

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



**VA Medical Center in Baltimore, Maryland  
November 15, 2018**

## **1. Summary of Why the Investigation Was Initiated**

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) began an investigation in 2014 based on a written complaint, stating that an unnamed “Chief” at the VA Medical Center (VAMC) in Baltimore, Maryland, instructed his or her staff to immediately close Compensation and Pension (C&P) consults for Audiology examinations upon receipt. The complainant alleged that as a result, the consults were closed before the Audiology examinations could take place. This anonymous complaint further stated that “this closing of the consult on the day received skews the data and gives the appearance of reporting fraudulent data to the staff.”

While investigating the initial complaint (later referred to as Issue 1), the OIG received these additional complaints:

- Issue 2: Psychologist 1 alleged that a service chief pressured her to remove from the Opioid Agonist Treatment Program’s (OATP) Electronic Wait List (EWL) those patients who were unreachable or referred for care (“fee-based”) in the community.<sup>1</sup> Psychologist 1 also added that the Veterans Integrated Service Network (VISN) wanted EWL numbers to be below 20 patients. She stated that in May 2014, the Methadone Program created a new “non-count” Transfer Clinic for patients who wanted VA care but were currently in some type of other care. She alleged that patients transferred to the new Transfer Clinic had their wait times unintentionally erased.<sup>2</sup>
- Issue 3: Psychologist 1 also alleged that veteran 1 died from undiagnosed AIDS after being referred into the community for VA fee-based care, but while being on an OATP EWL.
- Issue 4: In an email sent to the OIG Hotline on September 21, 2015, a complainant stated that the Chief of Mental Health’s suggestion that some patients be tapered off methadone was contrary to the standard of care.
- Issue 5: A medical support assistant (MSA) alleged during an interview that some Mental Health Clinic providers would come to her after an appointment to ask her to enter that

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<sup>1</sup> VA’s Fee Basis Program allows veterans to be seen by private providers outside the VA healthcare system and at VA expense.

<sup>2</sup> The Transfer Clinic is not a “place” but rather an administrative tracking system/list for individuals seeking to transfer from a VA healthcare setting because of service unavailability to either another VA facility or non-VA care in the community. For additional information, see VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, Appendix J, July 15, 2016.

appointment into VA's internal Veterans Health Information Systems and Technology Architecture (VistA). She stated that two employees in particular scheduled appointments after the actual appointment had occurred.

- Issue 6: Coordinator 1 alleged that VAMC Baltimore's Medical Administration Service (MAS) was prematurely closing Non-VA Care Coordination (NVCC) consults. She said that NVCC consults were being closed upon the scheduling of an appointment outside of VA. She also alleged that some of MAS's consults were closed after the patient was seen by a non-VA provider but before the resulting medical documentation was received by the facility.

## 2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed 53 current and former VA employees.
- **Records Reviewed:** VA OIG reviewed VA emails, a closed consult report, OATP EWL data, medical records, spreadsheets, and the results of a fact-finding investigation conducted by VA.

## 3. Summary of the Evidence Obtained from the Investigation

### *Issue 1: Investigation of the Closure of Audiology Clinic Consults*

#### **Summary of Anonymous Allegation**

- On June 2, 2014, VA Central Office (VACO) employee 1 forwarded an anonymous complaint to a then VA OIG employee. VACO employee 1 had previously received this complaint from VACO employee 2 on May 27, 2014. VACO employee 2, acting as an intermediary, forwarded an email to VACO employee 1 containing several allegations that she had received from a current and a former VAMC Baltimore employee. Both individuals wished to remain anonymous.
- In VACO employee 2's email to VACO employee 1, she attributed "an anonymous source" with these exact words:

The Chief of the service is asking employees to do the following during examinations: during the time of Audiology for C and P examinations to do the following. "As soon as you get a consult go in and close it. Put a note on it that you will be writing it up as soon as you see the patient. So, for instance, if they get a consult in "CPRS",<sup>3</sup> then they would write, "Veteran has been scheduled for MBS evaluation on such and such a date. This consult has been moved to The notes section of the chart. The report will be attached to this consult following the evaluation."

So basically, for Central Office's purposes, the consult was done.

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<sup>3</sup> CPRS stands for Computerized Patient Record System.

This goes onto a list in VistA software and is seen as a completed consult. This is manipulating the system so the Chief has good stats, and does not reflect the veterans true wait time on consults.

The standard procedure to follow was: supposed to mark when they got the consult, when it is scheduled and when the consult is done, and write it up.

This closing of the consult on the day received skews the data and gives the appearance of reporting fraudulent data to the staff.

### **Interviews Conducted**

- VACO employee 2 stated that she had no knowledge of the allegations, which she received from the current and former VAMC Baltimore employees. At the end of the interview, OIG agents asked VACO employee 2 to provide contact information for the two anonymous complainants because the allegation was somewhat vague. A few weeks after the initial interview, VACO employee 2 confirmed that she had forwarded OIG contact information to the two anonymous complainants. As of October 2018, neither complainant had contacted the investigating agent.

Because of the ambiguous language used in the anonymous complaint, OIG staff interviewed both C&P and Audiology staff.

- Coordinator 2 explained that a “consult” is a referral from one clinic to another. She stated that a majority of the consults are generated from the Primary Care Department. She said that employees are able to close consults at any time but that is not the proper practice. She further explained that a consult is only properly closed when (1) all notes have been added after the appointment and (2) the specialist signs off on the consult. She further stated that if someone were to receive a consult and then immediately close the consult, this could skew the numbers on generated reports. She did not know if the consult process was different for C&P exams but recommended that the agents speak with program manager 1. She recalled a “Consult Clean-Up” in May 2013 for all open consults. She stated that she reviewed the numbers every week and that she would notice any significant changes in the number of consults. She stated that she was not aware of anyone “gaming the system.” After OIG agents read the anonymous complaint to her, she stated that the allegation did not make sense. She further stated, “They can’t close a consult until the patient is seen. They are able to close the consult, but this is not what we do. This is not a practice of what we do here. I stress the right way. I have integrity in my job.”
- Program specialist 1 explained the consult process as follows: A primary care provider enters the consult into CPRS and the consult is transmitted electronically to the applicable specialty clinic. The specialty clinic staffer reviews the consult, adds notes into the system, and then the appointment is scheduled. She stated that a consult would be automatically closed after a patient has been seen, a progress note has been entered, and a provider has signed off on it. She said that there were four statuses for consults: pending, scheduled, closed, and active. She stated that there are certain clinics, such as the Eye

Clinic, where patients do not need a consult to be seen. She added that if a patient needed a routine eye exam, Primary Care staff would occasionally enter a consult. She said she felt clinics that do not require consults might close the consult after they receive it. She stated that from her perspective, it would be acceptable to close the consult as long as the clinic had a process to ensure that patients do not get lost in the VA system. A clinic might not want to have open consults on the record if the consult is not clinically necessary. She did not know the process for C&P consults and was unsure if the consult process was even used for C&P exams. OIG agents asked her if she had encountered any sort of patient wait-time manipulations or any sort of improper practices regarding the scheduling of patients. She replied, “No.”

- Senior leader 1 stated that she and coordinator 2 worked together on a “Consult Clean-Up Program” in 2013. This program originated with the National Leadership Council in 2012. She stated that the VA Maryland Health Care System (VAMHCS) had approximately 17,000 open consults in 2013. This program closed approximately 10,000 of the 17,000 open consults. Many of the consults had accidentally remained open due to errors, which included (1) consults related to deceased veterans; (2) duplicate consults; and (3) intra-facility consults, which remained open due to a computer glitch. She stated that this Consult Clean-Up Program followed the national business rules. With the exception of the aforementioned consults, which erroneously remained open, no other open consults were closed. She stressed that a consult should not be closed until the patient is seen by a healthcare provider. She stated that the question of when a consult could be closed was a decision left up to the facility. If a patient was a “no-show” at a particular facility, that facility could make the decision to close the consult and notify the patient’s primary care provider. When asked if she was aware of any improper scheduling practices, she stated, “I’m not aware of anybody doing anything they weren’t supposed to . . .” She continued, “We were telling them what they had to do and what our expectations were.” She also stated that VAMC Baltimore is the biggest facility in the VISN and that the VAMC’s numbers do not always look as good as the other sites because VAMC Baltimore staff are “painfully honest.”
- Program manager 1 stated that the C&P Clinic does not receive a consult but instead a request from VARO Baltimore, which would describe all the exams that are needed. C&P schedulers would look at the request and book individual appointments with each specialty clinic. She stated that C&P schedulers have access to each specialty clinic’s schedule. When the consult process outlined in the complaint was explained to her, she stated, “That doesn’t make sense to me.”
- Program manager 2 stated that the C&P Clinic schedules all appointments related to a veteran’s C&P claim. She further stated that the C&P Clinic staff, which have access to the schedule for all clinics, would schedule the appointment for the veteran. A consult is not generated because these appointments are scheduled directly by C&P personnel.
- A medical records technician stated that she scheduled C&P exams for veterans and that consults are not used when scheduling these exams. After the anonymous complaint had been read to her, she said this was not anything that her office would do. She stated, “I’m familiar with the consult process, so from my understanding, consults remain open until

after the veteran is seen by the doctor and results are submitted, then it's closed out." When asked, "To your knowledge, are you aware of any unethical scheduling practices at the Maryland Health Care System?" she replied, "No."

- An employee under contract to assist with scheduling (contract employee 1) stated that he did not use consults and that he had never heard of a consult. After OIG agents shared with him the content of the anonymous complaint, he said this scenario was not a scheduling practice conducted within C&P. He stated that he was not aware of any unethical or improper scheduling practices at VAMHCS.
- Contract employee 2 stated that she did not work with consults and she was not aware of any instances in which C&P used consults. After OIG agents shared with her the content of the anonymous complaint, she stated that this scenario did not make sense to her. She further stated that there were no similarities between this complaint and C&P's scheduling practices. She said she was not aware of any unethical or improper scheduling practices at VAMHCS. She also stated that she was not aware of any practices or policies that were meant to "game the system" or "skew the numbers."
- Program specialist 2 stated that six Audiology Clinics were located at VAMC Baltimore, Community Based Outpatient Clinic (CBOC) Loch Raven, CBOC Cambridge, CBOC Fort Meade, CBOC Glen Burnie, and VAMC Perry Point. She explained that after she made an appointment, she would close the consult. She referred to it as being closed or complete because it meant she had completed her task. When asked multiple times if the consults were actually closed within the scheduling system after an appointment was made, she gave conflicting responses that did not definitively confirm whether these consults were closed in the scheduling system.
- Service chief 1 stated that consults were not needed to schedule an appointment in the Audiology and Speech Pathology Clinic; this clinic was an "open" clinic and scheduling clerks from any part of the facility had the ability to schedule an Audiology appointment. He explained that his clinic did not schedule C&P exams and that consult management at VA started within the past two years, adding, "The story was that they had this enormous number of consults. And they said we need to reduce the number of consults. So they told all the service chiefs, reduce the number of consults. If you have consults sitting there, address the consults or get rid of the consults." When he was told VA OIG had received a complaint that the consults were being closed as soon as the appointments were being scheduled, he stated, "Once they're scheduled, I don't need that consult anymore." He continued, "So basically, I don't need that consult per se. And the issue that came up when they started to say reduce the consults, well, that's what I did. ...my interpretation was, we were told to close the consults. So, he was scheduled. I closed them. So, I guess that I was doing that."

Service chief 1 confirmed that this practice of closing the consult after the appointment was scheduled—but before the appointment took place—did reduce the number of consults. He stated that VA executive staff had told him to stop this practice of closing the consults prematurely. He said he provided VA executive staff with Microsoft PowerPoint graphs on a monthly basis that depicted (1) the total number of appointments

in his clinics, (2) the number of pending appointments, (3) the number of scheduled appointments, and (4) the number of completed appointments. When asked if he had stopped closing the consults on his own or if he was directed to stop, he replied that he was unsure because this issue came about during an executive staff meeting. However, he said he guessed that it was senior leader 2 who had told him to stop this practice. He stated that at one of these meetings, someone had suggested he was “gaming the system.” He said this suggestion had irritated him because they had already told him to get rid of the consults. He added that he was told to reduce the consults with no clear-cut direction or procedure. He also stated that he never received guidance via email or a general order. He confirmed that, although the Audiology Clinic might still be receiving unnecessary consults, they now remained open until after the patient’s scheduled appointment.

Service chief 1 was shown an email (dated late 2014) from senior leader 3 that was sent to several VAMC Baltimore staff members (administrative employee 1, VA employee 1, coordinator 1, senior leader 2, and service chief 1). In this email, senior leader 3 stated, “Audiology is now a non-consult service – no consult is needed to see Audiology.”

Service chief 1 explained that a meeting was held, followed by an announcement to advise VA personnel that they could directly schedule into the Audiology Clinic and that no consult was needed. He was shown a second email (late 2014) that was sent to him by coordinator 1. In this message, coordinator 1 wrote, “Forgive me and this is not directed towards you personally, but it gives the perception that we are gaming the system to lower our numbers versus ensuring patient care is being provided in a timely manner.” This email contained a lengthy reply from service chief 1 to coordinator 1 in which he indicated that an Audiology consult is not necessary and that they are “dealing with an old system that does not fit everyone but are asked to make it work.” He stated, “I just remember this is part of a discussion where I was saying about what you need, the old system. We dealing [*sic*] with an old system and nobody wants to modify the system. So that these things, when you say close a consult, you can close a consult and the computer recognizes it. As opposed to close/complete. Which is a contradiction. And that’s where the confusion comes in.”

He was shown a third email (late 2014) that he sent to senior leader 2. In this email, service chief 1 stated, “We are no longer ‘closing’ (Completed) consults once they are scheduled. I have made the appropriate modifications in the report to reflect this change.” He said this email was intended to inform senior leader 2 that these changes in the reporting of consults would cause a change in the Microsoft PowerPoint slides to VA senior executives.

