

Date: September 2, 2008

From: Assistant Inspector General for Investigations (51)

Subj: Administrative Investigation – Improper Altering of Patient Wait Times and Failure to Use the Electronic Wait List, Phoenix VA Health Care System, Arizona (2007-03117-IQ-0190)

To: Director, Phoenix VA Health Care System

1. The VA Office of Inspector General (OIG), Administrative Investigations Division, investigated an allegation that VA employees altered patient wait times in an effort to improve their performance measures at the Phoenix VA Health Care System. Employees allegedly cancelled and rescheduled appointments for the same date and time, thus creating a 0-day wait time. To assess this allegation, we interviewed you; [REDACTED] Medical Center Chief of Staff; [REDACTED], Chief of Health Administration Service (HAS); other HAS staff; and Patient Service Assistants, also known as schedulers. We reviewed VHA Outpatient Scheduling Processes and Procedures, scheduler performance plans, VA policies, and other relevant documents. We investigated and did not substantiate allegations of a mismanagement of resources, abuse of authority or improper hiring, and they will not be discussed further in this memorandum.

2. We found that it was an accepted past practice at the medical center to alter appointments to avoid wait times greater than 30 days and that some employees still continue this practice. We also found that some schedulers did not understand their performance standards and that the medical center did not use the electronic wait list (EWL) in accordance with policy. We suggest, in light of a May 2008 OIG report titled *Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3*, that you ensure all HAS staff, from management to schedulers, use the VistA scheduling package in compliance with policy to properly manage appointments; provide clarification on performance standards to schedulers and their supervisors to ensure that schedulers are not penalized for following VA policy; and ensure veterans are placed on the EWL when appointments cannot be scheduled within the 30- or 120-day requirement. We are providing this memorandum to you for your information and official use and any action you deem appropriate. No response is necessary.

Improper Altering of Patient Wait Times

3. VHA policy states that all outpatient clinic appointments must be scheduled using Veterans Health Information Systems and Technology Architecture (VistA) Scheduling options. It requires that all veterans with service connected ratings of 50 percent or greater to be seen within 30 days of the desired date for any condition; whereas it requires veterans with service connected ratings of less than 50 percent to be seen

within 30 days of the desired date only for a service connected disability. All other veterans must be scheduled for care within 120 days of the desired date. Policy defines "desired date" as the earliest date on which the patient or clinician specifies the patient needs to be seen. Veterans who cannot be scheduled for appointments within the 30- or 120-day requirement should be immediately placed on the EWL. VHA Directive 2006-055.

4. The following examples clarify how the VistA package calculates patient wait times:

- When a patient asks to see a doctor as soon as possible or a doctor asks that a patient be seen at the next available appointment, the appointment should be scheduled as a "Next Available" appointment, and the "desired date" defaults to the date it is created. Thus, if an appointment is made on June 1 and the "next available" appointment is August 1, the "desired date" defaults to June 1, creating a 60-day patient wait time.
- When a patient asks for a specific date or a doctor provides only a date range, such as "2 to 3 months" from today, the appointment is scheduled as a "Not-Next Available" appointment, and the "desired date" becomes the specific date requested by the patient or the first date of the date range requested by the doctor. Therefore, if today is June 1 and the patient asks for and is given an appointment on August 1 or a doctor provides a 2- to 3-month date range, the "desired date" defaults to August 1, creating a 0-day wait time.

5. Two medical center schedulers told us that it was common practice to alter appointments to obtain a 0-day wait time to avoid wait times greater than 30 days. A supervisory scheduler explained that, in the past, schedulers "conditioned themselves" to "fix" appointments so that they reflected zero. She said that they did this to avoid making appointments that showed up on a "negative list" generated by supervisors that listed appointments with more than a 30-day wait time. She explained that, in the past, to avoid having her name on the list, she scheduled appointments twice. She said she first entered the appointment in the "next available" function to find the next available date; she backed out of that function; and she then re-entered that same appointment date as a "desired" date, resulting in a 0-day wait time. She further told us that her managers previously told her to never use the "next available" function and to only enter appointments with a "desired" date. She said that in December 2007, the Assistant Chief of HAS, gave her a list of appointments with more than a 30-day wait time, and she, in turn, gave the list to two schedulers, instructing them to "fix" the appointments. However, she told us that since that time, she believed that schedulers entered all appointments correctly in the VistA package.

6. On the contrary, one scheduler told us that canceling and remaking appointments for the same date to get a 0-day wait time was a current practice. She said that she changed one as recent as 1-hour prior to her interview with us and that "they (supervisors) will ding the heck out of you if they see a number on the bottom" of their report. She said that management recently sent her a list of appointments with more

than a 30-day wait time, along with instructions to remake those appointments. Further, another scheduler told us that when he initially made appointments, he immediately remade the same appointment, if it reflected more than a 30-day wait time. He further said that every morning, his supervisor ran a report of appointments made for service connected veterans and that anything with more than a 30-day wait time was changed. As a result, he said that the schedulers "trained themselves" to change the initial appointments automatically to avoid showing up on this list.

