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

VA Medical Center in Shreveport, Louisiana
March 3, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based upon information reported to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline by an employee at the VA Medical Center (VAMC) in Shreveport, Louisiana, that a manager in Mental Health Services instructed employees in the Mental Health Care Line not to use the Veterans Health Information Systems and Technology Architecture (VistA) Electronic Waiting List (EWL), and to keep a "secret" list instead. The complainant also referred to a secret wait list kept on the Mental Health Clinic's shared network drive.

The investigation was expanded proactively to include whether schedulers outside the Mental Health Clinic were manipulating wait times in VistA. The proactive review did not include Mental Health because the OIG Office of Healthcare Inspections (OHI) was conducting an inspection of Mental Health in response to allegations from Senator Richard Burr, who at the time was the Ranking Member of the Senate Committee on Veterans' Affairs. The inspection results were published on January 7, 2016, *Healthcare Inspection: Patient Care Deficiencies and Mental Health Therapy Availability Overton Brooks VA Medical Center Shreveport, Louisiana*, Report No. 14-05075-447.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** Seven employees associated with Mental Health Services and the interim VAMC Director were interviewed to address the complainant's allegations. Five employees and the interim director were interviewed as part of the proactive investigation regarding non-Mental Health scheduling.

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

3. Summary of the Evidence Obtained From the Investigation

Mental Health Services

Interviews Conducted

- The complainant provided the list in question, which was a spreadsheet with multiple tabs containing the names and Social Security numbers of approximately 2,700 veterans who were patients of the Mental Health Services at VAMC Shreveport. He believed that, because of the shortage of providers in Mental Health Services, the spreadsheet was used to manipulate getting veterans in for appointments; although he was unsure exactly how the list was being used to do this. The complainant had an electronic copy of the list on his work computer and two hard copies of the list in his office. He provided information

to the media about the manipulation of wait times at VAMC Shreveport but did not provide the actual list. He stated that during a meeting (he did not recall the date); the complainant heard a manager in Mental Health Services instruct an administrative employee at the VAMC Overton Brooks not to use the electronic wait list.

- A Mental Health Services employee (MHS1) stated that about 4 or 5 months ago, a list of all patients who were seen in the Mental Health Department in the last 3 years was pulled. It was not a secret list. There was not another tracking system in place to serve the same purpose. The list was not for patients who had requested appointments; it was a list created to keep patients from "falling through the cracks." The employee identified the two individuals who compiled the list.

- MHS2 stated that in October 2013, Mental Health Services was short many providers and the witness feared some existing patients who were assigned to providers who had left the VA might "get lost through the cracks." So in January 2014, the Data Support System (DSS) was used to compile a list (on a spreadsheet) of all patients seen by Mental Health Services at VAMC Shreveport from approximately December 2012 until January 2014 (approximately 2,700 patients). [Note: The DSS is an executive information system that directly affects patient management, providing data on the patterns of care and patient outcomes, linked to the resource consumption and costs associated with the health care processes.] The spreadsheet was used as an organizational tool to ensure these patients' appointments were set and they were assigned to a Mental Health coordinator (a provider needed to see a patient three times before the provider was considered the patient's Mental Health coordinator).

  It was a waiting list for providers, not a list for patients waiting for a specific appointment. The list was not a secret; it was on the shared network drive for anyone in Mental Health Services to use. She stated that some of the information the complainant provided to the media about Mental Health Services, along with the list, was true, but in the wrong context. She provided a set of hard-copy emails, which indicated a difference of opinion among staff on how to move forward with scheduling patients to a newly assigned doctor. There was no evidence to show that there were patients waiting for appointments that they had requested.

  When re-interviewed, MHS2 stated that the original list in question was not used to hide patients who were waiting for an appointment. The original list in question did not have a malevolent purpose. It was used to make sure no veterans were lost. The deceased list was a list of veterans from the original list, and who had died. No veteran died as a result of waiting for an appointment. She did not know the purpose of the listed titled "appointments needed." Veterans who called in or walked in needing to be seen were seen. The complainant did not have to ask the witness the purpose of the original list in question because, at the time the list was being created, he was still in Mental Health and his assigned role was recovery coordinator. She opined that the complainant should have known what the purpose of the original list in question was. The information about the purpose of the list that the complainant provided the media was wrong.