- Senior leader 2 stated that consults in the VA system were a “mess” and used in a non-standardized way. He said he believed there was a period during which service chief 1 was scheduling consults and then closing them before the actual appointment; he also believed service chief 1 did this because “he was feeling the pressure.” He stated that he believed that this may have been due to the interpretation of new business rules in regard to consults. He further stated that they were getting pressure from the VISN a few years prior in regard to the number of open consults. He said he believed that the large amount of open consults was directly related to the staffing shortage of medical personnel at this

facility. He stated, “. . . we didn’t have the people or the infrastructure and the leadership to manage the volume of consults . . .” He stated that at some point, the Audiology Clinic was told to stop the process of closing the consults before the actual appointment. He added that different services were managing consults in different ways. He also stated that the facility needed to standardize its business rules. He said the Audiology Clinic is an open clinic and that clerks from any part of the facility have the ability to schedule an Audiology appointment. He stated that in the past few years, he had been attempting to use “consults only when necessary.” He said closing the consults before the actual appointment was not done to game the system. He added that the Audiology Clinic currently did not close the consult until the patient had been seen by his/her healthcare provider.

- When asked how the issue of the Audiology Clinic’s possibly closing consults before the actual appointment came to her attention, coordinator 1 replied that it had probably been by someone in the Consult Management Group because they were reviewing the consults of several services. She stated that the Audiology Clinic’s number of consults went from being very high to being low in a short period of time, which, in effect, sent up a “red flag.” She said she initially reviewed the consults to see what this clinic was doing correctly in order to pass along this information to other clinics for their benefit. However, she stated that following her review of the consults, she discovered that the clinic was closing the consults after the appointment was scheduled but before the veteran was actually seen by a healthcare provider. She said closing the consult before the actual appointment was “premature.” She stated that service chief 1 had assured her that the Audiology Clinic would take care of this issue. He had also assured her that the Audiology Clinic would keep track of all veterans who either canceled or rescheduled their appointments. She further stated that these issues were not a clear-cut case of a policy violation and that she did not know of any veterans who were harmed by this process.
- Former senior leader 1 stated that he did not know that the Audiology Clinic was closing its consults before the actual appointment. He added that service chief 1 should not have done this but that he did not think it was done intentionally to game the system.
- Senior leader 4 stated that he was not aware of this allegation and that the Audiology Clinic was currently an “open clinic” for which consults were not necessary to schedule appointments.
- OIG agents shared the content of the allegation with former senior leader 2 and he was told that a VAMC Baltimore employee had, during an interview, admitted to closing the consult prior to the actual appointment. Former senior leader 2 was also told that this employee had stated that the Audiology Clinic was an open clinic and, therefore, they did not need consults to schedule appointments for patients. Former senior leader 2 stated that he had no recollection of this allegation. When asked if consults were necessary to schedule appointments even though the Audiology Clinic was an open clinic, he replied that he was not sure of the scheduling practices of this particular clinic.

## Records Reviewed

- OIG agents requested a closed consult report for VAMC Baltimore’s Audiology Clinic from administrative employee 2. OIG agents reviewed that report, which contained all closed consults from VAMC Baltimore’s Audiology Clinic from January 1 through July 22, 2014. This report consisted of 100 pages associated with approximately 2,500 patients. The report showed the dates that consults were requested and when they were completed. The report also confirmed that some of the Audiology consults were requested and completed on the same date.
- OIG agents obtained complete access to approximately 26,370 emails that belonged to service chief 1 and program specialist 2. Through keyword search reviews, OIG agents identified the emails discussed during the aforementioned interviews. OIG agents also conducted a keyword search review of all emails between service chief 1 and program specialist 2. During this review, nothing of evidentiary value was discovered in reference to the premature closing of Audiology consults.

### *Issue 2: Investigation of the Removal of Patients from the Opioid Agonist Treatment Program’s EWL*

## Summary of Initial Complaint

- In July 2014, psychologist 1 contacted the OIG alleging that service chief 2 had pressured her to remove patients who were unreachable or referred for care in the community (fee-based) from the Mental Health Clinic’s OATP EWL. When interviewed regarding her concerns, psychologist 1 stated that there were a total of 440 patients in VAMC Baltimore’s OATP. Psychologist 1 reported that the largest number of patients she could recall being on the OATP’s EWL was 32 in 2011. She stated that her clinic had lost staff members who have not been replaced and that the clinic was “down three counseling positions.” She added that service chief 2 “pressured them” to remove from OATP’s EWL patients who continued to abuse drugs. She stated that this was not the “standard of care with methadone programs.”<sup>4</sup> She also said service chief 2 had told her that she should attempt to contact patients on the EWL and that if they could not be contacted, “Maybe we should take them off.” She said service chief 2 coded these removals in the system as “no longer needing care.” She further said service chief 2 removed patients from the EWL after stating that they were on the EWL in error. She added that service chief 2 had also directed her to remove from the EWL patients who were listed erroneously.

Psychologist 1 alleged that there was “pressure” from the VISN and VAMC Baltimore’s “front office” to keep the EWL numbers below 20 patients. She said that she and service chief 2 removed patients who were unreachable from the EWL. She stated that service chief 2 would ask her if she was able to contact the patient or if she had heard from the patient. If neither had occurred, the patient would then be removed from the EWL.

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<sup>4</sup> Throughout the course of this investigation, interviewees interchangeably used the terms “Methadone Program” and “OATP.” Methadone is one of several medications used by VAMC Baltimore’s OATP.

According to psychologist 1, VAMC Baltimore's OATP serves an indigent population so it is common for patients to lack reliable phone numbers and addresses. She said that patients who were deemed unreachable and subsequently removed from the EWL would typically return to the program at a later date. She also said that patients would be removed if they were referred for care in the community.

She stated that a new "non-count" clinic (also known as a Transfer Clinic) was created for patients who wanted VA care but were currently in some type of other non-VA care. She stated that in June 2014, service chief 2 told her and administrative employee 3 to create this Transfer Clinic. She alleged that when patients were transferred from OATP's EWL to the Transfer Clinic, this process "... zeroes out the wait time clock." She described the Transfer Clinic as a "non-billable clinic" and stated that "it's an imaginary clinic." She stated that she did not receive any clarification regarding this Transfer Clinic. She thought that it may be improper but later stated that "... it might be fine."

When asked what happened to the patients who were removed from the EWL, psychologist 1 replied, "I have... a database I was keeping, like not a secret wait list because I have the real wait list, but with a lot of notes on them, so I knew who they were, and when they came back I would just put them back on." She stated that she did not have any administrative support and that she was short-staffed. She further stated, "I didn't have the time to be trying to contact (the patients)."<sup>5</sup>

### **Summary of Historical Review of OATP's EWL**

- OIG agents requested that OIG's Office of Audits and Evaluations (OAE) provide historical summary EWL data pertaining to VAMC Baltimore's OATP. OAE provided a report, which contained the OATP's summary EWL data from January 2010 through July 2014. This report, which did not include the identities of specific patients, contained these summary fields: (1) Total Patients Waiting, (2) Unique Patients, (3) Wait Greater Than 14 Days, and (4) Wait Greater Than 30 Days. The overwhelmingly majority of summary data was listed in bimonthly increments.
- This report indicated that there were three periods during which 20 or more patients had been removed from OATP's EWL— namely, 2012, 2013, and 2014. In conclusion, the report stated, "Based on this summary data, it does appear they tried to keep it under 20 (patients), with a few exception periods." During an 11-month period between mid-2011 and mid-2012, "it looks like the same 40+ patients were sitting on the EWL. Then [in a matter of two weeks], all 47 were taken off . . ." The report further indicated that, "A few months later—[three months]—they started adding patients again. Appears they have been using EWL consistently since that time, but still keeping it under or around 20, with a few exceptions."
- OIG agents obtained a report listing all the patients who had been added to and removed from OATP's EWL from 2010 through 2015 from administrative employee 2.

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<sup>5</sup> In some instances, transcript quotes have been edited to improve readability by removing repetitive phrases or natural utterances/mild interjections such as "um."

- OIG agents subsequently compared the three time periods previously identified in the OAE report with the report provided by administrative employee 2.

The review identified the following using removal codes in Table 1.

<b>Table 1. EWL Removal Codes</b>	
<b>NN</b>	<b>Removed/No Longer Necessary</b>
<b>SA</b>	<b>Removed/Scheduled-Assigned</b>
<b>NC</b>	<b>Removed/Non-VA Care</b>
<b>ER</b>	<b>Entered in Error</b>
<b>CC</b>	<b>Removed/VA Contract Care</b>
<b>CL</b>	<b>Clinic Change</b>

- In 2012, 47 patients were removed from OATP’s EWL. These removals occurred during a two-day period. Some of these patients had been on the EWL for a period greater than 400 days. Of these 47 patients, 34 patients were listed as care no longer necessary (NN); 10 patients were listed as scheduled-assigned (SA); two patients were listed as receiving non-VA care (NC); and one patient was listed as entered in error (ER).
- In 2013, 29 patients were removed from OATP’s EWL. A majority of these patients were removed on a single date in 2013. Of these 29 patients, 17 were listed as NN, and 12 were listed as Scheduled-Assigned (SA).
- In 2014, 25 patients were removed from OATP’s EWL. A majority of these patients were removed on a single date in 2014. Of these patients, 14 were listed as under VA contract care (CC); six were listed as non-VA care (NC); three were listed as scheduled/assigned (SA); one was listed as entered in error (ER); and one was listed as a clinic change (CL).

**Comparison of OATP’s EWL to the “OATP Screening Database”**

- Psychologist 2 stated that in early 2015, shortly after she began working at VAMC Baltimore, she was asked by psychologist 1 to review a Microsoft Excel spreadsheet located on a shared drive and containing patient information. She reportedly saved this spreadsheet under a different file name so she could enter patient notes. She said this spreadsheet, which belonged to psychologist 1 and was placed on the Mental Health Clinic’s shared drive, was being kept separately from the EWL. She added that she was not sure why there should be a separate spreadsheet but that “it looked odd to me.”

- In mid-2015, OIG agents obtained a then current copy of OATP’s EWL from administrative employee 3. A review of this report disclosed that 17 patients were listed on the EWL. During that time frame, OIG agents, with the assistance of administrative employee 4, also obtained from the OATP shared drive a Microsoft Excel file named “OATP screening database.xlsb.” Administrative employee 4 located this file in a subfolder named “Scheduling” under a parent folder named “waitlist.” OIG agents compared patients from this “OATP Screening Database” to the then current copy of OATP’s EWL. The review disclosed that five patients who were listed in the OATP Screening Database were not listed on OATP’s EWL. These patients are referred to below as veterans 2, 3, 4, 5, and 6.
- The OATP Screening Database review indicated the following:
  - Veteran 2 was screened in mid-2015. A record notation seven weeks later stated that he was unable to be reached in over a month and was, therefore, removed from the EWL.
  - Veteran 3 was screened in mid-2014. A record notation six weeks later concluded that he was no longer interested in participating in OATP.
  - Veteran 4 was screened in 2014. His records indicated that he had been screened into the OATP program ten days earlier. The records also indicated that one month later, he was referred to an organization providing community care on a fee-basis.
  - Veteran 5 was screened in 2015. A notation in his records three months later conveyed that he was receiving community care at a local treatment center but that he had subsequently quit the program.
  - Veteran 6 was screened in 2015. His records indicated that ten days later, he was referred to a local treatment center for community care on a fee-basis and that he had been readmitted into the OATP nearly three months after his initial screening.

### **Interviews Conducted**

- An MSA stated that VAMC Baltimore’s OATP was then at capacity and new patients were referred to “outside” methadone programs. She reportedly did not know the last time the OATP had an EWL. She stated that psychologist 1 managed OATP’s EWL and that she was not aware of any removals from OATP’s EWL. She added that she was not aware of any policies in reference to keeping the EWL’s numbers “low” and had no knowledge of a “non-count clinic.” She observed that there were so many clinics within Mental Health that she did not know which clinic was assigned to which provider. She said that some clinics might have been created without her knowledge and that she was not aware of any unethical or improper scheduling practices being conducted at VAMHCS.
- Service chief 3 was interviewed in reference to the three “mass removal” periods during which patients were removed from OATP’s EWL. She said she transferred from another

VA facility to VAMC Baltimore in 2013 and, as a result, was unaware of these removals. She stated that service chief 4 or psychologist 1 may have knowledge of these removals. She explained that the EWL represented veterans who were waiting for care and were not receiving care at the time. When veterans received “care in the community,” which was also known as non-VA care or fee-based care, these veterans would be moved into the OATP Transfer Clinic. She stated, “It’s a holding clinic. It’s an administrative clinic.” She added that if a veteran was listed in the Transfer Clinic, it meant he/she was receiving “care.” She further stated, “We’ve been through the Joint Commission with this.” She remarked that VAMC Baltimore kept track of patients who were at the time in the Transfer Clinic but wanted to return to VA care. She said this request was noted in the internal Veterans Support Services Center (VSSC) database.

Moreover, service chief 3 stated that about one year before (in 2014), psychologist 1 had confided that she (psychologist 1) kept her own patient spreadsheet that was separate from the EWL. Service chief 3 said psychologist 1 had told her that she was keeping her own spreadsheet in order to keep track of those patients who were placed into the Transfer Clinic because they were receiving non-VA care due to OATP being at full capacity. She explained that she had advised psychologist 1 to stop maintaining this database and to use the official EWL. She stated that psychologist 1 had told her that she thought the Transfer Clinic was illegal and that VAMC Baltimore was gaming the system. After this issue was raised by psychologist 1, service chief 3 reported that she had discussed this matter with service chief 5. She stated that service chief 5 had told her that this process had been legally vetted and approved approximately one year before (in 2014), and that VACO may have provided advice in reference to this issue. Service chief 3 had no further information concerning the legality of the Transfer Clinic. She further stated, “I’ve been in and out of the OATP handbook that comes out of SAMHSA [Substance Abuse and Mental Health Services Administration], the federal guidelines, just so that I understand that we’re doing things correctly.” She pointed out that information contained in the OATP Screening Database did not transfer to the EWL. She stated that this practice of maintaining separate “log books” was inconsistent with the Joint Commission standards, as well as being a Health Insurance Portability and Accountability Act (HIPAA) violation. She said she believed that psychologist 1 may have maintained this separate database because of her “inflexibility” and her “worry that patients are getting lost.”