7. Another supervisory scheduler told us that the Chief of Outpatient Services instructed schedulers, in the past, to keep wait times at zero, so the schedulers automatically changed or cancelled appointments to avoid having any wait times greater than 30 days. He also said that schedulers were instructed to "fix" any appointments listed on their reports that reflected more than a 30-day wait time. He said that he did as instructed, because he had "a wife and kids and needed his job." He said that sometime in 2007, the Chief of Outpatient Services told the schedulers to stop "fudging" the numbers, and the supervisor said that since that time, he believed schedulers made entries correctly. However, one scheduler told us that it was sometime in 2008 when the Chief of Outpatient Services instructed them to "fix" only those appointments which schedulers made improperly when initially scheduling the appointments. The Chief of Outpatient Services said that, as an example, if a scheduler did not enter the proper "desired" date when the provider's note clearly gave one, it would be an improperly scheduled appointment that needed to be fixed.

8. The Chief of Outpatient Services also told us that he reviewed service connected patient appointments with more than a 30-day wait time to see if they were made correctly, and if they were not, he asked that they be corrected. He explained that if a scheduler did not enter a "desired" date when the provider gave one, it would be an incorrect entry and that appointments made the proper way were left untouched. He told us that he stressed at meetings that he wanted schedulers to make appointments the way they were trained, and it was a "gross misunderstanding" by the schedulers to zero out appointments with more than a 30-day wait time.

9. A scheduler at the medical center's Northwest Clinic told us that in the past, managers instructed him to zero out appointments reflecting over 30 days. He said that when he arrived at that clinic in January 2008, he found that the schedulers there were also "zeroing-out" any appointments reflecting more than a 30-day wait time; therefore, he continued to zero out appointments up through March 2008. He said that he received a daily report titled *Service Connected Veterans Awaiting Appointments* to find those with a wait time beyond 30 days, and he gave the report to the schedulers, instructing them to "fix" theirs and then pass it to the next scheduler. He also told us that although he managed new patient appointments, he entered all appointments using only "desired dates" regardless of the type of appointment made, because the Assistant Chief of HAS instructed him to go strictly by "desired" dates. He said that his only exception to those instructions was that he used the "next available" function when rescheduling patients that cancelled appointments.

10. The Assistant Chief of HAS told us that when she first arrived at the medical center in 2004, it was standard practice to alter appointments, and employees readily admitted to her that it was "gaming" the system. She said that prior to the VA Scheduling Directive, schedulers changed or cancelled appointments to avoid any indication that they made appointments with more than a 30-day wait time, and she said that old habits were hard to break. She told us that since she became a supervisor, she instructed her staff to schedule correctly and that she relied on her front line managers to make sure they followed her instructions. She said that she ran reports to monitor and compare the appointments with the physicians' notes. She said that a report she ran 3 weeks ago reflected more than 400 appointments with wait times greater than 30 days and that about 10 percent of those were done incorrectly. She told us that all schedulers took scheduling training, along with one-on-one training for 3 weeks when oriented to their individual positions, and that schedulers were aware of the new VA Scheduling Directive. Records reflected that the employees we interviewed took the required scheduler training in 2007 or 2008.

11. ██████████ Chief of HAS, told us that he supervised all schedulers in primary care and specialty clinics and that he was ultimately responsible for their scheduling practices. He said that the previous Chief of Staff and Director encouraged "fixing" appointments, but since you and ██████████ came onboard, the practice no longer existed. He said that he was not aware that schedulers were making appointments, cancelling them, and rebooking them to zero out the wait times. Further, he said that employees were instructed to correct only improperly scheduled appointments and that they ran a daily report to check for appointments with a wait time of more than 30 days, correcting only those that were made incorrectly.

12. ██████████ gave us the following example of an incorrectly made appointment: A physician's note said to give a patient the "next available" appointment. The scheduler went into the scheduling program on May 1, found the next available appointment was on August 1, or 90 days from then. If the scheduler put in May 1 as the "desired" date, they were incorrect, as that created a wait time of 90 days. ██████████ said that the scheduler should instead put in a "desired" date of August 1 to avoid a 90-day wait time. He told us that schedulers were not supposed to use the "next available" function in the VistA package, as it "skewed the numbers." However, ██████████'s example was contrary to VHA Directive 2006-055, Attachment D, which states that when an appointment is scheduled as a "Next Available," the "desired date" defaults to the date the appointment is created and that this is proper when a patient asks to see a clinician as soon as possible or the clinician requests the patient be scheduled for the next available appointment. In ██████████'s example, the proper way to schedule the August 1 appointment would be to use the "Next Available" function, which defaults the "desired" date to May 1, thus creating a 90-day wait time.

