

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



**VA Medical Center in Fort Harrison, Montana
December 20, 2016**

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based on information provided by a confidential complainant who alleged that paper wait lists were being used for veterans not currently scheduled for appointments. The complainant further alleged that the Department of Veterans Affairs (VA) Montana Health Care System (VAMHCS) also maintained an unusually high compliance rate for patients meeting the VA's policy of providing veterans with an appointment within 14 days of the veteran's "desired date" for the appointment. The complainant stated that it was unlikely that VAMHCS was reporting patient access accurately given that the hospital's doctor utilization rate was abnormally low.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed the complainant and 29 current and former VA employees.
- **Records Reviewed:** VA OIG reviewed emails, policy, medical records, training materials, reports, and closed consult data.

3. Summary of the Evidence Obtained From the Investigation

Issue 1: VAMHCS Use of Unauthorized Manual Waiting Lists

The complainant provided information indicating that VAMHCS clinics used manual wait lists as recently as May 2014, and that these lists were destroyed at the request of an associate service chief, pursuant to an email sent in April 2014. In that email message, an associate service chief indicated to other VAMHCS managers that at least two VAMHCS facilities maintained and subsequently destroyed unauthorized manual wait lists being used by those facilities.

Interviews Conducted

- Service chief 1 was questioned regarding the existence of an April 30, 2014, email authored by an associate service chief that indicated there were various non-sanctioned wait lists of veterans being used in VAMHCS. She stated that the day after she became aware of the email, she was advised that the director's office would address the issue of unsanctioned lists. She stated this email was the first time she had heard of any waiting list that may have existed outside the Electronic Waiting List (EWL).

- A nurse manager said she received an email showing that four nurses at VA Medical Center (VAMC) Fort Harrison were using paper wait lists that contained the names of 10 veterans who did not want to schedule appointments because these veterans had requested VAMC Fort Harrison nurses call them if an appointment became available. These veterans asked not to be placed on the VAMC Fort Harrison schedule. She stated that the nurses were to stop keeping any such list. She believed that the employees likely shredded the “lists,” and she added that those veterans were subsequently scheduled for appointments in the Veterans Health Information System and Technology Architecture (VistA).
- Medical scheduling assistant (MSA) 1 stated that he was aware that the Radiology Department and the Physical Therapy Department (formally known as Rehabilitation Services and Neurology Department) used manual wait lists. He believed those lists were sanctioned by VAMHCS management.
- Administrative employee 1 stated that he was a patient scheduler. He explained that to be able to see what all therapists were doing at one time for scheduling purposes, he maintained a written schedule book separate from the EWL. The separate list made it easier for him to see where he could “squeeze” in patients to see the different therapists. He stated that by the end of each day he confirmed that all appointments noted on his paper scheduling book were uploaded into VistA. He said he believed the scheduling book actually improved patient access. He stated that he understood the importance of correctly reflecting the patient’s desired date in VistA and was not aware of anyone purposely, inaccurately changing such dates.
- Administrative employee 2 confirmed that she was one of the individuals who scheduled appointments for veterans. She stated that her office (Radiology) did in fact keep a separate appointment book for veterans because of the nature of X-ray appointments. She further stated that using only VistA for maintaining appointments was simply not reasonable or efficient because of the limited input fields of the VistA system. A written appointment book provided the flexibility necessary to schedule patients in her department. The manual appointment X-ray book was approved by VAMHCS management. She stated that she locked up the appointment book at the end of each day so any personally identifiable information (PII) was not errantly disclosed, and staff ensure that the same appointment schedule was maintained in VistA. She also stated that she had never purposely changed a patient’s desired date to reflect more favorably on the hospital administration.
- A registered nurse stated that many of the nurses at VAMC Fort Harrison have kept handwritten lists of veterans who expressed interest in obtaining an earlier appointment, ahead of their scheduled appointment in VistA, and/or veterans who refused to have their name put on the EWL. The handwritten lists started because many of the providers were unable to fill cancellations or “ACA” [Advanced Clinic Access]¹ appointments in a

¹ According to the *Advanced Clinic Access: Key Concepts for Resident Providers* (a document on the VA intranet that is unavailable to the public), “An access problem is a delay problem. The goal of the VHA’s Advanced Clinic (footnote continued next page)”

timely manner using VistA alone. ACA appointments were time slots that were purposely left open in the scheduling system to provide scheduling flexibility for clinicians. She insisted that the separate handwritten lists the nurses were keeping in no way affected any records being generated in VistA. She stated that her previous list contained the names of two veterans, who have since been scheduled for appointments in VistA. She said a nurse manager had recently told her that they were to no longer maintain any such handwritten lists.

- An associate service chief that stated he oversaw all VAMHCS Community Based Outpatient Clinic (CBOC) nurses. In approximately June 2013, there was a review of the patient scheduling system during which all personnel were trained that no paper wait lists could be used for scheduling and all appointments should be placed in VistA. He stated that following the allegations at the Phoenix VA,² VAMHCS leadership requested that all facilities determine if any non-electronic wait lists were being used in VAMHCS. He also stated that he sent an email to all CBOC nurses requesting information concerning any physical/written wait lists. The only positive response he received for CBOC Missoula was a list for patients who already had scheduled VistA appointments, and who had expressed interest in being seen at the CBOC if there were a cancellation before their scheduled appointments. He stated that a nurse in a specialty clinic told him that her clinic had wait lists with approximately 10 veterans who did not have scheduled appointments. He explained that following the receipt of his email, these patients were scheduled for appointments. He stated that four of the patients refused to make appointments and only wanted to be called if there was an appointment available because of a cancellation. He stated that the nurse told him that she shredded the lists. He added that he did not instruct her to destroy the lists. He did not believe she destroyed the lists to hide the fact that the lists were maintained in her clinic.