- Psychologist 1 stated that service chief 2 specifically had told her to keep the EWL count under 20 patients. She said she thought this practice was “unethical.” Later during this same interview, she stated that this information may have come from the front office at VAMC Baltimore or VACO. She explained that if your EWL was over 20 patients, you would be required to submit weekly reports. She later stated that some of the patient removals from the EWL were within policy. When asked if anyone had specifically told her that if a patient was unreachable, that patient should be taken off OATP’s EWL, psychologist 1 replied, “Yes, yes. [Service chief 2].” She stated that the first two major batches of patients (mid-2012 and late 2013) removed from OATP’s EWL were “legitimate.” She explained that because she had refused to do it, service chief 4 had removed the last batch of patients (mid-2014) from the EWL and placed them in the

Transfer Clinic. She remarked that she did not believe this was the proper use of the Transfer Clinic.

As for the 47 patients who were removed in mid-2012, psychologist 1 stated that there were attempts to contact these patients before their removal. She added that this was part of the “Consult Clean-Up Project.” She said that, during this time, additional staff had been hired and the clinic had the capacity to handle more patients. She stated that she had probably removed these patients from OATP’s EWL. She said these removals were done correctly, were not improper or unethical, and were not done to game the system. For the 29 patients who were removed in late 2013, she said that she thought additional staff had been hired at the time and that the clinic had more capacity to take care of these patients. She stated that, as a result, these patients received care and were removed from the OATP EWL by her. She remarked that these removals were ethical and not done to game the system. Regarding the 25 patients who were removed in mid-2014, she explained that some of these patients had been placed on this EWL erroneously. She also stated that during that time, she believed that she was supposed to take patients from OATP’s EWL and place them in the Transfer Clinic but that her attempts to transfer them were unsuccessful because of technical difficulties. She later said that she had refused to conduct these removals and that service chief 4 may have conducted these patient removals. She stated that service chief 2, service chief 3, and administrative employee 3 had directed the removals of these patients. She later said that the patients who were removed during this period were “receiving care in the community,” thus, explaining why they were removed from OATP’s EWL and placed in the Transfer Clinic. Psychologist 1 denied that veterans were removed from the EWL to reduce its numbers and asserted that the veterans were actually receiving care.

Psychologist 1 initially said the idea behind the creation of the Transfer Clinic originated with administrative employee 3. Later during the interview, she stated that she was not sure who created the Transfer Clinic. She further stated that the Transfer Clinic was approved and “vetted” under the direction of senior leader 4. She explained that in order to move a patient from OATP’s EWL to the Transfer Clinic, the patient had to be removed from the EWL and then placed in the Transfer Clinic. She said she thought this process was improper because shifting patients in this way would restart their wait time. She stated that she believed the purpose of the Transfer Clinic was to lower the numbers on OATP’s EWL. She said that the Transfer Clinic was used to track patients who were receiving non-VA funded care in the community and that she believed the use of this clinic was in violation of the VHA scheduling directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010).

Psychologist 1 said she believed that if a patient were receiving care in the community not funded by VA, that patient should still be placed on the EWL. She also said she believed that transferring these patients from OATP’s EWL to the Transfer Clinic was done to game the system and was unethical. She explained that 109 patients wanted to receive VA treatment but that only 18 were listed on OATP’s EWL. She stated that this was “fraudulent” and “it’s not demonstrating what is happening, which is a tidal wave of need.” She observed that her clinic was understaffed while she was attempting to manage 109 patients, as well as her other duties. She stated that 51 of the patients were receiving

care in the community on a fee-basis and 55 others were receiving care in the community for which VA was not paying. She added that these patient numbers were estimates. She said there were no reporting requirements for the 55 patients and, therefore, it could be difficult to determine if and when they received care. She stated that she believed the 55 patients should have been listed on the EWL because they wanted to return to VA for their care. Therefore, according to psychologist 1, OATP's EWL entries should show 18 patients plus 55 patients, for a total of 73 patients.

Psychologist 1 said she wanted to receive guidance from outside VAMC Baltimore. So she contacted program director 1, program director 2, and a consultant. She stated that program director 1 had told her, "I'm trying to get some clarification from OMHO (Office of Mental Health Operations). I'm not familiar with a non-count Transfer Clinic. That appears to be a local solution." She said program directors 1 and 2 agreed with her that the use of the Transfer Clinic was "improper." She also said that she and service chief 4 had sought advice from administrative employee 3 and physician 1. She stated that administrative employee 3 and physician 1 thought this issue was "concerning" and that VAMC Baltimore "may not be doing this properly." She added that "I have received almost zero training on EWL stuff" and that she recently received contradictory direction. She remarked that a patient could potentially refuse care in the community for fear of losing his/her place on the EWL—which would result in that patient not receiving any care whatsoever.

Psychologist 1 said she created the OATP Screening Database discovered during the investigation. She explained that this list was a "log" of every patient who was "screened" for the OATP. She further explained that this database also contained the patients' disposition. She said she created this patient database because she was unable to access these data from CPRS. She stated that she used this list as a "checklist." When asked who knew about this list, she replied that she had consulted with physician 1 and psychiatrist 1. She stated, "I knew that you were not meant to have like a log for wait lists, and I asked about it, because I wanted to make sure I wasn't doing that . . ." She added that she created this list in early 2014 and that in mid-2014, she had discussed it with service chief 3 and had received her approval. She also stated that service chief 2 and service chief 4 knew about the list and that she was never directed not to keep the list nor was she ever directed to create the list. She stated that the list was originally a way of collecting information on who was screened and it "morphed" into a checklist. She observed that her OATP Screening Database was not a "secret wait list," not created to game the system, and not unethical or improper. She said this was her attempt "to make sure I'm not losing anybody." When asked who had access to the OATP Screening Database, she replied, "Everyone in the clinic knows about it and has access to it."

- Administrative employee 3 stated that the decision to create a Transfer Clinic was a group decision, which was discussed for approximately one month and included these individuals: senior leader 5, service chief 5, service chief 2, service chief 3, coordinator 1, himself, and other "clinical center directors." He explained that no legal guidance had been given during the Transfer Clinic creation and that MAS had said the Transfer Clinic was appropriate. He also stated that the Transfer Clinic was not created to game the system.

- Service chief 4 stated that in mid-2014, service chief 2 had told him that removing patients from OATP's EWL had been approved by service chief 3 and VISN-level employees. He said he had removed approximately 15 to 20 patients from OATP's EWL and conducted patient removals from the official OATP EWL in mid-2014 because service chief 2 directed him to do so in light of the creation of the Transfer Clinic.

Service chief 4 reportedly was advised that anyone receiving VA contract or non-VA contract care in the community could be removed from OATP's EWL because he/she was no longer waiting for care. He stated, "So, according to the institution, they were in the wrong list." He explained that these patients had been incorrectly placed on OATP's EWL when they should have been in the Transfer Clinic and that MAS had developed the Transfer Clinic, which came about when the Mental Health Clinic was "feeling pressure" to keep the EWL under 20 patients. He said this number was talked about in morning meetings with senior management staff, adding that administrative employee 3 created the Transfer Clinic under the direction of service chief 3. He stated that he was unsure if this clinic had been approved by VA regional counsel. When asked if these patient removals were done to game the system, he replied, "Well, it depends how you look at it. . . . I had reservations about the Transfer Clinic because it looked like an attempt to game the system. . . ." He further stated, ". . . it seemed to me that the main reason we were doing this finagling of worrying about a Transfer Clinic at all, instead of just keeping people on the EWL was because the VA, at the highest levels, doesn't want any EWLs . . . I assume, because it doesn't look good."

Service chief 4 reportedly never received a memo, general order, or email that discussed the issue of keeping OATP's EWL under 20 patients. He said that the Transfer Clinic "didn't quite feel right" to him, and that the rules and regulations around managing the EWL were not clear at the medical center level or the VISN level. He explained that service chief 2 was directed to remove approximately 10 to 12 patients from OATP's EWL around mid-2014, and that he did not know who directed service chief 2 to remove these patients. He stated that during the following week, they changed their mind and realized that was not the right thing to do. As a result, the patients were placed back on OATP's EWL. He said that although he thought they were wrong, the Transfer Clinic was approved by the VISN. He stated that the Transfer Clinic was created to track patients who were receiving non-VA care but may have wanted to return to VA care in the future. According to him, just because the patients were receiving care in the community did not necessarily mean that they did not want to come back to VA care and so they should have been placed on OATP's EWL. He stated, "I think the people who directed us to use it (Transfer Clinic) thought that it was the legitimate way to go. They weren't trying to game the system." He added that, based on policy, he believed the Transfer Clinic was "improper."

When questioned about the existence of the OATP Screening Database, service chief 4 stated that this list was created and managed by psychologist 1. He explained that he and psychologist 1 came up with the idea for the list and that no one had directed them to create it. He said the OATP Screening Database was a tracking database on the shared drive for all patients coming in to OATP for screening. He stated that this patient database was not created to game the system or hold "any bad intent," that it was not a

secret wait list, and that it could be used for performance improvement. He said the list was started in early 2014; he was not sure if his supervisors (service chief 2, physician 1, or service chief 3) were aware of its existence. He stated that he and psychologist 1 thought it would be a good way to keep track of patients who had been screened, what the disposition had been, and where those patients were receiving community care (non-VA care) if referred outside of VA. He said, “. . . we have kept databases for programs for a long time. They keep them in most of the programs. I think there has been sloppiness, in terms of maintaining those databases, for sure. They’re not particularly accurate, but again, never any intent to have a parallel kind of system or wait list or hidden—hiding anything. If anything, the effort is to try to be as transparent as possible and give as complete data as possible on where these patients are.” When asked about the five patients found on the OATP Screening Database but not on the OATP’s EWL, he replied that there was never a great system for tracking these things. He remarked that the list was created to try to improve the system and to add information that the system could not provide.

- Service chief 2 stated that there was “a lot of confusion” at the time of the three mass removal periods during which patients were removed from OATP’s EWL, and that he did not remove patients during the first or second period. He said he was unsure whether he might have removed patients during the third removal period. He said he “had no idea” about the mid-2012 removals and believed that psychologist 1 would have knowledge of these removals since she managed OATP’s EWL. When questioned about the late 2013 mass removal, he replied that he was not sure why patients were removed from OATP’s EWL but that psychologist 1 may know.

Service chief 2 stated that to his knowledge, nothing was unethical about the removals, and that the third removal period in mid-2014 might have occurred as a result of the formation of the Transfer Clinic. He reportedly removed from OATP’s EWL 12 to 14 patients who he thought were later put back there. He said he believed these patients were removed in error because of the confusion with the Transfer Clinic policy. He stated that there “was probably a little bit of confusion about exactly what the policy was at that time.” He said he did not think any patients were “lost” during this process. He stated that he did not believe anything was unethical about these removals and that he removed from OATP’s EWL patients who were either listed inappropriately or erroneously added by a scheduler. He said he directed service chief 4 and psychologist 1 to remove only the patients from OATP’s EWL who were listed on the EWL in error. He stated that he had received direction from service chief 3 on EWL procedures via an email in late 2014 and that this email, sent to him, psychiatrist 1, service chief 4, psychologist 1, and administrative employee 3, had clarified OATP’s EWL processes and mentioned the Transfer Clinic.

Service chief 2 reportedly was never directed to conduct patient removals from the EWL, just to keep the number of patients under 20. He said he was directed only to remove from OATP’s EWL patients who were listed there in error. He stated that service chief 3 and psychologist 1 were involved in the creation and implementation of the Transfer Clinic in early 2014. He also stated that he believed it was possible that VISN personnel and a senior management official were also involved. He said his understanding was that

the Transfer Clinic was to be used in conjunction with OATP's EWL in order "to ensure that every single veteran was accounted for in the system." He stated that the Transfer Clinic was not created to game the system nor did he see it as unethical. He said he believed that the Transfer Clinic was a place to account for the veterans while their non-VA care was being established. When asked who had created the Transfer Clinic, he replied, "I imagine that psychologist 1 probably set it up with MAS support." He stated that the VISN and possibly physician 2 were involved in the operation of the Transfer Clinic. When asked if he knew who had approved the creation of the Transfer Clinic, he replied that clinic approval was typically done by service chief 3. He stated that service chief 3 "probably" had approved the Transfer Clinic, which was created by MAS. When asked if it was improper to list a patient on the Transfer Clinic instead of OATP's EWL, he said he did not believe that this was improper and that it was not done to game the system.

Service chief 2 stated that when the Transfer Clinic was created, he had asked himself, "Is it, you know, something that we should be doing?" He said he knew that psychologist 1 and service chief 4 had also been confused by this issue and thought that psychologist 1 had told him that "she felt like all of this was unethical." He stated that before late 2014, psychologist 1 told service chief 3 and himself that she was using a separate Microsoft Excel spreadsheet containing patient data. He added that psychologist 1 also possibly told psychiatrist 1, service chief 4, and administrative employee 3. He further stated that before this interview, he had never seen this spreadsheet and that psychologist 1 had been advised to discontinue its use. He reportedly did not direct psychologist 1 to create this spreadsheet, had no knowledge of why it was created, and "hope[d]" that it was not created in order to game the system. He believed that this spreadsheet was unethical and improper.

