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

VA Medical Center in Atlanta, Georgia
May 4, 2017

1. Summary of Why the Investigation Was Initiated

VA OIG initiated this investigation in the wake of the 2014 investigation of the VA Medical Center (VAMC) in Phoenix, AZ, amid allegations that Veterans Health Administration (VHA) medical administrative service clerks were using unofficial lists or engaging in inappropriate practices to make patient wait times appear shorter.[1] Because such practices are contrary to VHA policy, a proactive inquiry was launched at VAMC Atlanta in 2014 to determine if similar prohibited activities were occurring at the facility.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** We interviewed 14 VA employees, including schedulers and a senior facility leader.

- **Records Reviewed:** We reviewed patient wait-time data covering a 2-two-month period from April through May 2014.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- Lead program support assistant (LPSA) 1 and a program specialist were interviewed to review the scheduling procedures in place at VAMC Atlanta before mid-2014. These employees were asked about their knowledge of the Electronic Wait List (EWL) and the use of the "desired date" when scheduling appointments. Both stated that they either received training or trained other employees to conduct appointment scheduling as described in VHA Directive 2010-027. Neither of them admitted to any intentional manipulation of wait times or fraudulent practices related to patient scheduling.

  During a follow-up interview, LPSA1 stated that before mid-2014, schedulers were trained to have patients scheduled within 14 days, and if an appointment was not available within 30 days, the patient was put on a recall list. She added that schedulers did not use the EWL because they did not have the need to do so; if the EWL was needed, it was used by the administrative office. She further stated that after mid-2014, all the schedulers were retrained.

- A senior facility leader stated that VAMC Atlanta conducted its own internal review of scheduling practices following the VAMC Phoenix incident. She said that during the

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

evaluation, the internal review team found no evidence of illegal or fraudulent activities associated with scheduling practices; however; she recalled there had been findings indicating that VAMC Atlanta staff were overwhelmed with the caseload, confused on how to carry out the proper scheduling techniques, and offered barely any training.

- Program support assistant (PSA) 1 stated that, before mid-2014, the scheduling procedures in Primary Care for both new and established patients were determined by asking the patients when they would like to be seen and, if the date was not available, she would schedule them for the next available date. She further stated that, after mid-2014, VA management urged schedulers "to engage" the patients more, by asking them what date he or she would like to be seen. She said she was never asked to do anything contrary to VA policy but added that the scheduling procedures were not clear before 2014. She also stated that she did not use alternate scheduling methods, such as a paper list.

- Medical support assistant (MSA) 1 stated that, before April 2014, he determined appointment dates by finding the next available appointment date and offering it to the patient. He added that the scheduling procedures he used before April 2014 were those he had been taught and nothing was done to intentionally manipulate patient wait-time data. He said that after April 2014, he was instructed to ask patients to give him their desired date and he would then attempt to schedule the appointment on or around that date. He also stated that he had never been asked to do anything contrary to VA policy or directives. He stated that only the Veterans Integrated System Technology Architecture (VistA) system was used for scheduling.

- PSA2 stated that before mid-2014, she determined appointment dates by asking the patient to give her his or her desired date and, if the date was not available, she would find the "next available date" and offer that date to the patient. She explained that the only change she noticed after mid-2014 was the addition of the Veterans Choice Program. She said that she had never been asked to do anything contrary to VA policy or directives. She further stated that the EWL was not used because there were no delays in scheduling beyond 30 days.

- An administrative employee in Primary Care stated that, in 2014, she supervised approximately 30 schedulers. She further stated that, at the time of her interview, there was more oversight and all the schedulers had been retrained to better probe information from patients about their next scheduled appointments. She added that schedulers were asking patients what date they would like to be seen by a provider and that before 2014, they had to deal with staffing issues, as they were "more patients than providers." She explained that there were intake clinics at which fee-based providers could see new patients on Saturdays, and there was a float intake team seeing new patients at three different locations, also on Saturdays. She further stated that a third intake team, composed of mid-level providers and assisted by a team lead Medical Doctor (MD), was attending to new patients on Saturdays.

  She also stated that she had never asked a scheduler to perform duties that were inconsistent with VA policy and procedure and, to her knowledge, there had never been a

paper wait list. She said she was aware that a data person saved appointments on a protected shared drive and ran appointments exceeding 90 days, which were then exported into a Microsoft Excel spreadsheet. She added that the system did not allow a patient to be scheduled past 90 days.

- LPSA2 stated that, before mid-2014, the way they scheduled patients (by informing the veteran of the next available date) was just standard practice because it was logical. She explained that, before 2014, she would maintain an electronic spreadsheet on the shared drive. She said this spreadsheet contained the names of patients who were past 90 days of being scheduled. She further stated that when a new clinic was established she would schedule patients from the list; she added that she had never been asked to manipulate the system.