Issue 2: Changes to Patient Desired Date Appointment Information

During the initial investigation about the use of unauthorized manual wait lists by VAMHCS, VA OIG conducted interviews of VAMHCS employees who advised there were changes made to veterans' desired appointment date data during the Rapid Process Improvement Event (RPIE) project initiated in 2013. The complainant alleged that the VAMHCS also

Access Initiative is to build a system in which patients have the opportunity to see their own providers when they choose. In order to do this, each clinic must manage its total resources (supply) to provide care. When the resources are managed well, openness or space in the clinic creates "capacity" to schedule or see patients. In an optimal system of "advanced clinic access," an organization provides enough openness or space in the clinic (capacity) for health services to meet the demand of its patient population at the time the demand occurs.

Advanced Clinic Access (ACA) is a fundamental shift from the past. Traditionally, health care organizations have viewed the demand for health care as insatiable. Therefore, the typical approach to access was predicated on the false belief that barriers needed to be constructed in order not to be overwhelmed by patient demand. Improving access therefore entailed complex scheduling systems, a wide variety of appointment types and lengths, long waits to see providers, the transfer of demand to other areas of the health care system such as urgent care or the emergency department, and elaborate triage systems that attempted to distinguish patients who could wait for care from those who could not."

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

maintained an unusually high compliance rate for patients meeting the VA's 14-day patient desired date access goal.

The complainant said it was unlikely that VAMHCS was reporting patient access accurately given that statistics associated with doctor utilization were abnormally low. The complainant stated he/she was aware of the RPIE project that was initiated in June 2013 to address a large number of patients who had appointments scheduled outside the VA's 14-day patient access goal. The complainant stated that veterans' desired dates were likely being incorrectly changed during the RPIE and desired dates were not being correctly input into VistA at the time of the interview in 2014. The complainant stated he/she was aware that statistical measurements of the facility's performance, which indicated the facility's high compliance rate with the 14-day desired date to appointment date ratio, were not accurate. The complainant believed these discrepancies were reported to the VAMHCS Director's Office.

Interviews Conducted

- Service chief 1 stated that 2013 statistical reports indicated VAMHCS was not in compliance with the Veterans Health Administration's (VHA) 14-day patient access goal. As a result, the RPIE project was formed to address this issue. She stated she understood the importance of accurately reflecting a patient's desired date of appointment in the EWL, and she was not aware of anyone inaccurately changing a veteran's desired date to reflect more favorably on the hospital administration.
- Administrative employee 3 said he was aware that VAMHCS management had discovered that improper scheduling practices had led to the misrepresentation of patient desired dates in VistA. He stated that, before June 2013, MSAs were incorrectly selecting the date of contact with the veteran as the desired date rather than the date the veteran requested for an appointment. The result of this incorrect desired date entry was the appearance of patients waiting longer for appointments than reported. In June 2013, he was assigned to conduct the RPIE to address the inaccurate statistical reporting. He stated that about 2,500 patient records were identified as being outside the 14-day window and that those records were reviewed to determine if the desired date was initially entered by MSAs incorrectly. He added that MSAs were also trained to prevent the continued entry of incorrect desired dates. He further stated that before the June 2013 RPIE, Veterans Integrated Service Network (VISN) 19 managers had weekly conference calls with VAMHCS management regarding the performance statistics. He said he had also heard that facility senior leader 1 had expressed some concern to VISN 19 management about desired dates, which should not just be changed to comply with the VA's 14-day access goal because that behavior could be unethical.
- A nurse manager reported that, in 2013, the VAMHCS Quality Management Department and administrative employee 6 provided her office with lists of patients who were scheduled for appointments 14 days after the veterans' listed desired dates. This performance issue spawned the RPIE "working group" at VAMHCS. It was determined that MSAs had made scheduling errors during the initial recording of many of these veterans' appointments. She stated that the RPIE working group employees changed desired dates in VistA only for veterans with inaccurate desired dates. She added that, in

her opinion, the lack of clinical resources significantly contributed to the facility's inability to regularly meet the 14-day access requirement. She said she was not aware of patients who had been harmed because of the access issues within VAMHCS.

- Administrative employee 4 said she was asked to participate in the RPIE project to address the high number of veteran patients waiting longer than 14 days for appointments. She stated that during the RPIE, she was instructed to correct all patient records with desired dates that showed the same date as the appointment's created date. She further stated that if she were able to correct the desired date with a justifiable reason, she would do so. However, she would also change desired dates from outside the 14-day limit to reflect dates within the 14-day limit even in circumstances in which there was no justification for the change. She added that she made these unjustified changes to the desired date because she felt that was what the RPIE leaders expected of her.
- A program manager reported that facility senior leader 2 had previously expressed concern regarding patients waiting more than 14 days for medical appointments. She stated that, at the time of the interview in 2014, VAMHCS's compliance rate with the 14-day policy was the worst in the nation. She and other VAMC staff discovered that VAMC scheduling employees were not being properly trained and that these employees were incorrectly entering the veterans' desired date in VistA. MSAs had been entering the date of the patient contact as the desired date rather than the date the patient requested an appointment. She recalled that, in 2013, VAMHCS managers had weekly conference calls with VISN 19 managers regarding correcting the desired date statistical deficiency. She stated that she and other Fort Harrison management staff selected current and former MSAs to review those patient records and correct any errant data in VistA for the June 2013 RPIE project. She also stated that VISN 19 officials did not provide specific direction on how to make those corrections but insisted that the statistical deficiency should be corrected. She recalled being present during two conference calls with a VISN manager and a VISN senior leader in which facility senior leader 1 expressed concern that VAMHCS should not just "make changes." She remembered that a VISN senior leader demanded that the problem be fixed.

