work As Required

The VAMC staff did not conduct appointment scheduling audits in accordance with VAMC policy, which inhibited the detection of scheduling errors. VHA Directive 2010-027, dated June 9, 2010, required facilities to conduct VISN-approved yearly scheduler audits of the timeliness and appropriateness of scheduling actions and the accuracy of dates used. Facilities were required to use the audit results to address performance deficiencies. This was superseded by the July 15, 2016 VHA Directive 1230, which required standardized biannual audits of the timeliness and appropriateness of scheduling actions, as well as the accuracy of the clinically indicated or preferred appointment dates for all active schedulers regardless of position or title.

[5] See *VHA Memorandum: Cancellation of Patient Care Activities (April 1, 2016)*
[6] This supervisor has since left the VAMC.

The VAMC Scheduling Audit Tool Standard Operating Procedure, dated June 19, 2015, required its scheduling staff supervisors to audit five appointments per month for each scheduler. According to the assistant chief of MAS, these results were reported to the VISN on a quarterly basis. However, VAMC management performed fewer than the required number of audits for the majority of its scheduling staff for each quarter from July 1, 2015 through June 30, 2016.

Supervisors did not complete the required number of appointment audits for approximately 51 to 58 percent of schedulers for each quarter from the 4th quarter FY 2015 through the 3rd quarter FY 2016. For example, in the 4th quarter of FY 2015, at least 151 staff scheduled five or more appointments in each month of the quarter, which was the minimum amount that would allow supervisors to complete the required five scheduler audits per month. However, supervisors audited fewer than the cumulative minimum of 15 appointments from this quarter for 81 of the 151 schedulers (54 percent). More recently, in the 3rd quarter of FY 2016, at least 149 staff scheduled five or more appointments in each month but supervisors did not conduct the minimum required number of appointment audits for 86 schedulers (58 percent).

The following example highlights the effect of not completing the required number of audits. Supervisors for one scheduler who routinely used incorrect dates when rescheduling clinic-canceled appointments did not complete the required number of scheduling audits for the scheduler. In the 3rd quarter of FY 2016, for example, the scheduler had nearly 2,200 scheduled appointments and supervisors should have audited 15 of this scheduler's appointments over this period. However, supervisors only audited five of the scheduler's appointments for the entire quarter. Table 1 summarizes the number of schedulers who did not receive the required number of appointment audits.

Table 1. Number and Percentage of Staff Who Did Not Receive Required Scheduling Audits

Fiscal Year	Quarter	Staff with 5 or More Appointments Each Month	Staff with 5 or More Appointments Each Month and Fewer than 15 Audits	Percentage of Staff Below Required Number of Audits
2015	4th	151	81	54%
2016	1st	139	80	58%
2016	2nd	158	81	51%
2016	3rd	149	86	58%

Source: VA OIG analysis of Business Intelligence Service Line appointment and scheduling audit data

Recommendation 4 addresses the need to ensure that supervisors conduct required scheduler audits.

Impact of Delayed Care

During our review of appointments for this report, we identified 55 veterans with wait times exceeding 30 days. We consulted with OIG's Office of Healthcare Inspections (OHI) to determine whether delays in care for those 55 veterans resulted in any adverse clinical impact. OHI's review of the patient records found no evidence that the delay in care resulted in adverse clinical impact to any of the affected patients.

Conclusion

We substantiated that the West Palm Beach VAMC had a higher than average rate of canceled cardiology appointments with some patients experiencing multiple cancellations. In addition, we found that scheduling staff were incorrectly recording clinically indicated or preferred appointment dates when rescheduling canceled appointments. We did not substantiate that schedulers intentionally manipulated wait times using patient cancellations.

The VAMC canceled appointments because it did not fully staff the Cardiology clinic. The inappropriate scheduling practices occurred because VAMC management did not train staff on local policies to reschedule clinic-canceled appointments within 14 days, staff did not follow national scheduling policies, and supervisors did not perform the required scheduler audits for all schedulers. As a result, VAMC management understated patient wait times, delayed patient care, and did not offer eligible patients care through the Veterans Choice Program.

Recommendations

1. We recommended the Director of the West Palm Beach VA Medical Center ensure recruitment efforts are progressing to fulfill cardiology clinic vacancies and that there are sufficient cardiologists for the needs of the Medical Center.

2. We recommended the Director of the West Palm Beach VA Medical Center ensure all scheduling staff are trained on the requirement to reschedule appointments canceled by the clinic within 14 days of the original appointment date.

3. We recommended the Director of the West Palm Beach VA Medical Center ensure schedulers are using the clinically indicated or preferred appointment dates when scheduling appointments.

4. We recommended the Director of the West Palm Beach VA Medical Center ensure supervisors perform the required number of scheduling audits for each scheduler as required by VAMC policy.