- MHS3 stated that when she first arrived in the Mental Health Clinic, there was already a

shortage of providers. But as the problem got worse and the provider shortage increased, leadership decided to do a DSS data pull. The EWL was not used because there was not a problem getting patients timely scheduled for their follow-up appointments. The problem was trying to assign them to a doctor when they did not know who that doctor was going to be. The DSS list in question was created to get an overall look at the patient population, which would show how the Mental Health Clinic was affected by the loss of the physicians. It was also used to integrate the patients who were lacking a provider into the new physician population.

- MHS4 stated that the list in question was a DSS data pull and had 2,707 names on it. It was a list created to prevent VA patients who did not have doctors assigned to them from falling "off the radar." He did not believe that the complainant knew the purpose of the list in question and that the complainant mischaracterized the list to the media. The Mental Health Assessment Consult Service (MHACS) was implemented, which ensured that any walk-in Mental Health patients would be taken care of that same day.

  When re-interviewed, he stated that the "appointments-needed" list consisted of veterans needing to be reassigned to a new doctor and new treatment team. The list came from the original list in question and was created based on the information from the DSS data pull. The veterans on the appointments-needed list did not have a reason to be seen other than to be assigned to another doctor. And the veterans did not need to be seen in order to be reassigned. At the time of the interview, the project associated with the original list in question was completed. The original list and associated lists were no longer being used.

- MHS5 stated that, in about April of 2013, things were chaotic in the Mental Health Clinic because there was a staffing shortage, that is, only one nurse practitioner serving hundreds of patients. However, any patients who walked into the clinic were seen. One of the staff members was tasked to collect the names of all the patients who had been "cast adrift" due to the loss of physicians. The list was developed to assign patients who were "adrift" to new doctors. The list was not for patients requesting to be seen. It was drawn from a database of patients who needed to be reassigned to a doctor because their doctor had "dropped off." The list was not used to circumvent numbers. He did not believe that what was said about the list in previous articles matched with what he knew the intent of the list to be. He further stated that he believed that the complainant would have known the intent of the list.

- MHS6 stated that, on May 7, 2014, during a Behavioral Health Integrated Team (BHIT) meeting, one of the staff brought up the list of about 2,700 (patients) because she was upset that Mental Health leadership had ordered staff to stop scheduling people from the list. According to the notes he took during the meeting, the staff member had said the list consisted of patients who needed to be scheduled for appointments. The witness heard later that the list was for review but that was not what the staff were told. He never saw the list in question; but it was his understanding that everybody on the list needed to be scheduled and they were using the list to establish who should be scheduled first, second, third, and so on. He stated that he received a complaint from a veteran about difficulties being scheduled. He also received a complaint from a staff member about how long it would be before a patient whose condition was deteriorating could get an appointment.

He was unable to characterize the list in question as a method of hiding patients needing to be scheduled. He acknowledged that the Mental Health Clinic did go through a period during which there was a shortage of doctors but he could not characterize how bad the shortage was. He did not believe that anyone would try to hide the names of patients needing care.

- The interim director, VAMC Shreveport, stated that, upon his arrival to the VAMC, there were emails and news reports about an alleged wait list in the BHIT program of the Mental Health Department. During his investigation, the witness learned that none of the names on the list were new patients waiting for an appointment. They were established patients in the Mental Health Clinic who were under active treatment and who needed to be placed into the appropriate program. The witness did not find the list in question being used to circumvent the timely scheduling of patients.

- MHS7 stated that she heard that the Mental Health Services Department was accused of having a secret wait list. But there was no secret wait list and no list representing patients needing appointments. Mental Health Services went through a period during which there was a shortage of physicians, so a list was created for patients whose physicians had left, to make sure that the patient was transitioned to the correct Mental Health team (and appropriate physician). To her knowledge, the list in question was not used as a substitute for the VistA EWL and was never used as a means of tracking patients calling in needing an appointment. She never instructed anybody to manipulate wait times in VistA in order to stay within the 14-day standard and never pressured staff to stay within the 14-day standard in order to get a bonus. She was aware of the articles that had come out locally about the list in question and was disappointed by them because there was no secret list and the information in the articles was not true.