- Service chief 5 stated that Transfer Clinics were used in Mental Health for substance abuse or opioid treatment, and in Managed Care, while the Mental Health Transfer Clinics were used for veterans receiving non-VA care in the community but want to come back to VA for their care. She further stated that the Managed Care Transfer Clinic was used for veterans receiving care at one VA facility and wanting to transfer to a different VA facility. She said she did not know who created, or approved the creation of, the Mental Health Transfer Clinic. She stated that about 18 months before this interview (late 2015), she had attended a meeting with administrative employee 1 and administrative employee 3 during which the creation of the Transfer Clinic was discussed. When asked if there had been a legal review regarding the creation of the Transfer Clinic, she stated, "As far as I know, no." She added that, following the Phoenix incident,<sup>6</sup> national scheduling auditors had conducted an audit of VAMC Baltimore. She said she believed these auditors had indicated that this Transfer Clinic was being used appropriately. She remarked that the Transfer Clinic was not created in order to game the system.

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<sup>6</sup> Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

- Former senior leader 1—in response to being told of the three OATP EWL mass removal periods—stated that he believed these removals were “appropriate” after attempts were made to contact the veterans. He further stated that it appeared that these removals were not done to game the system and that VAMHCS served tens of thousands of patients and, therefore, the removal of 29 patients from an EWL would not significantly have reduced their numbers. He said he believed that if a patient was receiving non-VA care, he/she should be removed from the EWL because he/she was no longer waiting for care. When told that this investigation had revealed that OATP’s EWL appeared to have been kept at approximately 20 patients, he commented that there was no directive given from his office to keep the EWL numbers under 20 patients. He stated that there was “a lot of pressure from Central Office” to keep the list at a minimal level. He further stated that VAMC Baltimore had many healthcare vacancies because they were underfunded. As a result, the facility was unable to keep up with the demand for patient care. He explained that VAMC Baltimore directors had not received bonuses “for a while” and that personnel were not rewarded for “getting their list down.” He said there were conflicts with people in the Mental Health Clinic, as well as with some poor supervisors. He added that some people in the department had been reassigned but that it was difficult to fire poor performers.

Former senior leader 1 stated that he had had no knowledge of the Transfer Clinic so he had contacted service chief 3 to find out what it was.<sup>7</sup> Former senior leader 1 said service chief 3 had told him that if VA could not provide care to a patient, VA would pay for the patient to receive non-VA care or care in the community. If the patient was receiving this non-VA care, the patient would be removed from the EWL and placed into the Transfer Clinic. This was done so that VA would not lose contact with the patient. If a patient “slot” became open at VA and the patient wanted to return to VA care, he/she would be brought back to receive care at a VA facility. He stated that service chief 3 had also told him that she and service chief 5 had this Transfer Clinic “vetted” and approved by VA personnel. He remarked that the Transfer Clinic did not seem improper because the patient received care. He also said he believed that this process was not done to game the system or “cheat.” He added, “I think they were trying to do the right thing and I think they did do the right thing.”

- Coordinator 2 stated that administrative employee 3 had sent her OATP’s EWL because, as part of her duties, she would conduct periodic reviews of the lists. She explained that although patients were receiving non-VA care in the community, the facility would still list the patient on the EWL. She said this was done to “track” the patients in non-VA care and then to offer them an appointment when one became available at VAMC Baltimore. She said this was also done to prevent patients from “falling through the cracks.” She did not find anything unethical or improper about the “reporting of the EWL,” adding that there was “no gaming of the system.”

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<sup>7</sup> During the conversation to schedule the interview, OIG agents informed former senior leader 1 that the Transfer Clinic would be one of the topics of discussion.

- Service chief 3 was interviewed in reference to the removal of patients from OATP's EWL. She stated that VAMC Baltimore's "addiction counselors" could only care for a maximum of 50 patients because of state regulations. Therefore, if each counselor had 50 patients, the clinic would be "at capacity." She explained that when the clinic was at capacity, a patient could wait for care and remain on VAMC Baltimore's EWL, accept the offer to receive non-VA care in the community that was paid for by VA, or receive care in the community that was not paid for by VA. She stated that the Transfer Clinic should only have been used for patients who were receiving care in the community for which VA was paying. She added that patients should have remained on the EWL if VA was not paying for their care. She also stated that there had been some confusion in the past regarding these issues. She observed, "But I think at that time it was not as clear to the staff, front line, and even to me, getting supervision from Chief of Staff and the MAS folks, what exactly we were supposed to do." She said there had been a change in oversight with the program manager and that "we're just all on the same page."
- Senior leader 4 was interviewed in reference to the removal of patients from OATP's EWL, the creation of a Transfer Clinic, and the alleged pressure by VA staff to keep the EWL list under 20 patients. He stated that he was not aware of any of these aforementioned allegations. He said, in the past, there were not enough OATP providers to handle the demand of patients who wanted to receive care in the clinic. He stated that the clinic was "vastly different now in how the clinic is administered and how we're taking care of patients." He said he believed that there was no deliberate attempt to hide or to not count the patients who were waiting for care. He stated that if patients needed care and there was no capacity at VAMC Baltimore, he would pay for them to receive care in the community. He said he had advised his staff, "Do not make decisions on what you think our budget is or what you think our financial status is. Make decisions on what the needs of the patients are."
- Former senior leader 2 was interviewed in reference to the removal of patients from OATP's EWL, the creation of the Transfer Clinic, and the alleged pressure to keep the EWL under 20 patients. He stated that he did not have any recollection of any of these allegations.

### **Records Reviewed**

- Service chief 3 provided an email (late 2014) she had originally sent to psychologist 1, service chief 2, service chief 4, administrative employee 3, and psychiatrist 1. The email stated, in part, "All patient lists regarding access are available for review via the protected mechanisms of VSSC [Veterans Support Services Center] and will not be kept anywhere else. No individual should be tracking wait times in any way independent of the VSSC process. *For clarity – no staff member or employee is to independently collect and keep information regarding Veteran access.*"
- At the request of the OIG, service chief 4 reviewed the medical records for the five patients mentioned during his interview to determine why they were removed from the EWL. He then explained that the purpose of the OATP Screening Database was to track

all referrals to the OATP program. He wrote, “It is *not* intended as a substitute for the official EWL, but rather to fulfill the following functions:

- To examine the demand for opioid agonist treatment (OAT) over time (e.g., by breaking down the number of screenings by month in order to look at trends);
  - To analyze the breakdown of the dispositions following screening (e.g., proportion of Veterans screened who are admitted, referred to detox, determined to not meet criteria for OAT, referred to community programs, etc.);
  - For Veterans referred to the community, to keep track of which program they were referred to and ensure that the multistep referral process is followed.”
- Service chief 4 provided this information on the five patients:<sup>8</sup>
    - Veteran 2: [Veteran 2] was removed from the EWL in mid-2015 because of inability to reach the veteran.
    - Veteran 3: [Veteran 3] was removed from the EWL in 2014 as he was not presently on OAT and had been accepted into residential treatment as an abstinence patient and had started at Perry Point. Plan was to relook at situation closer to discharge. Veteran was placed back on EWL after discharge from residential. [Psychologist 1] had checked in with him prior to discharge and then again afterwards and he did not want to be in treatment in the community but wanted to wait for a slot at the VA. He was removed again from EWL in 2015 when he was no longer interested in maintenance treatment.
    - Veteran 4: [Veteran 4] had previously been on our wait list from another screening the previous year (veteran had not followed up and had been pretty much AWOL [away without leave]) but [psychologist 1] took him off when it was discovered that he was now enrolled in office-based Suboxone treatment with [physician 3]. He was subsequently transferred to methadone treatment in the community and switched over to the transfer clinic per protocol at that time.
    - Veteran 5: Veteran had been referred to a community clinic but he did not show for his intake appointment there, telling the clinic that he no longer wanted maintenance treatment. He was therefore removed from the EWL.
    - Veteran 6: A review of the veteran’s chart revealed that he was in a community nursing home for what seemed like long-term treatment, so

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<sup>8</sup> See also page 11 for database notes regarding these patients.

methadone would not be necessary. The comment “refused community referral” refers to the veteran’s original statement that he did not want to be referred out. He later changed his mind and asked for a referral, which psychologist 1 completed. He was removed from the EWL when it was determined that he no longer needed OAT as he was in a nursing home level of care.

### **Review of EWL Removals Conducted by Administrative Employee 5 and VAMC Baltimore’s Response**

- The OIG requested that a VACO service chief review EWL removals at the VAMC Baltimore Methadone Clinic. The review was to focus on the three different time periods when 20 or more patients were removed from OATP’s EWL. The OIG requested that the review include a determination of whether the proper disposition codes were used when patients were removed from OATP’s EWL. This task was assigned to administrative employee 5.
- Administrative employee 5 gave the OIG three Microsoft Excel spreadsheets that reflected her review of the patient removals from OATP’s EWL: the first occurrence taking place in 2012, the second in 2013, and the third in 2014.
- The OIG’s review of the spreadsheets showed repeated instances in which administrative employee 5 was unable to locate documentation regarding a patient’s removal from OATP’s EWL. As previously mentioned, the 2014 removal was the only one conducted following the creation of the Transfer Clinic. Of the patients removed, 14 were sent to VA contract care (CC) and six were sent to Non-VA care (NC). For some of these removals, the spreadsheets contained notes stating that the patients were “referred to community,” “referred to county health dept.,” “referred to a needle exchange program,” and “referred for grant funded treatment in the community.” Some of the patients’ records were disposed of with simply a “CC” code and others with an “NC” code.
- The OIG requested that senior leader 4 conduct a review of the three time periods that were examined by administrative employee 5 to determine (1) the circumstances surrounding the removal of each patient and what had since happened to each patient, (2) who removed each patient from OATP’s EWL, (3) conclusions reached regarding the removals, and (4) whether the facility intended to take further action to determine if the patient currently desired to receive OATP care. For any deceased patients, the OIG requested that the facility note whether their removal from OATP’s EWL contributed to their deaths.
- Senior leader 4 responded as follows: “The chart reviews were performed by [senior leader 3]. The data source used for this review was VA’s electronic medical record (CPRS). The findings from the chart review determined that [psychologist 1] removed the majority (74.5%) of Veterans from the EWL. [Service chief 4] removed 20.5% of Veterans from the EWL and the remaining 5% were removed by 4 different individuals. Mental Health staff with scheduling privileges have received education about the business rule for the appropriate use of the VA Electronic Wait List (EWL). There were

no conclusions reached about the removals. However, the current Mental Health Clinical Center executive staff did not direct staff to remove these Veterans. Staff followed up with all Veterans placed on the EWL to ensure OATP services were offered to the Veterans. Veteran contact is documented. Currently, some Veterans are enrolled in either VA Maryland Health Care System (VAMHCS) or community OATP services; others have declined services or no longer receive care within VHA. There is no relationship or causal effect of removal of any Veteran from the EWL and death.” Senior leader 4’s response also included spreadsheets that documented senior leader 3’s work product.

### **Consultations Provided by VA OIG Office of Healthcare Inspections**

- At the OIG’s Office of Investigation’s request, the Office of Healthcare Inspections (OHI) conducted a review of VAMC Baltimore’s OATP Transfer Clinic to determine if the Transfer Clinic was created in accordance with all applicable VHA policies and procedures and if the Transfer Clinic was an appropriate way to track patients who receive OATP care in the community.
- OHI provided a response which stated that “VHA Handbook 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010 (expired June 30, 2015), is the controlling Handbook for this question. We reviewed Handbook 2010-027 and determined this scenario was not specifically addressed because opioid addiction treatment is generally a long-term treatment as opposed to the more often NVCC [Non-VA Care Coordination] scenario of episodic need with limited treatment duration.”

OHI’s response further stated, “Handbook 2010-027 4c(4)(c) (19)(i) states the following ‘(i) Patients provided authorization for continued Non-VA care need to be tracked and brought back within VHA as capacity becomes available. This needs to be from the oldest authorization moving forward, as clinically indicated.’”

OHI consulted with [a senior VACO official] for VA Central Office rule interpretation who provided this guidance via email:

- “If the VA DOES NOT have timely capacity (within 30 days) and arranges to BUY the care from a Non-VA provider, the patient would go to the Care in the Community Department to arrange authorization to formally refer the patient to a Non-VA provider. Their request would be in the Care in the Community department through the consult system for this. They would not be on an EWL or Transfer list.
- If the VA DOES have capacity but the patient chooses to go to a Non-VA provider on their own, they could choose to do that and we would not have a record of it on the EWL or a Transfer list.
- If the VA DOES have timely capacity and are being taken care of at one site, the patient prefers another site (that does not have capacity), they should be put on a transfer list to go to the other site when there is capacity.

- If the VA DOES NOT have timely capacity (before 90 days) for a program the patient wants/needs, then they would go on the EWL.”
- OIG agents subsequently noted to OHI that NVCC (formerly known as fee-basis care) coordinated services and payments for veterans receiving non-VA care for emergent and non-emergent medical care. Because the facility did not have timely capacity, VAMC Baltimore sometimes arranged for non-VA care through state programs and charities—which was not paid for by VA. The patients who received this care were removed from the EWL and placed into the Transfer Clinic.
- According to OHI, the senior VACO official, after being further questioned regarding patients who were receiving non-VA paid services outside the VA system, responded that these patients should be kept on the EWL until they opt to be removed from the list. As a result, OHI concluded that “Baltimore VAMC should have kept patients receiving Non-VA paid services on the EWL if they wished to receive VA OATP services when capacity allowed. Baltimore VAMC EWL patients receiving Non-VA paid services should not be placed on the Transfer Clinic list.”

The response stated that, according to the senior VACO official, the intent of the Transfer Clinic list was “to keep track of patients already receiving care at a VA site, but who want to ‘transfer’ their care from one VA provider to another VA provider.” According to the consultation, “[the senior VACO official] stated that he was not aware that VAMC has an obligation to track care not paid for by VA. However, he clarified that it was the patient’s choice to remain on the EWL, which is tracked by VA leadership to assess patient care needs and allocate resources.”

