DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

JAN - 8 2016

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-14-2520

Dear Ms. Lerner:

I am responding to your May 7, 2014, letter regarding allegations made by a whistleblower at the Department of Veterans Affairs (VA) North Central Federal Clinic in San Antonio, Texas and Austin Outpatient Clinic in Austin, Texas. The whistleblower alleged that the VA facilities in San Antonio and Austin, Texas did not follow proper appointment scheduling protocols. The VA Office of Inspector General (OIG) conducted an investigation into the whistleblower allegations and provided a report on May 6, 2015, to the Office of Accountability Review. The Secretary delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code 1213(d)(5).

OIG prepared the enclosed summary of their investigation and findings to respond to your request that VA provide you a report of VA's investigation into the whistleblower's allegations. The investigation revealed that Medical Administration Service (MAS) and non-MAS schedulers were utilizing the first available date as the patients' desired date when making appointments for VA medical care. Review of patient appointment data for facilities in San Antonio, Kerrville, and Austin revealed that the improper scheduling was systemic and was not limited to a particular clinic or supervisor. The investigation did not reveal any VA employee receiving a bonus or award specifically related to patient wait times. The investigation also did not reveal any clinic that was instructed not to utilize the Electronic Wait List when it was necessary to use one.

The South Texas Veterans Health Care System took immediate corrective action to retrain all employees who scheduled VA patients, to include all Medical Support Assistants (MSA) on May 7 and May 8, 2014. Further, efforts were taken to consolidate the MSA staff under the supervision of Health Administration Service to provide better continuity, further supporting the training and oversight of MSAs. Lastly, several actions occurred resulting in the replacement of supervisory positions with employees who could better perform the training and oversight of the intricate duties associated with the MSA positions.

The Honorable Carolyn N. Lerner

Findings from the OIG investigation are contained in the enclosed report, which I am submitting for your review. I have reviewed these findings and agree with the recommendations listed in the report. I have directed the Medical Center Director and the Veterans Health Administration to carry out the recommended actions. We will send your office follow-up information describing actions that have been taken by the Medical Center and other entities to implement these recommendations.

Thank you for the opportunity to respond.

Sincerely,

Robert L. Nabors II
Chief of Staff

Enclosure

REPORT FOR THE OFFICE OF SPECIAL COUNSEL PURSUANT TO THE PROVISIONS OF TITLE 5 U.S.C. § 1213
RESULTS OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS OF VIOLATION OF LAW, RULE, REGULATION, AUSTIN, TEXAS VA OUTPATIENT CLINIC AND THE SAN ANTONIO, TEXAS VA MEDICAL CENTER

OSC FILE DI-14- 2520

1. Summary of the information with respect to which the investigation was initiated.

An investigation was initiated based on information provided by Whistleblower, Medical Support Assistant at the North Central Department of Veterans Affairs (VA) Federal Clinic (North Central VAFC), San Antonio, Texas (TX) on or about May 7, 2014. The allegation was that the San Antonio and Austin, TX facilities did not follow proper appointment scheduling protocols. In particular, the individual alleged that scheduling staff were improperly directed to make patients' desired dates for appointments to be the same date as the first available date, and to avoid utilizing the Electronic Waiting List (EWL). The investigation was expanded to address additional similar complaints received during the investigation.

The San Antonio facility is part of the South Texas Veterans Health Care System (STVHCS). The STVHCS is comprised of two inpatient campuses: the Audie L. Murphy Memorial Veterans Hospital (San Antonio VA Medical Center (VAMC)) in San Antonio, and the Kerrville VA Hospital (Kerrville VAMC) in Kerrville, TX. VA also maintains multiple clinics in the San Antonio area, including the North Central VAFC, the Frank Tejeda VA Outpatient Clinic (Frank Tejeda VAOPC), and the VA Dental Clinic in San Antonio.

The Austin VAOPC is part of the Central Texas Veterans Health Care System (CTVHCS).

2. Description of the conduct of the investigation.

   a. Interviews: The VA OIG Investigators interviewed the complainant and numerous Medical Administration Service (MAS) personnel.

   b. Records review: Performance plans, appraisals and awards, and emails were reviewed.