  In follow-up telephone interviews with MHS1, MHS3, MHS4, MHS5, MHS6, and MHS7, all parties interviewed denied creating any handwritten lists and denied any knowledge of anybody else creating handwritten lists while working on the list in question. There was no mention of any handwritten lists created by anybody at any time.

Records Reviewed

- The complainant provided two sets of lists that appeared to be replicas of each other. Each set of spreadsheets contained the following:

  - A list titled “Original List,” which contained approximately 2,700 names and associated Social Security numbers. It was safe to assume that these were names of veterans/patients who were treated at Mental Health Services, VAMC Shreveport. They also contained what appeared to be the last name of the doctor treating the patients. Some appeared to have been assigned a new physician. Overall, the lists appeared to be consistent with what the VA OIG special agent was told in the interviews from those who had a working knowledge about the list. In summary, the list in question was a DSS data pull of patients who needed to be assigned to a new physician. There was no evidence to suggest that these lists were used as a substitute for the EWL or to hide the name of patients who wanted to be seen.

- A smaller list titled "Appts Needed" appeared to be a list extrapolated from the list titled Original List. For some of the patients, there were notes indicating the last time the patient had been seen. Many of the notes indicated that the patient had not been seen since 2013.

- A one-page list titled "Deceased" appeared to be a list extrapolated from the list titled Original List. There were notes associated with some of the patients. There was no information indicating the cause of death.

- A one-page list titled "Followed by Another VA" appeared to be a list extrapolated from the list titled Original List. There were notes associated with some of the patients, such as "Followed in Oklahoma." It appeared that this was a list of patients who were being treated by another VAMC.

- A two-page list titled "Seen Recent but No follow-up" appeared to be a list extrapolated from the list titled Original List. There were notes associated with some of the patients, the majority of which referenced a recall reminder that had been entered.

Non-Mental Health

Interviews Conducted

- A Medical Support Assistant (MSA1), Primary Care Unit, VAMC Shreveport, demonstrated how he would input a scheduling request in VistA. He used a method of finding the first available date in VistA, "backing out" of the VistA appointment grid, then entering the "next available date" as the "desired date," which reflected that there was no wait time. We brought to his attention that this manipulated the wait time and asked him about why he used that method. He stated that it was the way he was taught when he first became an MSA. He did not know that the way he was using VistA to schedule appointments was manipulating the wait times. If he booked a patient over 14 days in the future, he would get an email from his supervisor to redo the appointment schedule so it would show that the appointment date was less than 14 days from the desired date.

- An MSA supervisor stated that if a patient was scheduled outside the 14 days, she would send a note to the MSA who scheduled that appointment because that was what she was told to do. She has been a part of phone conferences with the Veterans Integrated Service Network (VISN) and other conferences where the 14-day concept was just "drilled in your head." The pressure to stay within a certain standard, whether it was 14 days or 30 days, started over 5 years ago and may have been as far back as 2005. She did not know where or who dictated the pressure to stay within a certain standard and thought it went as high as Congress. As recent as within the past year, there was pressure from the VISN and at VAMC Shreveport to stay within a certain standard but that had changed in the last 3 or 4 months. She stated that she received training earlier in the summer that emphasized using the proper desired date. She noted that if a patient was sick and he/she needed to be seen that day, the VAMC Shreveport staff would take steps to see the

patient that day. At the time of the interview, the VAMC Shreveport staff were using the actual desired date as opposed to the next available date when using VistA. In other words, they were not backing out of the system and reentering the next available date as the desired date.

- A former supervisor in Clinical Administration who oversaw all the front line MSA staff under the Business Office stated that he has heard of backing out of the VistA system in order to make it appear as if there was no wait time between the patient's desired date and the actual scheduled date. But to his knowledge, they did not practice that at VAMC Shreveport. He was not aware that any of the clerks had been using the backing out method to stay within the 14-day standard. He had not promoted that practice or been told by a higher up to promote that practice. He noted that the current supervisor, who also started out as a clerk, would not encourage that practice. He stated that he would not punish a clerk if he/she was not meeting the 14-day standard. He also noted that the last MSA training at the VAMC Shreveport was June 27, 2014.