The program manager stated that the MSAs were assigned to review clinical notes and worked with VAMHCS clinical staff to correct patient desired dates. In addition, all VAMHCS staff with scheduling access were retrained regarding desired dates and patient appointment scheduling policy. She stated that although she no longer received regular reports regarding patient access, she believed that those patient access times were no longer an issue for VAMHCS. She added that she worked with administrative employee 3, administrative employee 6, a supervisor, and various MSAs to make corrections to approximately 2,000 patient records provided by VISN 19. She also stated that she did not directly approve desired date changes but provided specific instructions to the MSAs about not changing desired dates without VistA records justifying such a change. She further stated that roughly 65 percent of the 2,000 patient records were modified during that RPIE project. She did not conduct, nor was she aware of, any follow-up review of the data changes to verify accuracy. She stated that she was not aware of MSAs arbitrarily changing patient desired dates and she denied giving any direction to MSAs not to follow scheduling policy.

When re-interviewed, the program manager stated that before the June 2013 RPIE, VAMHCS had been notified by VISN 19 that their facility needed to fix problems associated with extremely high noncompliance with the VA's 14-day access goal. She further stated that she began to research why VAMHCS had such poor compliance and discovered that MSAs were incorrectly scheduling appointments. She explained that MSAs were incorrectly recording the patient desired date as the date the appointment was entered in VistA. She said she also discovered that MSAs were using inconsistent training material, including instructions that the patient desired date be entered incorrectly as "today." During the RPIE project, MSAs were instructed to review comments in patients' VistA records to determine the most accurate desired date. She explained how the MSAs would then provide an updated date on a slip of paper so that other MSAs could update the record. She stated that if they could not find information in VistA to corroborate changes to a veteran's desired date, then clinical staff were instructed to contact the veteran and determine an accurate desired date. She denied providing any instruction for MSAs to change the desired date to the appointment date. She stated that she did not recall discussing quality control measures as part of the RPIE process but said that some measures should have been implemented. She added that facility senior leader 1 did request written direction from the VISN. She denied pressuring employees to make changes outside of VA scheduling policy.

- MSA2 stated that, in June 2013, he was ordered to report to Fort Harrison to work on a project related to scheduling errors. Most of the errors he observed were related to VAMHCS patients. He explained that he worked on the project for 1 day and reviewed patient records to see if there were errors related to the desired date. He stated that he found two primary errors made by MSAs when they entered desired dates in VistA:
 1. The doctor ordered a specific date for a follow-up appointment and the MSA entered the desired date as the date the patient was last seen at the clinic.
 2. The doctor ordered multiple follow-up appointments for a patient, the appointments were scheduled, and the desired date remained the date the patient was last seen at the clinic.

He further stated that if the desired date could not be changed based on the medical record review, the MSAs were instructed to contact the veteran and see if the scheduled appointment date was acceptable. If so, the desired date was changed to the scheduled appointment date. He reported that a program manager and a supervisor ran the project. He added that he did not receive any instructions to change a patient's desired date unless an error was found and/or the veteran was contacted to confirm the desired date.

- MSA3 stated that in 2013, there were changes in scheduling policy and that all MSAs received training at VAMHCS. Before June 2013, MSAs would attempt to schedule the appointment per the veteran's request, but if that date was not available, the scheduler would look for the next available appointment, which could be up to 60 or 90 days away.

She further stated that schedulers routinely used the “T” keyboard command³ in VistA when scheduling appointments to input the current date into the field. She explained that if appointments could not be found within 14 days, MSAs would schedule the patient and record the desired date as the date of the appointment.

She stated that in 2013, she was asked to review patient appointment lists and to identify what the correct desired date should have been by researching data recorded in VistA. She noted that during that project, administrative employee 6 and a supervisor provided guidance to the employees on desired date changes, but the guidance was not clear to her and other employees. She stated that all of the scheduled appointments needed to be within 14 days of the veteran’s desired date. She said she was not aware of anyone being told that he/she would be reprimanded if he/she were unable to change an appointment desired date to be within 14 days. Moreover, if an MSA could not corroborate the desired date through data in VistA, the appointment information would be given for further review to the specific clinic that originally scheduled the appointment. She stated that clinic schedulers, including her, would get these lists and review the medical records to determine the correct desired date.

She explained that if she could not figure out the correct desired date, she would just “get it done.” She stated that she and other employees, who may have originally put a desired date outside of the 14-day access goal, subsequently changed the desired date to the appointment date “just to get it off the list.” She said that she and others made thousands of changes or corrections to these lists. She stated that everyone involved in the RPIE was “mad” because they did not think that what they were doing was right. She noted that VA OIG would be able to identify the majority of appointments that were changed inaccurately because the entries showed the exact same date for desired and appointment. She stated that the schedulers tried to get the desired date from the patient’s Computer Patient Record System (CPRS) records. She added that she did not contact veterans to confirm the changes she had made to desired dates.