3. Summary of the evidence obtained from the investigation.

   - The complainant explained that VA is required to see a Veteran either 14 days before or 14 days after the desired date. However, if the first available date is more than 14 days out, a report is generated to management showing that VA

was not meeting its goal. In order to meet this 14 day standard, he was trained, at the Austin VAOPC, by Employee 1 and Employee 2, between December 2012 and July 2013, to "zero out" a patient by making the first available date the patient's desired date. Whistleblower would enter the Veterans Health Information Systems and Technology Architecture (VistA) system and, instead of scheduling the Veteran for their appointment, would search for the first available date. After locating the first available date, Whistleblower would inform the Veteran about the date. The Veteran would agree with the first available date, and Whistleblower would then log that date as the desired date. Whistleblower was never instructed to continue this practice in San Antonio, TX. Whistleblower assumed that San Antonio management wanted him to continue the practice at their facility, as well.

- The Lead Clerk for the Austin VAOPC admitted that for a 3 to 6 month period in 2011-2012, she would document a patient's desired date in close enough proximity to the appointment date to not go past the 14 day requirement, regardless of what the true desired date was. He indicated that a VA employee would provide her with a list of VA patients and the time between their desired date and the appointment date. If the time was over 14 days, the employee instructed her to "fix it." She never asked the employee what he meant by "fix it." She would go into the appointment system and then reset the patient's appointment for the same appointment date, but with a desired date that was within the 14 day time frame. The employee told her on one occasion not to have the desired date and appointment date on the same day because it would look like they were "gaming the system." She never thought she was doing anything wrong. The practice of manipulating the desired date ended just prior to moving into the new Austin VAOPC building.

- The employee who allegedly spoke to the Lead Clerk denied ever providing a list or spreadsheet to any VA employee and instructing them to change the desired date to comply with the 14 day timetable. He indicated there were other ways to schedule patients by overbooking and placing them in open administrative slots. He was aware of a practice, when he was a clerk, of making the desired date fall within the 14 or 30 day timetable, regardless of what the patient's true desired date was. He also stated that he could not provide a list or spreadsheet of patients to clerks because he did not have access to that type of report in the system. He said that he was never taught anything from VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*. This employee has since retired from Government service.

- A Management Analyst, Mental Health Product Line, San Antonio VAMC stated that a potential scheduling error is defined as a desired date which is equal to the create date. The potential error is forwarded to the scheduler to see if the patient actually wished to be seen on that particular day. She denied that the potential scheduling error spreadsheet was a mechanism for schedulers to manipulate a

patient's desired date. She also denied instructing the complainant to manipulate patients' desired dates or wait times.

- A Management Analyst, MAS, San Antonio VAMC stated that STVHCS utilizes the EWL if it is necessary. MAS schedulers are trained to not utilize the "next available date" function in VistA. Schedulers must receive a specific date or range of dates from providers. The desired date is established by the patient, while monitoring the date or dates the provider has indicated they wish to see the patient. Prior to 2009, San Antonio VAMC did have problems with schedulers making patients' desired dates the first available date. She denied having instructed any employees to manipulate a patient's desired date. She stated that lying about the wait times would not help a clinic because the data would not accurately reflect if there was an access issue. She explained that a scheduling error is when the created date equals the desired date. MAS sends out scheduling error spreadsheets to supervisors so clerks can review the appointment to make sure a potential scheduling error has not occurred.

- A Supervisor, MAS, North Central VAFC and a Lead Medical Support Assistant, MAS, North Central VAFC stated that schedulers should not change a patient's desired date. The EWL is not utilized at North Central VAFC because there is no need to use the EWL. Both denied instructing the complainant to manipulate patient appointment information. The complainant spoke with the Supervisor, MAS on one occasion about "the zero," but she was confused by the conversation because schedulers do not get in trouble for scheduling patients outside the 14 days.

- A Supervisor, MAS, Austin VAOPC, stated that she did not conduct training for the schedulers. She requested assistance in training schedulers from the Temple VAMC, but her request was denied. Until recently, little to no scheduling training and/or manual resources was available for schedulers to follow. On the whole, it was her assessment that the Austin VAOPC did not have enough providers for the number of patients that needed to be seen. Austin VAOPC schedulers used the provider date in the Return to Clinic Order as the patient's desired date. She stated that an Administrative Support Assistant, Austin VAOPC did have a list of appointments that had a wait time that was over 14 days that he would instruct schedulers to "fix."