- The VA OIG Office of Investigations also submitted a request to OHI to examine the delegated project by the VACO service chief to administrative employee 5—who was reviewing three different time periods (mid-2012, late 2013, and mid-2014) when 20 or more patients were removed from the OATP’s EWL. The background for the request further noted that the Transfer Clinic was not being used in July 2012 and December 2013, respectively. Moreover, a total of 102 patients had been removed from OATP’s EWL during these three periods. These removals involved a combination of (1) some patients being placed in the Transfer Clinic because they received community treatment and (2) other patients not being placed in the Transfer Clinic and being outright removed without being referred for community treatment. OIG agents requested OHI’s assistance in addressing any unresolved questions with respect to administrative employee 5’s work product and VAMC Baltimore’s response.
- In response OHI advised, “We did not identify discrepancies in the documented information on the spreadsheets... Of the 101 patients’ removals that we reviewed, seven patients had no [electronic health record (EHR)] documentation for their removal from the EWL. We are unable to evaluate whether these seven patients were appropriately removed from the EWL. The EHRs of another seven patients did not adequately support their removal from the EWL and indicated only that that they

were either receiving OATP services in the community or referred to community programs.”

“We concluded that none of the patients on the three spreadsheets experienced harm because of waiting for OATP treatment. None of the 10 deceased patients died because of not receiving OATP services. Of the five patients who were hospitalized, three were for suicidal ideation in the setting of opioid use. All three of these patients received substance abuse treatment but had issues adhering to the program or lacked motivation for sobriety, leading to their hospitalizations.”

- OHI was also asked to review any available medical records for veteran 2 and veteran 3 so as to determine if any additional information existed on their removals from OATP’s EWL.
- OHI’s response further stated that “we determined that OATP staff appropriately removed veteran 2 and veteran 3 from the EWL. Additionally, as of the date of our review, there are no death notices in the EHR documentation for these two patients.”

### *Issue 3: Summary of Investigation of Complaint Regarding the Death of Veteran 1*

#### **Summary of Allegation and Subsequent Investigation**

- During an interview, psychologist 1 stated that veteran 1 had died while on OATP’s EWL. She said that veteran 1 died from what his autopsy report indicated was “undiagnosed AIDS [acquired immunodeficiency syndrome]” after having been referred for care in the community on a fee-basis. She noted that veteran 1 had received non-VA care, then stopped going to his appointments altogether. She reported that he was “like really a wild guy, yelled all the time.” She stated that “he was a very difficult man, but he had a lot of chronic pain.” She added that veteran 1 was homeless and “using.” She said she felt that if veteran 1 had been receiving VA care, he “probably” would have been diagnosed with AIDS; she also noted that during veteran 1’s final months, he received care at Johns Hopkins Hospital.
- The OIG obtained veteran 1’s postmortem report from the Office of the Chief Medical Examiner, Department of Health and Mental Hygiene in Baltimore, Maryland. The report stated that veteran 1 died in 2013 and listed the cause of death as “Hypertensive Atherosclerotic Cardiovascular Disease” with the manner of death as “natural.” The report further stated that “diabetes mellitus, hepatitis C seropositivity, intravenous drug use, and acquired immunodeficiency syndrome (AIDS) are considered additional significant conditions in this man’s death.”
- Administrative employee 5 stated that veteran 1’s name was removed from OATP’s EWL in 2012 by psychologist 1. The reason for his removal from the EWL was listed as “REMOVED/NON-VA CARE.” She explained that veteran 1’s medical file did not contain any additional notes or documentation of a consult for him to be placed in non-VA care, adding that a consult was necessary in order for a patient to receive non-VA care.

- The OIG requested that senior leader 4 conduct a review to determine (1) whether veteran 1 received non-VA care, (2) who removed veteran 1 from OATP's EWL, (3) whether veteran 1's removal from OATP's EWL contributed to his death, and (4) whether proper documentation or a consult existed in veteran 1's medical records.
- At the conclusion of the review, senior leader 4 advised the OIG of the following: "The Veteran received community based Opioid Agonist Treatment Program (OATP) services starting in 2011. The VA electronic medical record contains the Non VA care consult for these services submitted by [psychologist 1 in 2011] and approved by [former service chief 2 in 2011]. There is no EWL note in CPRS detailing his OATP EWL status, but documentation supports the fact that patient was enrolled and participated in the community based OATP program after the referral was placed and approved. The Veteran remained an active patient in the VAMHCS for all other primary care, specialty, and mental health care. The attached medical examiner's death certificate [indicates], the patient died of hypertensive atherosclerotic cardiovascular disease, with other significant conditions of diabetes mellitus, hepatitis C, intravenous drug use, and acquired immunodeficiency syndrome by history. This allegation [VAMC Baltimore's inability to provide on-site OATP services to veteran 1 led to a failure to diagnose AIDS, which caused his death] was determined to be not substantiated."
- The VA OIG Office of Investigations also submitted a request to OHI to examine the results of the VAMC Baltimore's review of the death of veteran 1. OHI's response stated that "we found that veteran 1 started in a NVCC methadone program sometime [in 2011], even though the EHR did not reflect that an NVCC request was placed. His death was unrelated to his EWL removal in 2012."

#### *Issue 4: Response to Allegations of Improper Methadone Tapering*

##### **Summary of Allegation and OHI's Response**

OHI also addressed an allegation submitted by a complainant to VA OIG's Hotline. The consultation stated that "in an email sent to the OIG Hotline [in late 2015], the complainant stated that the Chief of Mental Health's suggestion that some patients be tapered off methadone was contrary to the standard of care." OHI concluded that "tapering methadone is not invariably against practice guidelines or the standard of care. The Federal Guidelines for Opioid Treatment Programs (Guidelines) describe the Substance Abuse and Mental Health Services Administration's (SAMHSA) expectation of how the federal opioid treatment standards found in Title 42 of the Code of Federal Regulations Part 8 (42 CFR § 8) are to be satisfied by opioid treatment programs (OTPs)."

The consultation findings noted that SAMHSA "has also published a Treatment Improvement Protocol (TIP) entitled Medication-Assisted Treatment for Opioid Addiction in opioid treatment programs that defines phases of treatment. In the TIP, tapering is considered to be optional, and continuing methadone treatment is considered the best choice for some, but not necessarily all patients. Thus, tapering might or might not be an appropriate choice for a particular patient and might or might not progress to completion, depending on individual clinical circumstances. The

complainant's statement that tapering patients off methadone is against the standard of care and against the practice guidelines is not supported by the TIP."

The consultation staff also referenced an article that indicated "methadone tapering is controversial given the effectiveness of ongoing treatment versus low rates of success with tapering, which they attribute to the chronic and relapsing nature of opioid dependence. The authors added, however, that tapering is an important component of any opioid treatment program, because the demand for methadone often outstrips community resources in the USA, and patient financial constraints can result in premature termination from methadone of substantial numbers of patients."

Further, "[I]n summary, there are no clear guidelines on when/if to taper methadone, except patients are not to be coerced into tapering. The decision should rest on clinical factors and patient preference. Tapering methadone is not invariably against practice guidelines or the standard of care, although it must be based on informed and sound clinical judgment . . ."

*Issue 5: Investigation of the Mental Health Clinic's Scheduling Inconsistencies/  
Paper Scheduling*

**Summary of Allegation**

- The MSA reported that some providers scheduled their patients in their personal handwritten appointment books. She said providers would come to her after the appointment to ask her to enter the appointment into the scheduling system. She stated that the provider would know about the veteran's appointment but she would not, because the appointment would not be in VistA. She explained that appointments should have been scheduled beforehand and that this practice prevented her from updating the patients' contact and insurance information. She added that OATP did get walk-in patients but that some providers scheduled their appointments the same day. For example, if a provider were to see a patient at 10:00 a.m., he or she would have her enter the appointment at noon after the veteran had left. As well, if a veteran was to be seen on a Tuesday, the appointment would likely be entered on a Thursday. She observed that this occurred often.

The MSA stated that two employees in particular scheduled appointments after the actual appointment had occurred. She identified addiction therapist 1 and addiction therapist 2 as providers who scheduled appointments in this manner. When asked if these two providers knew the proper scheduling policy, she replied she had told them the process and even went to the length of having a revenue specialist from Medical Administration Service (MAS) speak at a meeting to highlight the importance of prescheduling appointments. She remarked that she had been trying to correct this problem but that she "gave up."

The MSA further stated that she did not deal with desired or appointment dates when she entered the veteran's appointment into the system after the actual appointment had occurred. When told that this practice would make it appear as if the veteran waited zero days for his/her appointment, she replied, "I guess." She reportedly did not recall having to enter the appointed date requested by the patient.

The MSA said some of her providers scheduled their own appointments, some scheduled the appointment after the appointment, some had her schedule the appointment on the same day (walk-ins), and some had her schedule appointments for a future date. She added that she only scheduled appointments if the provider told her to schedule an appointment.

- Psychologist 1 provided a list of providers for whom the MSA was responsible for scheduling appointments, including:
  - Psychiatrist 2
  - Psychiatrist 3
  - Psychiatrist 4
  - Psychologist 1
  - Psychologist 2
  - Psychologist 3
  - Psychologist 4
  - Psychologist 5
  - Nurse practitioner 1
  - Nurse practitioner 2
  - Addiction therapist 1
  - Addiction therapist 2
  - Addiction therapist 3
  - Social worker 1
  - Social worker 2
  - Social worker 3
  - Social worker 4
  - Social worker 5
  - Pharmacist
  - Rehabilitation technician
  - Supervisor 1
  - Service chief 4
- When reinterviewed about the list of providers for whom she scheduled appointments in VistA, the MSA stated that all of addiction therapist 1's patients were scheduled after the appointment. She stated that a majority of addiction therapist 2's patients were scheduled after their appointment and that service chief 4 and psychologist 3 sometimes scheduled their appointments on the same day the patient was seen. She explained that this was not the policy and that the largest offenders of the scheduling policy were addiction therapist 1 and addiction therapist 2. She said she believed that service chief 4 was the supervisor for addiction therapist 1, addiction therapist 2, and psychologist 3.

### **Interviews Conducted**

- Psychiatrist 2 stated that he did not enter appointments for his patients into VistA. He explained that after seeing a patient, he would give them an appointment slip that reflected the patient's future appointment. He reportedly instructed his patients to give this appointment slip to the MSAs at the front desk in order to have their appointment entered into VistA. He stated that the veterans did not always give their appointment slip

to the MSAs; therefore, their future appointment did not get scheduled. He said he was not aware of any providers who submitted appointments to be scheduled after the actual appointment had occurred. He added that he did not preschedule appointments for veterans attending “open group sessions.” If a veteran arrived for an open group session, his/her appointment would be scheduled afterward.

- Addiction therapist 3 stated that she did not schedule appointments for patients nor did she have access to the scheduling of patients in VistA. She explained that after her appointment with the veteran had concluded, she would give him/her an appointment card. The veteran then would give the appointment card to one of the MSAs so that they could input the future appointment into the system.
- A pharmacist stated that she only saw patients for a smoking cessation group to write prescriptions and that she had no knowledge of VA’s scheduling practices. She added that she had no knowledge of any providers who scheduled their appointments after the actual appointment.
- Nurse practitioner 1 stated that his appointments were scheduled in advance of the actual appointment. He said that before leaving the facility, the patient would take the appointment card to one of the MSAs in order to schedule his/her next appointment and that he had never scheduled an appointment after the actual encounter with the patient.
- Psychologist 2 stated that she had access to the VistA scheduling system but that the MSA scheduled her future appointments. She explained that she wrote future appointments on a sheet of paper, which she gave to the MSA at the end of the day. She said that occasionally she had a walk-in appointment and that walk-in appointments would be entered into VistA on the same day of the encounter. She recalled that she once had a patient with a problem related to entering the appointment into VistA. She said it took a couple of weeks to sort out. She said she did not know of any providers who scheduled appointments after the fact. She stated that during team meetings, which occurred from February through July 2015, providers were reminded to preschedule appointments.
- Psychologist 3 stated that he and the scheduling clerks entered patient appointments into the system. He explained that he had preprinted appointment slips for his clinic and that he would fill in the veteran’s future appointment date and time. He further stated that he would give these appointment slips to the MSAs usually around lunch time and again toward the end of the day. He said these appointments needed to be entered into the system in order for him to attach any patient notes. He stated that during his first week in the OATP Clinic, he had the patients give the appointment slip to the MSAs on their way out. He said this practice was not successful, adding that he was not aware of any instances in which providers were scheduling appointments in VistA after the actual appointment. He estimated that between 40 to 60 percent of his patients are “walk-ins.” He concluded by stating that the OATP Clinic was attempting to create a system in which there were fewer walk-in appointments and more scheduled appointments.

- Service chief 3 stated that she was only aware of open groups whose appointments were scheduled after the fact. She explained that there was a sign-in sheet for the open group meeting and the patients were then entered into the VistA system following the meeting. She said she was not aware of any providers who did not preschedule their appointments, and would advise staff to do so.
- Nurse practitioner 2 stated that she did not schedule appointments for her patients because she did not have access to VistA. She said the MSA, as well as the other MSAs, scheduled future appointments in the system for the veterans. She stated that she would fill out her appointment form and give it to the MSA or give it to the other MSAs located near the elevator or give it to the veteran to submit before he/she exited the clinic. She said she would submit the appointment form to the MSAs on the same day that she filled out the form.
- Social worker 1 stated that she did not schedule appointments for her patients because she did not have access to VistA. She reiterated that most of the time, she would also give her appointment form to the MSA or the other MSAs located near the elevators. She said she might write five or six future appointments on a sheet of paper, which she would turn in to the MSA that same day. She stated that the MSA would usually enter the appointments into the system on the same day they were received. She added that the majority of providers, including herself, preschedule their appointments. She remarked that some providers scheduled patients after appointments but she did not provide any specifics.
- Psychologist 4 stated that he did not have access to VistA scheduling and that he would give a list of patients to the MSAs so that they could schedule future appointments. When asked when he handed the list to the MSAs, he replied, “If I’m lucky it would be the time of the appointment, but if stuff got in the way it might be at the end of the day.” He explained that for some “well routined” patients, he would hand them the appointment slip to give to the MSAs. He said he had many walk-ins. He also stated that he would notify an MSA if he had a walk-in appointment and that he kept a personal schedule book but that the appointments in his schedule book reflected those in VistA.

