DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

October 14, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-3424 (Supplemental)

Dear Ms. Lerner:

This Supplemental response is in reference to OSC File No. DI-14-3424, specifically the allegation "scheduling staff were improperly directed to 'zero out' patient wait times, in violation of agency policy" at the Eugene J. Towbin Healthcare Center in North Little Rock, AR or, as it is also known as, the Central Arkansas Veterans Healthcare System (CAVHS). This response also takes into account the Office of Inspector General (OIG) Report No. 2014-02890-ID-0057, Manipulation of Wait Times at VAMC Little Rock, AR.

In April 2015, the VA Office of Accountability Review (OAR) convened an Administrative Investigation Board (AIB or Board) at CAVHS to investigate the above allegation. The AIB was concluded on May 20, 2015, after two final telephonic interviews, and the report was finalized on June 5, 2015. Following are the AIB's findings:

1. Access Summary Reports, as well as VHA Support Service Center (VSSC) website updates, were provided to senior leadership, i.e., the Pentad, prior to daily Morning Report meetings. These reports were run by the Systems Redesign Coordinator and advance distribution of the reports was intended to allow for identifying issues and outliers, as well as asking questions during Morning Report. All departments were represented during these meetings when reports were reviewed. This included Medical Support Assistants (MSA) supervisors. The Joint Leadership Council[1] would also

[1] Memorandum No. 00-3, dated September 15, 2014, covers the Joint Leadership Council. This is the facility's highest governing body and includes the following membership: Chair, Medical Center Director or designee; Associate Medical Center Director; Associate Director, Patient Care Services/Nurse Executive; Chief of Staff; Deputy Medical Center Director or Designee; Strategic Management; Quality Management Manager; Patient Safety Manager; one Administrative Service Chief (not to exceed 2-year appointment); and one Clinical Service Chief (not to exceed 2-year appointment).

review these reports on a monthly basis.

2. The Chief of the Business Office testified that he runs the New Enrollee Appointment Request (NEAR)[2] call list every morning and Primary Care handles the follow-up actions regarding the list.

3. Any areas of concern regarding patient access resulted in development of action plans by senior leadership in coordination with other subject matters experts from the relevant service lines. Some action plans included feeing out clinical services and hiring additional personnel.

4. Witnesses testified that senior leadership has been very clear to supervisors and Service Chiefs, since 2008, in their communication that they were to follow the scheduling directive. According to the Acting Medical Center Director, the former Medical Center Director stated that "performance measures were not a consideration for doing anything wrong." The Acting Chief of Staff testified that performance measures for access were not a consideration for outstanding ratings and senior leadership bonuses. All managers were explicitly told to do things the correct way. She subsequently provided emails to the Board demonstrating that sort of communication.

5. During the AIB, there were two supervisory employees on Administrative Absence pending a review of all OIG and AIB evidence. Witnesses testified to the OIG that these two supervisors taught schedulers to "zero out wait times"[3]. When asked how these practices went unnoticed to senior leadership, the Acting Medical Center Director said "there were no red flags" despite audits taking place. Upon review of reports provided to the OIG, there did not appear to be obvious outliers that would have raised suspicion that deliberate manipulation of wait times was occurring.

a. The two scheduling supervisors did not deny instructing MSA staff to schedule appointments according to the way they had been taught and instructed, i.e., to zero out wait times. However, the team believes this

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[2] It is a tool to be used by enrollment staff to communicate to primary care coordinators and schedulers that a new enrollee has requested an appointment and is to be scheduled.

[3] Involves entering the next available "appointment date" as the "desired date" to give the appearance of zero wait times. VHA Directive 2010-027: "The desired date is defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date."

was standard practice in scheduling appointments as opposed to a deceitful means to manipulate data. Both supervisors subsequently took actions to ensure the VA scheduling policy was accurately followed by MSAs.

b. The Board asked both employees about the OIG's contention that they had exhibited a lack of candor in their testimonies to the OIG, i.e., OIG found that these two employees made false statements to the OIG special agents while under oath regarding their knowledge and/or participation in the manipulation of patient waiting times. These employees were placed on administrative absence as a result of this finding. Both employees attempted to justify to the Board why they made their respective statements to the OIG. It is important to note that the Board did not disagree with the assessment by OIG that these two individuals demonstrated a lack of candor.

6. Some of the safeguards, which have either been improved upon or implemented within the last year at CAVHS, include:

a. The addition of specific and real life scenarios written into training modules,
b. Training materials compiled into binders for easy reference,
c. Contact numbers of Master Schedulers provided to MSAs so they could ask questions when necessary,
d. A competency checklist was developed with direct observation of schedulers,
e. Refresher training for experienced MSAs, including Master Schedulers,
f. Random audits on zero wait time data using Structured Query Language or SQL reports for individual MSAs; and
g. A Mystery Shopper program. This Mystery Shopper Program utilizes employees enrolled in the Emerging Veterans Affairs Leaders (EVAL) Program[4], acting as a veteran and trying to make an appointment. This has been very successful and has yielded excellent results in ensuring the appointment system is working as intended and if not, in resolving issues which create impediments for veterans to make timely and accurate appointments.

There were several conclusions reached by the AIB:

[4] The Emerging Veterans Affairs Leader (EVAL) is a comprehensive program designed to identify employees who have (1) an interest in career development within the Department of Veterans Affairs (VA) and (2) have demonstrated leadership potential. Candidates selected for this program participate in a broad spectrum of developmental experiences over a six-month period.

1. The allegation that scheduling staff were improperly directed to 'zero out' patient wait times, in violation of agency policy, was substantiated. However, senior leaders at CAVHS were not responsible for directing the scheduling staff to follow that practice. Senior leaders took appropriate actions to ensure patients were scheduled for appointments in accordance with VA policy and to ensure patient appointment data from CAVHS was reported accurately.

2. The Board recommended that the two MSA supervisors be returned to full duty. Any culpability on their part, in terms of lack of candor during their respective OIG interviews, was to be assessed by local leadership. In addition, any disciplinary actions deemed appropriate was to be handled through the normal local procedures. As of the date of this response, one supervisor has been issued a proposed removal and a proposed action regarding the other supervisor is still being evaluated.

In summary, no further action was recommended regarding senior leadership at CAVHS.

I am hopeful that this information sufficiently answers any questions you may have regarding the patient wait times issues at CAVHS. However, if you have any additional questions, please feel free to contact my office.

Thank you for the opportunity to respond.

Sincerely,

Michael V. Culpepper
Deputy Director
Office of Accountability Review