- A program specialist stated that, in June of 2013, she participated in the RPIE project. She stated she reviewed notes from the clinical staff to determine if desired dates were correctly input in the scheduling system, and if she could not find a clinical note justifying a change to the desired date, then no change should be made to the record. She stated she knew that the standard for VA was a 14-day window between the desired date and the scheduled appointment, but she was uncertain where she had obtained this guidance. She estimated that 30 to 40 percent of the veteran appointment records she reviewed during the RPIE project had a justification to be changed based on clinical notes.
- MSA4 stated that he did not receive formal MSA training. He further stated that he usually entered the desired date as the date that he contacted the veteran and would then schedule the first available appointment that was acceptable to the veteran. He stated that in 2013, he was asked by his supervisor to work on a project to change desired dates for

³ Several date input fields are used when scheduling an appointment. MSAs can input the current date by striking the “T” (today) key.

veteran appointments. He said he was asked to participate in the RPIE project in June 2013 but did not. He stated that his supervisor instructed him and other MSAs that the desired date had to be within 14 days of the appointment date regardless of the veteran's actual desired date. He added that his supervisor had told him that if the veteran agreed that the "next available" appointment date was acceptable, then the date of the appointment should be used as the desired date. He stated that he did not believe that was correct and thus did not enter desired dates as instructed by his supervisor.

- Former MSA1 stated that, in June 2013, he worked on a special assignment with other employees regarding patient desired dates. The employees assigned to the project were required to review and change the desired appointment dates. He characterized the RPIE project as implemented "in order to make the records look better." He explained that the employees were instructed to research the last date the veteran was seen at VA, review the doctor's notes, and review when the doctor wanted the veteran to return to VA for an appointment. He further stated that desired dates were changed to the date the doctor recommended for the appointment, adding that he was uncomfortable because his name was associated with the changes; he expressed this concern to administrative employee 3 and a program manager, who told him that making changes to desired dates was not that "big of a deal." He reported that the project group was told the changes were being directed by the VISN and that administrative employee 3 and a program manager provided lists of patients to the employees to research. Once the MSAs annotated the corrected desired dates on the lists, the lists were given to him and he would make the change in VistA. He also stated that after he completed the changes, he gave the Microsoft Excel spreadsheets to administrative employee 3 and/or a program manager, who shredded the lists. He stated that he did not know if any employees wrote down arbitrary dates. He added that once he updated the desired date in VistA, the system overwrote the previous entry leaving no record of the previous desired date.
- A clinical technician stated that she did not participate in the June 2013 RPIE project and was not familiar with changes made to desired dates at VAMHCS. She said she was aware of the national interest in modification to patient wait times but was not familiar with that activity within VAMHCS. She also stated that she had previously received some training on the proper use of the VA's EWL but was no longer involved in patient scheduling.

When re-interviewed, the clinical technician said that she attended an online teleconference training on scheduling in approximately June 2013. She was told that veteran appointment desired dates needed to be within 14 days of the veteran's scheduled appointment. She stated that she did not recall ever being told to change the desired dates unless the desired date was incorrect. She added that she believed a program manager and a supervisor conducted the training. She stated that she was instructed to give names of veterans to the Patient-Aligned Care Team (PACT) if the veteran's appointment could not be scheduled within 14 days of the desired date. She further stated that she regularly asked a patient if the next available appointment date was acceptable, and if the patient agreed, then that date was entered as the patient's desired date. She added that she felt this practice was deceptive to the patient. She stated that she had not witnessed any delays in scheduling appointments that resulted in patient care issues. She also stated that

she did not believe that statistical reporting by VAMHCS was accurate regarding desired dates relative to scheduled appointments, and that the data did not accurately reflect the lack of clinical resources.

- Administrative employee 5 stated that she was not asked to participate in the June 2013 RPIE project. She said she was surprised that she was not included as she had previously developed and implemented the training for MSAs following a General Accountability Office audit of the facility between 2010 and 2012. She stated that she received calls from MSAs who worked on the RPIE project. She added that these MSAs told her that they were not comfortable with some of the changes that were being made to the desired dates in the veterans' records. She said she believed that some of the desired date information was initially incorrectly recorded by MSAs, such as instances when an MSA used the "T key" to enter the veteran's desired date into the system. The T key would automatically populate the current date into the veteran's record as the desired date. She stated that, in her opinion, it would be allowable to correct those types of errors. However, she believed the goal of the project was to reduce the number of veterans with appointments that were not within 14 days of the desired date, and that MSAs were encouraged to make changes to the desired dates that did not conform to VA policy. She further stated that she was told by service chief 2 that she (service chief 2) had received instruction from a program manager to keep her out of the RPIE project after the program manager found out that MSAs were calling her for her opinion about the changes that were being made to veteran desired dates. She stated that in May 2014, she reviewed a sample of five records related to the VAMHCS 2013 RPIE project that contained desired date changes. She explained that she told service chief 2 that she did not feel that many of the desired date changes were within VA policy. She stated that she and service chief 2 met with service chief 3 to discuss the findings. She added that she and service chief 3 then met with administrative employee 6 to discuss her findings. She stated that administrative employee 6 told them that she (administrative employee 6) felt the list of changes was legitimate at the time of the RPIE. She said that after administrative employee 6 reviewed the sample of five records, administrative employee 6 told them that she (administrative employee 6) was now not sure if the desired date changes appeared to be legitimate based on the VA clinical records.
- A supervisor stated that the reason the June 2013 RPIE project was implemented was because of incorrect input of desired dates by MSAs, who were using the appointment date as the desired date, or the date the appointment was made as the desired date. She further stated that her understanding of the RPIE goals were to train MSAs on the correct policy for the input of desired dates into VistA and to fix inaccurate data in the scheduling system. She said she was not directly involved with the RPIE and did not provide instruction to employees on how to make changes to veterans' records. She stated that pressure to fix the lists was not coming from her immediate leadership but from leadership at the VISN level.