He reportedly was unaware of any scheduling irregularities with other providers. He acknowledged that sometimes he would forget to give his appointments to an MSA to be entered into VistA and that he had “a million and one things to do.” He said he needed to enter the appointment into VistA but sometimes had higher priorities. He said, “I’ll get around to it when I get around it.” He explained that when he was forgetful, an appointment would not be entered until after the patient had been seen. He stated that it was not his intent to game the system. When asked how often there was a delay getting the appointment to an MSA, he replied “Six to one, half a dozen to the other, probably 50-50, something like that . . .” He said he did not schedule in this manner to benefit the clinic or himself. He added that he scheduled in this manner “probably the [sic] benefit myself because I’m inconvenienced or I’ve got other things to do.” When asked if he was told to schedule in this manner, he replied, “They tell us we have to do a lot of stuff on time.”

- Psychiatrist 4 stated that she had never been assigned to the OATP at VAMC Baltimore. She explained that she was a staff psychiatrist who met with patients in the clinics but did not have access to VistA scheduling. She further explained that after a patient selected his/her future appointment date, she would write that date on a routing slip that was then given to an MSA by either the patient or herself. She stated that at other times around mid-day, she would give a list of the patients she had met with during the morning to the MSAs so that they could schedule their respective future appointments. She also stated that later in the day, she would give another list of patients that she had met with in the afternoon to the MSAs so that they could schedule their respective future appointments. She said that sometimes she saw walk-in patients and that when these walk-in appointments occurred, she would make sure that these patient appointments were entered into the system by the MSAs. She remarked that she had no knowledge of any scheduling irregularities and concluded by stating, “My patients are all scheduled in advance.”
- A rehabilitation technician stated that she performed administrative duties, such as administering drug and alcohol tests and finding veterans fee-based programs in the community. She explained that she did not schedule appointments and that no appointments were scheduled for the patients that she interacted with on a daily basis. She said she had no direct knowledge of VA’s scheduling practices in OATP and had no knowledge of any scheduling irregularities. She observed that she had no knowledge of any providers who scheduled their appointment with their patients after the fact.
- Psychologist 1 stated that she thought that because of the no-show rate, some providers prescheduled their appointments but entered the appointment into VistA after the fact. She said they were under a lot of pressure and chronically understaffed. She added that they did not have enough MSAs and that sometimes the MSA was not around. She also said they “have gotten so much conflicting pressure about what is important at different points in time, ...and I think different staff have varying levels of tolerance for that.” She stated that this type of scheduling likely occurred because the clinic was short-staffed and because of the pressure of having a low number of no-show patients. She stated, “We were getting yelled at so much about no-shows that people just started not scheduling.” When asked if this type of scheduling was gaming the system, she replied, “Of course you are, yes . . .” She noted that entering patients into the system after their actual appointment instead of prescheduling them was gaming the system for the “purpose of getting the front office off our back.” She said she thought that this may have been done out of fear because of the “oppressive atmosphere.” She also stated that though she did not approve of this type of scheduling, she understood why people did it. She remarked that she did not know of any specific providers who actually scheduled in that manner and that she did not schedule in this manner.
- Supervisor 1 explained that the MSAs scheduled her appointments for her in VistA. She would give an appointment card to the veteran and also write the appointment down on a sheet of paper, which she then gave to an MSA to be entered into VistA. She said she tried to give the slip of paper to an MSA immediately; if not, she would give the slip of paper to an MSA that same day. She stated that for the last few years, providers had been told to schedule appointments and that she did not know anyone who did not preschedule

their appointment but she could see how it could happen because they had such a high no-show rate. She added that sometimes patients came to her and needed to see her immediately. She said she tried to call the MSAs before the appointment started but sometimes had to submit the appointment to the MSAs after the walk-in appointment had occurred.

- Psychiatrist 3 stated that MSAs entered appointments into VistA for her and that after her appointment with the veteran had concluded, she would give the veteran an appointment card. At this time, she would offer the patient the option of (1) turning in the appointment card to an MSA as he/she left the clinic, or (2) allowing her to do it herself at a later time. She stated that she also wrote down the name and future appointment date for each of her patients and then turned this information to the MSAs every Monday morning. She also stated that she was not aware of any providers scheduling their patients in their personal appointment books and waiting to enter them into VistA on the date of the actual appointment. She said she did not schedule her appointments in this manner and was not aware of any other providers scheduling in this manner either.
- Social worker 2 stated that she did not schedule patients in VistA but that the MSAs did. She explained that she filled out an appointment slip, which she handed to the patient. She stated that she told the patient to give the appointment slip to the MSAs to be entered into VistA. She said she also gave the patient an appointment card that he/she could keep in their wallet. She stated that sometimes patients did not go to the MSAs to have their appointments scheduled. She added that this occurred rarely but it had occurred earlier that week. She stated that if she discovered that the patient's appointment was not scheduled, she would call the MSA or write another appointment slip and have the appointment scheduled. She reportedly was not aware of any providers scheduling their patients in their personal appointment books and waiting to enter them into VistA on the date of the actual appointment. When asked how she scheduled walk-in appointments, she said that if a patient showed up with a crisis, she would have the appointment entered into VistA as soon as possible. She said that for open groups, an MSA would enter the appointments into VistA after the group session was over.
- Social worker 3 stated that he had VistA scheduling access but that he only entered appointments in VistA for walk-in patients. After meeting with his patients for their scheduled appointment or walk-in encounter, he said he would always write down their future appointment date and give the appointment slip to the MSA to be entered into VistA. When asked if he was aware of any providers scheduling their patients in their personal appointment books but not scheduling them in VistA until the date of the actual appointment, he replied that he thought that this may have been the culture of the clinic years ago while it was under different management. He explained that past management discouraged no-show patient appointments. He reported that he believed this information filtered down from the "front office." He estimated that this had taken place approximately five years ago (in 2010) and that he suspected this may still happen today (at the time of the OIG interview) but he was not aware of anyone scheduling in this manner. He observed that he did not schedule his appointments in this inappropriate manner and that all of his appointments were prescheduled.

- Social worker 4 stated that from mid-2014 through mid-2015, he had been assigned to OATP. He explained that he sometimes scheduled his own appointments in VistA and that at other times he used MSAs to schedule appointments for his patients. He added that he would usually schedule a future appointment at the time that he was meeting with the patient. He said he did not schedule patients using a paper schedule and was not aware of any other providers scheduling in this manner.
- Psychologist 5 stated that he had access to VistA scheduling but rarely used it. He explained that after his appointment with a veteran had concluded, he would give them an appointment card for their future appointment. The veteran would then give this appointment card to one of the MSAs to be entered into VistA. He stated that after the appointment was entered into VistA, an MSA would give the appointment card back to the veteran, which would serve as their appointment reminder.
- Service chief 4 estimated that he regularly saw approximately 15 patients as his caseload. He stated that when he scheduled an appointment, he would fill out an appointment card, which either he or the patient then gave to an MSA. He explained that if a patient showed up unscheduled, he would give the slip to an MSA after the appointment. He stated that he was not aware of providers scheduling appointments in paper appointment books and having the appointment added to VistA after it occurred. He said he was not surprised that providers were not prescheduling their appointments. He reportedly had told staff to preschedule appointments but then “the issue of no-shows began to crop up . . .” He said there was an implied message that no-shows were not good. He added that the most consistent messages from management were that providers should be prescheduling their appointments and that he had warned providers who use personal appointment books that it was “not the greatest idea.”
- Former senior leader 1—when told that providers had scheduled appointments improperly—responded “I’m not saying that’s appropriate, but you guys have to realize that no-shows are tremendously nonproductive—and that somebody else could be using that slot if you keep them down.” Further, “So I don’t know if these people were actually more productive doing it this way. Not that we’d want to do it that way, but if they kept their no-show rate down, actually, they’re increasing the volume of treatments they can give, right?” He explained that having a no-show created nonproductive work when the provider had to call people instead of interacting with patients. He stated that this problem had never been brought to his attention while he was at VAMC Baltimore.
- Administrative employee 6 stated that he had given a presentation to Mental Health providers on the importance of prescheduling an appointment so that the patient’s demographic and insurance information could be updated. He explained that the Mental Health Clinic had a large number of walk-in appointments in which the patients would bypass the MSAs, and so the demographic information would not be captured. He stated that after his presentation to Mental Health providers, he had noticed a downward trend in walk-in appointments.
- Social worker 5 stated that he did not schedule his patients’ appointments and that after seeing a patient, he would give him/her an appointment slip reflecting their future

appointment. He explained that he instructed his patients to give the appointment slip to the schedulers at the front desk in order to have their appointment entered into the system. He estimated that 90 percent of his patients turned in their appointment card to the schedulers after leaving his office. He stated that he kept his own appointment book at his desk in case the veteran did not turn in the appointment card to the scheduler. He reported that he was not aware of any scheduling problems or irregularities at VAMC Baltimore.

- Addiction therapist 1 said he did not have access to VistA scheduling but that he coordinated with the MSAs to enter some prescheduled appointments into VistA as walk-in appointments. He stated that he did this to keep the patient from being a no-show and that he had his own system to track clients. He stated that he would print off a sheet every Monday to track his patients. He confirmed that his patients' appointments may have been on his worksheet as having an appointment but that the appointments were not scheduled in VistA. He said he had been told by service chief 4 and psychologist 1, since he had been employed at VAMC Baltimore, to preschedule appointments. He further said, "Well it's not mandatory, but, you know, ...they suggest to do that."

Addiction therapist 1 said that if he prescheduled an appointment, he would have an MSA enter it the same day. He added that he typically scheduled an appointment to meet with the patient at the same time the patient reported to get his/her medication and that the patients' medication times are scheduled ahead of time. He explained that if he prescheduled an appointment and the patient missed the appointment, it created a no-show. He said that he then had to call the patient and that "takes too much time." He stated that he tracked patients using his own computerized scheduling system and that if a patient had many no-shows, "It looks like the client is not really being responsible . . ." He later said that "It doesn't look good in the chart."

He estimated that he would preschedule 20 out of 50 patients. He said that for the remaining 30 patients, he would have them entered into VistA as walk-ins. He explained that if a patient was a walk-in, he would fill out a sheet of paper and give it to an MSA to have them enter the appointment into VistA. He said if he saw a client late in the day, he may not be able to enter it into VistA until the next day because the MSAs had left work for the day. He stated that if he waited longer than two days, a supervisor would notify him to enter an appointment into VistA. He said that policy had changed with respect to the procedure for appointment scheduling and treating them as walk-in patients. He remarked that from time to time, the front office would reiterate, "why they would prefer to preschedule and [he] guess[ed] they attribute it to funding and other types of stuff."

Addiction therapist 1 stated that seven to eight providers had come and gone in the Mental Health/OATP Clinic, which had caused patient caseloads to be shuffled. He said being short-staffed was an ongoing problem in this clinic. He stated that there had not been a medical director for this program for the past 18 months and that there may have been approximately 70 patients who were not seeing a counselor regularly but were continuing to receive medication. He observed that patients had died while participating in the program but he did not have specific names of the patients who died. He stated that he had been keeping a list of patients who had died while in the program but his

computer had crashed approximately six months before his interview. He said he believed that patients were not receiving the necessary level of care because of a lack of supervision and quality control checks. He stated that some patients had not seen a case manager in six or seven months even though patients should meet with a provider at least once a month. He explained that he had nine patients transferred to his clinic who did not have a treatment plan but should have.<sup>9</sup>

- Addiction therapist 2 stated that he typically did not have appointments scheduled for his patients because the patients were “not really reliable.” He said most mornings, he would have the MSA enter patient appointments into VistA for those patients he knew would arrive that same day to obtain their methadone. These patient names would come from his appointment book. He explained that he scheduled in this way to lessen the risk of a no-show appointment and that addiction therapist 1 scheduled his patients in the same manner. He said that OATP did not have a scheduling policy but that service chief 4 and psychologist 1 indicated during staff meetings that they prescheduled appointments. He added that he had chosen not to preschedule appointments because he wound up with many no-show appointments. He observed that if he were able to enter the appointment into VistA himself, he would have a better result. He said that he discussed the matter of providers having access to VistA scheduling in a staff meeting approximately one year before his interview.
- Senior leader 4 stated that he was not aware of this particular allegation and that this practice of scheduling patients off the books was not allowed. He observed that if this behavior were to be discovered, it might lead to an employee’s suspension or removal.
- When former senior leader 2 was told that two providers scheduled patients in this manner in order to keep their no-show rates low, he stated that he was not aware of any providers using paper calendars to schedule appointments. He said he was not aware of this particular allegation, adding, “I would not... support paper calendars and misrepresenting no-show rates or any behavior of that kind.”

#### *Issue 6: Closing Consults for non-VA care before the Actual Appointment*

##### **Summary of Allegation**

- Coordinator 1 stated that Medical Administration Service (MAS), who worked with non-VA care consults (NVCC), was closing consults prematurely. She said that NVCC consults were closed based on the appointment being scheduled outside of VA. She reported another issue in which NVCC consults were being closed once notes were received from the non-VA medical facilities. She stated that it was a problem because the notes were being reviewed administratively but not clinically. Using the example of a mammogram consult that was closed when the report was returned by the non-VA provider, she said she did not believe this report was reviewed because it indicated the mammogram did not occur. She explained that no one can close a consult with

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<sup>9</sup> The investigating agents referred addiction therapist 1’s complaints to the VA OIG Hotline. OHI conducted an inquiry and the results were published in October 2017, <https://www.va.gov/oig/pubs/vaoig-16-01091-06.pdf>.

documentation that does not meet VA standards. She said this issue had since been corrected, adding that it was her understanding that MAS was not closing consults until the medical documentation had been returned and the requesting supervisor had reviewed the notes.