- A Former Supervisor, MAS, Austin VAOPC, stated that he filed an administrative grievance with Employee 3 , CTVHCS, regarding what he perceived to be a lack of training and guidance on how to properly and accurately schedule patients at the Austin VAOPC. He admitted that Austin VAOPC schedulers did make the patient's desired date the first available date but did not know that it was wrong to schedule that way. He felt that he was never properly trained to schedule and noted that there were not enough providers at the Austin VAOPC.

- An MAS employee at the Kerrville VAMC, from 1996 to April 2014, told us that she was instructed to make patient wait times equal zero at the Austin VAOPC by supervisors Employee 4 and Employee 5 . She also stated that she was taught how to manipulate the desired date by Employee 4 and Employee 6 .

- The Chief of Health Information Management Services (also known as MAS), San Antonio VAMC, indicated that a spreadsheet is created to monitor scheduling errors. One type of scheduling error is when the create date and the patient's desired date are the same day. This is a scheduling error for two reasons: 1) it appears in the system to be an emergent care scenario, and 2) the scheduling system will default to today's date if the scheduler does not input anything for the patient's desired date. The spreadsheets are forwarded to the appropriate supervisors, and then to the schedulers, to verify that the appointments are correct. The emails that were previously sent out may have confused the schedulers because supervisors were not explaining what the schedulers needed to do. He stated that he has never denied the use of the EWL. The San Antonio VAMC uses the EWL, but only sparingly. He also stated that it is difficult to provide oversight to groups of schedulers who are not within his chain of command (referring to non-MAS schedulers). He confirmed that STVHCS has 491 individuals who have scheduling keys. Of the 491 individuals, 223 are MAS employees, and 268 are considered non-MAS schedulers who report to other service lines.

- An MAS employee with the VA Dental Clinic in San Antonio stated that he was trained by a former VA employee to make the desired date the first available date. He indicated that he was not aware it was wrong to schedule patients that way until he took the Talent Management System (TMS) online training in May 2014. He also stated he was not surprised he was not properly trained because the former employee would take short cuts."

- A Medical Support Assistant, Mental Health Clinic, North Central VAFC, denied that he has ever made a patient's desired date the first available date. And that he ever falsified a patient's desired date to reduce wait times. He stated that he understood that a scheduling error was defined as the patient's desired date and the appointment's create date was the same. He also understood that he might have made scheduling errors because he was scheduling too quickly and hit the wrong keys. He has never been trained on the EWL and has never had to use one. He believed that schedulers who were incorrectly reporting patient's desired dates were not properly trained.

- The Lead Clerk, Austin VAOPC, admitted she had previously made the patient's desired date the first available date. She stated that she first learned she was scheduling wrong a few months prior to the interview. She no longer schedules in that manner and if she had known it was wrong to schedule patients that way, she would never have done it.

- A Medical Support Assistant, Austin VAOPC, admitted to making a patient's desired date the first available date in 2012. He had read VHA Directive 2010-027, and admitted the directive was not followed by his supervisor at the time. However, he did not directly identify the individual who instructed him to change the desired date to the next available date.

- A Medical Support Assistant, Austin VAOPC, admitted to making the patient's desired date the first available date in order to zero outpatient wait times. He stated that that process of scheduling was utilized at the Austin VAOPC from 2008 to 2013. He was never aware that scheduling that way was wrong and, if he had known it was wrong, he would not have scheduled that way.

- A Medical Support Assistant, MAS, San Antonio VAMC, admitted that when he first started as a scheduler, he was recording the desired date from patients correctly. He stated there was a "list" that came out showing that his patient wait times were extended. He was approached by his supervisors, regarding his extended wait times. He was also approached by his lead clerk, who instructed him to make the patient's desired date the first available date. He was not aware if the list he was on was called a scheduling error list. He denied that he was on the list because his create date and desired dates were the same day. He stated that he was on the list because of the extended wait times. He also admitted he began to utilize the first available date as the patient's desired date because he did not want to be removed from his job.

- Another Medical Support Assistant, MAS, San Antonio VAMC, stated that when he first began scheduling, he did not know what a desired date was. He would schedule patients according to when the provider wished to see the patient. He said that he was not adequately trained as a scheduler when he first began scheduling. In 2011, he was scheduling appointments so that the patient's desired date was the first available date. He received a list of appointments that he was instructed to reschedule from his lead clerks, Employee 7 and Employee 8, and was instructed to reschedule the appointments on the list, which he had previously scheduled. He did not understand what the problems with the appointments were but claimed the "days don't match." He was unable to explain what he meant by the "days don't match" but believed it had something to do with wait times.

