VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Veterans Health Administration

Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center

August 17, 2010
10-01857-225

ACRONYMS AND ABBREVIATIONS

EWL	Electronic Wait List
PCIE	President's Council on Integrity and Efficiency
VISN	Veterans Integrated Service Network

Report Highlights: Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center

Why We Did This Review

We conducted this review to determine the validity of an allegation that senior officials in Veterans Integrated Service Network 20 (VISN) instructed employees at the Portland VA Medical Center to use unauthorized wait lists to hide access and scheduling problems.

OIG has reported problems since 2005 with schedulers not following established procedures for making or recording medical appointments. This practice has resulted in data integrity weaknesses that impacted the reliability of patient waiting times and facility waiting lists.

What We Found

We did not substantiate the allegation. However, we did find that the Portland VA Medical Center Eye Clinic personnel did not notify patients to call and schedule their follow-up appointments from the end of May through the beginning of September 2009. This occurred because the Portland VA Medical Center's automated recall system failed to generate and distribute postcards to 2,963 patients that remind them to call the medical center and schedule their follow-up eye appointments.

To address this issue, Portland VA Medical Center staff stated that in September 2009, they revised the reminder postcards to enable the recall system to print the postcards. They also started monitoring transmission reports to ensure the recall system mailed the postcards. In addition, medical center staff stated they contacted the 2,963 patients who did not receive a reminder postcard to schedule a follow-up appointment. We found that reminder postcards were transmitted and printed from September 2009 forward. However, staff had not contacted an estimated 189 of the 2,963 patients to remind them to schedule an appointment. Approximately 2,500 of the patients who were contacted experienced an average delay of 128 days in receiving care because of the recall system's failure.

What We Recommended

We recommended that the VISN Director ensure that the Portland VA Medical Center Director reexamine the list of patients that did not receive a reminder postcard and ensure each patient was contacted to remind them to schedule their follow-up care.

Agency Comments

The VISN Director and Portland VA Medical Center Director agreed with our findings and recommendations and stated they have scheduled or seen all patients that did not receive a reminder postcard. We consider these actions acceptable to address our recommendations.

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

INTRODUCTION

Objective

The OIG conducted a review at the Portland VA Medical Center to determine the validity of the allegation that the senior officials in Veterans Integrated Service Network 20 instructed employees at the Portland VA Medical Center to use unauthorized wait lists to hide access and scheduling problems. The OIG received an anonymous e-mail alleging the use of unauthorized paper wait lists, and that the eye clinics had over 3,500 patients waiting more than 30 days for appointments. Appendix A describes the scope and methodology used to answer the allegation.

Electronic Wait List

VHA uses the Electronic Wait List (EWL) as the official wait list. The EWL is used to manage newly-enrolled patients and other already registered patients waiting to be scheduled. No other wait list formats (such as paper lists or electronic spreadsheets) are to be used for the scheduling of outpatient appointments.

VHA Directive 2009-070 states that if an appointment cannot be scheduled within 30 days of the desired date (14 days for mental health) due to capacity, patients must be scheduled for an appointment outside of that desired timeframe or placed on the EWL.

Recall/Reminder

The Portland VA Medical Center uses recall/reminder software for patients that need to return to a clinic and the timeframe specified by the provider is several months into the future. The patient is advised to expect to receive a reminder postcard or letter to contact the clinic to schedule an appointment according to the timeframe given by the provider. The reminder is sent 7 days prior to the recall date.

RESULTS AND RECOMMENDATIONS

Allegation — Senior Officials in VISN 20 Instructed Employees To Use Unauthorized Wait Lists To Hide Access and Scheduling Problems.

On March 1, 2010, the OIG received the following anonymous allegation:

> *Employees at the Portland VA Medical Center are being instructed by VISN 20 Network Director and Deputy Network Director to use paper wait lists to hide the access problems. Eye Clinic alone has over 3,500 patients waiting more than 30 days.*

We interviewed the VISN 20 Deputy Network Director, Portland VA Medical Center Eye Clinic supervisors, and 19 employees authorized to schedule patient appointments—14 for eye clinics, 3 for primary care clinics, and 2 for podiatry clinics. No one admitted to either instructing or being instructed to use unauthorized paper wait lists. We also conducted visual inspections of schedulers' work areas and found no evidence of paper wait lists.

We confirmed that the Portland VA Medical Center uses the EWL. As of March 1, 2010, the medical center listed 523 patients on the EWL including 71 for eye clinics.

During our review, an employee informed us that a problem had occurred with the medical center's recall system. Portland staff generated a list of patients who might not have received their reminder notices to call the medical center to schedule their follow-up appointments. A medical center employee provided us with a list of over 4,500 patients. From the list, we determined that 2,963 patients did not receive a reminder to call the medical center and set up their appointments. Based on the information available, it appears that this list was the alleged paper list. In our opinion, it was not used to hide problems in providing patients with timely access to care. Instead, it was being used to correct the problem with the Portland VA Medical Center's recall system, which we discuss in a separate finding.