### **Interviews Conducted**

- Service chief 5 stated that former service chief 1 was in charge of NVCC consults until approximately late 2014. She explained that MAS did not close consults after the scheduling of an appointment and that approximately three to four years ago (in 2011 or 2012), MAS closed some consults upon receipt of a bill but before receiving the medical records associated with that particular appointment. She remarked that it was difficult to get medical records from non-VA providers. She stated that MAS changed the process and refused to pay the providers until the latter had sent the medical documentation. She added that [at the time of her interview] MAS did not close consults until the medical documentation had been received.
- When reinterviewed in late 2015, coordinator 1 reported that during one particular weekly consult meeting, MAS had approximately 580 open consults. However, during the following week's meeting, MAS had only one open consult. She estimated that these meetings occurred in the summer of 2014. She reportedly "did some digging into their list and realized that some of the consults that were being closed were being closed based on an appointment being scheduled, not based on the patient actually being seen." She further stated that some of MAS's consults were closed after the patient was seen but before medical documentation was received. She added that the returned documentation was not being clinically reviewed before the consults' closure.

Coordinator 1 stated that she reviewed approximately 100 of these closed consults. She said, "The majority of the ones that I looked at were closed based on the comment that the patient is scheduled." She further stated that the majority of the consults she reviewed were closed "way in advance of the appointment . . ." She said that coordinator 2 ran the consult report for her, that she and coordinator 2 reported these findings to senior leader 4, and that senior leader 4 asked her to discuss her findings with service chief 5. She explained that she and coordinator 2 met with former service chief 1 and service chief 5 on an unspecified date in the summer of 2014 to discuss the matter. She reported that former service chief 1 stated that there was no way that this could occur.

Coordinator 1 said that as of the date of this interview (late 2015), she did not know if these consults had been corrected. She clarified her statement from the first interview and admitted that she knew the issue involving Audiology consults had been corrected. She said she created a spreadsheet reflecting the results of her review of the estimated 100 consults. She explained that on an unspecified date in the summer of 2014, she had shared with service chief 5 what she had found and reviewed several consults with her. She said service chief 5 had told her that she would speak with former service chief 1.

Coordinator 1 stated that she had emailed the spreadsheet to service chief 5 but not to former service chief 1. When asked if there were any emails in reference to her meeting

with service chief 5, coordinator 2, and former service chief 1, she replied that she had emailed coordinator 2 after the meeting but otherwise did not believe that other emails existed. She said that former senior leader 1 was not present at this meeting, adding that she spoke with senior leader 4 about the matter.

- Former senior leader 1 stated that he had no knowledge of the closure of NVCC consults before the actual appointment. He further stated that it was never brought to his attention. He also said that it would be inappropriate to close consults in this manner and that neither MAS nor service chief 5 had been accused of gaming the system or of any other unethical practices.
- When reinterviewed in mid-2016, coordinator 1 stated that she and coordinator 2 had reviewed (in early May 2014) a report on NVCC consults having decreased from approximately 500 open consults to approximately 20 in a two-week period. During the interview, she reviewed with the investigating agents a copy of the spreadsheet previously referenced. Although the spreadsheet contained 29 consults, according to her, one was erroneously listed. She explained that her initial review consisted of 100 randomly selected patients from the consults that had been closed. Of the 100, she said that 71 were closed correctly, 28 were “completed” after the appointment was scheduled but before receiving the appropriate medical documentation, and one was removed because of an ER visit. She further explained that since medical documentation was not attached, she was unsure whether the consults had been closed before or after the actual appointment. She said she thought that they were closed to get the numbers down because NVCC consults were a problem. She observed that no one was instructed to do anything illegal or wrong.

Coordinator 1 stated that since her previous interview in late 2015, she had reviewed approximately half of the 28 patients’ records. She said that of the ones she had reviewed, all but one had proper medical documentation attached to their folder. She explained that there was a delay between the patient’s actual appointment and the time that VAMC Baltimore received the medical documentation from the non-VA provider and that she blamed staffing shortages for this problem. She said that MSAs were using a “complete update” note option that completed the consult and that she believed that at times the MSAs used the wrong codes. She also stated that she believed that this was not malicious but a training issue, which she had addressed with service chief 5. She added that the MSAs were short-staffed. When asked if any patients had been harmed, she responded, “Not that I know of.” She remarked that patients saw their provider and did not fall through the cracks.

Coordinator 1 said she recalled that one of the patients was a no-show for his/her appointment; however, the consult was “completed” and the provider paid. She stated that the patient was contacted and reported not wanting the appointment. She further stated that VA may have still been billed for the canceled appointment. She observed that this consult should have been “discontinued” and not “completed.”

- Coordinator 2 said she did not recall the NVCC 2014 meeting with coordinator 1, former service chief 1, and service chief 5. She stated that in 2014, the facility held weekly

meetings regarding consults with business managers for all services. She added that she did not recall specifics from those meetings nor did she recall any discrepancies with NVCC. She remembered when NVCC had approximately 500 open consults that abruptly went down to approximately 20 even though she could not provide any details. She stated that, compared to other services, there were more open consults greater than 90 days for NVCC. She did not recall any NVCC consults being closed improperly or before the actual appointment. She further stated that she was not aware of any gaming of the system regarding consults.

- Former service chief 1 said that her service oversaw NVCC consults. She stated that there was a delay between the time her service would receive the bill from the non-VA provider and the time it would receive the non-VA provider's medical records—adding that it could take 60 to 90 days to receive the medical records. She explained how her service was supposed to close the consult once medical records had been received. However, this was not the case around the summer of 2013. In 2013, she said, consults had become a performance measure. She stated that approximately 3,000 NVCC consults were open and that her service was unable to identify which of the related patients had been seen by their non-VA provider. In order to differentiate between those patients who had been seen by a non-VA provider and those who had not, her staff either (1) administratively closed a consult when care had been provided and a bill had been received or (2) administratively closed a consult when the patient had been seen and the medical documentation had been received. She stated that if a consult was administratively closed because the bill had been received, medical documentation would be attached to the consult at a later date. She estimated that approximately 1,700 to 1,800 consults were administratively closed in this manner. She said that her service administratively closed the consults to narrow down the number of patients who had not been seen.

Former service chief 1 further stated that in mid-2014, an associate service chief conducted a fact-finding investigation on NVCC consult closures during which everyone on her staff was interviewed. She explained how her service was only allowed to administratively close a NVCC consult for which her staff were unable to obtain medical documentation when the vendor had been contacted three times. She said the fact-finding investigation found that her staff were administratively closing NVCC consults without contacting the vendor three consecutive times. As a result, she said she was told by service chief 5 not to close the consults until the medical documentation had been received. She stated that as part of the fact-finding investigation, a review of the administratively closed consults was conducted. She did not know the results of the investigation. However, she reported that when she left, consults were closed once medical documentation was received. To her knowledge, the administratively closed consults were corrected. She stated that consults were now closed once the bill and medical documentation have been received. She remarked that the closing of consults without attaching the medical documentation was not done to game the system. Rather, it was a way to determine which patients had already received care and which patients were still waiting for care. She said that, to her knowledge, no patients were harmed. She also stated that no one was disciplined as a result of the fact-finding investigation.

Initially former service chief 1 said her staff did not close NVCC consults before the appointment. Later she stated that a former VA employee was closing out NVCC consults “when she did the authorization,” which was before the patient’s appointment with the non-VA provider. She explained that when she was notified about these NVCC consult closures, she had pulled the former VA employee into her office and told her, “No, you’re not supposed to be doing this.” She said she reviewed a few of the consults that the former VA employee had closed. She explained that if the patient had not been seen, her service would restart the process. She also stated that the former VA employee’s consults were reviewed as part of the fact-finding investigation.

Former service chief 1 was shown an email that coordinator 1 had sent to service chief 5 in mid-2014, and which service chief 5 had then forwarded to her. Former service chief 1 had replied as follows, “. . . she is one of my authorization clerks. . . she knows better.” When asked about this email exchange, former service chief 1 claimed not to know what the email meant. She said she thought that it was probably one of her “problem clerks” who had closed a consult and was looking for the medical records. She recalled that the email had an attached spreadsheet listing consults that had been closed inappropriately. She later stated that the “problem clerk” was the former VA employee and that the consults were corrected.

Former service chief 1 was shown another email (mid-2014) she had written and sent to service chief 5 and the associate service chief, which stated, “What should have happened is that someone (one of my authorization clerks) should have contacted the patient to confirm if he or she had the appointment. If the appointment is confirmed, it would have been up to the clerk to secure the medical documentation to complete the consult. In this case, this consult should have been discontinued because the patient missed his appointment and a new request was entered on 1/9/14; the appointment was confirmed with the patient and there is still no documentation. I administratively completed this consult too.” After re-reading her email, former service chief 1 stated, “It was probably for a consult that was not closed per my direction, and so they were asking about it.” She reported that she could not recall any information about the patient or the email. She stated that a clerk did not confirm that the patient was seen. She said the employee in question was more than likely the former VA employee.

Former service chief 1 was shown another email (mid-2014) she had sent to physician 4 and program specialist 3. In this email, she wrote, “Hi [physician 4] I tried calling, but no answer. On the new consult, we just need for you to request the same service as the previous Non-VA request and also state in the justification ‘consult required to attach medical documentation.’ We have found that some consults were closed prematurely.” After reviewing that email, she explained that because her service had found the medical records, she was asking physician 4 to recreate the consult so those records could be attached. She said this was part of a review into the administratively closed consults.

Former service chief 1 was shown another email (mid-2014) that was part of a chain of messages between former service chief 1, the associate service chief, and service chief 5. In the message, she had written, “Attached is a listing of the Non-VA requests where

various personnel were checking for medical documentation. There are a number of claims that I do not know the status because I was not given the sheets back from those employees. I have also entered the kind of care requested for the consults where there was no documentation.” After seeing the email, she said this was part of the review to correct the consults that were administratively closed and to check if her office had the medical records. She stated that all of the administratively closed consults were examined during this review.

- The associate service chief stated that he recalled the fact-finding investigation into whether former service chief 1 had told staff to close consults. He said he conducted this investigation with a union representative and an Employee Labor Relations official but could not recall their names. He stated that he interviewed all NVCC employees and submitted a final report to service chief 5. He added that he did not review any consults or records nor could he recall if consults were closed before the appointment or the manner in which consults were closed. He stated that he had recommended more training and the establishment of a standard operating procedure to close consults. He reported that he could not recall if service chief 5 had followed up with him on his recommendations. He said he had not kept any documentation from the fact-finding investigation and did not recall any gaming of the system.
- When reinterviewed, service chief 5 stated that former senior leader 1 created a consult review team after the VAMC Phoenix story broke. She recalled that coordinator 2 had contacted her regarding consults “disappearing” out of the system. She said she had contacted coordinator 1 who reported a glitch in the system. She stated that coordinator 1 had told former service chief 1 that the consults were added back to the system. She recalled receiving an allegation that consults were being closed improperly but could not recall who had made the allegation. She further stated that coordinator 2 had compiled a list of closed NVCC consults, which coordinator 1 had reviewed and forwarded to her as a listing of improperly closed NVCC consults. She remarked that someone had made an allegation that NVCC consults were “batch closed.” She reportedly directed the associate service chief to conduct the fact-finding investigation into the closing of NVCC consults. She said all NVCC employees were interviewed. She added that, during an interview conducted during the fact-finding investigation, former service chief 1 stated that she had been directed by the Central Business Office in DC to close consults. She also said that former service chief 1 had provided a copy of the directions given by the Central Business Office and that her interpretation of these directions from the Central Business Office did not agree with that of former service chief 1.

Service chief 5 explained that a statement contained in the associate service chief’s report was inaccurate and that the report indicated that it was the belief of service chief 5 that “[former service chief 1] deliberately and intentionally had staff close consults that were over 30 days old without regard for the Veterans needing care.” She acknowledged making that statement and said she was upset that former service chief 1 had not made sure all the medical documentation was there before closing the consult. She stated that “my thinking was you should have made sure that they actually were seen and not that

they said they were being, because the outside provider said yeah, we saw them. But we didn't have any documentation to support that.”

Service chief 5 recalled that the associate service chief had made three recommendations: that (1) administrative action be taken against former service chief 1, (2) NVCC employees receive immediate training on NVCC consult management, and (3) a review of all NVCC consults be conducted. She reported that she did not take administrative action against former service chief 1 because she forgot. She said that no disciplinary action was taken against any employee. She reflected that, had she taken action against former service chief 1, it would have been a letter of admonishment because she (former service chief 1) had misinterpreted the direction she was given. She stated that all NVCC employees received immediate and continued training on the management of NVCC consults.

Service chief 5 said, starting in mid-2014 and for three to four months, a review was conducted for approximately 1,200 to 1,500 NVCC consults. She named these individuals as having taken part in the review: a medical administration specialist, program specialist 3, program specialist 4, supervisor 2, supervisor 3, and administrative employee 6. She explained how these six employees would find the non-VA medical documentation in the system and add it as a note to the NVCC consult. For NVCC consults that did not have proper medical documentation, the reviewer would contact the provider to request the medical documentation and then follow up at a future date to ensure it was received. She could not find any documentation of the review but said there may be some related emails. She stated that, to her knowledge, all consults have had proper medical documentation attached to them. With the exception of NVCC consults that were discontinued because the patients were able to be seen by VA before their scheduled non-VA appointment, she said there was no indication that consults were closed before the appointment occurred. She stated that the fact-finding investigation did not reveal any gaming of the system as a way to lower the numbers.