Management Comments

The VAMC Director concurred with our recommendations and stated that a new cardiologist started in June and two additional cardiologists have been selected with start dates to be determined. The Director reported that all scheduling staff have been trained on the requirement to reschedule clinic-canceled appointments within 14 days of the original appointment date, as well as the scheduling policies outlined in VHA Directive 1230. The VAMC has assigned schedulers additional training on updated scheduling practices, and the facility is assigning this training when new schedulers are hired. Finally, the VAMC has drafted an action plan to work with specific scheduling auditors to complete the mandated VHA audits.

OIG Response

The Director's planned corrective actions are acceptable. We will monitor the facility's progress and follow up on the implementation of our recommendations until all proposed actions have been completed. As of July 2017, the VAMC had not provided us with the evidence necessary to close Recommendation 2. Once we receive such evidence, we will determine whether the actions taken are sufficient to close the recommendation. Appendix B provides the full text of the Director's comments.

Appendix A Scope and Methodology

Scope

We conducted our review from September 2015 through June 2017. We focused on canceled appointments and scheduling practices at the West Palm Beach VAMC from October 1, 2014 through June 30, 2016.

Methodology

We reviewed applicable national and local policies, procedures, and guidance related to scheduling processes. We conducted a site visit at the West Palm Beach VAMC to assess the merits of the allegations. We analyzed the facility's clinic and patient cancellation data. We interviewed 32 staff members, including schedulers, supervisors, nurses, physicians, and cardiology and MAS leadership about scheduling and facility operations. We also reviewed individual clinic-canceled and patient-canceled appointments to determine if staff canceled appointments appropriately, rescheduled canceled appointments timely, and used correct clinically indicated or preferred appointment dates.

To evaluate the first allegation, we identified 4,957 appointments for all the VAMC's outpatient clinics during the period April 1 through September 30, 2015 whenever the scheduling records showed that staff marked an appointment as canceled by patient and rescheduled the appointment on the same day. We reviewed a statistical sample of 120 of these 4,957 appointments to determine if staff followed appropriate scheduling practices and if staff recorded accurate dates in VA's electronic scheduling system.

To evaluate the second allegation, we identified 4,660 cardiology appointments that staff marked clinic-canceled from October 1, 2014 through February 26, 2016. In total, we reviewed 187 of these appointments. From the FY 2015 cancellations, we reviewed 40 appointments entered as canceled by clinic from 31 dates we statistically selected. From cancellations that occurred from October 1, 2015 through February 18, 2016, we randomly selected and reviewed 50 "count[7]" clinic cancellations. From cancellations that occurred from October 1, 2015 through February 26, 2016, we randomly selected and reviewed 30 patients who experienced a single "non-count[8]" clinic cancellation. In addition, we separately reviewed all 67 appointments for 30 veterans who had experienced multiple "non-count" cancellations.

[7] According to VHA Directive 1230, a "count" clinic is set up to transmit patient care encounter workload and meets the definition of an encounter or occasion of service. An encounter is defined as a professional contact between a patient and a provider with the responsibility for diagnosing, evaluating, and treating the patient. Examples of occasions of service include clinical laboratory tests, radiological studies, and medication administration.
[8] According to VHA Directive 1230, a "non-count" clinic is established for internal use only and does not meet the definition of an encounter or an occasion of service.

To evaluate whether supervisors audited the required number of appointments, we compared scheduler audit data to completed appointment data from the 4th quarter of FY 2015 through the 3rd quarter of FY 2016. We obtained completed appointment data for each month of these quarters and identified staff who scheduled five or more appointments in each month. We then compared these staff members to scheduler audit data for the corresponding quarter to determine the number of staff who did not receive the required minimum number of scheduler audits.

We identified patients from our sample cases who waited more than 30 days for care when rescheduled for an appointment following a clinic- or patient-canceled appointment. We consulted with OIG's Office of Healthcare Inspections to determine if delays in care for these patients resulted in any adverse clinical impact.

Data Reliability

We used computer-processed data from the VHA Support Service Center's No Show and Cancellation Cube and Completed Appointments Cube. We also used data from VHA Supervisory Appointment Tool's Cancellations Consolidated Facility Detail Report, Appointment List Report, and Scheduler Audit Detail Report, as well as the Corporate Data Warehouse. To assess the reliability of these data sources, we compared the patient level details of data selected for review from the VHA Support Service Center and Supervisory Appointment Tool with the clinical data available for each patient in VHA's Computerized Patient Record System. We compared multiple appointment date and time stamps, clinic names, staff remarks, and other extracted data to ensure that the appointments selected were valid for review and to ensure that our data sources fairly represented the appointments. We found the information to be sufficiently reliable for our review purpose.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix B Management Comments

Department of Veterans Affairs Memorandum

Date: July 6, 2017

From: West Palm Beach, Medical Center Director (548/00)

Subj: Review of Alleged Delay of Care and Scheduling Issues at the West Palm Beach VA Medical Center (VAMC). Project Number 2015-02583-R5-0136

To: Assistant Inspector General for Audits and Evaluations (52)

In response to the draft report for the Review of Alleged Delay of Care and Scheduling Issues at the West Palm Beach VAMC, I concur with your assessment of the allegations and recommendations. Listed below are recommendations and an implementation plan with targeted completion dates.