13. Records reflected that the 2008 Performance Plan for schedulers listed the use of the scheduling package as a critical element and that for a fully successful rating, the scheduler should have no more than four substantiated instances of non-compliance. The Assistant Chief of HAS told us that schedulers were not permitted more than four

errors quarterly and that supervisors reviewed appointments to check for any errors. ██████ told us that he believed that scheduling was incorporated into the schedulers' position descriptions and that performance wait times would fall under the "umbrella" of scheduling. One supervisor told us that schedulers were not pressured to reduce wait times and that their performance plans did not contain wait time measures; however, another supervisor told us that patient wait times were contained in his own performance measures. Two schedulers told us that making appointments with more than a 30-day wait time adversely affected their performance evaluations.

Failure to Use the Electronic Wait List

14. The OIG report *Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3* stated that EWLs were a key tool used in determining how well medical facilities met their patient care requirements and were instrumental in making sure all veterans were treated timely. It further stated that incomplete EWLs compromised VHA's ability to access and manage demand for medical care.

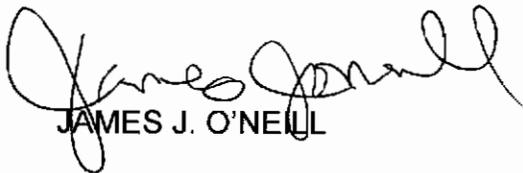
15. You told us that the medical center used the EWL and that if a patient could not be scheduled for an appointment within 120 days, they were entered into the EWL. On the contrary, ██████ told us that only the medical center's dental patients were placed on the EWL. He said that when he arrived at the medical center in 2006, there were 1,000 dental patients on it, but by the end of the year the number was zero. ██████ told us that the EWL was designed for patients who could not be seen in 30 days of a desired date; that the medical center used and monitored the EWL; and that when they found a patient mistakenly listed on the EWL, they corrected the error. However, the Assistant Chief of HAS told us that the medical center did not use the EWL. She said that previous and current managers, specifically ██████ told staff to get patients off the EWL by scheduling appointments for them and to not use it. The Chief of Outpatient Services told us that the medical center did not have electronic wait lists. One supervisory scheduler told us that the EWL was never implemented at the medical center, and another said that the Chief of Outpatient Services instructed him to stop using it.

16. One scheduler told us that he never used the EWL, because the Assistant Chief of HAS told him not to use it. Another told us that VA Central Office sent an electronic mail message saying that schedulers could use the EWL; however, he said that he had not yet been trained on it nor had his supervisor said he could use it. A third scheduler told us that his clinic did not use the EWL; he did not have access to it; and that two different supervisors and the Chief of Outpatient Services told him not to use it. He said that his clinic had plenty of appointments exceeding 30 days, but if a patient needed a follow up in 1 or 2 weeks, to accommodate the patient, his clinic had to overbook. Another scheduler said that rather than use the EWL for patients that could not get appointments within the required time, she either telephoned the patient at a later date or had the patient telephone her to see if there were any cancellations. She said that no one told her not to use the EWL, but she said that she had not yet

received training on it. In a report titled *Service Connected Veterans Awaiting Appointments SC 50-100 Percent*, dated April 22, 2008, we discovered 39 appointments with a wait time in excess of 30 days, with 8 of those being more than 100 days, and none were on the EWL.

17. We concluded that it was an accepted past practice at the Phoenix VA Health Care System to alter appointments to avoid wait times greater than 30 days, and that through a failure to properly communicate a requirement to adhere to policy, some employees continued this practice. The Assistant Chief of HAS said that altering wait times continued until she became a supervisor; one supervisor believed the practice ceased in 2007; and another said it ceased in January 2008. However, one scheduler said he continued the practice until March 2008, and two others said that they still alter appointments. Further, management and staff were confused as to the proper way to schedule patient appointments. [REDACTED]'s example of an incorrectly scheduled appointment was actually the correct way, and the Assistant Chief of HAS instructed one scheduler to go strictly by "desired" dates, even though policy specifies times when scheduling a "next available" appointment is appropriate. Additionally, scheduler performance plans reflected that they should have no more than four instances of non-compliance; however, it was left to interpretation as to what constituted non-compliance. Some schedulers believed that included making appointments with a wait time greater than 30 days, further adding to the scheduling confusion. Finally, employees were confused about the use of the EWL. You told us that it was being used, whereas, [REDACTED] said they only used it for dental patients. [REDACTED] said that they used and monitored the EWL, but the Assistant Chief of HAS said that they did not use it. One supervisor said that they never implemented the EWL, and another said that they were instructed to stop using it.

18. We suggest that you ensure that all HAS staff, from managers to schedulers, use the VistA scheduling package properly to manage appointments in compliance with VA policy; provide clarification on performance standards to schedulers and their supervisors to ensure that schedulers are not penalized for following VA policy; and ensure veterans are placed on EWLs when appointments cannot be scheduled within the 30- or 120-day requirements. We are providing this memorandum to you for your information and official use and whatever action you deem appropriate. It is subject to the provisions of the Privacy Act of 1974 (5 USC § 552a). You may discuss the contents of this memorandum with those named in it, within the bounds of the Privacy Act; however, it may not be released to them. No response is necessary. If you have any questions, please contact Ms. Linda Fournier, Director, Administrative Investigations Division, at (202) [REDACTED]


JAMES J. O'NEILL