- A former supervisor who was involved with, and had experience with, scheduling patients using VistA stated that before she knew better, she used the backing out method when she used VistA to schedule patients for appointments. She did it that way because that was the way she was trained a "long time ago" by her coworkers when she first started using VistA. She stated that her supervisors would emphasize that they wanted patients scheduled within the 14-day standard but nobody instructed her to use the backing out method in order to accomplish that goal. As a supervisor, she would get a daily list, which would show who had scheduled patients outside the 14-day standard. She would contact the individuals on that list and try to find out why that was happening. But there was no reprimand unless she noticed that the same person was appearing on the list every day. She stressed that it was important to schedule patients within 14 days of the desired date; but she never instructed staff to use the backing out method in order to stay within the 14-day standard. She stated that she did learn later that clerks were using the backing out method but it was not something that she taught. She did not check on how the clerks were scheduling to see if they were using the backing out method.

- A program specialist stated that she handled the scheduling training for the clerical staff and the clinical staff. Prior to being a program specialist, she had supervisory responsibilities over the clerical staff and was in charge of scheduling. She provided training to new employees. For current VA employees, there is mandatory refresher training; however, she noticed that a lot of employees were not attending. She was aware that employees were using the backing out practice in VistA in order to stay within the 14-day standard and the latest 30-day standard. But she was not instructing that practice to anybody. She stated that she has trained staff NOT to manipulate the system. Although she believed that the first-line supervisors were the reason clerks continued to use the incorrect method to avoid having their staff being on the over 14 -day report, she did not provide any evidence to support her belief. She noted that when she was a clerk, she was told to use the backing out practice and she did. When she became a supervisor, she did not want her staff to be on the over 14-day list because she believed it reflected negatively on her. She explained that back then, the list of clerks who had made appointments over 14 days would go to her supervisor (who would then confront her) and

ask why those persons were scheduling "wrong." It was pretty much forbidden to be outside the 14-day standard and it was part of the culture at VAMC Shreveport. Under the new chief, it has not been that way.

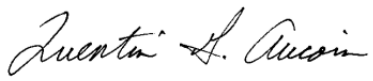
- The interim director never directed anybody to manipulate wait times so that they would remain within the 14-day standard. He was not aware of anybody else directing staff to manipulate wait times during or prior to his tenure at the VAMC Shreveport. He never pressured staff at VAMC Shreveport to stay within the 14-day standard so he could get a bonus. He never pressured staff to stay within the new 30-day standard so that he could get a bonus. He has not discouraged staff from using the EWL. He never directed anybody at VAMC Shreveport to use a hard copy list as a substitute for the EWL.

4. Conclusion

- The investigation did not corroborate complainant's allegation that employees in the Mental Health Care Line were instructed not to use the VistA. The evidence revealed that there was a spreadsheet used in the Mental Health Clinic, VAMC Shreveport, identifying approximately 2,700 veterans who needed to be assigned to a Mental Health provider. However, it was not a list used in place of scheduling patients who wanted to be seen, nor was it used as a substitute for the EWL. There was no evidence that the manager instructed employees in the Mental Health Clinic to avoid using the EWL or to keep a secret list. None of the witnesses interviewed, who had knowledge of the subject matters in the complaint, corroborated the complainant's allegations that the employees in the Mental Health Care Line were instructed not to use VistA, EWL, and to keep a secret list instead. With regard to the spreadsheet, no one denied the existence of the spreadsheet but did deny allegations regarding the purpose of the list and that it was a secret list.

- The proactive review of non-Mental Health found evidence that some schedulers outside the Mental Health Clinic at VAMC Shreveport were inputting patients' appointments into VistA in a way that manipulated the actual wait time between the desired date and the actual date of the appointment. However, there was no evidence that schedulers were intentionally manipulating wait times. Evidence indicated that there had been inappropriate training years ago that carried through into present day work activities. There was also some evidence of a culture existing in the past, more than 2 years ago, which may have promoted manipulation of wait times. But that culture was not apparent at the time of this investigation or in the recent past. There was no evidence of specific patient harm.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 11, 2015.



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