- An Administrator Officer of the Day, San Antonio VAMC, admitted that there was a time when the patient's desired date was not the date they wished to be seen, but was the first available date. In 2005, she was originally trained in TMS to make the patient's desired date the first available date. She explained that a scheduling error was when the create date and desired date were the same day. She denied that the scheduling error was based on wait times. She further stated that scheduling errors were corrected so that the desired date was equal to the appointment date. She did not believe a scheduler would lose their job if they had multiple scheduling errors; rather that scheduler would be retrained.

- A Supervisor, MAS, San Antonio VAMC, stated that she learned how to schedule in 2007 from Employee 7, Lead Clerk, MAS, and Employee 9, Supervisor, MAS. When she first learned to schedule in 2007, she was taught to make Wait Time Two equal zero by scheduling a patient's desired date on the first available date. She explained that if the wait time was too long then her name would be reported on a list and she would be contacted by either Employee 7 or Employee 9 to fix the error. In order to make sure her name was not on the list, she would make the wait time equal zero. She further explained that desired dates were not an issue when she began scheduling in 2007. When she returned to scheduling in 2013, she learned that she had been taught to schedule incorrectly in 2007.

- A Lead Clerk, MAS, San Antonio VAMC, stated that she has been a scheduler since April 2000. She recalled a VA training video on scheduling which taught schedulers how to locate and schedule patients on the first available date by going in and out (of the VistA scheduling system). She would enter into the system and input "T" to look up appointments beginning "today." From there, she would locate the first available date and communicate that to the patient. If the patient was able to come in on that day, she would exit the VistA scheduling system and then log back in then input the first available date, which the patient agreed to, as the patient's desired date. She would then book the appointment on that day. She also was instructed to make Wait Time Two equal zero. If a scheduler did not make Wait Time Two equal zero, that appointment would appear on a list, and supervisors would instruct schedulers to fix the appointment. She was not aware if anyone had been disciplined for not "fixing" the appointments that appeared on the list. She admitted that when she became a lead clerk, she taught other clerks how to make the patient's desired date the first available date. She did not know she was doing anything wrong by scheduling that way. The EWL, while frowned upon, is used when necessary.

- A Program Analyst, MAS, San Antonio VAMC, stated that he was employed as a scheduler from 1993 through 1998. In 2009, he returned to VA and has served as a scheduler, lead clerk, and supervisor. In 2009, to schedule a patient, he would locate the first available date for the patient and see if they desired to be seen on that day. If so, he would then go back out of the system and log back in, making the patient's desired date the first available date and schedule the patient on that day. He stated he would not ask the patient when they wished to be seen because that was not how they were trained to schedule. He was trained to tell the patient what the first available date was and to work to find the patient an appointment day that worked with their schedule. He recalled receiving scheduling error spreadsheets but denied that they had anything to do with the wait time. He explained that scheduling errors were appointments in which the created date was equal to the desired date. If a scheduler used "T" to search the availability and did not go back out of the VistA scheduling system once they located the first available date and scheduled the appointment, those

appointments would be scheduling errors because searching using "T" would make the desired date equal "today," which would also be the created date of the appointment.

- A former MAS Supervisor, San Antonio VAMC, denied ever instructing an employee to manipulate patient appointment data.

- A Lead Clerk, MAS, Austin VAOPC, stated that In 2008, she attended a 1-week training course for schedulers in Temple, which consisted of classroom training, PowerPoint presentations, and mock scheduling. She was trained to make the patient's desired date the first available date. Some schedulers continue to make the patient's desired date the first available date out of habit, because that is how they were originally taught to schedule. In 2008, the official training was that the EWL was never to be utilized because everyone could be scheduled. In 2008, schedulers were not even trained on how to utilize the EWL. Today, the EWL is only for new patients. In 2009 or 2010, the Austin VAOPC schedulers were made independent of MAS Temple. She stated that training got worse at that time.

- A Patient Advocate, Austin VAOPC, admitted that there was a time when there were problems with schedulers zeroing outpatient wait times. When the Austin VAOPC separated from the Temple VAMC's MAS and became independent, it was difficult for Employee 4 to monitor her staff. He believes that schedulers could become confused over how to properly schedule. MAS schedulers are not the only VA employees who can schedule patients. Many of the different service lines also have their own schedulers who report directly to non-MAS supervisors and chiefs. He stated that training could be better for the non-MAS schedulers. Centralizing scheduling would ensure that all schedulers are receiving the same training and being monitored. He doubted that service line chiefs and supervisors were properly monitoring how their schedulers were actually scheduling patients.