1. We recommended the Director of the West Palm Beach VA Medical Center ensure recruitment efforts are progressing to fulfill cardiology clinic vacancies and that there are sufficient cardiologists for the needs of the Medical Center.

Medicine Service had three positions (1 FT PA, 1 FT Physician and 1 FT ARNP) that have been hired and brought on board from January 2017 – April 2017.

As of 7/6/2017, Medicine Service has completed recruitment for 3 FT Cardiology physician vacancies:

- 1 FT Cardiology physician started at the WPB VAMC with an EOD of June 25, 2017.
- Recruitment for the second provider vacancy was initially declined due to salary but was reengaged and completed an interview Thursday, May 25, 2017. The provider agreed to the initial salary offer following the May 25th interview and is currently completing pre-employment + credentialing and privileging. EOD pending.
- Recruitment for the third provider vacancy is underway; an interview was completed July 3, 2017 and the physician is currently completing pre-employment + credentialing and privileging. EOD pending.

Medicine Service will maintain active recruitment / posting for FT Cardiology physician vacancies will remain on USA Jobs until all positions have been permanently filled.

Responsible service: Medicine Service. Target completion: September 30, 2017.

2. We recommended the Director of the West Palm Beach VA Medical Center ensure all scheduling staff are trained on the requirement to reschedule appointments canceled by the clinic within 14 days of the original appointment date.

All scheduling staff was trained and provided a copy of the Memo dated April 1, 2016, entitled Cancellation of Patient Care Activities in April and May 2016. A copy of the Memo is provided to new scheduling staff during MAS Scheduling Training.

January 1, 2017 through June 30, 2017, Cardiology Cancel by Clinic before appointment rate averaged 6.67% compared to OIG report of 15% from October 2014 through February 2016.

Randomly reviewed 27 Cardiology clinic cancellations for the month of June 2017, (25) 93% were rescheduled within 14 days of original appointment or seen the same day by a PA or ARNP.
2 appointments original appointment dates of June 26th will be rescheduled.

MAS will continue to educate new schedulers and work with the clinical services to ensure patients are rescheduled within 14 days of the original appointment.

Responsible service: Medical Administration Service. Completed / Ongoing.

3. We recommended the Director of the West Palm Beach VA Medical Center ensure schedulers are using the clinically indicated or preferred appointment dates when scheduling appointments.

All schedulers (371 schedulers) with the scheduling key completed the Scheduling Directive Webinar 1230 recorded training in TMS by November 2016. All new schedulers are assigned this training.

As of May 23, 2017, all MAS and CBOC scheduling staff (172 schedulers) have attended the National Mandated MSA Refresher Training. New schedulers also attended the National MSA Onboarding Training. Non- MAS schedulers will complete training by October 1, 2017. Scheduling keys will be removed for non-compliance if schedulers do not complete the National Mandated MSA Refresher Training.

As of February 1, 2017, all new MSAs must complete the National MSA Onboarding Training prior to assuming job duties.

Three new scheduling modules (Scheduling Training Module 1- General Scheduling Topics, Scheduling Training Module 2 - Established Patients Topic and Scheduling Training Module 3- New Patients Topic) have been updated in TMS and all new schedulers are assigned this training prior to obtaining scheduling access. MAS Trainer collaborates with Education service to ensure training is documented appropriately prior to giving access to any scheduling keys.

As of July 6, 2017, 27 of the 236 non-MAS schedulers have attended the MSA Refresher Training. Training sessions are offered thru October 1, 2017. Those who do not complete training within the required timeframe will have scheduling keys relinquished.

Responsible service: Medical Administration Service. Target completion: October 1, 2017.

4. We recommended the Director of the West Palm Beach VA Medical Center ensure supervisors perform the required number of scheduling audits for each scheduler as required by VAMC policy.

MAS scheduling audits are conducted monthly. Results are reported to Compliance Committee and the VISN.

MAS has drafted an action plan to work with the Non-MAS scheduling auditors to complete all scheduling audits as mandated. This has been reported and will be followed in Compliance Committee. The MAS Trainer has provided one on one training with non-MAS scheduling auditors and will continue to provide support.

As of June 30th MAS trained Nursing, Audiology and CVT Coordinator on scheduling audits. Email sent on June 5th to all services to review staff with the scheduling key to ensure accuracy and remind them of mandatory scheduling audits and training. Master list is in the process of finalization.

Responsible staff: Medical Administration Service. Target completion: September 30, 2017.

(Original signed by)

Donna Katen-Bahensky, MSPH
Medical Center Director

For accessibility, the format of the original memo has been modified to fit in this document.

Appendix C OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Ken Myers, Director Josh Belew Robin Frazier

Appendix D Report Distribution

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