Service chief 5 was shown an email she had sent to former service chief 1, the associate service chief, and program specialist 3 and in which she wrote, “Are we legally closing them? I don't want us to close them just to get them off the books. What happens to the ones that we have not received claims and documentation for?” After reading this document, she said the email was in reference to the consult closure group. She stated that she did not think anything was wrong but just wanted to make sure that everything was done appropriately. She added that these consults were “legally” closed because the patient had been seen.

Service chief 5 was shown an email she had sent to former service chief 1 and in which she wrote, “From what I have been told so far, [the former VA employee] is updating the consult to say ‘Funding was Approved’ but it is closing the consult.” After consulting the email, she said this may have been a glitch in the system because adding a remark should not close a consult. She added that the former VA employee no longer worked at VAMC Baltimore.

Service chief 5 was shown an email she had sent to former service chief 1 and the associate service chief, and in which she wrote, “We need to make sure that I am able to let [former senior leader 1] know exactly how many were appropriately closed (records and bills received and scanned into the medical record) and those that need follow-up.” After reading the email, she stated that she needed to make sure that all the patients were seen and that the consults were not batch-closed.

Service chief 5 was shown an email she had sent to senior leader 6 and in which she wrote, “I don’t know how many were closed inappropriately. The list contains approximately 1500 entries (some can be duplicates). Out of those, I don’t know how many need to be re-opened. I have staff already working OT to go thru the list and make contact with the providers. I just let everyone know that any provider who has not responded within 24 hours needs to be called.” After reading the email, she said she could not recall whether any consults had needed to be reopened. She said she could not remember if they made the consults “active” or “scheduled” instead of “complete.”

Service chief 5 was shown an email she had sent to former senior leader 1, senior leader 4, the associate service chief, and administrative employee 2 and in which she wrote, “We are finding that initial review of these cases shows that approximately 75% have been closed appropriately. I am sure that more will be found to be appropriately completed when doing a second review.” After consulting this email, she observed that, at this point in time, her office had been able to verify that 75 percent of the consults had been closed appropriately with the medical documentation attached. She stated that the other 25 percent likely belonged to those for which they had to contact the non-VA providers because the medical documentation was missing.

Service chief 5 was shown an email she had sent to a registered nurse and in which she stated, “We have reviewed all of our consults and they were closed appropriately.” After consulting this email, she stated that this was in reference to the review of the 1,200–1,500 NVCC consults. She explained that, based on the documentation obtained by the reviewers, it appeared that the patients had been seen and that notes had been added to their consults.

- The medical administration specialist stated that he reviewed NVCC consults to ensure medical documentation from non-VA providers had been attached. He said he conducted reviews for only two to three days, which totaled six to eight hours of overtime. He recalled that some consults did not contain the medical documentation from the non-VA provider but he could not recall how many. He stated that he received a paper list of names that he would review and annotate as to whether non-VA medical documentation was attached. He said that, once completed, the list would be returned to service chief 5. He stated that he did not know whether consults were closed before the actual appointment because he did not review that issue. He observed that he did not think this was done to game the system.
- Program specialist 4 stated that she reviewed NVCC consults to ensure that medical documentation was attached to the patients’ medical file. She said she recalled that some of the patients’ records did not have the medical documentation from the non-VA

provider attached. She reportedly would contact the non-VA provider to request the medical documentation and would note this action on the spreadsheet. She said she was given paper spreadsheets to review—two sheets at a time—that contained the list of the patients' files. She explained that once she had completed the sheets, she would give them to service chief 5. She stated that she worked on these spreadsheets for approximately two to three weeks, adding that she did not think this was done to game the system. She also stated that she could not recall if any consults had been closed before the actual appointment because she did not know if her list contained open or closed consults. She said she did not keep any documentation pertaining to this review and remarked that she provided all of the applicable documentation to service chief 5.

- Supervisor 2 stated that she did not review consults but reviewed patients' CPRS records in order to determine if non-VA medical documentation was attached. She worked on this review for approximately six hours over a two-day period for overtime or compensatory time. She said she did not know if consults were closed before the actual appointment because she was not sure if she reviewed consults. She stated that she did not believe there was an effort to game the system. She said she received a paper sheet containing patient data that she annotated to indicate if medical documentation existed or not; once she had completed the sheet, she gave it to service chief 5. She added that she did not follow the process after that point nor did she conduct any further follow-up.
- Program specialist 3 stated that in 2014, she was working at VAMC Baltimore for service chief 5. She said she recalled conducting a review for approximately one to one-and-a-half months to determine if medical documentation from non-VA providers was attached to patients' medical records in CPRS. She reportedly conducted this review at VAMC Perry Point. She stated that she received a paper list of patient data from former service chief 1. She explained how her review had found that no consults were closed prior to the actual appointment. She said that some consults were closed because the patients were a no-show for their appointments. She stated that she did not know the exact reason for this review. She said she did not keep her work product and shredded the patient list upon completion. Based on her review, she stated that she did not think there was an effort to game the system. She explained that once medical documentation had been located, received, or attached to a patient's file, the consult would be removed from this list. She added that former service chief 1 would routinely generate a new list and that she would continue to follow up with medical providers to ensure that medical documentation was received for each patient on the list.
- Supervisor 3 said she recalled conducting a review of NVCC consults. She stated that program specialist 3 gave her a paper list of patient names and asked her to check in CPRS to see if medical documentation was received from the non-VA provider and entered into the patient's medical files. She said she would annotate whether or not the medical documentation existed on the paper sheet and then give it back to program specialist 3. She stated that she did not keep any work product or documentation and that she worked part-time on this review for about one month. She said she reviewed more than 30 patient files during this period. She explained that some consults had medical documentation attached but others did not. She reported that she could not remember if some of the consults had been closed before the actual appointment and was unsure

whether she would have reviewed this question. When asked if it appeared that the closing of the consults were done to game the system, she replied, “That’s not what I was looking for.”

- Administrative employee 6 stated that he did not conduct this review of closed NVCC consults. He explained that he was instead assigned to contact patients with future appointments at VAMC Baltimore. He added that he would give the patients a phone number to schedule an appointment with a non-VA provider to be seen sooner.
- Coordinator 1 contacted OIG agents and informed them that she had completed her review of the 29 patients on the NVCC consult list from mid-2014. She stated that she had been able to identify medical documentation for all but two of the completed consults. OIG agents requested that senior leader 2 review the two consults for which coordinator 1 could not identify documentation and provide a written memo with his findings. OIG agents received a memo signed by senior leader 4 stating that both consults were clinically reviewed. One patient opted to terminate her pregnancy and did not require specialty care. The second patient received requested home skilled nursing care for surgical site drains.
- Senior leader 4 was interviewed about the allegation that MAS closed non-VA consults before all medical records and documentation had been received by VA. He said he was not aware of this allegation, adding that it was a “bear” to obtain records from outside providers.
- Former senior leader 2 was also interviewed about the allegation that MAS closed non-VA consults before all medical records and documentation had been received by VA. He stated that he had no recollection of this allegation. He said the incentive for private sector providers to provide documentation to VA was very low because VA paid them before they had actually provided the documentation. He remarked that he had lobbied unsuccessfully to change this policy.

### **Records Reviewed**

- Coordinator 1 reviewed an email she sent to service chief 5 in mid-2014 that contained the previously mentioned spreadsheet. In this message, coordinator 1 stated, “The attached list highlights some of the consults originating from [coordinator 2’s] weekly list dating back to 4/14/14. The very last column indicates the status of my findings.” She explained that she used this consult listing provided by coordinator 2 to randomly select the 100 patients she reviewed.
- Coordinator 1 provided an email in which she clarified that in mid-2014, she reviewed approximately 100 consults. However, she documented her findings for only 29 of these consults. She stated that on the date of this email (late 2015), she had conducted a follow-up review, which determined that (1) consults were closed without proper documentation being attached or entered into CPRS; (2) for many of the consults on the attached list, documentation was received and scanned into VistA Imaging after the consult was closed; and (3) for some consults that were closed prematurely, the documentation was

not received. She added that those consults should have been “cancelled” or “discontinued” versus “closed” or “completed.”

- During the investigation, OIG agents located an email (mid-2014) from service chief 5 to these individuals: senior leader 4, senior leader 6, administrative employee 2, and former senior leader 1. The associate service chief was cc'd on the message. Attached to the email was a report from the associate service chief regarding his fact-finding investigation into allegations of inappropriate management of NVCC consults. The investigation, directed by service chief 5 in mid-2014, was completed in approximately two weeks. The report stated that “this investigation was convened to inquire into the facts and circumstances surrounding an allegation that [former service chief 1] implemented a process and directed the NVCC staff to close consults referred to Non-VA facilities that were open greater than 30 days even if medical records or documentation were not received.”
- The report listed these “significant procedural issues”:
  - In early May 2014, after service chief 5 had been told that NVCC consults were disappearing, she sent an email to former service chief 1 to inquire about the status of this concern.
  - That same day, former service chief 1 sent service chief 5 an email that included an email string from a Chief Business Office (CBO) mail group that had questions regarding NVCC Consult Completion. The associate service chief noted that “the emails in the string did not give guidance to close NVCC consults that did not have medical records or documents from Non-VA facilities.”
  - The next day, service chief 5 sent an email to the NVCC staff directing them not to close NVCC consults unless proper medical records and documentation had been received from non-VA facilities.
- The fact-finding investigation included 11 statements from NVCC staff members and from former service chief 1. Four employees (VA employee 2, VA employee 3, VA employee 4, and the former VA employee) stated that former service chief 1 directed them to close NVCC consults that did not have medical records or documents from non-VA facilities. The report indicated that VA employee 4 stated that former service chief 1 was following guidance given during a “NVCC consult clean-up” in 2013 by a former associate service chief. VA employee 4 further stated that the former associate service chief “pushed to have the consults closed as the work was being completed via overtime.” According to the report, former service chief 1 stated that the former associate service chief directed her to close “NVCC consults that did not have medical records or documents from Non-VA facilities.” Former service chief 1 further stated that this direction was given “during the April 2013 NVCC consult clean-up.” Former service chief 1 stated that “there were over 1200 consults that were required to be placed in a completed status and the former associate service chief pushed to have the consults closed as the work was being completed via overtime.”

- The report listed three conclusions:

**Conclusion 1:** NVCC consults should not be closed or placed in a completed status unless proper medical records and documentation are received from non-VA facilities.

**Conclusion 2:** Former service chief 1 directed staff to close NVCC consults that did not have medical records or documents from non-VA facilities.

**Conclusion 3:** After reviewing all of the evidence and following additional questions submitted to former service chief 1, it is the belief of service chief 5 that former service chief 1 “deliberately and intentionally had staff close consults that were over 30 days old without regard for the veterans needing care. There was no evidence found to support the assertion that the claims were closed based on directions given by the [former associate service chief]. All evidence reviewed stated the exact opposite, namely, that [the former associate service chief] was clear that no consults were to be closed without medical documentation.”

- The report listed these “Recommendations/Actions”:
  - Appropriate disciplinary or other administrative action should be taken with respect to former service chief 1 “for directing staff to close NVCC consults that did not have medical records or documents from non-VA facilities.”
  - All NVCC staff “will receive immediate training on NVCC consult management.”
  - A review “of all affected NVCC consults will be conducted. Clinical providers will be notified of all patients whose consults were erroneously closed. MAS staff will work closely with providers to ensure that each patient still needing to be seen is scheduled to be seen within 30 days.”
- In mid-2016, service chief 5 provided OIG agents with Microsoft Excel files regarding the consult review:
  - Four of the files were titled “consults” with different dates appended to the file name. The Microsoft Excel files contained between approximately 1,200 to 1,500 entries, which included patient name, schedule status, date entered, and clinic name.
  - One of the four files, titled “consults” and dated mid-2014, contained a comment section with approximately 27 entries. Some of the comments read, “discontinued,” “medical documentation was not submitted,” “patient has not been scheduled,” and “No claims or Medical records submitted for treatment.”
  - Two of the Microsoft Excel files were related to pending consults open over 90 days. Of those two files, one contained a remarks section with approximately 38 entries discussing the status of the consult.
  - One of the files was related to consults open less than 90 days.

- One file was related to “linked consults.”
- One file was related to completed “PCC Consults” authorizations.
- One file related to closed consults; however, the file was dated early 2013.
- These files did not contain the final work product of the consult review team.

#### **4. OIG Conclusions**

The OIG substantiated the following allegations:

- The Audiology Clinic had been closing consults before the actual corresponding appointment.
- The Opioid Agonist Treatment Program (OATP) transferred patients who wanted VA care but were currently in some type of other non-VA care from the Electronic Wait List (EWL) to a new “non-count” Transfer Clinic.
- Some Mental Health Clinic providers would not schedule appointments in VistA until after the appointments had taken place.
- In the past, the Medical Administration Service (MAS) had been prematurely closing Non-VA Care Coordination (NVCC) consults prior to receiving the supporting medical documentation from private medical providers.

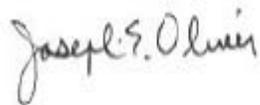
The OIG did not substantiate these allegations:

- A VA employee was pressured to remove patients from OATP’s EWL who were unreachable or referred to care in the community on a fee-basis
- The VISN wanted the OATP’s EWL numbers to be below 20 patients.
- Veteran 1’s death was related to his EWL status.
- Tapering methadone was against practice guidelines or the standard of care.<sup>10</sup>

VA OIG referred the Report of Investigation to VA’s Office of Accountability and Whistleblower Protection on October 17, 2017.

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<sup>10</sup> There are no clear guidelines on when/if to taper methadone; the only exception is that patients are not to be coerced into tapering. That decision should rest on clinical factors and patient preference.



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for Investigations

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