When re-interviewed, the supervisor said she was not involved in the planning or selection of employees who would participate in the project. She stated that she was asked to send the email from the VAMHCS Director notifying the employees who had been assigned to work on the project. She further stated that her other duties were to take

reports from the program manager and forward them to clinical staff and nurse managers for correction of desired date scheduling that was outside of the 14-day VA access goal, and/or desired dates that appeared, in the program manager's opinion, to have been entered incorrectly. She explained that administrative employee 6 and the program manager worked with facility senior leader 2 to implement the project and that service chief 2 was asked not to have administrative employee 5 participate in the RPIE project. She stated that she felt that the changes made during the June 2013 RPIE were about the "numbers." She said she felt that it was known by VAMHCS staff that the goal of the June 2013 RPIE project was to fix undesirable metrics concerning desired dates.

- Administrative employee 6 stated that, in 2013, VISN 19 officials contacted VAMHCS leadership on multiple occasions regarding veteran wait times. She stated that VISN 19 officials advised that VAMHCS had very poor compliance with the desired date metric. She stated that she, facility senior leader 1, service chief 1, service chief 3, and others were involved in these discussions with a VISN manager. She further stated that VISN 19 officials directed Fort Harrison management to fix the errors with desired dates as they were not meeting performance measures. She stated that she did not believe there was much value added to the patients to correct any desired date errors as the patients had scheduled appointments. She recalled that VISN 19 officials indicated that they (VISN 19 officials) were receiving pressure from their chain of command to achieve better compliance with the desired date issue. She stated that a group of MSAs and nurse managers reviewed patient records to determine if the desired date was entered correctly for veterans whose desired date was more than 14 days apart from their appointment. She added that MSAs were instructed to only change desired dates if there was information in the record to support a change. The project took about 2 weeks to complete. She stated that she was told that a nurse manager was instructing MSAs to change desired dates to be within 14 days of the appointment. She explained that she and the nurse manager discussed the policy of only changing desired dates correctly per VA policy. She stated that she believed the nurse manager misunderstood the original directions and that only incorrect desired dates were changed during the RPIE project. She further stated that VISN 19 management was happy with the results of the RPIE. She also stated that the program manager prepared MSA training so that all future desired date data were entered correctly into VistA. She stated that MSAs were to refer all cases in which no appointments were available within 14 days of the desired date to the PACT nurse, so the nurse could triage those cases to see if the patient could wait for the appointment. She added that VAMHCS did not have the resources to see all patients within 14 days of their desired date.

When re-interviewed, administrative employee 6 stated that MSAs on the RPIE project were instructed to change records only when that change could be validated. She said that on a couple of occasions during the June 2013 RPIE, she reviewed records that were not within the 14-day goal and she instructed those employees not to change the record because no evidence could be found to support the change. She stated that during the June 2013 RPIE, only two MSAs were tasked with actually changing the appointment in VistA while the remaining employees were tasked with researching patient records and making a determination on an accurate date. She further stated that no quality control mechanisms were implemented during the RPIE project to ensure that dates entered by

MSAs were done so correctly. She stated that a review of the changes was not conducted because VAMHCS staff were trying to correct the access issues to get VISN management “off their backs.” She also stated that she felt VISN 19 management was primarily concerned with the appearance provided by the VAMHCS access statistics. She stated that VAMHCS’s current scheduling trend (at the time of the interview in 2014) of MSAs entering the desired dates as the appointment dates would not be an accurate representation of patient access at VAMHCS.

Moreover, she denied giving specific directions to any of the RPIE participants to make changes to desired dates without clinical justification. She stated that administrative employee 5 was not included in the RPIE because of conflicts between her and the program manager. She added that, in May 2014, administrative employee 5 brought her a list of patients showing that some of the changes made during the RPIE were not correct. She stated that she was unsure of what to do in response to this claim and added that most of the appointment dates had already passed. She further stated that during a meeting with VISN staff, facility senior leader 1 specifically asked if VAMHCS staff were being told to “change the dates,” and, in response, was told to “fix your errors.” She did not believe that VISN management conducted any quality control or ask about quality control processes taking place during the RPIE. She stated that she was sure VISN management was aware of the RPIE process and that VISN officials were aware that changes would be made to patient desired dates. She added that, since the RPIE, VAMHCS management had set up an access committee to clearly define the processes that need to take place for patient scheduling.

- Facility senior leader 1 stated that VISN 19 staff had sent VHA Support Service Center (VSSC) staff access lists to VAMHCS relating to the number of veterans waiting more than 14 days for an appointment. She further stated that VISN 19 staff had told her and other VAMHCS management to comply with VA policy regarding wait times. She stated that VISN 19 staff would send lists of patient names to VAMHCS management asking why patients were waiting a certain number of days. (The RPIE project was initiated to address this issue.) She confided that she did not feel comfortable with the task and that it was not a “value added” exercise because making changes to patients’ desired dates did not, in fact, change patient wait times or improve access to care. She further stated that the purpose of the RPIE was to ensure the patient’s desired date was changed accurately to reflect a true accounting of the patient’s wait time. She said that if the date could not be figured out, staff would let it go and do nothing with the patient’s record. She stated that she did not have any knowledge of anyone using arbitrary dates and said that the intent of the RPIE was to make the data accurate. She also stated that VHA provided no guidance on how to correct the errors. All the instruction that VAMHCS staff received was verbal, though she had asked VISN 19 staff for an email instructing her on what to do. She did not believe that she ever received a response. She explained that once the RPIE was completed, the objective was to prevent future scheduling errors, adding that after completing the RPIE, pressure from VISN 19 management and from the VISN manager declined, and VAMHCS staff stopped receiving regular VSSC reports.
- MSA1 stated that he worked on the RPIE project and that the program manager was the RPIE project supervisor. He added that he felt the RPIE’s purpose was to fix desired