- An Administrative Officer, Health System Specialist, Mental Health Product, San Antonio VAMC, stated that she never knew that her schedulers were making patient wait times equal zero. When she became the AO in November 2011, she was aware that schedulers were not correctly capturing patients' desired dates. She held multiple trainings with the employees in an attempt to correct "bad habits". She never instructed her employees to incorrectly make patient wait times under 14 days. A scheduling error is when the desired date equals the create date. She recalled the scheduling error emails from MAS which referenced the directive. She admitted that the concept of scheduling errors seemed to confuse schedulers. She stated that there is pressure to get patients seen in a timely manner, but there is no pressure to manipulate the data.

- Employee 10, Director, STVHCS, stated that STVHCS has MAS schedulers and schedulers that are non-MAS, who report to clinical services. Employee 10 stated

that there has always been some level of confusion regarding how to schedule patients. Scheduling is a complicated and confusing process that is not clear to either the administration or front line schedulers. She has never been threatened that she could lose her job if the patient wait time metric was not met. For her Fiscal Year 2013 performance appraisal, the patient wait time metric was such a small portion of the criteria evaluated that not meeting the goal would not have shifted her overall rating. She has never instructed anyone to zero out wait times or to make a patient's desired date the first available date. Knowing how far out a clinic is scheduling is a better indicator of access rather than the desired date. The desired date is a movable date, but looking at how far out the first available date is for a clinic is a more reliable gauge for access. She relies on data in order to make decisions about resources. Without accurate data, she is unable to make informed decisions about where the real issues are. She denied that she ever told anyone that the EWL is not allowed to be used, even if there is a justified reason.

- Multiple performance appraisals, self-assessment, and rating narratives were reviewed. For a limited number of schedulers, lead clerks, supervisors, and chiefs, there were goals or metrics associated with patient wait times. A review of bonuses and awards associated with multiple VA employees did not reveal any evidence that a VA employee was provided an increased performance rating or a bonus for patient wait times.

- A review of VA employee email data for VA facilities in San Antonio and Austin, did not uncover any emails from any VA employee which indicated an individual or group of individuals were being instructed to manipulate or falsify patient appointment data.

- No employee was aware of a current hard copy or separate patient waiting list. Additionally, they were never instructed to destroy any documentation related to patient appointment data. Numerous employees opined that there was no malicious intent by any employee to defraud or mislead anyone regarding wait times. Many individuals indicated problems with scheduling ranged from improper training, lack of supervision, to non-centralized scheduling.

- A spreadsheet of appointment data titled 4DD-309HU Texas Appointments 671 674 674BY which was provided by the VA Office of Inspector General, Investigative Data Systems and Analysis Division was reviewed. The spreadsheet contained appointment data including schedulers' names, patients' names, clinic names, created dates, desired dates, and appointment dates. The appointment data contain a random selection of days from January 1, 2011 to January 1, 2014. Almost all schedulers and clinics associated with 674BY (Austin VAOPC) had zero wait times. Almost all schedulers and clinics associated with 671 (San Antonio VAMC, North Central VAFC, and Frank Tejeda VAOPC) had wait times that equaled zero (Attachment 101). For a wait time to equal zero, the desired date had to be the same date as the appointment date.

In multiple instances, for a variety of clinics, many schedulers had created dates 1 or 2 months prior to the desired date with a zero wait time.

4. A listing of violations or apparent violations of law, rule, or regulation.

The investigation revealed that MAS and non-MAS schedulers were utilizing the first available date as the patients' desired date when making appointments for VA medical care. Review of patient appointment data for facilities in San Antonio and Austin revealed that the improper scheduling was systemic and was not limited to a particular clinic or supervisor. The investigation did not reveal any VA employee receiving a bonus or award specifically related to patient wait times. The investigation did not reveal any clinic that was instructed not to utilize the EWL when it was necessary to use one. Based on testimony, it appears that the problems were identified and resolved around May 2014.

5. A description of any action taken or planned as a result of the investigation.

No action was taken or is planned to be taken because the practice seemed to be widespread and due to lack of proper training and other causes, such as the decentralization of scheduling. In addition, there was insufficient evidence to support action against any current employees.