Conclusion We did not substantiate this allegation.

Finding Missed Reminder Notices Delayed Patients' Care

Portland VA Medical Center eye clinic personnel did not notify 2,963 patients to call and schedule their follow-up appointments from the end of May 2009 through the beginning of September 2009. This situation occurred because of the following circumstances at the medical center:

- The recall system did not generate and distribute reminder postcards to 2,963 patients needing a follow-up eye appointment. According to medical center staff, the system's postcard settings for eye clinic reminders were changed allowing 212 keystrokes per line. However, the actual postcard could not accommodate more than 65 keystrokes per line causing the postcards not to be transmitted and printed.

- The Clinical Applications Coordinator did not monitor transmission reports to ensure reminder postcards were transmitted to Sacramento where they are printed and mailed to the patients.

As a result, the Portland VA Medical Center eye clinics delayed follow-up care to over 2,500 patients by an average of 128 days, and an estimated 189 patients never received a postcard and did not have an appointment scheduled.

Recall System

The eye, podiatry, dermatology, and primary care clinics at the Portland VA Medical Center use a recall system to remind patients when they are due for a follow-up visit. The recall system is only used for existing patients and only when a patient needs to return to the clinic (recall date) for follow-up care more than 90 days out. The Portland VA Medical Center's recall system generates a postcard, which is transmitted to Sacramento where it is downloaded, sorted by Zip Code, automatically printed, cut, sealed, and mailed to patients.

Reminder Postcards Not Sent

From May 27 through September 2, 2009, reminder postcards were not sent to 2,963 patients for 25 Portland VA Medical Center eye clinics. During this same timeframe, the recall system generated reminder postcards to patients of Portland VA Medical Center's Podiatry, Dermatology, and Primary Care Clinics.

The Clinical Applications Coordinator told us her investigation determined that the parameters for the eye clinic postcards were exceeded causing the postcards to not print. Specifically, the recall software limits each line on the postcard to 65 keystrokes. The postcards that did not print had approximately 212 keystrokes on one line.

The postcards are set up to transmit automatically to Sacramento when the reminder date (7 days prior to the recall date) is reached. The scheduler enters the recall date provided by the practitioner into the system. The scheduler cannot alter the recall system settings.

Neither the Clinical Applications Coordinator nor the information technology staff could tell what caused the parameters to change on or around May 27. In September 2009, the Clinic Applications Coordinator reset the postcard to ensure postcard parameters were met. In addition, Portland VA Medical Center staff said that in September 2009, they took the following actions to ensure this problem did not occur again:

- Monitoring of the transmission reports weekly to ensure the transmission of reminder notices. The transmission report shows the total number of postcards transmitted each day. By reviewing the transmission report, the medical center staff can determine whether postcards were sent as intended.

- Implementing a monitoring process to tell if postcards were sent. Once a week, an office automation assistant at Portland VA Medical Center receives the undeliverable cards. If no cards are received within a 3-week time period, staff notify the Health Administration Specialist Coordinator and initiate an exploration of the reason behind the low volume of returns.

To validate the information received from the medical center staff and the transmission and printing of the postcards, we reviewed transmission reports from September through December 2009. We found that reminder postcards were transmitted and printed from September forward.

Delay in Care

A total of 2,963 veterans did not receive a reminder postcard which caused a delay in care for approximately 2,500 veterans. According to Portland VA Medical Center staff, to ensure these patients received their care, staff optometrists or the Nurse Care Manager triaged all 2,963 cases and identified which patients needed to be scheduled immediately for a visit and which patients were to be put back on recall for a future appointment. For those patients put back on recall, clinic schedulers established recall dates in increments. For example, they gave 10 patients a recall date 30 days out, 10 patients a date of 31 days out, 10 patients a date of 32 days out, and so on. Staff spread out the appointments like this to prevent an overload due to a large number of patients at the clinics at the same time.

Some patients remembered to schedule their follow-up appointments without a reminder postcard. However, we reviewed outpatient visit and recall data and identified a projected 2,500 patients whose care was delayed beyond the

initial 30 days required for scheduling an appointment. The average delay was 128 days. This included a projected 189 patients who had not received their follow-up appointment. Medical center staff confirmed a lack of documentation supporting a follow-up of patients had occurred—scheduling them for an appointment or putting them back on recall.

Conclusion

Most patients who did not receive reminder postcards experienced delays in receiving eye care. Medical center staff implemented controls to monitor the transmission reports and postcards returned as undeliverable to reduce the time it takes to become aware of unsent reminder postcards. However, the Portland VA Medical Center needs to ensure all patients who did not receive a reminder notice are contacted to schedule their follow-up care.

Recommendation

We recommend that the VISN Network Director ensure that the Portland VA Medical Center Director reexamine the list of patients that did not receive a reminder postcard and ensure each patient is contacted to remind them to schedule their follow-up care.