dates that were beyond 14 days from a patient's appointment. He further stated that VAMHCS management did not give him an explanation on how these dates were to be properly fixed. He stated that he and former MSA1 were assigned to record changes to the desired dates provided to him by the MSAs who had reviewed the patient records. He further stated that many of the desired dates were changed to match the appointment date. He said he was bothered by the fact that he had to change the desired dates because it was not what the patient wanted and was not what he was trained to do. He stated that making those changes was "fudging" the numbers. He added that patient access did not improve as a result of the RPIE project.

- Administrative employee 3 stated that he had been selected by facility management to lead the RPIE. He reported that a VISN manager used to have regular contact with VAMHCS management regarding high numbers of patients who appeared to be waiting 14 or more days for medical appointments. He stated that he understood those high numbers of patients were a result of MSAs incorrectly selecting the date the veteran contacted the VAMC for an appointment rather than the date the patient requested to be seen or was asked to return by his/her doctor. He added that he supervised the overall project and that administrative employee 6 and a program manager instructed RPIE employees as well as supervised the day-to-day processes of the project. He stated that all records of veterans with a desired date beyond 14 days of the scheduled appointment were opened and reviewed during the project. The records identified as initially having the wrong desired date input into the system were corrected by the MSAs. Those records without clinical justification of a different desired date in VistA were not changed and/or referred to clinical staff for review and correction. He stated that he never discussed with other employees ethical concerns associated to changing patient desired date records. He added that he was not aware of any MSAs arbitrarily modifying patient desired dates to fit within the 14-day target. He stated that he was not asked by VAMC or VISN 19 management to conduct quality reviews or follow-up verification on desired dates changed during the RPIE project. He also stated that he did not give instruction nor did he observe instruction being given to MSAs directing them to enter arbitrary desired dates in patient records. He said that the MSAs lacked an adequate formal or standardized training program on how scheduling is appropriately entered into VistA.
- An assistant service chief stated that MSA training consisted of online training modules and on-the-job training. He characterized the training as "not good." He further stated that, in June 2013, he was asked to participate in the RPIE project. He said the project concerned fixing veteran appointment desired dates that had been incorrectly entered into the scheduling system. He stated that he was dismissed from the RPIE project for technical reasons, as his scheduling access had been terminated.
- Service chief 2 stated that she was asked to be on the RPIE project, but she was excused from the project after she explained that she did not have knowledge of scheduling practices. She also stated that administrative employee 5 worked for her and that the program manager told her not to have administrative employee 5 participate in the RPIE project.

- Former MSA2 stated that she had originally been taught to use “today’s date” as the desired date because no one had given her the definition of a desired date. She explained that the purpose of the RPIE was to make the numbers look better with the “higher up people.” She stated that the RPIE project made scheduling more consistent because employees began doing it the same way. She further stated that during the RPIE, she and other MSAs changed and “manipulated” desired dates to show a date 14 days before their scheduled appointment. When asked how she picked the new veteran’s desired date, she said she counted back 14 days from the appointment, verified that the new date was a weekday, and selected that date to meet the 14-day standard. She added that she was “pretty sure” that the program manager told her and other MSAs that if they could not find the information to support a change in the desired date, then they were to go back 14 days from the appointment date and pick a date. She stated that she and other MSAs would add a note indicating that it was the veteran’s desired date even though this was not true. She further stated that toward the end of the RPIE project, some MSAs called veterans to coordinate appointments. She said she assumed that about 80 percent of all the appointment changes were done with random numbers and “everyone was doing it.” She stated that she trained about 10 other MSAs to go back 14 days and use an arbitrary date if they could not find information regarding a veteran’s desired date.
- MSA5 stated that she was assigned to the June 2013 RPIE project for approximately 2 weeks. She explained that she was trained to think that the desired date was the date the veteran requested to be seen. She stated that during the RPIE, she was informed by administrative employee 3 and the program manager to research VistA and see if appointments were entered incorrectly. She said the only appointments she suggested to be changed were in cases when the scheduling MSA used the T key to enter the desired date as the date the contact took place. She stated that the T key error in desired dates comprised about 50 percent of the changes made to desired date data during the RPIE. She added that she was told by RPIE supervisors that if the MSAs were not able to find clinical notes, they were not to make changes to the desired dates. She stated that some MSAs did choose to make changes without justification, but she did not provide the names of these MSAs. She said it was “implied” by the people who were running the RPIE that everything needed to be fixed. She also stated that during the VAMHCS training, she was told that VA directives required all patients to be scheduled within 14 days of the patient’s desired date.
- Facility senior leader 2 stated that VISN 19 staff were reviewing VAMHCS patient data with long wait times. She said she ordered the formation of a team composed of the business office and clinicians to review desired date and scheduled appointment issues. She stated that she relied on this team and had them do a “deep dive” into fixing the access issues and preventing them in the future. She added that it was her understanding that scheduling errors accounted for about 80 percent of the desired date wait time issues. She stated that the RPIE project was intended to review each patient record, through chart review and by calling the patient, to find out if the patient needed care. She recalled having conversations with a VISN manager regarding the desired date/wait time issue; they had discussed getting patients in for appointments earlier, if possible. She stated that because some scheduling entries were not correct, employees were retrained in scheduling procedures. Regarding the process of changing dates with the RPIE, she

stated that facility senior leader 1 expressed concern to her about changing the records, but she advised facility senior leader 1 that the VISN manager said it was “fine.” She explained that, after the RPIE project, they had a reduction in wait times, the metric stabilized, and the data were more accurate. When asked if the VISN manager had provided anything in writing regarding the RPIE, she responded, “I don’t think so” and “I don’t know.”