- A health systems specialist stated that, before mid-2014, the MSAs scheduled patients as instructed. She said the instruction involved hands-on training and the use of the VA's Training Management System. She further stated that VAMC Atlanta never tried to "game the system," and that she was not aware of any paper list nor had she ever instructed an employee to schedule patients in a manner that was not in accordance with VA policy. She added that, at the time of the interview (March 2016), the MSAs were trained to engage the patients more by asking them to select a date he or she wanted to be seen.

- MSA2 stated that, before mid-2014, the scheduler's goal was to schedule patients within 14 days and, when scheduling a patient went beyond 90 days, the EWL was used. He said that, before mid-2014, he would schedule patients by finding the next available appointment date; at the time of his interview, he had been instructed to ask patients for their desired date and attempt to schedule the appointment on or around that date. He said he was not aware of any paper wait list and stated that he used VistA only for scheduling. He also stated that he had never been asked to do anything contrary to VA policy or directives.

- PSA3 stated that, before mid-2014, schedulers would inform the patient about the next available appointment date; at the time of her interview, she said they asked the patients what date they would like to be seen. She explained that, after mid-2014, all the schedulers were given a refresher course to make sure everyone understood how to schedule properly. She said that she was not aware of any type of wait list and that they had no need to use a wait list because the schedulers were able to schedule patients on Saturdays. She further stated that she was unaware of any schedulers using a logbook or a paper wait list. She also stated that she had never been instructed to perform her duties beyond the scope of VA policy and directives.

- PSA4 stated that, before 2014, schedulers were not required to ask patients for the date they wanted their next appointment to be scheduled; instead, staff were scheduling the next available date. She added that schedulers did not schedule past 30 days and did not have access to the EWL. She said they "just scheduled the appointments." She further stated that the schedulers were not using the EWL because they had received no instruction on its use; besides, they did not have any patients scheduled past 90 days. She

explained that at the time of her interview (March 2016), schedulers had been trained to ask a patient when he or she would like to be seen by a provider and, if the date fell beyond the 30 days, the patient was given the choice to "opt in" or "opt out" of the Choice Program. She also stated that, since mid-2014, the schedulers had all been retrained, which had improved the way they scheduled and engaged with the patients. She said she was never instructed to do anything contrary to VA policy or directives. She further stated that before 2014, the scheduling procedures used resulted from a lack of training, and it was "just the way things were done."

- PSA5 stated that, before April 2014, she determined appointment dates by finding the next available appointment date and offering it to the patient. She explained that if a patient could not be scheduled within 30 days, the staff would use a temporary paper wait list. She added that the staff would then check the list and schedule the patient when an appointment became available and that patients would only remain on the paper list for a couple of days; the list was written on a form with the patient's name, last four SS numbers, and telephone number. She said that the lists were shredded when they were no longer needed and that this situation existed because of a lack of access to the EWL, which replaced the paper lists after April 2014. [Later, the same day of her interview, PSA5 contacted VA OIG to say that she had been mistaken about certain details related to the list. She stated that she now recalled that the list was used for tracking patients' medications.] She further stated that the scheduling procedures they had used before 2014 were what she was taught and there had been no intentional manipulation of wait-time data. She said that, after mid-2014, she was instructed to ask patients for their desired date and to attempt to schedule the appointment on or around that date.

- MSA3 stated that, before April 2014, she determined appointment dates by finding the next available appointment date and offering it to the patient. She explained that in the case of established patients, if a patient could not be scheduled within 90 days, staff would use a temporary paper wait list. She stated that staff would check the list and schedule the patient when an appointment became available; she added that this list system was only used for a few months and that patients would only remain on the paper list for 1 to 2 days until an appointment slot opened up. When all of this activity had been completed, the lists were shredded. She said that, before April 2014, she did not have access to the EWL, the scheduling procedures used were what she was taught, and nothing resembling the intentional manipulation of wait-time data had taken place. She added that, after April 2014, she was instructed to ask patients for their desired date and to attempt to schedule the appointment on or around that date. She also stated that she had never been asked to do anything contrary to VA policy or directives.

Records Reviewed

- VA OIG reviewed a sample of patient wait time data covering a 2-month period from April through May 2014. The data indicated that for established patients, approximately 95 percent of appointments had a wait time of 14 days or less and that for new patients, approximately 89 percent of appointments had a wait time of 14 days or less.

4. Conclusion

Our investigation determined that employees were not scheduling patient appointments according to VA policy. Schedulers were using the next available date rather than the veteran's desired date when scheduling appointments. Testimony from the interviewed employees did not reveal that the manipulation was part of an organized intentional scheme to influence wait times. Instead, the employees interviewed stated that they were not familiar with the proper scheduling procedures because of a lack of knowledge and/or training. Most of the schedulers interviewed said they were not aware of the use of paper wait lists; one employee explained that if a patient could not be scheduled within 90 days, the patient's name was placed on a paper wait list. The employee also stated that the paper wait list was only used for a few months, and that was before April 2014.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on August 10, 2016.

JEFFREY G. HUGHES
Acting Assistant Inspector General
for Investigations

For more information about this summary, please contact the Office of Inspector General at (202) 461-4720.