Management Comments and OIG Response

The VISN Director and Portland VA Medical Center Director agreed with our findings and recommendations and stated they have scheduled or seen all patients that did not receive a reminder postcard. We consider these actions acceptable to address our recommendations.

Appendix A Background, Scope, and Methodology

Background

The Portland VA Medical Center consists of two campuses located in Portland, Oregon and Vancouver, Washington. The Portland VA Medical Center also has community-based outpatient clinics in Bend, Salem, and Warrenton (Camp Rilea), Oregon, as well as a mental health clinic in Longview, Washington.

The Portland VA Medical Center is a teaching hospital, providing a full range of patient care services, with state-of-the-art technology as well as education and research. The Portland VA Medical Center provides comprehensive health care through primary care, tertiary care, and long-term care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. The Portland VA Medical Center is a part of the VA Northwest Network (VISN 20), which includes facilities in Alaska, Washington, Oregon, Idaho, and Northern California.

Scope

The review focused on activity at the Portland VA Medical Center's eye clinics related to the EWL for the period May 2009 through March 2010 and the recall/reminder system for the period May through September 2009.

Methodology

To assess the validity of the allegation, we performed a site visit to the Portland VA Medical Center. During this site visit, we interviewed schedulers, facility management, and VISN officials to determine the process for scheduling patients and whether staff was using alternative wait lists to hide access problems. We also obtained, reviewed, and analyzed wait time reports and the EWL.

From the universe of 2,963 patients who did not receive reminder postcards from May 27 through September 2, 2009, we reviewed a statistical random sample of 94 veterans and found that 80 of the 94 experienced a delay. Projecting our results to the universe, we estimate 85 percent (2,522) patients experienced a delay in care. A 90 percent confidence level gives a margin of error of plus or minus 5.9 percent (176), or between 79 percent and 91 percent (2,346 and 2,698) of patients experienced a delay in care. These delays exceeded the initial 30 days allowed for scheduling an appointment by a projected average of 128 days with a margin of error of plus or minus 12 days for a 90 percent confidence level. The sample results ranged from 13 days to 304 days.

Six of the 94 patients reviewed did not receive a reminder postcard and did not have an appointment scheduled. This situation projects to 189 patients not receiving care. A 90 percent confidence level gives a margin of error of

plus or minus 4.1 percent (121) or a confidence interval of between 68 and 310 patients experiencing a delay in care.

Reliability of Computer-Processed Data

To address the allegation, we assessed the reliability of data on patient names, appointment dates, and recall dates on the list provided by the Portland VA Medical Center. We validated the information provided by comparing it to information found in the Veterans Health Information Systems and Technology Architecture System. We concluded that the data used was sufficiently reliable.

Compliance with Quality Standards for Inspections

We conducted our review work from March through June 2010 and performed work in accordance with the President's Council on Integrity and Efficiency (PCIE) Quality Standards for Inspections. These standards require that we be competent, independent, and plan and perform the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on the allegation.

Appendix B Agency Comments

Department of Veterans Affairs **Memorandum**

Date: July 28, 2010

From: Director, VA Medical Center Portland, OR (648)

Subj: Response to OIG Report on Alleged Use of Paper Wait List

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

Thru: Network Director, VISN20 (10N20)

1. Enclosed is a response to the Office of Inspector General Review on the alleged use of a paper wait list at the Portland VA Medical Center. The purpose of the review was to determine if the facility was using paper wait lists inappropriately to hide an access problem. As a result of the review, the OIG audit team did not substantiate this allegation.

2. During the review, the OIG was informed of a problem that occurred with the medical center's recall system. Accordingly, a medical center employee provided OIG with a list of over 2,900 patients who did not receive their reminders to call the medical center to schedule their appointment. This was identified as the alleged paper list.

3. The Portland VA concurs with the two findings listed in the report (below):

    a. The Recall System did not generate and distribute reminder postcards to over 2,900 patients needing a follow up eye appointment due to a change in the system's postcard settings.
    b. Clinical Applications Coordinator did not monitor transmission reports to ensure reminder postcards were transmitted to Sacramento where they are printed out and mailed.

4. At the time of the audit, Ophthalmology Service had begun to review and triage the 2,900 patients who did not receive their reminder cards. All priority patients were scheduled immediately. Those not deemed as priority were put back through the recall system. As of June 30, all 2,900 patients have been scheduled or seen as appropriate.

5. If there are any additional questions or comments about this response, please contact Frederick White, Executive Assistant to the Director at 503-721-1098.

/s/

JOHN E. PATRICK
Medical Center Director

cc: Director, VHA Management Review Service (10B5)

Appendix C OIG Contact and Staff Acknowledgments

OIG Contact	Larry Reinkemeyer, Director 816-997-6940
Acknowledgments	Joe Janasz, Audit Manager Lance Kramer, Senior Auditor Robin Frazier, Senior Auditor Oscar Williams, Senior Auditor

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