- Service chief 3 stated that, before June 2013, there never was a very good process to train the MSAs on how to properly schedule veterans. He explained that it was only in the past year (from the date of interview in 2014) that the training of MSAs had improved. He stated that the RPIE was initiated because facility senior leader 2 was concerned about the poor statistics for patient access. He added that his responsibility regarding the RPIE was to address the “shortfalls” that were developed in the RPIE. He said he did not think that anything in the RPIE was meant to be done incorrectly and he did not believe MSAs were forced to “cook the books or anything like that.” He stated that no one approached him to confide that they were uncomfortable with participating in the RPIE with respect to what they were tasked to do. He further stated that administrative employee 6 and the program manager reported directly to leadership regarding the details and progress of the RPIE. He described how “the VA is driven by numbers” and it makes people do things to “keep the bear off their back.” He said he felt that, during the past 4 years, the facility was too short on staff to support the needs of the veterans.
- MSA6 stated that she participated in the June 2013 RPIE project and was asked to make changes to the desired dates to ensure they were within 14 days of the patient’s appointment. She further stated that she had ethical concerns with regard to making changes to patient’s desired dates for appointments that had already been scheduled. She reported that she and the other MSAs had discussed their ethical concerns but had followed instructions and made the desired date changes. She stated that she was asked by a nurse manager to make changes to patients’ desired dates to ensure that they were within 14 days of the patients’ appointments.
- A VISN manager stated that her duties included monitoring patient access statistics for facilities within VISN 19. She said she had previously observed patient wait time statistics increase within VISN 19 and she requested that facilities review their patients waiting more than 14 days for appointments. She stated that VAMHCS management was asked to review medical records for patients on the VSSC reports. She further stated that at no time did she ask any employee to make changes to patient desired dates. She said she requested that appointments entered in error be corrected and/or patients be referred to non-VA providers for care. Many of the issues associated with incorrectly scheduled appointments were due to unclear VA policy related to desired dates. She also stated that because of the high turnover of MSAs, there was confusion among most of the employees on how to properly use the VistA scheduling applications. She added that she instructed VAMHCS staff to review patient medical records (for those identified in VSSC reports as waiting more than 14 days) and to determine what could be done to address the patient’s appointment. She said she suggested that staff should inquire as to how to get the patient seen earlier by a clinician and understood that the facility would not make changes to desired dates. VAMHCS staff did not communicate to her that

changes were being made to patient desired dates. She stated that improvements in VAMHCS's goal of meeting 14-day patient wait times took place over a period of months and not weeks. She added that she did not know about the VAMHCS June 2013 RPIE project until after she had become aware of a VA OIG investigation when visiting VAMC Fort Harrison shortly before the current interview (conducted in August 2014). She was not aware that the majority of VAMHCS wait times had statistically dropped to near zero days.

- A VISN senior leader stated that he believed there had been flawed and inappropriate use of the VistA scheduling package by VA employees. He further stated that patients were being scheduled for follow-up appointments when the patients should have been put in a non-count clinic. The non-count clinic would have resulted in the patient receiving notification approximately 30 days before the date they were asked to return and requesting that the veteran contact VA to schedule an appointment. He stated that because patients were being inappropriately scheduled for distant follow-up appointments, VA access measures were inaccurately reflecting that the patient was waiting long periods of time. He added that there was a national VA request that all facilities go back and review their practices to ensure they were using the scheduling package correctly and to determine if patients were scheduled in error. He stated that he had no recollection of events around June 2013 in which VAMHCS and/or other facilities were asked to take corrective action to address thousands of patients with wait times beyond 14 days. He also stated that many facilities were not using the non-count clinics, also known as recall lists and that they subsequently were instructed to use this scheduling method.

He further stated that instructions to modify patient desired dates did not come from VISN 19 and that he did not "push" employees to change data. He recalled having a teleconference with VAMHCS staff regarding patient access but stated that desired dates were not discussed. Rather, during that teleconference, he said he discussed why some patients should have been placed on a "recall list." He stated that facility senior leader 1 had expressed objections to making changes to patients' scheduled appointments. He added that her objections were associated with transferring those patients to the non-count clinic recall lists and that her comments were not associated with the modification of desired dates. He stated that he did not follow up reviews of patients waiting beyond 14 days at VAMHCS. He also stated that he was unaware that thousands of names were removed from Fort Harrison's VSSC 14-day access lists.

Records Reviewed

- The VA OIG Office of Healthcare Inspections (OHI) conducted a review of a sample of 40 patient records where patient desired dates were changed by VAMHCS during the RPIE project. The review found that 63 percent of the sampled desired date records were changed without supporting information in the patient's VistA medical records. However, no information was developed that indicated VAMHCS MSAs manipulated or delayed the scheduling of actual patient appointments.

- VA OIG reviewed the June 2013 RPIE debriefing. The review indicated that administrative employee 3 communicated to facility senior leader 2 and other supervisors that no changes were made to patient records unless clinical documentation demonstrated the need.
- VA OIG reviewed a copy of a PowerPoint presentation titled, “A Guide to Scheduling.” This presentation was provided to VAMHCS employees during the training following the June 2013 RPIE project. The review disclosed the presentation provided instruction not to schedule appointments past 14 days of the desired date. According to this presentation, if no appointments were available within 14 days, employees were instructed to communicate with the patient’s medical provider or nurse to make a clinical decision to overbook the patient, schedule the patient for a nurse visit, schedule the patient for a telephone visit, or adjust the return to clinic orders.
- VA OIG obtained and reviewed statistical reports for VAMHCS desired date/appointment date access times for the period May 1, 2014, to May 14, 2014. The review indicated a high compliance with the VHA 14-day access goal.
- VA OIG reviewed VA emails provided by facility senior leader 2. The emails showed that VISN19 management was communicating with the facility directors requesting that facilities review VSSC 14-day access lists to ensure patients waiting more than 14 days were immediately addressed; facilities were also asked to report every 2 weeks as to their progress in addressing the VSSC 14-day access lists. The emails also showed that VAMHCS staff were communicating with facility senior leader 2 regarding the progress of the June 2013 RPIE and the progress on addressing the VSSC 14-day access lists.

Issue 3: Improprieties Regarding Closure of Patient Consults

During the investigation, VA OIG received information that the VAMHCS had administratively closed approximately 6,000 patient fee-based consults prior to the input of the consult medical records into the VA medical record system.

Interviews Conducted

Service chief 2 stated that facility senior leader1 wanted to administratively close VAMHCS fee-basis consults if they had remained open for a long period of time. She stated that her office attempted to obtain medical records from the provider and/or the VA National Activations Office (NAO) before closing the consults; however, her staff could not confirm that all records were received before closing. She stated that she was instructed by VAMHCS executive leadership again to close the consults, and pursuant to this direction, her office closed approximately 6,000 open fee-basis consults if the NAO had paid the claim. She stated that her office had verified that the veterans received glasses or hearing aids before closing the records even if her office did not have a copy of the actual records. She estimated that about half of the closed consults (3,000) were for hearing or ophthalmology care. She stated that all of the closed consults were considered medically as “low risk.” She added that facility senior leader 1 formed a committee to review the closed consult issue and that the committee voted to close the low-risk

consults that had been paid by NAO. She stated that her department had been working with NAO to obtain the records for the closed consults. She also provided a listing of the closed consults to VA OIG.

Records Reviewed

OHI reviewed the closed consult data provided by service chief 2. The review found that VA policy would allow consults to be closed in the manner conducted by VAMHCS. As provided in a VHA memo dated May 23, 2013, VA medical facilities were directed by the Under Secretary for Health to close unresolved VA consults no later than May 1, 2014. Further clarification was also provided through VHA training materials that gave direction to resolve VA consults pending for more than 90 days. The referenced VAMHCS consults were closed when consults were paid by VA within VHA policy. OHI found no allegation of patient harm related to the closing of the consults. We reviewed a December 20, 2005, memo by the Acting Deputy Under Secretary of Health for Operations and Management. The memo stated that local facilities maintain latitude associated to the requirement for the receipt of non-VA medical records before a consult is closed.

4. Conclusion

Issue 1

VA OIG found that the VAMHCS Fort Harrison Outpatient Clinic nurses individually maintained unauthorized written wait lists of patients, who had requested that they be called if an appointment became available. Nurses in this department reported that the veterans did not want to schedule a future appointment in the system. This situation was corrected in the weeks before the VA OIG investigation.

VA OIG found that the Radiology Department and the Rehabilitation Services and Neurology Department maintained written lists of appointments that emulated appointment information that was contained in the VA's electronic scheduling system(s), and the use of the written documents was authorized by VAMHCS management.

Issue 2

VA OIG found that MSAs had conflicting definitions of a veteran's desired date.

VA OIG determined that non-supervisory VAMHCS MSAs had retroactively changed veteran desired appointment date records without the proper supporting documentation or information during the VAMHCS RPIE project in June 2013.

VA OIG found that VAMHCS and VISN management failed to conduct quality control during the RPIE project to ensure that changes to patient desired dates were appropriately supported by the patients' medical records and were in compliance with VA policy. The unsupported changes made to patient desired date information artificially increased VAMHCS's compliance with VA policy, with regard to the 14-day VHA access goal, following the RPIE project. VAMHCS management also failed to monitor the accuracy of patient desired date input following the RPIE project.

Issue 3

VAMHCS is authorized to make payment for medical care provided to eligible veterans (fee-basis consults) when that care is not available through a local VA medical facility. The investigation identified that “low risk” medical fee-based consults consisting of predominately hearing aid fittings, chiropractic, and optical (glasses) appointments were administratively closed after VA received a bill for the service from the vendor. We found no allegation of patient harm related to the closing of consults. OHI confirmed that VAMHCS closed consults after VA had paid the provider for services but before the provider medical records were received. However, the investigation revealed that, pursuant to a December 20, 2005, memo penned by the Acting Deputy Under Secretary for Health for Operations and Management, local facilities maintain latitude in regard to the requirement for the receipt of non-VA medical records before closing a consult. Thus, VA policy indicates fee-based consults may be closed in the manner conducted by VAMHCS.

VA OIG referred the Report of Investigation to VA’s Office of Accountability Review on February 27, 2016.



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